

Greater Manchester Health and Social Care Strategic Partnership Board

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Date: 28 July 2017

Subject: Mental Health Transformation – Next Steps

Report of: Warren Heppolette, Executive Lead, Strategy and System Development, GMHSC Partnership

SUMMARY OF REPORT:

The paper outlines the approach to ensure the full implementation of the GM Mental Health Strategy. It recognises progress against the objectives of the strategy to date and the significant work still to take place. The paper outlines a broad investment framework for the implementation of the strategy. This framework blends locality level resources as part of GM's collective commitment against the Mental Health Investment Standard and a financial envelope proposed to be secured from the Transformation Fund.

The paper recognises the challenges facing mental health service access currently for GM residents and outlines our key performance deficits. It also considers the implications for commissioning mental health following the GM Commissioning Review and the opportunity of the new care models developing in localities and across GM.

KEY MESSAGES:

This represents a historic statement of intent, backed by investment, to radically improve the mental health and wellbeing of GM residents.

Our aims are that:

- We will better connect public services, communities and individuals to improve mental wellbeing and life chances.
- We will secure key gains in access to a good range of mental health services.
- We will eliminate the current fragmentation of services and improve the experience of service users through the system.
- We will use our Partnership to agree the standards which underpin the quality of care provision and have agreed, measurable and defined outcomes.

- We will seek to improve public attitudes and behaviour towards people with mental health problems and reduce the amount of stigma and discrimination that people with mental health problems report in their personal relationships, their social lives, at work and also in their treatment within the services.

There has been no part of the GM system from health and care commissioners, NHS providers, service users and carers, VCSE partners and wider public services which has not been involved in the production of the strategy, the work to date and the development of the proposed next steps.

PURPOSE OF REPORT:

This paper outlines the approach to ensure the full implementation of the GM Mental Health Strategy. It proposes the investment framework to underpin the implementation of the plan for the next 4 years.

RECOMMENDATIONS:

The Strategic Partnership Board is asked to:

- Note the progress which has been made against the GM mental health strategy over the past year;
- Agree the proposed mental health transformation areas and the investment framework providing an overall envelope of £133.9m;
- Support the onward process to work with localities to support their local investment and transformation plans for mental health;
- Support the onward process to develop business cases against which transformation funding for the GM mental health programmes can be allocated; and
- Support the further work to apply the findings of the GM Commissioning Review to the future commissioning of mental health in localities and across GM.

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1.0 INTRODUCTION

1.1. This report outlines the investment and implementation framework, including the proposal to the transformation fund, to deliver the Greater Manchester (GM) Mental Health (MH) and Wellbeing Strategy and GM commitments aligned to the NHS England's Five Year Forward View for Mental Health (5YFVMH). Agreement and endorsement of the proposal is sought from the Strategic Partnership Board Executive.

1.2. The report will cover the following areas:

- Mental health (MH) in GM, the background to the HM MH & Wellbeing strategy
- Progress that has made against the GM MH & Wellbeing strategy since it was published in February 2016
- An outline of the proposed GM MH transformation work areas and an indication of the overall investment required
- The investment framework for MH
- The implications of the GM Commissioning Review for MH commissioning
- Next steps to maximise digital capabilities to improve MH in GM
- The approach towards implementation of the GM MH strategy and next steps to develop further understanding of the investments in MH and support required at locality level.
- Performance on mental health across GM

2.0 OVERVIEW

2.1. The GM devolution agreement has provided an unprecedented opportunity to address challenges to improved MH and wellbeing in GM. GM has a strong track record of collaboration with all key stakeholders, in particular between NHS commissioners, local authorities and business. By building on these partnerships and working more closely with the third sector, service-users and carers, it will be possible to draw on the many resources and insights that already exist to promote and improve MH. By working together, breaking down artificial and bureaucratic barriers, organisations will be able to provide integrated care to support mental, social and physical wellbeing and improve the lives of those who need most help.

2.2. We are clear that the transformation in mental health care and support, and outcomes, is a key contributor to the long term sustainability of the health and care system and the success of GM as a place. Economic benefits are associated with early intervention; e.g. early intervention services that provide intensive support for

young people experiencing a first psychotic episode can help avoid substantial health and social care costs: over 10 years perhaps £15 in costs can be avoided for every £1 invested.

- 2.3. Mental illness can seriously affect the lives of individuals and families. People with mental health problems are far more likely to experience physical ill health and those with serious mental illness are likely to die 15-20 years earlier than those without. Health costs for people with long-term conditions are at least 45% higher if they also have a mental health problem. Employment rates in GM for people with severe mental illness (SMI) are below the national average and sickness absence across the workforce is high. Common mental health problems (for example, anxiety, stress and depression) are now the most frequent reason for people needing time off work.
- 2.4. This package starts to rebalance the levels of investment in mental and physical health and seeks specifically to tackle those areas in most urgent need of support – the provision of reliable crisis care for children and young people, support to new mothers and the delivery of physical health checks and health improvement support for people with serious mental illness.
- 2.5. The quality of mental health care across GM has seen improvements in recent years. Skilled and committed front-line staff and the development of community-based services and widespread integration of health and social care has meant that fewer people need access to inpatient care and the number of inpatients dying by suicide has reduced. However, much still needs to change to meet the needs of individuals and communities.
- 2.6. Unless action is taken to address poor mental health in GM, it will not be possible to build a future where there are increased opportunities, economic prosperity and sustainability of the health and care economy in GM. Addressing MH and wellbeing and building resilience are crucial to unlocking the power and potential of individuals and communities.
- 2.7. Within GM, MH and wellbeing is seen as a whole system issue requiring a whole system response. To address this, the GM Health and Social Care Partnership (GMHSCP) agreed a single GM wide MH and Wellbeing Strategy in January 2016, for launch in February 2016. The strategy set out our collective ambition and focused on shifting the balance towards early intervention and prevention, improving access and providing integrated, sustainable services that support the whole needs of the individual. The strategy highlights 32 strategic initiatives which incorporate the national priorities set out in the 5YFVMH. However, it does go further to address key challenges to GM, particularly around employment, suicide prevention and the resilience of communities.
- 2.8. Significant progress has been made against the year 1 priorities of the GM MH and Wellbeing strategy. Despite the progress to date, further work is needed if we want to make sustainable, system wide change and address historic underinvestment and areas of poor performance in MH.

- 2.9. Funding for transforming MH services comes through 2 routes. The first, totalling £77.6m is through additional monies that have gone directly into CCG baselines to support their commitments to deliver the 5YFVMH. A detailed process is underway to look at how we can support realignment of existing funding streams (in CCG and LA baselines) to the agreed priorities of the GM MH and Wellbeing strategy and locality plan objectives. The second route of funding to transform MH services, totalling £56.2m, is through GM Transformation Fund, which will support the commitments already made at locality level to invest in MH. Together these two funding streams will generate a **single investment framework** for transforming MH and wellbeing in GM.
- 2.10. In developing the investment framework a significant amount of engagement across the GM system has taken place. There have been individual discussions with all localities and a specific engagement session with stakeholders from health and social care organisations across GM. This has shaped the content and understanding of investment requirements and the impact this will have on transforming services.
- 2.11. Key priorities for investment have been identified for a number of reasons. These are because they may be an area of historic underinvestment, poor performance, central to achieving sustainability of the health and social care economy and they have been highlighted by the wider system and service users as the right areas to invest financial resource.
- 2.12. Each key priority for investment that has been proposed also sets out whether this should be commissioned and coordinated at a GM or locality level. The commissioning level attributed to each investment has been selected because geographically this appears to be the most suitable mechanism for delivery. The decision has also been informed by the level of existing provision and variation in service outcomes.
- 2.13. We have also recognised that related investment in MH and wellbeing will also be through other connected areas of work such as through locality plans, elements of the GM Population Health strategy and the transformation funding awarded for the delivery of the GM Dementia United strategy.
- 2.14. Any new proposals to commission MH services either at a GM or locality level will need to be cognisant of the GM commissioning review and take its recommendations into account. There is also the requirement to focus on the enablers of care, in particular the use of digital technology and capabilities to improve service delivery and service user and carer experience.
- 2.15. Further information will be brought forward for approval at a later date that set out the detailed business cases for the proposed pan-GM activities and investment plans on MH at locality level.
- 2.16. An overview of the proposed workstreams and attached funding is given in the table below:

Ref	Investment Priorities	Overview	Key Projects	Budget
Mainstream, Locality Funding				
1	GM CCG and Locality Baselines Funded Programmes	MH must do's: mandated programmes of work set out in the 5YFVMH that Localities are committed to deliver FYFV national programme outcomes	<ul style="list-style-type: none"> • Treatment Access - Additional psychological therapies • High quality MH services - CYP IAPT • Expand Capacity – Psychosis treatment • Individual Placement Support into Secondary Care – Severe mental illness • Referral to Treatment - Community Eating disorder teams • Eliminate Out of Area Placements for non-secure for non-specialist acute care • Reduce suicide rates • Increase baseline spend on MH to deliver MH Investment standard • Dementia diagnosis rate/post diagnostic care & support • MH Access & Quality standards – 24/7 access to community, home & liaison teams 	Up to £77.683m
Transformation Funding				
2.1	CCG Locality Plan Support	Will support the delivery of the 5YFVMH and GM MH Strategy through locally sensitive additional resource	<ul style="list-style-type: none"> • Enhanced Adult Crisis & Urgent Care programme options - • Integrated IAPT/Primary Care RAID programme 	Up to £10.800m excluding MMH £4.0m + and slippage in 2.2 & 2.3
2.2	GM Coordinated Programmes: Other transformation programmes	Delivered through the Theme 1 Population Health Work Stream of the GM 'Taking Charge' Strategy and other Transformation Boards	<ul style="list-style-type: none"> • Suicide prevention, overcoming MH stigma and Supporting Communities of Identity • Work & Health across the life course • Dementia United • Health & Justice 	Up to £6.800m

2.3	GM Coordinated Programmes: Mental Health	Projects to deliver 5YFVMH and GM MH Strategy	<ul style="list-style-type: none"> • 24/7 Community-based access and Crisis Care (children and young people) • GM iThrive Network and CYP MH Workforce development (NHS, LA and VCSE) • Improving mental wellbeing, building capacity and resilience of communities (including schools) • GM Perinatal and Parent-Infant mental health • Liaison Mental Health – Core 24 access GM 	Up to £34.625m
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3.0 PROGRESS AGAINST THE GM MH & WELLBEING STRATEGY TO DATE

3.1. The GM MH and Wellbeing strategy was supported by the GMHSCP Board and has received strong commitment from colleagues working across localities and at a GM level since it was launched in February 2016.

