

Improving mental  
health services in  
systems of  
integrated and  
accountable care:  
*emerging lessons  
and priorities*

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## Foreword

Nothing stands still. Not the NHS, not the people we treat or the communities they live in, not the staff or the many organisations who we work with.

While the NHS continues to evolve, all areas are being challenged to become “Integrated Care Systems” (ICSs) by 2021, with the aim of health and care organisations working together more closely in a “pragmatic and practical” way. This will involve complex changes including to contracting and funding flows.

Changes to “behind the scenes” of the health and care system is not something that most people who interact with these services will be aware of, and nor should they be.

Patients have no need to keep up with the latest health service acronyms. The only change they should be aware of is receiving better, more joined up care, which people with mental illness could stand to benefit most from.

This evolution is likely to change how care is delivered across England and brings opportunity for mental health services to be incorporated more fully with the wider health and care system rather than being unhelpfully annexed, with patients’ care often disjointed and partial as a result.

As ICSs will focus on prevention as much as treatment, there is a key opportunity for NHS organisations, local councils and other system partners to make progress in reducing morbidity and mortality rates for people with severe mental illnesses, as well as improving patient experience and reducing unmet need.

I’m proud that mental health services have made remarkable improvements to the availability and quality of services provided to patients in recent years, and of the strong track record of the leaders of these services to deftly work across complex systems and to innovatively redesign and adapt.

But mental health services remain under exceptional operational, workforce and financial challenges and have often been relegated to the side lines of local area planning. Our patients can suffer as a result.

So, while health services are systematically reviewed and re-configured as ICSs develop, it is essential that the voices of mental health services and their patients are heard, and not diluted or fragmented, in order to stay on track towards the end goal of delivering better, seamless care. The very existence of mental health trusts is because of a time when mental health services, and the needs of their patients, were drowned out by the acute sector. We cannot move back to that in the name of integration.

This guide aims to understand the priorities and lessons for improving mental health services in established and emerging ICSs and makes recommendations that reflect the opportunities and challenges for areas in doing so. I am particularly grateful for the time and patience of people working in the local areas who have shared their highs, lows, and everything in between.

There will be no end to this evolution, so I am in no doubt that these messages of advice will evolve and adapt along the way. I do hope that this provides a useful framework for local areas at this point in their evolution and that our recommendations to national bodies are acted on to enable this.



**Dr Adrian James**

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## 1. Introduction

In seeking to achieve a sustainable and high-performing health system, the NHS faces a major challenge of delivering good care through the cost-effective use of resources; reducing unwarranted variation in outcomes, quality and safety; and working to prevent disease. Achieving this 'triple aim' is dependent on breaking the traditional divide between primary care, community services, social care, mental health services and hospitals, and taking full accountability for population health outcomes.<sup>1</sup>

As well as NHS organisations, local authorities and the voluntary sector have a key role in promoting wellbeing and improving mental health in their communities. Over the next decade, the population of England is forecasted to grow by 5.9%, which will lead to greater demand across public, independent and third sector services.<sup>2</sup>

Improving care for vulnerable populations, and those who have complex health and care needs, is integral to these developments. For example, delivering integrated whole system care for the increasing population of older adults, including the very old, will not just need greater capacity across dementia, old age psychiatry and social care services, but true integration and new ways of working.

One of the core groups that stand to benefit most from health system reform are people living with mental illnesses, and alcohol and substance use disorders; given the associated impact on quality of life, morbidity and mortality. Mental illness remains one of the largest single causes of disability in England<sup>3</sup> with up to one in five mothers suffering from depression, anxiety or psychosis during pregnancy or in the first year after childbirth<sup>4</sup>, at least one in eight children and young people aged 5–19 have at least one mental disorder<sup>5</sup>, one in six adults have a common mental disorder and 1–2% of adults have a severe mental illness.<sup>6</sup> Mental illness also disproportionately affect people living in poverty, those who are unemployed and who already face discrimination.<sup>7</sup>

Local health systems are expected to make changes to reduce the fragmentation of healthcare. The introduction of any new model of care, whether it be a population-based model, or an accountable provider collaborative model, is likely to significantly change the delivery of care in the respective area. As these new models aim to reduce the traditional divide between primary care, community services, mental health services and hospitals, there is an opportunity to integrate mental health comprehensively into the wider health system.

At a time of rapid expansion, there is a compelling case to advance our understanding of these issues and the associated impact on the delivery of mental health services and given the mental health sector's experience of innovation in service redesign and delivery, there is an opportunity for its leaders to support others in changes across the local system.

## Purpose of research

Through a combination of research, policy analysis, site visits and interviews, this report aims to better understand the priorities and lessons for improving mental health services in established and emerging ICSs and make recommendations that reflect the opportunities and challenges in doing so. As ICSs and STPs are evolving, we recognise this is an iterative process and that further lessons and priorities will emerge as more ICSs are established across the country.

