Wiltshire Council

Health Select Committee

Monday 1st November

Subject: **Community Mental Health Services Update**

Cabinet Member: **Councillor Jane Davies, Cabinet Member for Adult Social Care, SEND and Inclusion**

Key Decision: No decisions required – supplied for information

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Executive Summary

This report is provided to the Committee for information. It summarises:

- The Community Mental Health Framework from NHS England and associated priorities
- Work underway within B&NES, Swindon and Wiltshire and anticipated impact on service users, carers and our communities
- Measuring our impact – moving from outputs to outcomes
- Leadership and governance of implementation
- Looking forward – the future for Community Mental Health Services

This report is a briefing report, however should Council colleagues wish to investigate any aspect of the report, further meetings can be scheduled accordingly.

Proposal(s)

This is a briefing paper, no formal recommendations are made to the Board however should council partners wish to receive further reports or updates, then this can be arranged.

Reason for Proposal(s)

Briefly explain the justification for the proposal.

Claire Edgar
Director of Adult Social Care

Wiltshire Council

Health Select Committee

Monday 1st November

Subject: **Community Mental Health Framework update**

Cabinet Member: **Councillor Jane Davies, Cabinet Member for Adult Social Care, SEND and Inclusion**

Key Decision: **None required - supplied for information**

Purpose of Report

1. The purpose of this report is to provide an briefing to the Health and Wellbeing Board regarding the implementation of the Community Mental Health Framework (CMHF) across B&NES, Swindon and Wiltshire (BSW).

   It summarises the key features of the plan, how this is being implemented across BSW and specifically Wiltshire, and the anticipated impact for service users, carers and our wider stakeholders.

   The CMHF is a long term programme of work and its development will continue in the coming years. This report also summarises the key features of the next stages of this transformation programme and its link to the wider Mental Health Strategy for BSW.

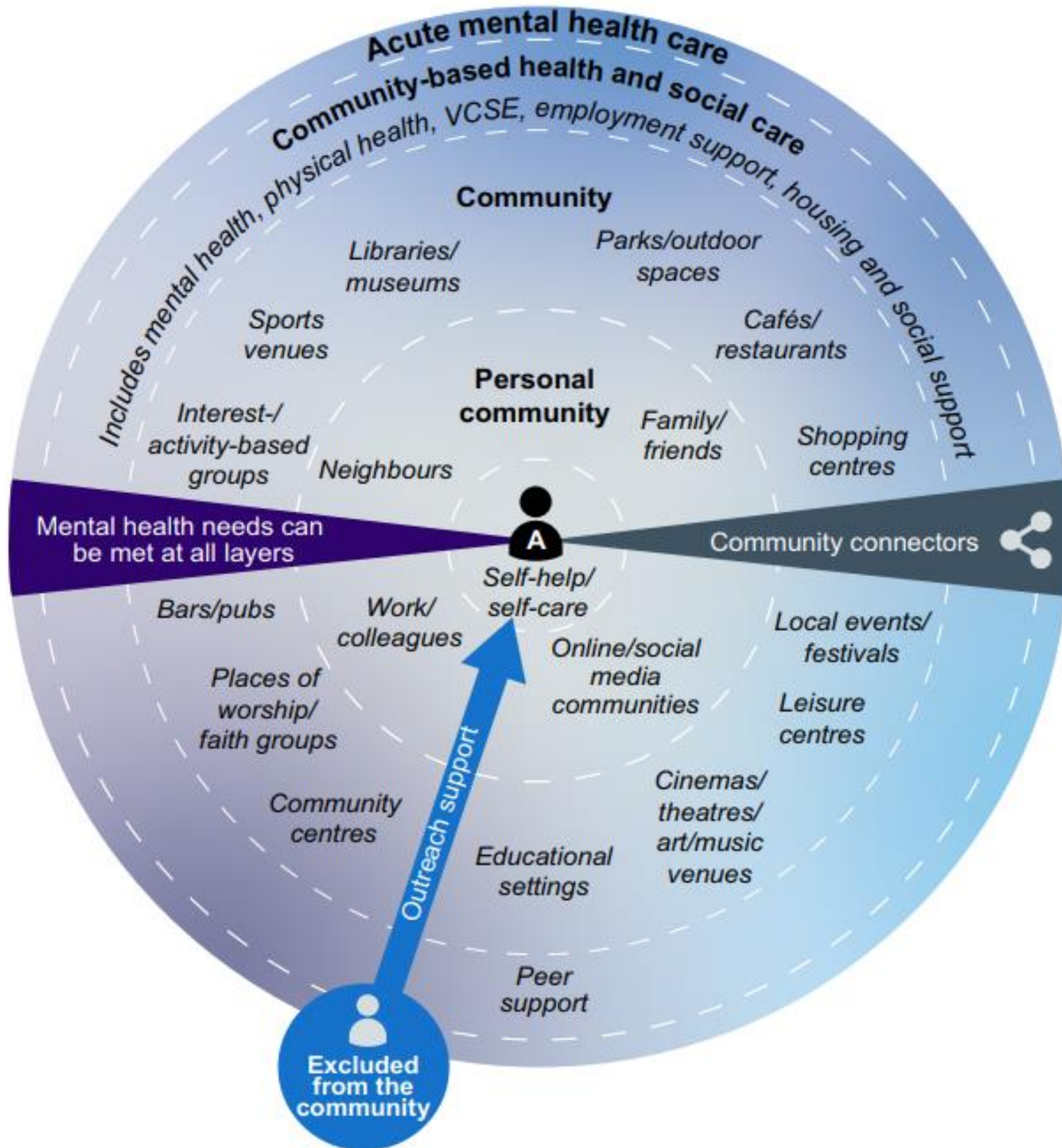
   Council colleagues are asked to note this briefing at this stage. Further more detailed updates regarding specific pieces of work can be provided at the direction of the Committee, and opportunities to do this are welcomed by all members of the CMHF Programme Team.