3.2. The strategy prioritised the following activities for years 1 and 2:

- Suicide prevention
- Work, health and employment
- 24/7 mental health and 7 day community provision for children and young people
- 24/7 mental health and 7 day community provision for adults including embedding the Crisis Care Concordat
- Integrated place based commissioning and contracting aligned to place based reform
- Integrated monitoring, standards and key performance indicators across mental health services
- Redesign of the provider landscape

In addition to the points listed above, Dementia United, improvements to Attention Deficit Hyperactivity Disorder (ADHD) services for all age groups and Eating Disorder services for children and young people were also prioritised.

3.3. Since June 2016, a MH Implementation Executive has been in place which has been independently chaired by Steven Michael (formerly Chair of the National Mental Health Network and Foundation Trust Chief Executive). This independent chairing has been essential for bringing commissioners, providers (including VCSE)

and GM Healthwatch from across the system together, developing relationships and creating an environment which facilitates collaborative working.

- 3.4. The MH Implementation Executive has been fundamental in turning the priorities set out in the GM MH strategy into an initial set of key workstreams, providing leadership and identifying Senior Responsible Owners and key individuals within the system to deliver the strategy. It has also been providing expertise, guidance and sense-checking on proposals for the development of a dashboard for measurement of MH performance across GM and this proposal to the transformation fund. The workstreams currently under the MH programme are at different stages of development.
- 3.5. To date under the Children and Young Peoples (CYP) MH working group, a single GM specification for ADHD and Eating Disorder services has been developed and put in place. A model for CYP community-based crisis care response and support has been drafted too. In addition, a collaborative Tier 4 Children and Adolescent Mental Health (CAMHS) provider alliance has been established and work to introduce the iTHRIVE model (a framework for supporting children and young peoples' mental wellbeing) across localities has already been initiated.
- 3.6. The Strategic Clinical Network (SCN) have also set up a GM network for Perinatal and Parent-Infant MH and drafted a model for greater provision of this across GM.
- 3.7. Under governance of the Crisis Care working group, the principles set out in the [Crisis Care Concordat](#) have been embedded across GM with the development of a Crisis Care Concordat performance dashboard completed. A cost-benefit analysis has been undertaken on The Sanctuary service (a place that provides adults experiencing MH crisis a space to find support) has been undertaken. This has demonstrated that the current Sanctuary model will need revising to increase its effectiveness and sustainability. Funding for a police control room triage service which employs mental health nurses to support frontline police offices has been agreed between Clinical Commissioning Groups (CCGs) and the Greater Manchester Police and Crime Commissioners office (GMPCC). Reducing the numbers of people in police custody needing a place of safety during a mental health crisis (section 136) has been a continuing priority and at 1%, the rate is 5 times lower than the rest of England & Wales.
- 3.8. Under the Suicide Prevention working group, a GM strategy has been launched with leadership provided by Rochdale's Director of Public Health. An audit of completed suicides from 2015 has been undertaken and the draft findings reported, to support improved data collection and formulating action plans to reduce suicide across GM.
- 3.9. For Work and Health, an effective Working Well programme is in place across GM, which includes a talking therapies service and caseworkers. Plans are in place to extend this programme using a 5 category population model which identifies gaps in support for people

- 3.10. GMHSCP colleagues provided strong support to the merger between Greater Manchester West (GMW) and the Manchester Mental Health and Social Care NHS Trust (MMHSCT). This transaction was completed in 2016 and the new Trust was formally established on 1 January 2017. Service improvement programmes in line with MH priorities are in place across the new Trust to transform the city's services.

4.0 MENTAL HEALTH INVESTMENT FRAMEWORK

4.1. The outcomes we are committing to deliver

- 4.1.1. The GM MH and Wellbeing strategy was developed at the same time as NHS England's 5YFVMH was being developed and incorporated the 'must do' priorities set out in the national strategy. GM worked closely with national colleagues to ensure alignment and fidelity to national objectives. However, we recognised and pursued the opportunities to go further and think radically about prevention, early intervention and social prescribing to improve the mental wellbeing of the GM population.
- 4.1.2. The 5YFVMH gives a clear indication to the public and people who use services of what they should expect from mental health services, and when. This includes commitments to improve access to, and availability of, MH services across the age range. It focusses on the development of community services to reduce pressure on inpatient settings, and provide people with holistic care that recognises their mental and physical health needs.
- 4.1.3. We will remain focussed on the impact this has for GM residents and the reliability with which they receive support for their mental health needs. We are making new commitments to residents of GM with this package:
- Making sure everyone in a mental health crisis is able to get immediate support (and that no one ends up in a police cell when they are in mental health crisis)
 - Helping new mums who experience significant mental health problems – babies and children whose mum's suffer poor mental health can be affected through their whole life.
 - Making sure people with serious mental illness have their physical health better looked after – at the moment those people die on average 15-20 years earlier.
- 4.1.4. The changes which this package will secure will mean that over the next 4 years we will ensure that:

4,000 more children will access evidence-based mental health care interventions – including better access for ADHD, eating disorders + those with disabilities	Intensive all-age home treatment will be available in every part of GM as an alternative to inappropriate hospital admissions	No GM acute hospitals without all-age mental health liaison services, and specialist sites all meeting the national 'core 24' service RAID standard + RADAR
At least 1,700 more women each year can access evidence-based specialist perinatal mental health care + additional local parent-infant MH support pathways	30 people fewer or 10% reduction suicides and all areas will have multi-agency suicide prevention plans in place (including acute hospital standards) by 2017	Increased access to evidence-based psychological therapies to reach 25% of need - 33,600 more people helped – primary care and LT condition care pathways
1,600 people with SMI who can access evidence-based Individual Placement and Supported Employment will do so - and GM Work & Health model support	15,000 people with SMI will have access to evidence based physical health checks and interventions – targeting smoking and obesity	60% people experiencing a first episode of psychosis will access NICE concordant care within 2 weeks
Inappropriate out of area placements will be eliminated for adult acute mental health care - with targeted city-centre action, expanded local GM MH rehab specialist units + GMP/L&D triage	New models of care for tertiary MH will deliver quality care close to home, reduced inpatient spend, increased community provision and new crisis care models for children and young people	Right number of CAMHS/Eating Disorders/LD/Secure T4 beds in the right place – esp reducing the number of inappropriate out of area placements for children and young people

4.2. Confirmation of strategic priorities

4.2.1. We have aligned local, GM and national objectives to inform the proposed priorities of this package. The objectives are organised according to:

- Improving Mental Wellbeing & the Resilience of Communities
- Integrating physical and mental health programmes
- Children and Young People's Mental Health
- Perinatal Mental Health
- Adult Mental Health: IAPT
- Adult Mental Health: Community, Acute and Crisis Care
- Suicide Prevention
- Work & Health

- Health & Justice
 - Older People and Dementia
- 4.2.2. Delivery of these objectives will create a step change in mental health provision across GM. The impact of this delivery will principally be seen in new models of community-based care in localities.
- 4.2.3. Within Local Care Organisations, mental health provision will integrate with services for both physical health and the social needs of individuals, breaking down traditional care silos and making a significant contribution to realising parity of esteem for mental health. Primary care (including Out of Hours services) should form a part of each of the relevant pathways within this programme. There will also be a new focus in primary care on the physical health care of people with severe mental health problems, including psychosis, bipolar disorder and personality disorder. Specifically, new models of enhanced primary care and collaborative specialist care that meets the physical and mental health needs of people with severe mental illness will have been fully trialled.
- 4.2.4. The new care models will also recognise those wider factors impacting on mental health and well-being. Taking a place-based approach, they will align with reformed public services and with the offer from the VCSE sector. The new single commissioning functions will further enable this integration within the 10 localities.
- 4.2.5. Further information on each of the strategic priorities is given below.
- 4.2.6. **Improving mental wellbeing and the resilience of communities:** By improving the capacity of children, young people, adults and communities to deal with difficult emotions and experiences and reducing social isolation people will develop greater confidence and live happier lives.

Resilience and mental wellbeing are developed through activities that promote wellbeing, building social capital and developing psychological coping strategies (MIND & Mental Health Foundation [MHF], 2013). Using the 5 ways to wellbeing model and working across the health and social care, private and in particular the voluntary sector, we will work with GM residents to improve connectedness, levels of activity, encourage learning and opportunities to people to volunteer.

We will progress evidence-based approaches to increase knowledge and understanding of mental health for GM residents. In addition, we will support to public campaigns to tackle MH stigma and promote positive MH and wellbeing.