Ultimately, the Royal College of Psychiatrists (the College) hopes ICSs will:

- enable improvements to mental health services to be made at pace, in line with national policy priorities, including through the development of five year plans;
- provide a foundation to sustain improvements made in the *Five Year Forward View for Mental Health*<sup>8</sup> and the *NHS Long Term Plan*<sup>9</sup> through longer-term outcomes-based plans and contracts;
- provide an opportunity to better integrate mental health into primary care, urgent care, social care and specialised commissioning, including delegated commissioning across a region; strengthen engagement between NHS organisations, local authorities and the voluntary sector on population health management;
- proactively address the recruitment and retention of the mental health workforce;

In doing so, we envisage that both long- and short-term mental health outcomes are improved for the population through greater coordination and cooperation across multiple organisations and agencies.

We have been collecting information to understand how mental health leaders have been working with their local areas to improve mental health services. We have spoken with 21 leaders working across the following 14 ICSs, STPs and provider collaboratives:

1. Bedfordshire, Luton and Milton Keynes/ North East London
2. Black Country and West Birmingham
3. Devon
4. Frimley Health and Care
5. Greater Manchester Health and Social Care Partnership
6. North Cumbria Health and Care System (formerly West, North and East Cumbria STP)\*
7. North East and North Cumbria\*
8. Northamptonshire Health and Care Partnership
9. South East London
10. South London Mental Health and Community Partnership
11. South West London Health and Care Partnership

12. South West Regional Secure Services
13. Surrey Heartlands
14. West Yorkshire and Harrogate Health and Care Partnership

\* NB: Cumbria sits across two STP areas – West, North and East Cumbria Health and Care Partnership in the north and in the south in Healthier Lancashire and South Cumbria. The former was selected to become an ICS in May 2018, and developed as North Cumbria Health and Care System. North East and North Cumbria ICS was launched in March 2019 in the 3rd wave of ICS development, and is an amalgamation of four existing ICSs, including North Cumbria Health and Care System.

Given the importance of leadership, particularly, clinical leadership, we have also conducted a survey of psychiatrists through the Royal College of Psychiatrists' Research Panel<sup>10</sup> asking about their understanding of, involvement in and priorities for ICSs and STPs.

This project builds on our report, *Mental health and new models of care: lessons from the vanguards*, developed in partnership with the King's Fund, which primarily focused on multispecialty community providers and primary and acute care systems.<sup>11</sup> It also draws on the findings from a College's seminar with national and local leaders involved in the formation of ICSs. Learnings from other integrated models of healthcare from the United States, Scotland and Wales are also drawn on (see Appendix 5 for background information).

## 2. Policy context

This chapter sets out the policy context relating to NHS local planning, contractual and legislative reforms and considers the important and unique role of mental health services in ICSs.

### Planning processes, contractual and legislative reform

The *Five Year Forward View*, set out a strategy for achieving the 'triple aim', which included the formation of Sustainability and Transformation Partnerships (STPs) – collaborations between health and care organisations across England.<sup>12</sup> These partnerships included both NHS organisations and local councils and, together, they developed proposals to run services in their area in a more coordinated way.

In 2017, following the formation of 44 STPs, NHS England encouraged advanced STPs to become Integrated Care Systems (ICSs) (formally known as Accountable Care Systems) – a more evolved version of an STP. Between 2017 and 2019, 14 ICS, including two devolution deals, were formed across the country in two 'waves'.<sup>13</sup>

ICSs bring together local organisations in a pragmatic and practical way to deliver 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. Through an ICS, commissioners make shared decisions with providers on population health, service redesign and the implementation of the *NHS Long Term Plan*, as well as working with local authorities at 'place' level (250-500k population size).<sup>14</sup>

In January 2019, the *NHS Long Term Plan* went a step further and called for all STPs to become ICSs by April 2021, with funding flows and contract reform to support the move.<sup>15</sup>

In its subsequent guidance for health and care leaders – '*Designing integrated care systems (ICSs) in England*' – NHS England set out the different levels of management that make up an ICS, describing their core functions, the rationale behind them and how they will work together.<sup>16</sup> A ICS maturity matrix outlines the core capabilities expected of emerging ICSs, developing ICSs, maturing ICSs and thriving ICSs (see Appendix 3). For a system to be formally named an ICS, it needs to meet the attributes of a maturing ICS.

The national implementation framework for the *NHS Long Term Plan*<sup>17</sup>, published in June 2019, aims to support STPs/ICSs to undertake strategic planning for their local system five-year plans to be agreed by mid-November 2019. It sets out broadly what the NHS needs to deliver from 2020/21 through to 2023/24, including national 'must dos' and how local areas build capacity to deliver and phase progress in line with their STP. NHS England's national mental health programme team published detailed



implementation guidance for mental health providers and commissioners<sup>18</sup> to support this. 2019/20 is a transitional year to start implementation of the LTP. Key deliverables for mental health in the 2019/20 operational planning and contracting guidance for the NHS can be found in Appendix 4.