Relevance to the Council's Business Plan

2. The information contained within this report is relevant to:
   a. The Council's Joint Strategic Needs Assessment – we would expect that the delivery of the CMHF will have a positive impact on inequalities outlined in the JSNA
   b. The Health and Wellbeing Strategy for Wiltshire
   c. Wider Council strategies such as its Economic Strategy and implementation of Community Infrastructure Levy funding

1. The Community Mental Health Framework – National context

The Community Mental Health Framework (CMHF) was published by NHS England in 2019. It set out a new and ambitious model of mental health provision that would provide integrated community health care for people with all levels of mental illness. The diagram below sets out this vision:



The principles and aims underpinning the CMHF are set out in the statements below:

Key aims

People with mental health problems will be enabled as active participants in making positive changes rather than passive recipients of disjointed, inconsistent and episodic care. Delivering good mental health support, care and treatment in the community is underpinned by the following six aims:

1. Promote mental and physical health, and prevent ill health.
2. Treat mental health problems effectively through evidence-based psychological and/ or pharmacological approaches that maximise benefits and minimise the likelihood of inflicting harm, and use a collaborative approach that:
   - builds on strengths and supports choice; and
   - is underpinned by a single care plan accessible to all involved in the person's care.
3. Improve quality of life, including supporting individuals to contribute to and participate in their communities as fully as possible, connect with meaningful activities, and create or fulfil hopes and aspirations in line with their individual wishes.
4. Maximise continuity of care and ensure no "cliff-edge" of lost care and support by moving away from a system based on referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support. Instead, move towards a flexible system that proactively responds to ongoing care needs.
5. Work collaboratively across statutory and non-statutory commissioners and providers within a local health and care system to address health inequalities and social determinants of mental ill health.
6. Build a model of care based on inclusivity, particularly for people with coexisting needs, with the highest levels of complexity and who experience marginalisation.

Alongside the redesign of core community services, NHS England also required systems to focus on improving specific pathways for people with the following conditions:

- Personality Disorders & Complex Emotional Needs
- Older Adults
- Young people aged 16-25
- Community based rehabilitation
- Eating Disorders

Building on the CMHF, the subsequently published Long Term Plan for the NHS reinforced these ambitions with new access standards and metrics.