While improving the mental wellbeing of all GM residents is imperative, to reduce the social gradient in health, we will consider targeted interventions with people at increased risk of poor mental wellbeing such as those from socio-economically deprived backgrounds. We will also consider evidence-based approaches to improve mental wellbeing in people with severe and enduring MH problems.

When setting out detailed plans to deliver this priority it will be essential to engage stakeholders from across the wider system and encourage co-production approaches with localities and communities.

- 4.2.7. **Integrating physical and mental health:** We will start to turn around the appalling truth that people with serious mental illness die 15-20 years earlier than the general problem. So much of this gap relates to the support they receive to improve their physical health. In GM by 2020/21, the ambition is for 15,000 people with SMI to have access to physical health checks which are integrated as part of the care they receive for their mental health. Levels of obesity and in particular smoking, alcohol and substance misuse are much higher in people with SMI. People with SMI are also much more likely to have a long-term chronic condition. This will require the review of services to promote easier access, better continuity of services for people with SMI and to ensure that health and social care professionals have the knowledge and skills to facilitate a better journey for the service-user.

Integrating delivery of physical and mental health care and ensuring people with SMI receive a full annual physical health check will help to address barriers to recovery and aim to reduce demand on acute treatment by addressing physical health problems earlier.

Providing better integration of physical and mental health care for people with SMI can support:

- Reductions in health inequalities (by providing better access to smoking cessation, alcohol and substance misuse programmes and lifestyle support)
- Enable the development of common shared care protocols for prescribing and physical health checks
- Holistic assessment, treatment and ongoing support for people with multiple co-morbidities
- Better end of life experiences

- 4.2.8. **Children and Young People's (CYP) mental health:** In GM we will ensure that by 2020/21 at least 3,920 additional children and young people each year will receive evidence-based treatment, representing an increase in access to NHS-funded community services to meet the needs of at least 35% of those with diagnosable MH conditions.

We will implement delivery of the evidence-based iTHRIVE model throughout GM to support effective delivery of children and young people's (CYP) services. Work will be done to provide further training of the CYP workforce to enable them to embed iTHRIVE into professional practice. There will also be a focus on improving the mental health pathway for CYP and promoting shared learning and system-wide effective responses to adverse childhood experiences. We would include in this support a school, college and university leadership programme which equips senior educational leaders, in small clusters/learning sets, to review their approach to

meeting the MH needs of their school/college and to work through their commissioning plans and training strategies.

The iTHRIVE model will be used as a basis for ensuring CYP support and access is suited to the need of the child or young person and their parents or carers in their particular circumstance. This may mean self-help and library resources for those who require minimal support through to home treatment teams, RAID services, CYP safe spaces and suitable inpatient access.

Currently there is little to no provision for children and young people (CYP) who experience mental health crisis or need more intensive support in the community. Establishing 24/7 crisis care and community provision for CYP will be essential to deliver on the pledges set out in the GM MH strategy and also to deliver the 5YFVMH.

4.2.9. **Perinatal mental health:** By 2020/21, there will be increased access to specialist perinatal MH support in Greater Manchester, in the community or in-patient mother and baby units, allowing at least an additional 1,680 women each year to receive evidence-based treatment, closer to home, when they need it. This will support:

- Community Parent-Infant MH Early Help Hub Programmes
- Developing and Sustaining GM Perinatal Infant MH Model
- GM Integrated Mother Baby Unit - GM Specialist Perinatal MH Teams
- Specialist in-patient/outreach
- Local Parent-Infant MH Early Help/Attachment Programmes
- Extended Fast-Track IAPT Access

4.2.10. **Adult Mental Health: IAPT:** By 2020/21, there will be increased access to psychological therapies, so that at least 25% of people (or 84,000 in GM) with common MH conditions access services each year. The majority of new services will be integrated with physical healthcare and it is intended that 168 new MH therapists are co-located in primary care to maintain quality in services, access and recovery standards across the adult age group. Through this we will build a robust invest to save model for integrating psychological therapies into primary care through GP collaboratives. We also want to increase the number of employment advisors based in IAPT services to support more people with staying in work and getting back into work. IAPT services will cover:

- Core MH IAPT – low and high Intensity (incorporating services for medically unexplained symptoms, co-morbid depression, anxiety disorders and physical long-term conditions)
- Primary Care Rapid Access, Interface and Discharge (RAID)

- Reconfigured secondary care Health Psychology Services
- Targeted action to address lower rates of access and recovery for key groups, including BME populations.

4.2.11. **Adult Mental Health: Community, Acute and Crisis Care:** By 2020/21, adult community MH services in GM will provide timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary care, social care and other sectors. Our ambitions are to achieve:

- At least 60% of people experiencing a first episode of psychosis to be referred and treated with a NICE approved package of care within 2 weeks
- Well established and effective crisis and acute care that includes Crisis Resolution and Home Treatment Teams (CRHTT)
- Significantly reduced Out-of-Area Hospital Placements
- Embedded Crisis Care Concordat principles in all emergency response service across GM
- An established and effective Control Room & Street Triage to support police officers who respond to people in crisis and to provide more suitable alternatives to the use of section 136.
- Better MH support for people who work in the armed forces and military veterans

Liaison mental health will ensure all-age Core-24 compliant support for acute hospitals with 24/7 A&Es and a modified Core-24 service in hospitals with Urgent Care Centres. Implementation and roll out will begin with specialist hospitals to improve early detection and treatment of mental health problems in people with existing physical health problems/ medically unexplained symptoms and people attending acute hospitals in a mental health crisis. The benefits of this are reduced inappropriate inpatient admissions, shorter lengths of stay, fewer delayed discharges and reduced re-admissions.

4.2.12. **Suicide prevention:** We launched our Suicide Prevention Strategy in February 2017. The strategy outlines the actions we will take to reduce the number of people who die by suicide by 10% by 2020/21.

Implementation is underway and will ensure:

- All 10 boroughs (and GM as a whole) will achieve Suicide Safer Communities Accreditation (the 'nine pillars of suicide prevention') by 2018
- Mental Health Service Providers will collaborate to work toward the elimination of suicides for inpatient and community mental health care settings by

continuous quality improvement in relation to 10 key ways for improving patient safety

- We will strengthen the impact and contribution of wider services
- We will offer effective support to those who are affected
- We will develop, train and support our workforce to better assess and support those who may be at risk of suicide
- We will use the learning from evidence, data and intelligence to improve our plan and our services.

4.2.13. **Work and Health:** The GM Employment & Health Programme will support the integration of health, skills and employment systems to enable delivery of improved health outcomes and economic growth as set out in the Greater Manchester Strategy and the GM Health and Social Care Strategy.

The programme objectives will create a system response to ensure:

- An effective early intervention system available to all GM residents in work who become ill and risk falling out of the labour market
- Early intervention for those newly out of work who need an enhanced health support offer
- Better support for the diverse range of people who are long-term economically inactive
- Development to enable GM employers to provide 'good work', and for people to stay healthy and productive in work

4.2.14. **Health and justice:** GMHSCP and the GM Mayor have undertaken a first joint procurement for two key services: an integrated Policy Custody Healthcare Service and a Liaison and Diversion Service for Greater Manchester.

People of all ages who commit, or are suspected of a crime, will have a health assessment while in custody and those with mental health, learning disabilities, substance misuse or other vulnerabilities will be identified as soon as possible and then supported to access appropriate services.

These two services have historically been commissioned separately, but by bringing them together, service users will be supported faster, streamlining the way they are assessed. The information gained will be shared with relevant Youth and Criminal Justice agencies to enable more informed decisions on how to improve their physical and mental health, with the aim to reduce reoffending.

4.2.15. **Older people and Dementia:** At least two-thirds of those with dementia will have a formal diagnosis and access to appropriate post-diagnostic support. Unwarranted variation in diagnosis rates and post-diagnostic support between localities in GM

will be reduced. By March 2020/21 people with suspected dementia can expect to receive a diagnosis within 6 weeks from referral. By March 2020/21 people who are newly diagnosed with dementia can expect to have a named coordinator of care, a care plan, and at least one annual review of that care plan. Our objective is to make GM the best place to live in the UK for dementia care.

Dementia United is the five-year, GM-wide dementia strategy and support programme aligned to the Living Well with Dementia pathway. The direction and support it offers will enable GM to meet the Dementia United standards, build on work that is already taking place and develop a campaign and platform for improvement. It will be delivered through key partnerships, listening to the voice of people with dementia and those who care for them, and offering the opportunity to have a 'big conversation' across GM.

Dementia United is made up of 4 work priorities designed to help localities improve their dementia care.

- Priority 1: Locality delivery – describes the delivery system within localities
- Priority 2: Regional support – describes the regional support architecture
- Priority 3: Intelligence – describes the infrastructure for intelligence
- Priority 4: Innovation, research and evaluation

This structure gives GM a clear roadmap for what it wishes to achieve and marks a move from focusing on diagnosis to focusing more broadly on the experience of care, post-diagnostic support and health and social care utilisation.

Over the course of the five-year programme we expect to achieve 222,000 fewer hospital bed days and 72,000 fewer permanent admissions to residential care as people are supported to stay well and at home. We also want to see clear reductions in the inappropriate prescribing of antipsychotic medication and fewer demands on the police because people with dementia have gone missing.