NHS England proposes that service integration can be delivered locally in a number of ways, such as through collaborative arrangements between different providers, local 'alliance' contracts and through Integrated Care Provider (ICP) contracts.

The development of these reformed contracts is underpinned by the 2016 *New Care Models Programme* where 50 'vanguard' sites tested out one of five new models of care.<sup>19</sup>

Service integration occurs horizontally and vertically. Horizontal integration allows services to be coordinated by grouping organisations providing a similar level of care under one management umbrella, consolidating resources to increase efficiency. This can include GP federated models, provider collaboratives and mergers between NHS trusts.

Vertical integration coordinates services by organisations delivering care at different levels of the health system, such as primary medical care, community services and hospital services, under one management umbrella. Examples include multispeciality community providers (MCPs), primary and acute care systems (PACSSs), and primary care networks and ICPs that are central to the *NHS Long Term Plan*. This is crucial in delivering joined up care and new ways of working – for example, delivering better outcomes for older adults across Long Term Plan commitments to improve community-based integrated mental and physical health care and community and crisis mental health care for older people.

In addition, NHS England and NHS Improvement are proposing legislative change to reduce the fragmentation of care. While reforms to commissioning, public health and regulation by the Health and Social Care Act (2012), aimed to make the NHS more responsive, efficient and accountable, fragmented services still remain.

NHS England argues that service improvements through ICSs can be achieved within the current statutory framework, but legislative change would allow this to happen more quickly.<sup>20</sup> NHS England and NHS Improvement's recommendations to Parliament and Government for legislative change are included in Appendix 7. In the October 2019 Queen's Speech the government committed to consider these proposals and subsequently bring forward legislation.<sup>21</sup>

## The case for change: why do mental health services matter in an ICS?

### *Demand and use of mental health services*

ICS leaders have a clear role to identify and quantify the drivers and outcomes for addressing local population health through population health management approaches and reducing unwarranted variation. This aligns with the role local councils have in working with NHS organisations and the voluntary sector to support and influence mental health through prevention, early intervention and tackling inequalities.<sup>22 23</sup>

Across the country growth in population and incidence of mental illness will lead to greater demand for mental health services.

Ahead of the *NHS Long Term Plan* the College argued that more children and young people in the population suggests capacity will need to be increased for child and adolescent mental health services (CAMHS), parenting programmes, self-harm, substance misuse and criminal justice liaison services.<sup>24</sup>

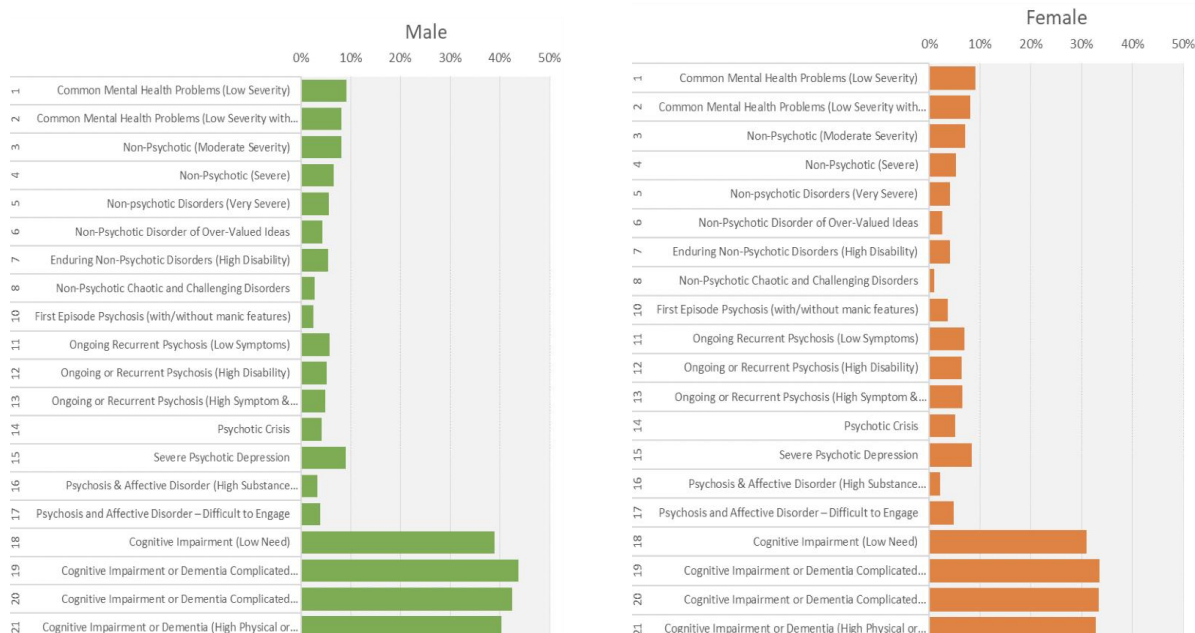
An increase in people aged 30–45 indicates a greater demand in the future for Improving Access to Psychological Therapies (IAPT), maternal wellbeing, workplace wellbeing and early intervention service.