The roadmap summary below provides a diagrammatic overview of the key features of each aspect of the CMHF and the key elements that systems would be expected to deliver by the end of 2023/24:

By 2023/24 - Priorities for Community Mental Health transformation

NHS

Dedicated focus[6] (CEN / 'personality disorder', Community rehab, Eating disorders)

Model development	Care provision	Workforce	Data & outcomes	CEN / 'personality disorder'	Community rehab	Eating disorders
Joint governance with ICB oversight[1]	"Must have" services[3] commissioned at PCN level tailored for SMI[7]	Recruitment in line with indicative 23/24 MH workforce profile	Record access data from new model (inc. primary, secondary and VCS orgs)	Dedicated function linked to core model: increased access to dedicated function and consultation, support, supervision and training to core model		
Model design coproduced with service users, carers & communities	"Additional" services[4] commissioned at PCN level tailored for SMI[7]	Expand MHP ARRS roles in primary care	Interoperable standards for personalised and co-produced care planning	Embed experts by experience in service development and delivery		
Integration with primary care with access to the model at PCN level[2]	Improved access to evidence-based psychological therapies	Staff accessing national training to deliver psychological therapies	Routine collection of PROMs using nationally recommended tools	Development of trauma-specific support, drawing on VCSE provision	Ensure a strong MDT approach[5]	No barriers to access e.g. BMI or weight thresholds
Commissioning and partnership working with range of VCSE services	No wrong door approach means no rejected referrals recorded	Multi-disciplinary place-based model[5] in place	Waiting time measured for CMH services (core & dedicated focus areas)	Co-produced model of care in place to support a diverse group of users	Clear milestones are in place to reduce reliance on inpatient provision	Early intervention model (e.g. FREED) embedded
Integration with Local Authority services	Tailored offer for young adults and older adults	Staff retention and well-being initiatives	Interoperability for activity from primary, secondary and VCSE services		Co-produced care and support planning is undertaken	Clear arrangements in place with primary care for medical monitoring
100% PCN coverage for transformed model	Principles for advancing equalities embedded in care provision	Dedicated resource to support full range of lived experience input	Impact on advancing equalities monitored in routine data collection		Supported housing strategy delivered in partnership with LAs	Support across spectrum of severity and type of ED diagnoses
Shift away from CPA towards personalised care	Support for co-occurring physical needs & substance use	Staff-caseload ratios to deliver high quality care				Joint working with CYP ED services including transitions
Alignment of model with IAPT, CYP & perinatal	Trauma-informed & personalised care approaches	Place-based co-location approaches				Accept self-referrals, VCS referrals and Primary Care referrals.

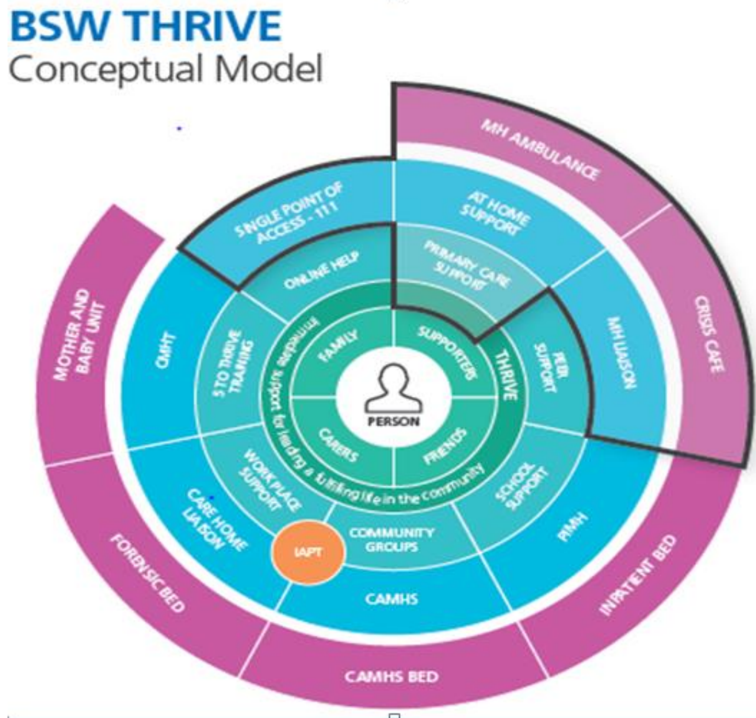
1. Governance to include commissioners, primary care (inc. PCN leadership), mental and physical health services, local authorities, VCSE, service users and carers
2. "PCN level" defined as a footprint of typically 30,000 and 50,000 people (this can also be thought of as "sub-place", "localities", or "clusters of wards"). More targeted, intensive and longer-term input for people with more complex needs can be provided at the wider community or "place" level of around 250,000–500,000 people (this can also be thought of as a "PCN-cluster")
3. Must-have: physical health checks, EIP, employment support, psychological therapies, social prescribing, personalised care planning, care coordination, peer support, outreach for inequalities
4. Additional: advocacy services, carer support, community assets, culturally competent services, financial advice, housing, social care, support groups, volunteering & education
5. Should include clinical psychologists; MH nurses; MH pharmacists; occupational therapists; primary care staff; psychiatrists; psychological therapists; social workers; community connectors; paid peer support workers
6. Systems should have commenced work on 2 of 3 dedicated focus areas in 2021/22, meeting relevant expectations. Where appropriate, aspects of core transformation model should be applied to dedicated focus areas
7. In this context 'SMI' covers a range of needs and diagnoses, including but not limited to; psychosis, bipolar disorder, 'personality disorder' diagnosis, eating disorders, severe depression and mental health rehabilitation needs – some of which may be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use