5.0 THE APPROACH TO INVESTMENT

- 5.1. New models of care, health and social care integration and devolution all present opportunities to improve how mental health services are commissioned and funded, such as moving towards population-based commissioning and personal budgets. However, the risks associated with ambitious new systems must be carefully managed. A focus on mental health, and keeping up levels of spending, must be maintained, despite the challenging financial circumstances.
- 5.2. The implementation of the GM MH strategy and the commitment to GM residents is underpinned by significant additional transformation funding but this is not the only investment in mental health services. GM transformation funding builds on both the foundation of existing local investment in MH services and the ongoing requirement – repeated in the 2016/17 NHS England planning guidance – for CCGs to increase

baseline investment by at least the overall growth in CCG allocations – and improve Right Care outcomes. We should emphasise that this investment capability rests on our having secured transformation funding and the strong financial management of the GM system in ensuring that funds can genuinely be protected for transformation. The reversal of that investment capability remains a constant threat.

- 5.3. Additionally, the implementation of locality plans will support the implementation of new models of integrated care through Local Care Organisations (LCOs), and locality ambitions to extend approaches to prevention, early help and asset and community based approaches to improving health. In each case locality plan investments will support our comprehensive mental health & wellbeing ambitions.
- 5.4. This blending of mainstream and GM Transformation Fund investment is essential to maximise the shift in resources to improve MH. Through the commissioning review we have also identified specific programmes where there is a clear rationale for GM level co-ordination and delivery

The Mental Health Investment Standard and Delivery Priorities

- 5.5. The government has provided new monies into CCG baselines to support delivery of the 5YFVMH. This new CCG investment is not seen in isolation and should not be used to supplant existing spend or balance reductions required elsewhere but will focus on delivering 10 local delivery priorities:
 - Expanded service capacity – with full implementation of new access and waiting time standards for adult psychological therapy and Early Intervention in Psychosis, with further standards for other mental health services over the next five years
 - Extended access to psychological therapy services, especially for people with long-term physical conditions (e.g. asthma and diabetes)
 - Expanded high quality all-age MH services – with a priority on CYP IAPT, Community Eating disorder teams and eliminating Out-of-Area admissions and placements for non-secure or non-specialist acute care
 - Delivery of key MH access and quality standards – Improved crisis care, including the provision of 24/7 Crisis Resolution and Home Treatment (CRHT) services in all local areas and liaison mental health services in community, home & all general hospitals
 - Improved support for new mothers and fathers with mental health problems, during pregnancy and in the year after giving birth
 - Better help for the physical health of people with a severe mental illness, for example improved access to smoking cessation services
 - Doubling the provision of Individual Placement and Support for people using mental health services who want help with employment

- Reducing suicide rates
- High rates of dementia diagnosis with adequate post diagnostic care and support
- Increased baseline-spend on MH and a 'data and transparency revolution' to ensure better information is available about spending on mental health care in local areas.

5.6. As the national planning guidance makes clear in a number of areas, successful implementation of the 5YFVMH is dependent upon establishing services which are sustainable for the long-term. That sustainability is predicated on evidence which shows the savings realised across the health and care system outweigh the investment needed to deliver services. In order to ensure that this fundamental economic case is met, it will be critical for local organisations across GM to agree how they will share both the costs of investment and the proceeds of savings and efficiencies. This will include how savings will be identified, especially where they accrue in other areas of the health system, and require reinvesting into mental health services.

5.7. The majority of new funding over the period is included in CCG baselines to support delivery of Local Transformation Plans and achievement of the 5YFVMH objectives. Work to understand current GM locality investments in MH was carried out in line with the national 5YFV planning guidance. All GM CCGs have confirmed planned increases in MH funding 2017/18 at least in line with the required minimum requirement of the Investment Standard – that is 2.8% average. This means that they have committed to at least ensure a rise in MH investment in line with the relative increase in CCG funding allocations. This represents the largest proportion of investment in the standards and objectives outlined in this paper.

5.8. The specific required additional 5YFVMH funding has been profiled to increase CCG allocations over time to support transformation and plan for recruitment of the additional workforce required, as set out in the indicative table below.

Locality Committed Additional Baseline CCG Net Investment (£ to support local 'must do' MH FYFV delivery options)					
Investment Area	2017/18	2018/19	2019/2020	2020/21	Total
Bolton (10.1%)	£1.516m	£2.036m	£1.952m	£2.342m	£7.846m
Bury (6.5%)	£0.976m	£1.311m	£1.256m	£1.507m	£5.049m
HMR (8.0%)	£1.201m	£1.613m	£1.546m	£1.855m	£6.214m

Manchester (21.1%)	£3.167m	£4.254m	£4.077m	£4.892m	£16.391m
Oldham (8.1%)	£1.216m	£1.633m	£1.565m	£1.878m	£6.292m
Salford (9.5%)	£1.426k	£1.915m	£1.836m	£2.203m	£7.380m
Stockport (10.0%)	£1.501m	£2.016m	£1.932m	£2.319m	£7.768m
Tameside & Glossop (8.3%)	£1.246m	£1.674m	£1.604m	£1.924m	£6.448m
Trafford (7.4%)	£1.111m	£1.492m	£1.430m	£1.716m	£5.748m
Wigan (11.0%)	£1.651m	£2.218m	£2.126m	£2.551m	£8.545m
Total Planned and Committed Investment	£15.011m	£20.163m	£19.323m	£23.187m	£77.683m

- 5.9. To support implementation of the National Operating Model related to this additional CCG baseline investment, NHS England has now developed a MH delivery plan. This aims to provide a comprehensive overview of delivery activities for 2017/18, to clarify key responsibilities across the system, and to provide a clear timeline for implementation. Please see Appendix 4 for further information on this.
- 5.10. If we are to secure and maintain the benefits of this additional investment, each locality must establish an aligned commissioning plan for mental health as part of their locality plan and delivered through their Single Commissioning Function. Local council services have a vital role in improving mental health support. Social care is a key component of mental health care in all local areas, including in the operation of the Mental Health Act. Public health and early-years services help to prevent mental ill health and ensure children have the best start in life, for example through commissioning evidence-based parenting programmes. Drug and alcohol services are also crucial because a large proportion of people with substance misuse problems also have poor mental health.
- 5.11. However, local government pressures are seen as a key risk to meeting the aspirations in this report. There is currently a lack of detailed information on the investment and disinvestment decisions taken in relation to mental health over recent years. This is a feature of fragmented commissioning which the establishment of the Single Commissioning Functions being established in each locality are clearly intended to avoid in future. However, in order to move forward we must understand and progress from the recent past.

- 5.12. As a result, work has been initiated to understand the recent change in GM local authority investments in mental health over recent years. It is acknowledged that overall the pressure on social care funding budgets has been very challenging. While this work requires further analysis, it is clear from a provisional analysis that across GM Councils returns on average since 2014/15, there has been:
- Significant reduced net expenditure in CYP MH services – approximately 30%
 - Increased net expenditure in Adult MH short and long term services – approximately 15% - and at least one council reporting reduced expenditure
- 5.13. However, it is important to recognise that pressures on more generic budgets often have a disproportionate effect on those suffering mental ill health. For example, reductions in available supported accommodation, residential care and help at home services. As LAs have had to restrict eligibility criteria for care and support due to affordability, MH Providers are also reporting increasing pressures on NHS services. This represents significant risks to achieving improved mental health and wellbeing in GM. We will support more joined up and transparent commissioning to minimise unexpected consequences of individual organisational decisions across the health and social care system.
- 5.14. The development of GM Locality Plans provides the opportunity to agree an approach between partners to achieve the ambition of the GM MH and Wellbeing Strategy. As such, the journey to fully transform mental health services – as the 5YFVMH states – should be thought of as longer than a five-year programme. This roadmap prioritises objectives for delivery by 2020/21 and therefore describes the next stages in that journey whereby locality matched commitments for additional investment in MH enables access to GM Transformation Funds.

GM Transformation Funding

Locality TF Envelope to deliver 5YFVMH and locality objectives

- 5.15. A financial contribution within the Transformation Fund envelope exists to be distributed to localities to support their local mental health objectives. This element recognises the differential starting positions across localities and introduces an opportunity for a degree of flexibility and, potentially, innovation. It has been identified that activities related to 24/7 Community-based Access & Crisis Care (Adults) and Integrated IAPT are most suitable to be considered for delivery at a locality level first. If it is later considered that these are delivered at GM cluster-level, MH Trust provider or GM-wide level, these can be reviewed.
- 5.16. Further engagement with localities will be to identify mental health investment baselines for locality-led activities, planned increases in investment and commitment to delivering the GM MH strategy and 5YFVMH. This process will also highlight locality variations in planned and matched increases in mental health investments over time and support localities with refreshing their locality plans and programme budgeting over the coming years.

- 5.17. Within the available envelope for additional TF investment for locality-led activities, **each locality will receive a fair, population based, share of the TF monies attributed to this element of the programme. This resource will be released on submission of an agreed locality mental health plan which details the objectives, the application of the new delivery model within the LCO and a confirmed Single Commissioning Plan between the CCG and Local Authority.** For more information on the approach to implementation, please see **section 8**.

GM MH 5YFVMH Transformation Fund Investment Priorities					
2. i. CCG Locality MH Plans to Deliver 5YFVMH and GM MH Strategy					
Draft Figures in £000s	2017/18	2018/19	2019/20	2020/21	Total
24/7 Community-based Access & Crisis Care (Adults)	550	1,250	2,500	4,000	8,300
Integrated IAPT +	250	500	750	1000	2,500
TOTAL additional TF contribution to Locality MH Plans	800	1,750	3,250	5,000	10,800

GM Coordinated Programmes of Work to be delivered through other Transformation Fund Work Streams

- 5.18. In the first instance we must recognise that Transformation Funding which supports a number of the objectives in the GM MH and Wellbeing Strategy has already been committed. These often speak to our Public Service Reform and Population Health ambitions and include:

- Suicide Prevention
- Work & Health
- Dementia United
- Health & Justice

- 5.19. The summary investment associated with each programme is presented below. It is intended that they will be delivered through other programmes within the Health and Social Care Partnership with links to MH Programme governance.