A greater number of older adults, including the very old, means that there will be an increased need for capacity in dementia, old age psychiatry and social care support services.<sup>25</sup>

When applying these demographic changes to the current age-gender profiles of patients receiving care in each 'care cluster', a more detailed estimate of where increased demand for specialist adult mental health services may present over the next 10 years is given (Figure 1).<sup>26</sup>

Demographic changes such as these are reflected in the *NHS Long Term Plan* and the *Mental Health Implementation Plan*. ICSs now have a critical role when developing their five year plans to take this into account while adapting to local needs and health inequalities.

*Figure 1. Estimated percentage growth in care cluster caseload in England (Male and female), 2018-2029*



ICSs also need to assess the use of healthcare resources across a system that goes beyond their individual organisation.

For example, we know that adult and older adult mental health service users utilise acute emergency services disproportionately – 7% of the adult (over 15) population in England utilise mental health services, but 17% of all A&E attendances and 24% of all non-elective inpatient admissions are for patients who are also mental health service users (Figure 2). The difference in spend on a subset of A&E and inpatient activity for mental health patients compared to the rest of the population suggest significant opportunities to reduce spend on potentially avoidable emergency care – nationally around £65m on A&E and £1.4bn on inpatient services.<sup>27 28</sup>

Figure 2. Proportion of England population and acute health point of delivery

Population sub-group	% of England population (15+)
<b>All mental health service users</b>	<b>7.0%</b>
Cognitive impairment including dementia	1.8%
Psychoses	1.8%
Personality disorders	0.2%
Common and other mental health	1.8%
Mental health, unassigned	1.5%
<b>Rest of population</b>	<b>93.0%</b>
Acute physical health services only	44.2%
'Well population' (no acute demands)	44.8%

Acute healthcare point of delivery	% utilised by mental health service users
Accident & Emergency attendances	17.2%
Non-Elective admissions	23.7%
Elective (overnight) admissions	8.9%
Elective (day case) admissions	8.1%
Outpatient attendances	9.3%
Diagnostic imaging	13.0%

Despite the prevalence of mental illness, two-thirds of people do not have access to evidence-based treatment<sup>29</sup> and people with severe mental illnesses die 15-20 years earlier than the rest of the population. Based on data from 2012/13 to 2014/15, the gap in life expectancy in England is 19 years and 16 years respectively for male and female mental health service users when compared with the rest of the population. Prior to this, the gap had only reduced marginally over the preceding 7–8 years.<sup>30</sup>

Users of specialist mental health services are more likely to die from any physical health causes than those who don't. Many 'excessive' deaths could be prevented or delayed by the more widespread use of evidence-based interventions, including health checks and extended lifestyle support, medicine reviews and community falls prevention.

Given the focus of ICSs on prevention as much as treatment, this should provide an important opportunity for NHS organisations, local councils and other system partners to make progress in reducing mortality for people with severe mental illnesses.

### *Capacity and capability of mental health services*

For ICSs to make changes leading to the best possible patient outcomes, the capacity and capability of mental health providers must be considered.

Three years into the *Five Year Forward View for Mental Health*<sup>31</sup>, local services have made remarkable improvements to the availability and quality of services provided to patients, namely in children and young people's eating disorder services, perinatal services and improving access to psychological therapies (IAPT) services.<sup>32</sup> The introduction of the first waiting time standards for mental health means increasing numbers of people are now accessing treatment and support, with an estimated 2.5 million people in contact with NHS-funded secondary mental health, intellectual disability and autism services in England during 2017/18.<sup>33</sup>

But mental health services are at a critical point in their evolution and under exceptional operational, workforce and financial challenges. While the Long

Term Plan seeks to shift towards a longer term planning process, some of the building blocks that underpin these policy changes, such as funding, workforce and data, may remain susceptible to in-year planning and operational changes.

Mental health trusts are overall, financially stable organisations with a posted overall surplus of £297m in 2017/18, compared to a planned surplus of only £125m. Given the payment mechanism between commissioners and mental health trusts is predominantly via block contract, this is likely to represent underspending. This is important for mental health trusts when considering their position in the wider health economy, particularly regarding system control totals. Mental health trusts should play a key role within ICSs to influence decisions over new investment and ensure funding reaches frontline mental health services.

It is also evident that the mental health workforce is particularly challenged. There are, however, promising signs of growth in the psychiatric workforce with a 2.5% increase in psychiatrists in the NHS in the past year<sup>34</sup> and an increase of 31% in doctors choosing to train in psychiatry after the first and re-advertised recruitment rounds in 2018 compared to 2017.<sup>35</sup> But a high proportion of vacant posts remain across psychiatry, nursing and allied health professional roles.