In place by end of year
In progress by end of year
Planning underway by end of year

2. Local context

In 2020/21, systems were required to produce a draft outline of their plans for implementation of the CMHF. Within BSW, we collaboratively developed our new offer, co-creating a new model of provision that would deliver earlier help and support to service users and carers as well as targeted improvements for people with more specialist needs (as outlined in the care pathways above).

Our conceptual model underpins our Thrive Strategy which not only focuses on community mental health services, but also considers wider service provision across all aspects of mental health. This is summarised in the diagram below:



As with the CMHF, we want to develop and enhance our mental health system through providing more support in the community – largely delivered by third sector organisations – with wider secondary provision then aligning with this. In making these changes, we want to keep more people living well in their communities, reducing demand for secondary mental health provision and supporting improved mental health and wellbeing for our populations.

Delivery of this model is contingent on a number of factors, specifically:

- Building and developing community wellbeing and resilience, supporting people to access community based services when they need it
- Enabling individuals to connect with one another and services, empowering them to take control of their mental health and wellbeing
- Addressing physical and mental health needs, positively reducing the impact of severe mental illness on a person's physical health
- Co-producing our new model with service users, carers and families – making sure that their lived experience underpins the changes we deliver
- Providing better and earlier support for people in crisis, enabling them to access local services to avoid admission to hospital based settings
- Through our new model, walk alongside people so that we help them to reach the support they need
- Ensure that we are making and taking opportunities to develop a new mental health workforce that is built from our collective skills and expertise
- Train wider health and care staff and people in our communities to recognise and support people with mental health needs
- Make best use of digital solutions so that people can access help and support via a range of applications and media

These are our long term strategic aims and represent the foundations of our five year strategy for Mental Health. Our CMHF implementation reflects these aims.

3. Delivery 2021/22

In order to deliver our new model of provision, we were provided with additional system investment of £5.64m (comprising uplifts to our existing baseline plus a further £1.59m transformation funding to support implementation of the CMHF).

As we moved out of the Covid pandemic, we focused on sustaining some of the changes we had made throughout Covid and implementation of our CMHF ambitions within the additional resource allocated. Key achievements are summarised below.

Core community mental health services and underpinning service model

As outlined, a feature of our new model is the development of our third sector offers, aligned with community mental health service provision, so that we deliver an increasingly seamless service for people across our communities. To that end we have:

- Established our third sector Mental Health Alliance, bringing together the skills and expertise of our core third sector providers in readiness to deliver our new 'Access Mental Health' (Single Point of Access) service. Additional funding approved for this model, recruitment commenced with postholders starting from Jan 2022. For Wiltshire, our third sector partners are Alabare and Rethink Mental Illness, both of whom are founding members of our third sector alliance.
- Invested in our third sector capacity to 'walk alongside' individuals as they progress through their individualised pathway, recruiting new staff to work with people from point of contact and into secondary mental health services where appropriate
- Completed local knowledge and engagement sessions, using the input of service users and people with lived experience to co-produce our integrated offer, building on the existing strengths and resources of both individuals and communities, including in

Wiltshire. Healthwatch Wiltshire also completed an independent review of our current methods for engaging with an co-producing our transformation plans. The outputs of this review contributed to our revised governance approach which has now been implemented across our system.