GM MH 5YFVMH Transformation Fund Investment Priorities
2. ii. GM Coordinated Programmes of Work to be Delivered through the Theme 1 Population Health and Other Transformation Board Work Streams of the GM 'Taking Charge' Strategy

Draft Figures in £000s	2017/18	2018/19	2019/20	2020/21	Total
Suicide Prevention, Overcoming MH Stigma and Supporting Communities of Identity	200	250	300	350	1,100
Work and Health Across the Life-Course – including IPS	/	100	400	600	1,100
Dementia United	550	550	600	600	2,300
Health & Justice – including Liaison & Diversion / Adult MH Secure Care Pathway	750	775	775	/	2,300
TOTAL GM-wide Level Programmes	1,500	1,675	2,075	1,550	6,800

GM Coordinated Programmes of Work to Deliver 5YFVMH and GM MH Strategy

5.20. The specific mental health Transformation Fund proposition proposes TF investment to accelerate GM MH performance and outcomes across localities through GM Wide Co-ordinated programmes where there is a clear rationale for joint action and GM level application (for example where limited or variable or where there is an economy of scale which can be achieved).

GM MH 5YFVMH Transformation Fund Investment Priorities					
2. iii. GM Coordinated Programmes of Work to Deliver 5YFVMH and GM MH Strategy					
Draft Figures in £000s	2017/18	2018/19	2019/20	2020/21	Total
24/7 Community-based Access & Crisis Care (CYP) - New GMCYP crisis care 24/7 pathway pilot & specialist in-patient/outreach, Extended vulnerable groups support - adverse childhood experiences, Looked-after children, youth offending and risky behaviours	1,650	3,000	3,500	5,240	13,390
GM iThrive Network and MH Workforce development	300	640	561	509	2,010
Improving Mental Wellbeing, Building Capacity and Resilience of Communities	100	125	150	250	625
Introducing Perinatal and Parent-Infant MH model	450	1,100	1,300	1,500	4,350
Liaison MH Core-24 across key GM Acute Hospitals	1,250	3,500	4,000	5,500	14,250
TOTAL GM-wide Level Programmes	3,750	8,365	9,511	12,999	34,625

6.0 GM COMMISSIONING REVIEW: IMPLICATIONS FOR MENTAL HEALTH

6.1. Deloitte were commissioned by the GMHSCP to undertake a review of health and social care commissioning across GM building on the work of [Commissioning for Reform](#) publication. The scope of the Deloitte commissioning review included:

- Designing a truly place-based approach to public service reform, with investment led commissioning at its heart;
- Defining the support provided by the services commissioned at the GM spatial level;
- Designing a framework for responsive and effective commissioning support services in the context of the new commissioning landscape.

6.2. The outcome of the review described a streamlined landscape of 2 main commissioning levels. These are:

- Locality level: LAs and CCGs come together to form a single, small and strong Strategic Commissioning Function (SCF) with a broad set of responsibilities across public services (including mental health). The SCF is seen as responsible for setting the commissioning and place-based strategy and leading on local growth and economic reform policies.

- GM level: The Joint Commissioning Board (JCB) taking on a formal role in the commissioning and contracting of services, including those previously commissioned by NHS England regional commissioners such as specialised mental health services. The JCB would also then develop common standards, model specifications, and outcome frameworks for all key services; so that SCFs can commission services in a more uniform way across GM and through the support of a GM Commissioning Hub, discharging agreed specialist commissioning functions on behalf of CCGs, LAs and NHS England.

6.3. For a diagram of the proposed MH commissioning framework, please see Appendix 2.

6.4. Impact on commissioning of MH services in GM

6.4.1. For GM MH commissioning, the locality level will remain the core building block, with locality-integration happening around coterminous LA and CCG boundaries to incentivise public service mental health reform on a locality basis. It will be at this level that the single Health and Social Care Operational Commissioning function will be actioned to hold the new provider models to account for the outcomes localities seek. MH commissioning decisions will predominantly be taken at locality level by a single Strategic Commissioning Function (SCF).

6.4.2. The proposed GM Commissioning Hub has a key opportunity to support mental health commissioning in relation to an agreed set of collaborative commissioning priorities for mental health. We envisage a small and strategic unit, with the transactional costs of commissioning reduced through formally releasing agreed sessions of locality commissioner resource to act as GM strategic leads for particular work areas. It is also intended that there will be Operational Leads to support Strategic Commissioning Leads. This is to ensure co-production with providers using resource from the current MH workforce. This approach maximises the expertise and resources available and drives efficiency, with reduced need to recruit additional staff.

6.4.3. MH commissioners across GM will have the opportunity to formalise their existing commitment to joint working as part of the new framework of collaborative commissioner and provider network meetings.

6.5. Changing the approach to contracting for MH

6.5.1. We will seek to ensure the best spend of the GM funding through improving financial and clinical sustainability by changing contracts, incentives, integrating and improving IT & investing in new workforce roles. By shifting away from simplistic block contracts, it would significantly improve our intelligence on spend, activity and outcomes.

6.5.2. A key stage on this journey is the move to Service Line Reporting (SLR) for mental health. SLR provides data on financial performance, activity, quality, and staffing. It enables us to plan service activities, set objectives and targets, monitor a service's financial and operational activity, and manage performance.

- 6.5.3. SLR is a critical first step to more comprehensive approaches to support outcomes or value-based commissioning and provide the insight to inform new incentives to drive change. We will ensure the specific MH payment and contracting changes are considered through the GM Incentivising Reform work to support this objective.

7.0 MAXIMISING DIGITAL CAPABILITIES TO IMPROVE GM MENTAL HEALTH

- 7.1. Transforming our use of digital is a key enabler to the delivery of the GM ambition for improving health and social care. The GM H&SC Partnership adopted an information management and technology strategy in June 2016. To support the delivery of the strategy a Digital Collaborative has been established and priority areas of work identified. The priorities laid out in the strategy are based on ensuring that as a whole system we have the right information available to the right people at the right time, supporting the delivery of care.

- 7.2. GM is currently negotiating a Digital Transformation fund with NHS England and the Department of Health. This will sit alongside our wider GM Transformation Fund to ensure we are optimising the use of digital technology in improving services. This fund will support the delivery of locality plans as well as GM wide priorities such as the implementation of an information exchange (secure online system providing a single place for the exchange of information) and information governance.

- 7.3. Mental health, as with other service areas, will be a key area of focus for the Digital Strategy and related Transformation Fund. In order to optimise the use of technology in mental health we need a clear understanding of our current position across our main providers with a view to optimising our existing systems across pathways of care. Some of this information already exists through a national digital roadmap exercise that has been undertaken. However, this is now out of date and focused primarily on the acute environment rather than a whole system of care. We are looking to build on this initial work to gain a fuller understanding of how we can optimise the use of digital in the delivery of mental health and wellbeing services. This will include a number of steps:

- Clarifying our goals in relation to digital for mental health;
- Assessment of our current state;
- Identifying existing common technology and good practice;
- Identify target improvements;
- Clarify investment requirements and priorities for bridging the gap.

8.0 APPROACH TO IMPLEMENTATION

- 8.1. The programme will transition into implementation phase at pace once the overall financial investment against the GM MH & Wellbeing strategy has been formally

ratified. The initial objectives will be to develop the locality mental health plans, single commissioning intentions and business cases for the pan-GM projects.

Locality-led activities and transformation funding

- 8.2. Within the available envelope for additional TF investment for locality-led activities, **each locality will receive a fair, population based share of the TF monies attributed to this element of the programme.** Further engagement is planned with each locality to fully understand their current financial investment in MH and the maturity of planning for or current service provision for adult urgent and crisis care, integrated IAPT and primary care RAID. **This resource will be released on submission of an agreed locality mental health plan which details the objectives, the application of the new delivery model within the LCO and a confirmed Single Commissioning Plan between the CCG and Local Authority. The agreement underpinning this aspect of the Locality Plan will be an addendum to each locality Investment Agreement and progressed and monitored as part of the wider transformation.**
- 8.3. The intention is to undertake this piece of work over a three month period, with the ultimate objective of having a clear view of what is their current position in terms of service provision across these key elements of MH. Subsequent funding allocation to the localities will support them in delivering the key themes and allow them to operate from a sound position by which they are able to deliver their 5YFVMH and GM MH strategy aspirations.
- 8.4. The MH programme team will ensure that across the three workstreams there will be appropriate scrutiny and delivery assurance to ensure the realisation of benefits remains firmly on track across the programme life cycle. The assurance process will have rigour via both the MH Programme Board (balance scorecard, benefits realisation review etc.) and quarterly locality assurance meetings. There is also an expectation that regular updates on the progress of the MH programme are brought to SPB level.

GM-wide coordinated activities and transformation funding

- 8.5. Once the business cases for the pan-GM projects are developed (which will include financial, resource and benefits profiles), they will be assessed to ensure their potential to successfully deliver. This will be undertaken via the existing TFOG (Transformational Fund Oversight Group) process which will apply the necessary scrutiny to the individual business cases.
- 8.6. The consensus within the senior MH programme team is that the Partnership will be in a position to instigate the transformational fund process for each one of the pan-GM projects in September/ October 2017.
- 8.7. The timelines for implementation for the other two key workstreams are not defined at present. We anticipate that significant additional work is required before we will be in a position to move into implementation for both of these workstreams. Further

discussion is required with the Population Health programme to agree the scope and delivery of the work on suicide prevention.