The College has argued that the mental health workforce plan, *Stepping Forward to 2020/21: Mental Health Workforce Plan for England*, came too late in the planning cycle. There are now significant difficulties in translating this at a local level, which impacts on the delivery of the mental health programme.<sup>36</sup>

Senior health leaders have argued there is too much variety in the quality of relationships between Health Education England and NHS providers and have called for a closer relationship between arm's-length bodies, universities and employers.<sup>37</sup> The College agrees that the separation of service planning, workforce planning and financial planning has had a negative impact on NHS services. Coordinating workforce planning and training at national and local levels must be given far greater priority.<sup>38</sup> ICS leaders have an opportunity to consider the workforce challenges across a larger geography, use updated workforce data to track progress and put joint plans in place to recruit and retain NHS staff, taking into account indicative figures from the Long-Term Plan Mental Health Implementation Plan, and ensure sufficient mental health leadership capabilities.

Previously, many improvements and challenges faced by mental health providers occurred in isolation from the wider local health and social care system. This might reflect why the quality of STP mental health plans has been variable. There has also been a lack of guidance from the centre on the best way to do this at a 'place-based' level in an organisationally-agnostic way.

The College's previous research looking at the mental health components of MCPs and PACS, found that while many vanguard sites included some mental health components in their care models, with several reporting promising early results, the full opportunities to improve care had not been realised. The level of priority given to mental health in the development of new models of care has clearly not always been sufficiently high, which is inconsistent with the spirit of the commitment in *Five Year Forward View for Mental Health*.<sup>39</sup>

As the introduction of any new model of care is likely to significantly change the delivery of care in an STP/ICS area, it is essential that mental health is considered at the beginning of the process.

### *Tackling the major policy challenges*

Ultimately, the development of ICSs needs to help solve the well-established, large-scale challenges noted previously and support successful delivery of the Long Term Plan's ambitions. At a local level, examples of successfully doing so would be:

- ending inappropriate out of area placements for acute inpatient treatment or rehabilitation
- delivering integrated whole system care across different types and tier of services for complex conditions such as dementia and for people with learning difficulties
- a workforce that meets the demand for mental health services, is fully valued and supported and working in multidisciplinary teams to deliver high quality care
- development of culturally competent mental health services with full engagement across minority groups.

As part of our research, RCPsych's Research Panel members were asked what they thought the markers of success would be for their Integrated Care System in 5 years' time. A range of markers was suggested, with many centring around more joined-up ways of working and patient care pathways – further details of their feedback can be found in Appendix 10.

### 3. Mental health in integrated care systems

This section describes the changes happening across local health systems and the impact on the mental health of the population. This covers approaches to population health management and contractual models for greater cooperation and integration.

These changes are occurring across different 'tiers' of the health and care system (figure 3). Case study snapshots illustrating the breadth of changes happening across the country are included in this section, with more detail in Appendix 8.

#### Approaches to population health management

Population health means the health outcomes of a group of individuals, including how these outcomes are distributed within the group. It is an approach that combines patterns of health determinants, health outcomes, and policies and interventions that link the two.<sup>40</sup>

Population health management aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities by focusing on the wider determinants of health and the role of people and communities.<sup>41</sup>

The King's Fund framework for population health centres on four pillars:

- the wider determinants of health
- health behaviours and lifestyles
- the places and communities we live in, and
- an integrated health and care system.<sup>42</sup>

The role of ICSs in the first three of these pillars needs to acknowledge that the reach of the NHS does not extend easily to all these areas – ICSs need to strengthen the way NHS organisations work with local authorities and the voluntary sector in implementing effective action in this area, based on best practice.<sup>22 23</sup>

The fourth pillar is a central component for ICS development, supported by population health management techniques that use big data to drive planning and delivery of care. With quality data, this can involve identifying local 'at risk' groups through segmentation and risk-stratification. Interventions then can be targeted at preventing ill-health, improving care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

ICSs can use population health management approaches by:<sup>43</sup>

#### 1. Better understanding the needs of the population

- Joint Strategic Needs Assessment (JSNA), undertaken in partnership between the NHS and the local authority
- Individual patient timeline creation
- Patient pathways in real life
- Unwarranted variations (underuse/overuse of services).

## **2. Analysing opportunities to improve the quality of care:**

- Find duplication in healthcare costs, any gaps in care, triple fail events (instances where all three aspects of the triple aim fail to be achieved) and address them.

## **3. Maximising the predictive power of intervention:**

- 'Impactibility' modelling: identify those who will and will not respond to preventive interventions before intervening.

## **4. Financial impact assessment:**

- Assessing long-term financial viability and capturing multi-sector financial impacts outside of healthcare costs, enabling a single budget for a broad scope of healthcare services.