- Creating new mental health practitioner roles in primary care with a core group of seven Primary Care Networks (PCNs) that compliment and align with our developing access model. Of the PCNs choosing to take up this offer, two are in Wiltshire – Chippenham, Corsham and Box PCN and North Wiltshire Border PCN
- Improving the number of people on our GP Severe Mental Illness registers receiving holistic health checks, achieved through commissioning an external provider working in partnership with the third sector. Performance improved to 41.9% of people receiving an annual health check by the end of 2021/22
- Developing our community wellbeing houses to provide earlier support to people in crisis and to enable supported discharge from inpatient care – we have two wellbeing houses in Wiltshire provided by Rethink Mental Illness.
- Recruited to new roles in our community Eating Disorders services, including both third sector and statutory roles, to provide earlier intervention and support for people with eating disorders
- Increased capacity to support people with personality disorders/complex emotional needs – we successfully recruited two new clinical practitioners into our Wiltshire services to provide specific therapeutic interventions
- Developed our approach to transitions for young people aged 16-25, with recruitment of three new practitioners (one each for B&NES, Swindon and Wiltshire) responsible for supporting young people to transition from children and young people's services to adult services
- Increased psychological interventions for 18-25 year olds to provide earlier support for those with emerging personality disorders/complex emotional needs or who are experiencing emotional dysregulation

Although we made good progress in the first year of our development work, this was in the context of our continued pandemic response and therefore we know that progress was perhaps not as rapid in some areas as we would have wanted it to be.

A key reason for this was our ability to recruit to our planned posts – largely within AWP and Oxford Health. As with other mental health trusts nationally, both providers have been affected by the reducing number of registered mental health staff and consequently their ability to recruit to new roles. We have continued to work with both organisations to identify how we can implement innovative approaches and new roles, and this will be a feature of our future plans.

Delivery 2022/23

At the start of 2022/23, NHS England once again asked systems to set out their plans to develop and expand their community mental health provision in line with the ambitions set out in the CMHF. We have, once again, co-produced our plans with service users and carers and highlights are outlined below:

Improving access to services

Establishing our Access Mental Health service is one of our agreed priorities for this year, and we are working with third sector alliance and AWP services to develop this. This will transform our core adult community services to create a more responsive and dynamic secondary care offer that is able to respond and align with this. Key features of our plans include:

- Extending our Alliance Wellbeing Team to support PCNs and secondary care providers across BSW, providing a 7 day service comprising 22 Wellbeing Practitioners and 22 Wellbeing Peer Practitioners (2WTE / PCN). Recruitment is well underway and we are implementing revised models in all three localities, including Wiltshire

- Our new access staff will collaborate with wider third sector partners and secondary care services, drawing expertise to the service user as and when needed - including EIP, IPS, housing, social care and specialist pathway support. Early help and timely interventions will reduce the number of high intensity users, create more resilient communities and enhance community engagement.
- As part of and alongside a redesign and restructure of our PCLS and core mental health provision, increasing our senior psychology posts across our system (Consultant, Band 8A and Band 7), providing therapeutic interventions and treatment for people with Serious Mental Illness
- Levelling up our Family Therapy support in Wiltshire and providing interventions and supervision of staff already trained in this model within our CMHTs

We piloted the use of this new access model in our B&NES locality during Covid to reduce both waiting times and caseload for PCLS. During this pilot period 60 people who were on the waiting list were reviewed by our third sector team. Of these only 1 remained with PCLS and was subsequently seen in secondary services, the remaining 59 were supported by community-based alternatives and were not seen within secondary care. As a result, we have extended this pilot into Swindon and Wiltshire. We anticipate that this will have a similarly positive impact to that which was seen in B&NES, with early evidence showing that our third sector partners in Wiltshire took over 40 calls in the first week of operation. We expect that this will enable us to mitigate demand and capacity risks during the winter period. We expect that this will enable us to mitigate demand and capacity risks and, based on the evidence so far, we forecast that this could mitigate up to 10-15% of the demand on PCLS services each month.

Alongside operational capacity developments, we are also implementing our new Advice and Guidance system. We will be piloting this over this year with both signposting and advice for clinicians to reduce demand where clinically appropriate and to provide a more immediate response to clinical queries. Analysis suggests that c30% of referrals into PCLS are triaged without the need for assessment and it is this group of patients that will be targeted initially, with direct support to primary care, eliminating the need for a referral and giving timely support to service users and carers.