Risk framework

8.8. There are a number of potential risks and barriers by way of which the delivery of all the core workstreams could be fundamentally undermined, the following are some of the key ones that need to be reviewed and subsequently managed as part of programme delivery to ensure they are fully mitigated against:

- Control of specialised commissioning; by delaying the delegation of responsibility for specialised commissioning to GM this creates unnecessary risk on projects such as ithrive, where the scope for efficiencies are significantly reduced. The integration of care pathways around the individual and not fragmented by commissioner provides the rationale for that delegation. More significantly it invites us to rebalance investment across that pathway to support prevention and early help and avoid the development of crisis. We believe this is an essential means of controlling spend in expensive specialist services through better co-ordination and greater investment in preventative and early intervening services.
- The financial pressures in the system that we currently face are unprecedented and this could potentially result in further investment reductions by localities in MH as pressures to realise efficiencies drive out service transformation investment. In GM, due to our financial performance to date, we have been able to avoid such a scenario; however, if not effectively managed, this may well be a key risk we face system wide in GM.
- Digital: we need to acknowledge that some parts of GM are starting from very low base in terms of the maturity of their systems infrastructure, which undermines the core process which we are aiming to instil. To mitigate this risk there is an urgent need for access to the national TF digital funding, which will allow for the required systems development to take place.

Mental health programme governance

8.9. To facilitate the delivery of the three work streams, an updated programme and governance structure has been developed. It has been structured to ensure that the all the key stakeholders are suitably engaged within the appropriate forums. The proposed governance framework will allow for efficient reporting flows between the various forums and what we anticipate will be a streamline and effective decision making model. However, the governance structure will be monitored to ensure it is working efficiently and facilitating programme delivery.

8.10. The design of the governance model has been established to allow for the many stakeholders involved in the MH programme to have a voice that will be both heard and acted upon. For example, in the structure the patient, carer and public group underpin all the work that is being undertaken within the programme, so they have a real influence across the portfolio of work.

8.11. Projects within the MH programme will be designated into four key themes with a Projects Oversight Board attached to each one. They are:

- Children and Young People's Mental Health (CYP MH)
- Adult Mental Health
- Population Health
- Dementia

This approach will allow for Project leads and subject matter experts working on related projects (for distinct populations groups) to come together in one place. It is recognised that there will also need to be strong links between each of these Projects Oversight Boards via the MH programme so that interdependencies of the different works areas are well managed. For example, it is proposed that perinatal mental health work will report into the CYP MH Board but this will need to be brought into the Adult MH Board also.

8.12. The delivery of each of the four themes and the Projects Oversight Boards will be chaired by senior leads from within the system. The assumption is that these chairs will be able to impart their experience and knowledge to successfully steer the projects within the remit of their individual Boards. These Boards will be facilitated by a GM wide improvement collaborative that will provide insight and recommendations in relation to the various projects across the four themes.

8.13. Assurance of benefits realisation will be provided by a series of senior Boards, namely the MH Programme Delivery Board. This Board will include system leaders that will monitor delivery and provide invaluable feedback to project leads to ensure delivery of benefits remains on track. Reporting will also be undertaken at Boards across the wider system, including:

- Provider Federation Board
- GMCA
- Association of GM CCG's

8.14. To support the delivery of the MH programme, it is also proposed that a senior level programme team meeting is established (led by the MH Senior Responsible Owner and involving senior managers from the Strategic Clinical Network). In addition, an operational delivery team meeting will be set up which will include individual project leads and any co-opted functional leads (for example finance and workforce colleagues). Both of these meeting groups will be linked by the core MH programme team (the MH Programme Manager and Head of Cross-Cutting Programmes) who will attend both meetings.

8.15. Please see Appendix 3 which provides a diagram of the proposed governance architecture to ensure the successful implementation and delivery of the delivery of the MH Programme.

9.0 RECOMMENDATIONS

9.1. The Strategic Partnership Board is asked to:

- Note the progress which has been made against the GM mental health strategy over the past year;
- Agree the proposed mental health transformation areas and the investment framework providing an overall envelope of £133.9m;
- Support the onward process to work with localities to support their local investment and transformation plans for mental health;
- Support the onward process to develop business cases against which transformation funding for the GM mental health programmes can be allocated; and
- Support the further work to apply the findings of the GM Commissioning Review to the future commissioning of mental health in localities and across GM.

APPENDIX 1:

MENTAL HEALTH PERFORMANCE IN GM

- a. Nationally monitored performance metrics for mental health related to delivery of the 5YFVMH do not tell the whole story of how we could and should measure progress on our mental health ambitions. However, they provide useful indicators around service access for GM residents. Nationally measured performance metrics include:
- waiting times and recovery for Increasing Access to Psychological Therapies (IAPT);
 - patients with suspected psychosis starting treatment within 2 weeks of referral to support Early Intervention in Psychosis (EIP);
 - waiting times for Children and Young People (CYP) accessing treatment for Eating Disorders (ED);
 - diagnosis rates for Dementia.
- b. As an area, GM exceeds the national access target to IAPT services (1.25%), achieving 1.40% access levels on aggregate across the area (based on national data for Q3 2016/17, published February 2017). However, achievement of the recovery rate of 50% across GM is variable but improving. For EIP, GM has succeeded in achieving above the national performance target for early access to treatment, although there are concerns around whether treatment always meets the NICE recommendations for care. There are also particular pressures sustaining current levels of performance, with EIP teams under growing pressure as referrals continue to increase. In terms of CYP accessing treatment for ED, average waiting times across GM are reducing although there has been variation in achieving the 1 week and 4 week waiting time targets. Dementia diagnosis rates have been consistent across GM for the last 2 years at 67%. This is above the national target of 50%.

- c. Urgent and emergency mental health care across GM has improved as a result of ongoing work to implement the principles set out in the [Crisis Care Concordat](#). Plans to establish a health based Place of Safety for the city of Manchester and appropriate facilities for children and young people across GM who experience mental health crisis are in development. In addition, there is a need to significantly reduce inappropriate Out of Area Placements/ Treatment (OAP/ OATs). This problem largely affects residents from the City of Manchester area. OAP/ OATs have a significant impact on outcomes for people experiencing severe mental health problems and are also of high cost to the health and social care system. It is also imperative that psychiatric intensive care unit (PICU) facilities for women are reviewed to ensure there is sufficient provision.
- d. Historically Mental Health services across GM have been commissioned on a block contract basis across several CCG's, Local Authorities, and a range of NHS England contracts and associated contracts. A number of these contracts include indicative activity targets against which performance is monitored. Currently the focus is on activity based targets meaning reliable MH outcome data has been difficult to obtain. A number of commissioner led initiatives are taking place across GM to shift towards an outcomes-based commissioning approach for MH.
- e. Data quality continues to be a priority area for improvement with continuing discrepancies between the data submitted via Unify and the data published by NHS Digital from the Mental Health Services Dataset (MHSD). Where required Provider Trusts are reviewing how the MHSD is populated and have robust action plans to address any gaps during 17/18. The issue of discrepancy between the two datasets is not limited to GM: there are a significant number of trusts across the country where there is a similar or even greater discrepancy between Unify and the MHSD; historic low levels of investment in electronic patient records systems has also played a contributory factor in terms of the ability to collect large amounts of data accurately.
- f. There are also issues with the completeness of our understanding on mental health provision in GM because of the limited data that is available from across the wider system (for example, in the Third Sector), which have limited digital capability to support systematic data collection. However, this challenge is a national one and not unique to GM.
- g. NHS England are expecting all areas (through Sustainability & Transformation Plans) to address these data issues over the coming years and further develop their own quality and outcome frameworks to measure performance across a range of health issues, including MH. This process of measuring MH system performance will be facilitated by CCG initiatives to unpick MH multilateral block contracts currently based on activity rather than outcomes. Importantly, a quality and outcomes framework will

need to bring in data from the wider health and social care system and link with broader outcomes, for example employment, increased wealth and housing. This will provide a more complete picture of how mental health improvements and transformation in GM are contributing to improved population outcomes for its residents.

- h. The GMHSCP has been developing an early version of a MH performance dashboard. It seeks to extend beyond access and waiting time KPIs to better reflect people's experience of care and the wider drivers of underperformance. It includes a wide range of performance and outcome metrics. It covers IAPT, EIP, ED, Memory Assessment Services and Dementia Diagnoses, MH service users family and friends test recommendations, numbers of Out of Area Placements (OAPs), waiting times for Healthy Young Minds assessment and treatment, use of section 136 and a number of additional performance metrics related to people receiving MH inpatient care. It is populated with validated local data from the 3 MH provider Trusts in GM (NW Boroughs, GM Mental Health and Pennine Care).
- i. An advantage of using local data returns to assess MH performance across GM is that data is available much more quickly compared to nationally collected performance data, which can take between 3-9 months to be released. Using this local data has enabled identification of early performance trends ahead of the release of nationally validated data. However, national data does have the advantage of having greater completeness and being subject to more robust validation.
- j. Next steps to further develop the MH performance dashboard will be to link in with system performance dashboard development work being undertaken by the GMHSCP Performance and Assurance team. It will also need to link into the development of a wider system performance dashboard being developed by the GMCA and ongoing work to look at how devolution of health and social care in GM is effectively evaluated. The MH performance dashboard must continue to evolve in alignment with national performance measurement for mental health.
- k. Please see below for illustration of the mental health performance metrics framework developed so far.