Figure 3. NHS health system 'tiers'

Tier	Population size	Purpose	Typical model of care	Priorities from the Long Term Plan*
<b>Neighbourhoods</b>	30-50,000	Network practices  Integrated models of care for a defined population	GP federations  Primary care networks  Multispecialty community provider  Primary and Acute Care Systems	<ul style="list-style-type: none"> <li>• Integrate primary and community services</li> <li>• Implement integrated care models</li> <li>• Embed and use population health management approaches</li> <li>• Roll out primary care networks with expanded neighbourhood teams</li> <li>• Embed primary care network contract and shared savings scheme</li> <li>• Appoint named accountable clinical director of each network</li> </ul>
<b>Place</b>	250-500,000	Borough council level  Integrate primary care, local authority and hospital services	Primary and Acute Care Systems  Urgent and emergency care networks	<ul style="list-style-type: none"> <li>• Closer working with local government and voluntary sector partners on prevention and health inequalities</li> <li>• Primary care network leadership to form part of provider alliances or other collaborative arrangements</li> <li>• Implement integrated care models</li> <li>• Embed population health management approaches</li> <li>• Deliver Long-Term Plan commitments on care delivery and redesign</li> </ul>

<b>Systems</b>	1+million	System strategy and planning Hold places to account Implement strategic change Manage performance Manage funding across health system	Sustainability and Transformation Partnerships  Integrated Care Systems  Devolution agreements	<ul style="list-style-type: none"> <li>• Streamline commissioning arrangements, with CCGs to become leaner, more strategic organisations (typically one CCG for each system)</li> <li>• Collaboration between acute providers and the development of group models</li> <li>• Appoint partnership board and independent chair</li> <li>• Develop sufficient clinical and managerial capacity</li> </ul>
<b>Region</b>	2-3 million	Regional teams work collaboratively across commissioning, providers and training and workforce  Hold systems to account	Provider collaboratives	<ul style="list-style-type: none"> <li>• Deliver service integration locally through collaborative arrangements between different providers (e.g. through local ‘alliance’ contracts or give one lead provider responsibility for integration of services)</li> <li>• Manage whole pathways of care</li> <li>• Work closely with ICSs to support improved commissioning of services for people within the same population footprint</li> <li>• Wherever possible, these collaboratives should seek to avoid inpatient admissions, and provide high quality alternatives to admission.</li> </ul>

Adapted from: NHS England. Designing integrated care systems (ICSs) in England. 2019. Available from: <https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf>

During 2019, NHS England committed to investing in population health management solutions to support ICSs understand their greatest health need and match NHS services. They envisage that ICSs will be able to routinely identify missed elements of pathways of care for individuals and ensure gaps are filled, as well as supporting greater transparency of health and social care data on population health outcomes and organisational performance.

New national commitments on tackling health inequalities are expected to lead to greater awareness and ability to respond to and manage inequalities across different pathways.<sup>44</sup> Implementing population health management capabilities to segment and stratify local population to understand needs of key groups and resource needs is a requirement of ICSs reaching 'mature' status.<sup>45</sup>

Reducing unwarranted variation is also a core responsibility of ICSs. NHS England expects all ICSs to bring together clinicians and managers to implement appropriately standardised evidence-based pathways.<sup>46</sup> In mental health, the *Getting It Right First Time* programme (GIRFT) for children and young people's services, adult acute services and rehab services are working with pilot providers to gather data and build the evidence about what works to reduce unwarranted variation and improve the quality of care.<sup>47</sup> This will be shared with other providers nationally as the programme develops over the next two years and should form a part of ICS population management approaches. There is agreement that savings made through the GIRFT programme are reinvested locally in mental health.

The College has argued that public mental health and wellbeing should be a major focus within population health management approaches, recognising the role of poor mental health as a major risk factor for many other conditions. This should include work on perinatal mental health, children and young people (where some of the greatest opportunities for prevention lie), and on wider services such as addiction, homelessness or housing services and employment support. This data can help clinicians to work with partners, including local authorities and the voluntary sector, to redesign pathways and services, and to understand the quality, strategic, commercial and financial opportunities and risks of a capitated approach to contracting.<sup>48</sup>