Eating Disorders service developments

Over the course of the coming year we will continue to recruit to new posts across our eating disorders services. Whilst we have had some challenges in recruitment, we achieved a 69% fill rate on the new workforce we had planned, with the remainder now being recruited. This will enable us to deliver the following improvements this year:

- Aligning our service offer across BSW through the common use of a digital CBT approach and shared group resources.
- Investing in the development of a FREED model to provide rapid access and early intervention for particularly our 16-25 cohort of service users, building on best practice from South London and the Maudsley (SLAM). We anticipate that this development will help mitigate current surges in demand, provide a more responsive service for this cohort of our population and improve access and equity of service for our student/young adult population

- Investing in a new physical health monitoring service for people with Eating Disorders, ensuring that co-morbid physical illness is picked up and addressed through a structured review process.

Through implementation of our new approach to Eating Disorders, we are operating an open service with no barriers to access, we are delivering early intervention and we have implemented a new approach to medical monitoring. Continued implementation of these quality improvements will provide more targeted and early support for our service users.

Personality Disorders/Complex Emotional Needs

Much of the work we have planned for this year focuses on increasing the knowledge, understanding and capacity of staff across all mental health services to support people personality disorders/complex emotional needs. To that end, we have commenced and are making good progress in:

- Rolling out a new Mentalisation Based Therapy (MBT) service in Wiltshire following successful completion of Health Education England training.
- Supported by the roll out of our new advice and guidance system – Cinapsis, we will be able to offer more advice and guidance to staff working in primary care
- Core training remains a focus of our plans, and we anticipate that as our primary care workforce expands (through ARRS workers) and we develop the role of third sector staff in multi-disciplinary teams, we will complete further training and development.

Improving services for children and young people aged 16-25

- Identify and address variation across the three BSW localities to ensure consistent representation from specialist mental health providers and the voluntary sector in Swindon, Wiltshire and BaNES.
- Working across system partners to design and document a new flexible transitions process which allows young people to remain in services beyond the age of 18.5 where this is clinically appropriate and the best way of meeting their needs, or to access adult services early.
- Delivering training across children and adult services about their respective pathways and models.
- Embedding the role of the enhanced third sector offer into the 16 – 25 clinical pathway so these services are working in partnership. This will mean that the support provided by the third sector is incorporated into care planning both alongside treatment and at the point of discharge, and that clinicians have a good and up to date knowledge of the offer.
- Creating a process for shared screening, triage and assessment of new transition cases between specialist mental health providers and the third sector. This will be done through an MDT approach across specialist mental health providers and the third sector. Initially this will focus just on complex cases, but over time it will widen to a broader remit.
- Identifying the training needs of system partners (particularly the third sector) and offering training to support them to better meet the needs of 16 - 25 year olds.
- Working with young people aged 16 – 25 to involve them further in shaping service design.

Older Adults

In our older adults service improvements, we are focusing on improving services for adults with functional mental illness (ie those people who have a diagnosed severe mental illness and who are over the age of 65) and those with dementia. The key activities we will be undertaking in year are:

- Asset mapping and gap analysis of current community support and interventions – working across B&NES, Swindon and Wiltshire
- Multi-professional Approved Clinicians in post – these are new roles which are supported by NHS England and come from all areas of practice, whether therapies, psychology or nursing.
- System agreement on a consistent prescribing formulary for dementia medication – recognising that we have different formularies across B&NES, Swindon and Wiltshire

- Review dementia diagnosis rates in primary care to understand process improvements to be made so that we can ensure that we are recording diagnosis and supporting older adults to access services for their needs
- Stratification of care home capacity to inform MDT model for the future building on pilot in Swindon

This workstream is well-supported by service users and carers, including representatives from Wiltshire.

Community rehabilitation

We agreed as a system that we would not prioritise specific work in this area this year, but that we would undertake a comprehensive review of best practice nationally, build a strong understanding of our local position and then co-develop an action plan to address this. This will be implemented in 2023/24. This work has commenced and is progressing well. In addition to this we are starting a piece of work with Local Authority partners to review our Section 117 aftercare arrangements.