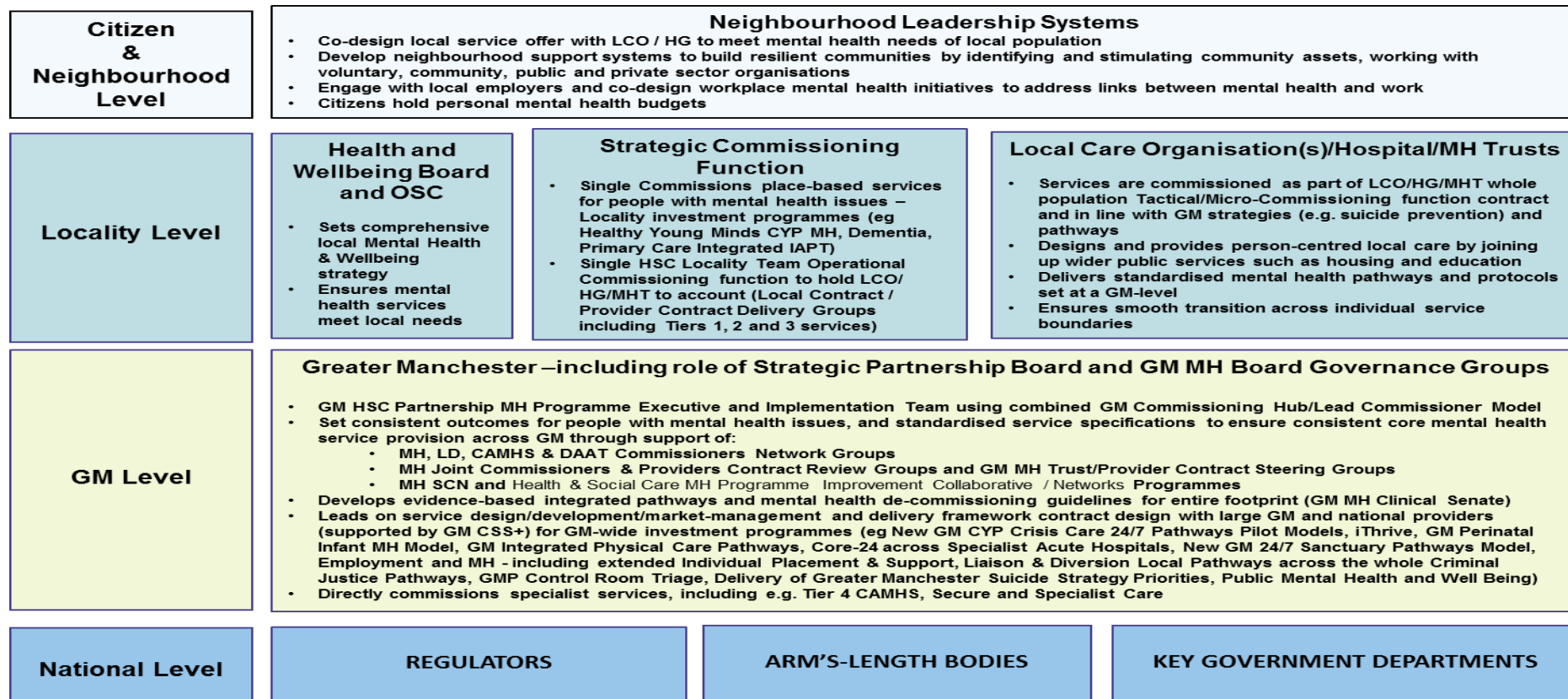
MENTAL HEALTH PERFORMANCE METRICS FRAMEWORK

Greater Manchester Mental Health (NHS Provider) Performance : Q4/March 2017																
SERVICE	KPI	Target	Reported	Manchester	Bolton	Salford	Trafford	HMR	BURY	Stockport (PCFT)	T&G	Oldham	Wigan			
IAPT	Prevalence	3.75%	In month actual	CCG Target	CCG Target	CCG Target	CCG Target									
			In month Target	CCG Target	CCG Target	CCG Target	CCG Target									
			Cumulative Qtr. (Jan, Feb, Mar)													
			Cumulative Qtr. Jan, Feb, Mar)													
Recovery	50% per Month	Quarter	158/733 21.56%	201/348 57.76%	120/276 43.48%	265/436 60.78%	102/181 56.35%	100/193 51.81%	67/124 54.03%	102/202 50.50%	116/193 60.10%	534/954 56.00%				
6 weeks - Completed Treatment	75%	Quarterly	204/749 27.24%	310/364 85.16%	246/303 81.19%	419/475 88.21%	166/185 89.73%	166/197 84.26%	111/138 80.43%	174/209 83.25%	192/205 93.66%	997/997 100.00%				
18 weeks - Completed Treatment	95%	Quarterly	582/749 77.70%	364/364 100.00%	300/303 99.01%	466/475 98.11%	184/185 99.46%	196/197 99.49%	135/138 97.83%	207/209 99.04%	205/205 100.00%	997/997 100.00%				
MAS	Referral to Diagnosis 12 weeks	80% per Quarter	Cumulative Qtr. (Jan, Feb, Mar)	41.50%	93/96 96.88%	80/104 76.92%	78/104 75.00%	89/89 100.00%	49/49 100.00%	158/158 100.00%	85/90 94.44%	65/70 92.86%	N/A			
EIP	Patients with suspected psychosis must be seen within 2 weeks of referral	50% per Quarter	Cumulative (Jan, Feb, Mar)	N/A	33/37 89.19%	31/41 75.61%	16/21 76.19%	10/17 52.82%	15/18 83.33%	9/10 90.00%	8/15 53.33%	12/28 71.43%	18/24 75.00%			
GATE-KEEPING	Admissions to adult facilities of patients who are under 16 years old	0	In month	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
FFT	Mental Health service users Friends and Family Test - recommend		In month	N/A	59/60 98.33%	38/46 82.61%	84/99 84.85%	73.00%	96.00%	96.00%	97.00%	88.00%	122/129 95%			
	% of discharges from inpatient wards on CPA Followed-up within 7 days	95%	Cumulative Qtr	261/267 97.75%	110/110 100.00%	136/138 98.55%	82/83 98.80%	70/70 100.00%	41/43 95.35%	49/50 98.00%	52/56 92.86%	60/61 98.36%	153/161 95%			
	Out of area placements- OAPs appropriate and inappropriate	number of appropriate OAPs placed in quarter period	1	2	1	0	Data under development						9			
		number of inappropriate OAPs placed in quarter period	126	4	18	4	Data under development						0			
	Additional Bed Occupancy by: Adults Older People PICU		Cumulative Qtr.	2630/12420 101.69%	3907/3780 103.36%	4242/4242 100.00%	3993/3870 103.18%	Data under development						3563/3737 95.00%		
			Cumulative Qtr.	3301/3600 91.69%	1123/1350 83.19%	1414/1350 104.74%	913/900 101.44%	Data under development						1967/2093 94.00%		
			Cumulative Qtr.	1664/1620 102.72%	580/540 107.41%	730/720 101.39%	539/540 99.81%	Data under development						653/681 96.00%		
	Average Length of Stay by: Adult Older Adult Organic PICU		Monthly	114	45	40	59	15	20	17	16.6	31.4	21			
		Monthly	107	66	47	55	70.70	32.5	45	36.70	31	78				
		Monthly	0	52	94	87						75				