## North East London: a national dashboard for population health management

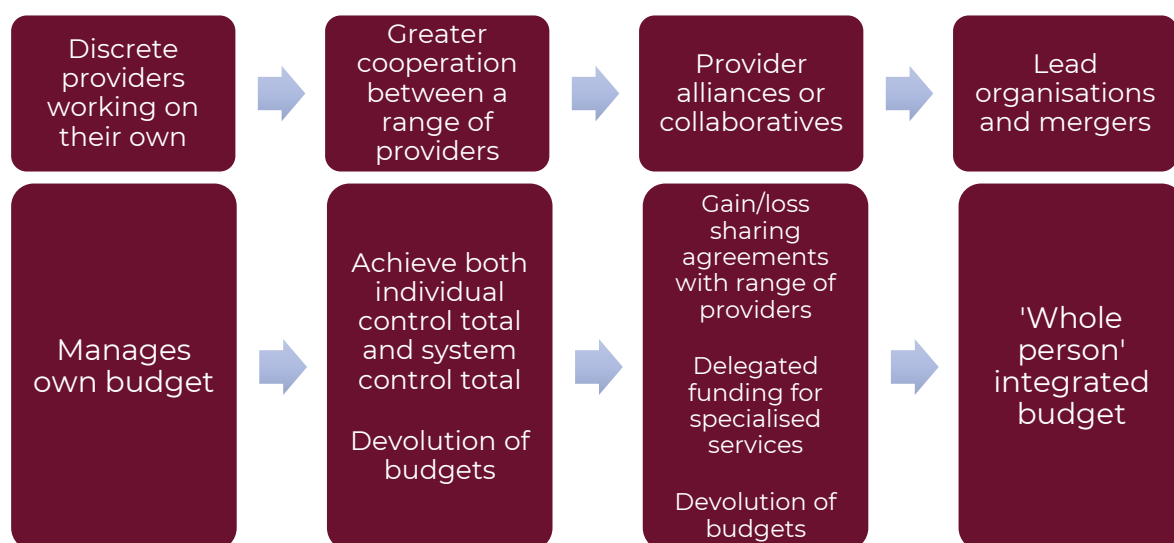
North East London Commissioning Support Unit, Cerner, OptiMedis-COBIC UK and Imperial College Health Partners are developing a national population health management dashboard for ICSs across the country.

The new performance and population health management dashboard provides a way to monitor activity, identify and effectively target resources to improve patient outcomes by joining together disparate elements of the health and care system. This involves combining national and local data including health, social and wider determinants of care.

Linking patient-level data from acute services, primary medical care, social care, mental health, community services and continuing health care, has enabled leaders to accurately assess how mental health conditions impact on activity and costs across the system. Initial work has focused on how activity and cost differ for people across four primary care registers (depression, dementia, serious mental illness and learning disabilities) alongside four long-term condition pathways (diabetes, chronic obstructive pulmonary disease, cancer and chronic kidney disease). This analysis is helping to shape the development of new whole-person pathways.

## Contractual models for greater cooperation and integration

ICSs provide an important opportunity to integrate mental health services within primary, acute, urgent and emergency care and social care. In seeking to do this, areas have taken a variety of approaches. This can be considered on a spectrum from:



The payment mechanisms needed to underpin these models include gain/loss share agreements, whole person integrated budgets, delegated commissioning, and devolution of budgets.

## **Provider collaboratives**

The Long-Term Plan Mental Health implementation plan sets the direction for the specialised commissioning mental health budget to be increasingly devolved to providers in NHS-led provider collaboratives.

A target for all appropriate specialised mental health services, and learning disability and autism services, to be managed through NHS-led provider collaboratives by 2023/24 has been set.

Initially focused on specialised MH and Learning Disability and Autism services, these collaboratives will play an increasing role in managing full pathways of care

Provider collaboratives are when similar NHS trusts, such as mental health trusts, come together to form a partnership to deliver health services to a wider population. These partnerships often bring together clinical expertise, experience and innovation, aiming to improve quality, use resources most effectively, and deliver best practice consistently to all patients.<sup>49</sup>

Provider collaboratives are:

- financially and clinically responsible for their patient population which will span several CCGs
- able to pool financial risk across the partnership allowing resilience to volatility in demand
- clinically-led with patient benefits at the centre
- able to demonstrate a mature partnership between providers with appropriate governance and clinical leadership
- backed up by contracts, explicitly governance and decision-making processes to support key relationships and resolve items of dispute, and
- held to account and incentivised through a set of system-wide outcome and performance measures, instead of being monitored against provider-focused and specialist services-specific measures.<sup>50</sup>

These partnerships do not mean a new organisation is formed. Given the potentially large footprint of providers, these partnerships often span ICS boundaries so often work in addition to population health plans at ICS level.

In many areas of the country, provider collaboratives are already responsible for some specialised mental health services (CAMHS tier 4, adult eating disorders and adult secure care). The policy ambition is for 75% of the population to be covered by a provider collaborative by 2020 and for further

roll out to all regions from April 2020. There is also an ambition for provider collaboratives to takeover other specialised mental health services as soon as possible post-April 2020.<sup>51</sup>

While many areas of the country are currently focusing solely on specialised commissioning services there are other areas which are taking responsibility for the whole patient pathway, thinking more strategically about the placement and care of a cohort of patients. It is envisaged that provider collaboratives will become the delivery vehicle for the *NHS Long Term Plan* in mental health. Working with ICSs, they will integrate pathways further and provide a mechanism for empowering clinicians and local leaders to improve their services.