Workforce

The development of the CMHF is contingent on making best use of existing and new roles across our system. Considerable work is underway across services to support this including:

- **Recruitment to Wellbeing Peer Practitioner roles** – these are new roles in our third sector services, they are integral to the delivery of our access model as outlined and are a core component of new workforce to support the CMHF
- **Developing Trainee Nurse Associates/Nurse Associates –** AWP developing these Nurse Associate roles across their services. Work continues to assess the level of Trainee and Registered Nurse Associates within services, including in BSW.
- **Registered Nurse Degree Apprenticeship (RNDA) –** an initial cohort is undertaking the accelerated two-year programme, with work underway to assess the prospects to support further applicants. This includes recruit-to-train initiatives.
- **Mental Health Wellbeing Practitioners (MHWPs)** – after recruiting an initial cohort of MHWBPs work is underway to recruit more MHWBP colleagues across AWP services. These roles are a key element of our changing community services as the community mental health framework is taken forward; MHWBPs provide wellbeing-focused psychologically informed interventions and coordinate care plans for adults with severe mental health problems.
- **Multi-Professional Approved Clinicians** (MPAC) – AWP's initial cohort of MPAC trainees are now well into their training, having started in the training programme in June 2022. An approved clinician is a mental health professional able to take certain decisions under the Mental Health Act; this programme enables clinicians from several different professions to train to become MPACs, supporting services, which may be struggling to recruit sufficient doctors.
- **Physician Associates** – Physician Associates (PAs) are healthcare professionals with a generalist medical education who work alongside doctors, providing medical care as an integral part of the multidisciplinary team. PAs work under the supervision of a doctor but can work autonomously with appropriate support. Work is underway to introduce Physician Associate roles into a number of our services.
- **Clinical Associate Psychologists** (CAP) – AWP colleagues in BSW currently have three trainee CAPs nearing qualification. Further trainees will be added this year to add to the psychological professional workforce and increase capacity for psychological therapies across the system.

We have a newly established Mental Health Workforce Planning Oversight Group in place where we review these initiatives, share learning and experience and consider how we can further transform our workforce to deliver the aims and objectives of the CMHF.

Measuring our impact

In addition to planned service improvements, we are required to develop a new approach to measuring our impact – using a new outcomes framework and methodology. We have been working with colleagues in Bristol, North Somerset and South Gloucestershire (BNSSG) ICS to co-develop our outcomes framework. Given that much of the data covers adult services provided by AWP which spans both BSW and BNSSG, bringing together the two systems will ensure that we are making efficient use of our business intelligence resources and ensure that there is a pan-Trust approach to measuring outcomes.

<table>
<tr><td rowspan="4">Access to early support and treatment</td><td>People will receive first contact from Access services within 24 hours</td></tr>
<tr><td>People will have to wait a maximum of 4 weeks from initial contact to evidence informed treatment</td></tr>
<tr><td>People will access the right support first time:

• % of people accessing advice & guidance (reducing referrals into secondary MH care)
• Patient survey</td></tr>
<tr><td>Supporting metrics:

• How many people needed access to a service (i.e. total referrals)?
• How long did their support last (i.e. length of treatment)?
• How many people are still awaiting first contact (i.e. waiting list size for assessment)?
• How many people are still awaiting start of their treatment (i.e. waiting list size for treatment)?
• How many people are still receiving treatment (i.e. the active caseload)?</td></tr>
</table>

<table>
<tr><td>People will experience equal access to support</td><td>Programme of work to test equity of service for all, aiming to answer key questions:

• Do rates of service request mirror those of the population being served?
• Is a timely response for assessment and treatment provided equitably for all groups?
• Is the range of treatment options offered the same for all groups?
• Are the outcomes achieved the same for all groups?</td></tr>
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<table>
<tr><td>People will receive support aimed at preventing crisis episodes and avoidable harm</td><td>People will be supported by their community mental health team, reducing their use of other services

• How many A&E attendances were there due to issues related to mental wellbeing?
• How many admissions were there to Acute Hospital inpatient services due to issues related to mental wellbeing?
• How many people were detained under s135 or s136?
• How many people were admitted into a Health-based Place of Safety?
• Evidence of appropriate drugs monitoring / medication review (incl. the impact on physical health)</td></tr>
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	People will be supported by their community mental health team, minimising their need for crisis / inpatient support
	
	• How many people required support from mental health intensive / crisis teams?
	• How many people were admitted to an acute mental health inpatient bed?
	  ○ Total admitted into an NHS or private bed in the region
	  ○ Total admitted into a non-NHS bed outside the region
	• How many people required s117 aftercare?