Greater Manchester Mental Health (NHS Provider) Performance : Q4/March 2017

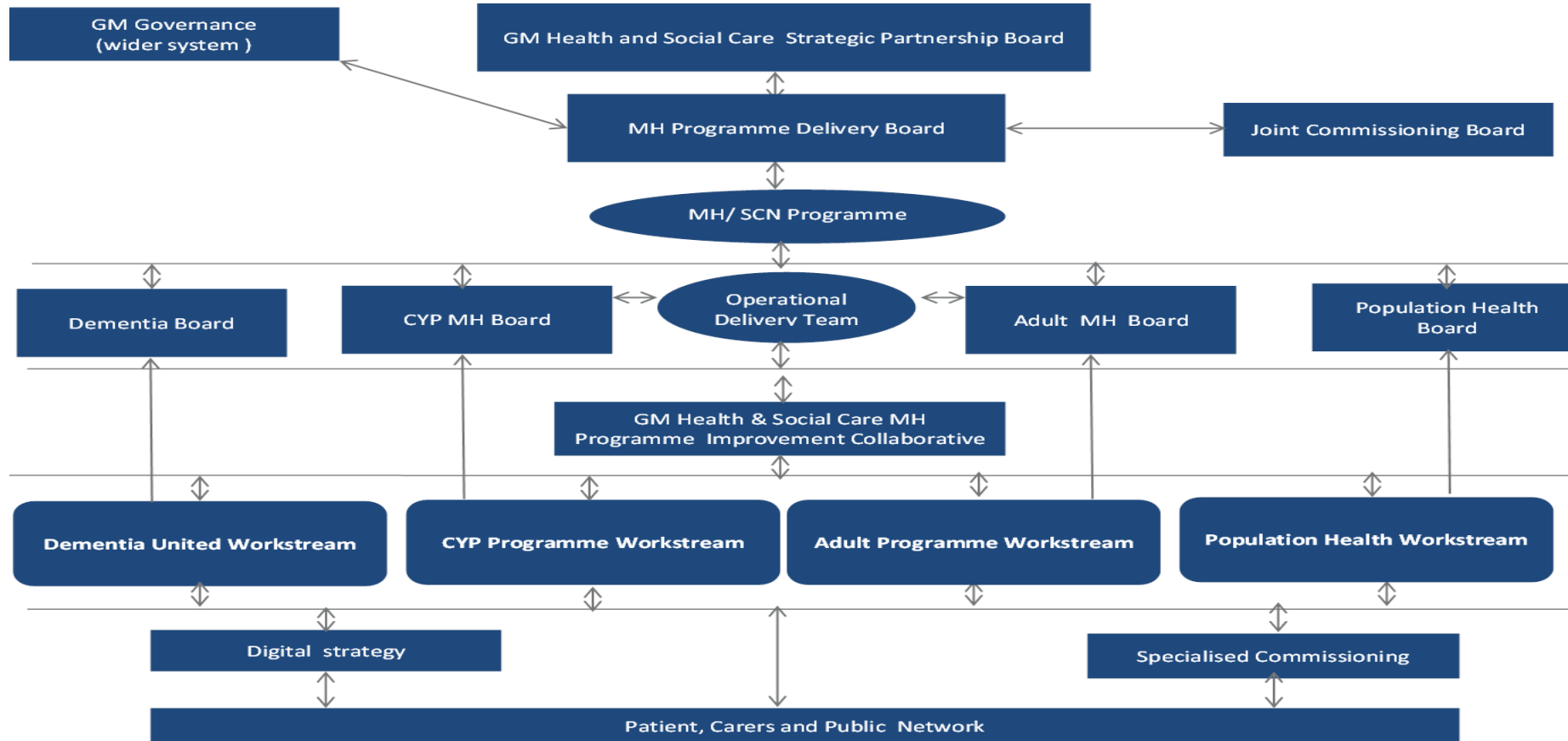
SERVICE	KPI	Target	Reported	Manchester	Bolton	Salford	Trafford	HMR	BURY	Stockport (PCFT)	T&G	Oldham	Wigan								
HEALTHY YOUNG MINDS	Section 136 number / 100,000 CCG 18+ population			New Economy have supplied separate figures																	
	Number of level 4 & 5 Incidents / 100,000 18+ population		Number in quarter period		21		18		8		42		45		43		40		55		11
	A& E Following a referral to mental health services the percentage of patients who see a mental health practitioner within one hour of referral	75%	Monthly	79.85%	80.41%		72.00%		98.55%		53.00%		53.00%		53.00%		53.00%		62.00%		Data under development
	A&E Following a referral to mental health services the percentage of patients who see a mental health practitioner within two hours of referral	95%	Monthly	91.03%	92.27%		82.00%		100.00%		86.00%		86.00%		86.00%		86.00%		80.00%		Data under development
	% of patients discharged from A&E within 4 hours	95%	Monthly	48.70%	94.65%		100.00%		100.00%		91.70%		91.70%		91.70%		91.70%		88.75%		Data under development
	Readmissions : Percentage of patients readmitted within 30 days of discharge	10%	Number in quarter period	8.86%	10.43%		14.12%		7.40%		12.70%		12.70%		12.70%		12.70%		9.40%		9.00%
	Unexpected Deaths		No in quarter period		10		18		8		11		8		14		12		13		17
	Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards	95%	Cumulative Qtr.	194/194 100.00%	108/109 99.08%		116/121 95.87%		58/58 100.00%		114/114 100.00%		96/96 100.00%		112/112 100.00%				123/124 99.19%		193/193 100.00%
	Home Based Treatment Services- Treatment episodes (ref + 2 contacts)		Number treatments in quarter period	N/A	357		219		181		Not available										
	CPA Reviews in 12 Months	95%	Number in quarter period	94.30%	96.11%		95.55%		97.02%		94.60%		94.60%		94.60%		94.60%		94.60%		
HEALTHY YOUNG MINDS	First contact within 12 weeks	95%	Mar	N/A	N/A		N/A		N/A	57/86 66.30%		99/100 99.00%		65/94 69.10%		26/31 83.90%		33/33 100.00%			
	Treatment within 18 weeks	98%	Mar	N/A	N/A		N/A		N/A	85/86 98.80%		99/100 99.00%		88/94 93.60%		28/31 90.30%		33/33 100.00%			
EATING DISORDERS	The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment.	95%	Mar	N/A	N/A		N/A		N/A			1/1 100.00%				1/1 100.00%				1/2 50.00%	
	The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment.	95%	Mar	N/A	N/A		N/A		N/A	2/2 100.00%		1/1 100.00%		1/1 100.00%				4/4 100.00%		3/4 75.00%	

APPENDIX 2: COMMISSIONING FRAMEWORK IN GM FOR MENTAL HEALTH



Devolution offers the opportunity to push decision making as close to citizens and neighbourhoods as possible

APPENDIX 3: DRAFT MEW GOVERNANCE STRUCTURE FOR THE GM MENTAL HEALTH PROGRAMME



APPENDIX 4: NHS ENGLAND MENTAL HEALTH DELIVERY PLAN OBJECTIVES 2017/18

Children and Young People’s Mental Health

Key Planning Guidance Deliverables: 17/18

- At least 30% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service.
- Commission 24/7 urgent and emergency mental health service for CYP and ensure submission of data for the baseline audit in 2017.
- All services working within the CYP IAPT programme.
- Community eating disorder teams for CYP to meet access and waiting time standards: All localities expected to baseline current performance against the new standard and start measurement against it.

Full FYFVMH Deliverables: 17/18

- Reduce the number of out of area placements for CYP and use of in-patient beds overall.
- Mobilisation and implementation of the recommendations from the Tier 4 CAMHS review.
- Monitor outcomes and progress in the new Crisis Care service models for CYP, in line with the wider Crisis Care pathway.

Perinatal Mental Health

Key Planning Guidance Deliverable: 17/18

- Increase access to evidence-based specialist perinatal mental health care: regional plans and trajectories in plan to meet national ambition of 2,000 additional women accessing care.
- Commission additional or expanded specialist perinatal mental health community services to deliver care to more women within the locality.

Full FYFVMH Deliverables: 17/18

- Build perinatal MH capability by developing a competence framework describing the skills needed in the workforce.

Adult Mental Health: IAPT

Key Planning Guidance Deliverable: 17/18

- Commission additional psychological therapies for people with anxiety and depression, with the majority of the increase integrated with physical healthcare, so that at least 16.8% of people with common MH conditions access psychological therapies.
- Ensure local workforce planning includes the numbers of therapists needed and mechanisms are in place to fund trainees.

Full FYFVMH Deliverables: 17/18

- Up to £54 million in 2017/18 will go directly to training new staff and delivering new ‘early implementer’ integrated services. Remaining funds in 2017/18 will support further training, quality improvement and expansion of current IAPT services.
- Increase the number of employment advisors in IAPT through funding, monitoring and reporting on Employment Advisors in the IAPT project.

Adult Mental Health: Community, Acute and Crisis Care

Key Planning Guidance Deliverable: 17/18

- Expand capacity so that more than 50% of people experiencing a first episode of psychosis start treatment within two weeks of referral with a NICE-recommended package of care.
- Commission effective 24/7 CRHTTs as an alternative to acute in-patient admissions.
- Reduce the number of OAPs for non-specialist acute care: localities plans in place to eliminate appropriate OAPs by 2020/21.
- Deliver integrated physical and mental health provision to people with SMI, in line with national ambition of 140,000 people with SMI receiving a full annual physical health check.
- Assure that service development plans are in place to meet ambition of all acute hospitals with all-age liaison services by 2020/21 and 50% meeting Core 24 service standard for adults; assurance of successful Wave 1 bidders plans.
- Increased access to IPS: insure preparedness for IPS expansion; STP areas selected for targeted funding.

Suicide Prevention

Planning Guidance Deliverables: 17/18

- Reduce number of suicides compared to 2016/17 levels in line with national ambition to reduce suicides by 10% by 2020/21: delivery of local implementation support which includes action to deliver the requirement that all local areas have local multi-agency suicide prevention plans by the end of 2017.

Full FYFVMH Deliverables: 17/18

- Support learning from suicides and preventing repeat events.
- Contribute to the annual multi agency suicide prevention plans review, led by PHE.
- Participate in the Prevention Concordat programme which will support the objective that all local areas have a prevention plan in place.

Older People and Dementia

Planning Guidance Deliverables: 17/18

- CCGs continue to work towards maintaining a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.
- Increase the number of people being diagnosed with dementia, and starting treatment, within six weeks from referral; with a suggested improvement of at least 5% compared to 2015/16.

Full FYFVMH Deliverables: 17/18

- Monthly reporting of diagnosis rate.
- Update dementia extract.
- Reduce variation between geographies.

Secure Care, New Care Models and Health and Justice

Full FVFVMH Deliverables: 17/18

- Developing early stage regional plans for roll out of forensic community services.
- Deliver community based alternatives to secure inpatient services such that people requiring services receive high quality care in the least restrictive setting.
- £36 million funding to support the Secure Care objective held centrally from 2017/18, allocation to specific localities will be determined through a bidding process.
- 75% of population with access to liaison and diversion.
- Support learning from suicides and preventing repeat events.
- 6 NCM sites chosen, going live in 2017 and supporting to delivery local services.

Infrastructure, Finance

Planning Guidance Deliverables: 17/18

- Ensure data quality and transparency: ensure that providers are submitting a complete accurate data return for all routine collections; development of quality and outcomes measures in line with national guidance; engage with CCQ in relation with EBTPs.
- Increase digital maturity in mental health in line with the national guidance.
- Increase baseline spend on mental health to deliver the Mental Health Investment Standard.

Full FYFVMH Deliverables : 17/18

- Ensure that MHSDS is delivering relevant, timely and accurate data.
- Support delivery of national payment system, CQUINs and Quality premium schemes.
- Support finance collections, including on programme lines of spend.
- Develop a new annual schedule of updates to the MHSDS will allow NHS partners to work together.
- Development of oversight and assessment frameworks.