	People will be supported to prevent / avoid harm • E.g. total incidents of self-harm (list to be expand by quality colleagues)
	Supporting metrics: • Bed availability compared to national benchmark • Admission rate compared to national benchmark

Patient and carer experience of service	People have a positive experience of service and support; people do not experience stigma • Friends & Family Test (FFT) • Total responses to FFT • Service user survey
	Carers feel supported and central to the support offered to service users • Carer survey

The service will help service users on their recovery journey	People's care will be effectively coordinated • % of people with SMI / Complex needs with a link worker
	People will have improved physical health • Mortality gap for people with SMI reduced • Annual physical health check for people with SMI (LTP target)
	Clinician Reported Outcome Measures (CROMs) • Mental Health Cluster Tool (requirement for statutory MH providers)
	Patient Reported Outcome Measures (PROMs), used to understand outcomes for patients (some of which are noted below) – incl. holistic tools • Tools to be agreed in year 1
	People will be able to live more independent lives • Reduction in the number of people with SMI frequently attending their GP
	People able to access education & training • The number of people in employment

	• Data from the Improving Placement Support (IPS) service
	People have access to safe, warm home and a health standard of living • The number of people living in settled accommodation

The workforce feels supported and effective at delivering the service	Staff retention will be above the national average • Turnover rate • Vacancy rate
	Survey results indicate that staff feel that they can make a difference AND that they are enabled by IT to do their jobs • Annual NHS staff survey results • Local staff survey
	Supporting metrics: • Sickness rate (target to be in line with national average for MH services) • Supervision rate (target = 85%) • Appraisal rate (target = 90%) • Statutory/mandatory training rate (target = 90%) • Usage of bank / agency staff (baseline in year 1)
Good quality data will be collected to support monitoring & oversight	The system will ensure timely and accurate Mental Health Services Data Set (MHSDS) submissions • % of providers routinely submitting an MHSDS return (target = 100%) • Data Quality Maturity Index (DQMI) score for each provider (target = 95%) • % patient interventions submitted to MHSDS with a valid SNOMED (clinical coding tool) code assigned (target = 70%) • % patients with protected characteristics recorded (target = 95%

Whilst much of this data is already collected, consolidating this into a single, overarching suite of indicators and report will enable us to link together key metrics such as staff and patient experience. We are also aiming to gather this data by place area, so that we understand the impact of our new model on people from B&NES, Swindon and Wiltshire specifically.

This is a large scale piece of work and will take time to develop over the coming year. As we produce this new data set, we anticipate that we will expand and develop the indicators used, including how we start to use information from other partners (eg Police and Local Authorities) to supplement this core data set and evidence outcomes achieved through increasingly integrated service provision. Likewise, how we share the information we gather with system partners is also important so that we are using data and insights from our population to inform wider work.

As we develop this outcomes framework, we will develop and deepen our understanding of specific inequalities affecting our population. We also intend to align this with the Population Health Management Programme so that we can evidence both impact and outcomes for people from specific groups across our BSW population.

Implementation of a new care planning process

As part of CMHF implementation, NHS England requires all systems to move away from the current Care Planning Approach (CPA). CPA is currently used as an assessment tool around

which treatment is planned by providers. The intention is to move towards a more goal based approach to care planning and work is underway within AWP and across the system to understand what tools we will deploy to enable this.

Leadership and Governance

Given the size and scale of the work underway it is important that we have a structured approach to leadership and governance.

To that end we have a well-established Community Services Framework Oversight Group, at which all places are represented. Beneath this group sit a range of sub-groups aligned with the specific pathways outlined. These are led by provider representatives, with lived experience leads represented in every sub-group.

The CSF Oversight Group reports to the Thrive Working Group and through that to the Thrive Programme Board. This enables us to connect practical delivery and oversight to wider strategic discussions, ensuring that we are taking a whole system view of the future direction of travel informed by evidence gathered through existing transformation.

Future direction

The CMHF was intended as a 5 year transformation programme and as such additional transformation funding will cease at the end of 2023/24. We are in the process of developing our plans for 2023/24, building on what we have set out to do this year and delivering the ambitions set out in the CMHF roadmap.

We know, however, that the transformation work that is happening in community services is the start. The development of the NHS 10 year plan in the coming year, alongside the development of our BSW system Mental Health Strategy, will require us to deliver further transformation in mental health and wellbeing services. This will be informed by our increasing understanding of population health needs and outcomes.

We have started to work on our revised Mental Health Strategy already. Colleagues from Wiltshire Council are and will continue to be part of this development work, and we would welcome the opportunity to share the outputs of this with you in early 2023.

Conclusions

The Committee is asked to **note** this report.

As outlined, this is a briefing document and we would welcome the opportunity to present more specific plans and outcomes in greater detail over the coming months.

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