#### **West Yorkshire and Harrogate Health and Care Partnership**

Improving mental health, learning disabilities and autism services are all national priorities and a local West Yorkshire and Harrogate Health and Care Partnership priority. They have a dedicated work stream within its ICS led by Dr Sara Munro (Chief Executive, Leeds and York Partnership NHS Foundation Trust). The NHS providers of secondary mental health services in West Yorkshire (Bradford District Care NHS Foundation Trust, Leeds and York Partnership NHS Foundation Trust, Leeds Community Healthcare NHS Trust and South West Yorkshire Partnership NHS Foundation Trust) have come together to form a provider collaborative (West Yorkshire Mental Health Services Collaborative) to ensure consistent outcomes for people accessing services based on integrated and standard operating models for acute/specialist mental health services. This will mean services are planned and delivered according to the needs of the population, through networked models of care and not an individual organisation.

Shared and aligned governance has been put in place to allow the four trusts to make timely decisions together to support service delivery and change, within a robust and challenging governance framework. This includes Committees in Common where the Chair and Chief Executives of the four trusts meet quarterly to oversee and make decisions relating to the programme. The Committees in Common do not undermine the statutory responsibilities of the trust Board and its directors who remain accountable for the services and the care provided by their trust.

The collaborative is also underpinned by a programme board which includes third sector, local authority, commissioners and HEE. This joint approach supports relationships with the West Yorkshire and Harrogate Joint CCG Committee.

### **South West Regional Secure Services**

South West Regional Secure Services are piloting a new approach to commissioning secure mental health provision for a regional population to provide care for people as close to home as possible, for the shortest appropriate period and in the least restrictive setting.

As the accountable provider, Devon Partnership NHS Trust is leading eight organisations to commission and deliver medium and low secure mental health services for adults. The partners include five NHS organisations, two independent sector organisations (Elysium and Cygnet), and one community interest company (Livewell Southwest). The partnership covers 22,000 square km, a population of five million people, within a budget of around £71 million. Following a shadow period that commenced in October 2016, the programme went live in April 2017.

The long-term vision for the partnership is to stop inappropriate patients being sent on out-of-area placements altogether and to reduce reliance on inpatient services, by investing in community forensic services. There are currently limited community forensic services across the region and the aim is to have seven fully-commissioned teams over the next five years. The members of the partnership developed a shared vision, clinical model and business model for a comprehensive secure mental health pathway, supported by its senior clinicians and leaders. They have introduced the following key actions:

- introducing a single point of access across the region, standardising the assessment and acceptance criteria
- implementing a regional approach to bed management to optimize in-region bed occupancy
- implementing a regionally coordinated repatriation plan for those people placed out-of-region – more than 140 people have already been returned to in-region services
- developing clinical networks standardising delivery of inpatient care and developing a shared set of clinical and patient-rated outcomes
- engaging with patient networks to ensure co-design
- successfully proposing the commissioning of additional specialist beds in the region, helping to address the historical under-provision of services locally
- re-profiling the use of some in-region beds to provide women's services, commissioning additional female secure beds and planning to introduce more women's services
- developing inpatient care pathways to reduce length of stay and address barriers to timely discharge
- developing community alternatives to support people in the community by developing a specification for comprehensive community forensic teams and successfully bidding for national monies to invest in a community forensic service across one county
- developing integrated working partnerships with accommodation providers
- enhancing existing specialist community forensic teams, namely Pathfinder services and FIND services
- engaging with and develop integrated solutions with commissioners and providers across Criminal Justice pathways, and
- contributing to the national design workstreams for community forensic teams, prison healthcare and women's services.

Provider collaboratives build on other emerging form of cooperation integration, including:

- **Greater cooperation** - NHS services and local councils coming together to run services through a joint plan, with commissioners maintaining existing service contracts with their providers.
- **Provider alliances** – when different organisations within a patch come together to agree on a common aspiration for their population, allowing local systems to agree on a risk and gain share mechanism.
- **Integrated Care Providers** - an organisation responsible for the integrated provision of primary medical services with wider NHS and potentially local authority services, which enters into an ICP contract with the commissioner(s) of those services.
- **Mergers and acquisitions** - when two or more organisations form a single organisation with a single governance and decision-making process, management structure and full pooling of assets.

See Appendix 9 for more details and examples of these other contractual models.



## 4. Emerging themes: opportunities and challenges for mental health leaders

This chapter draws out the emerging themes from discussions with local and national health system leaders when seeking to improve mental health services in ICSs.

Recommendations are made under each theme for national leaders and advice for local leaders based on feedback from the case study areas, discussions with the College's Integrated Care Systems Expert Reference Group, the College's existing policy framework and draw on lessons from three other countries that have sought to make similar changes (further detail in Appendix 6).

They are designed to support prioritisation of mental health as ICSs develop over the next 12-18 months, taking account of the variable pace of change in different areas and the importance of evaluating and learning in real time.

The recommendations should be considered in conjunction with the guidance provided by NHS England, particularly:

- [Designing integrated care systems \(ICSs\) in England](#)
- [NHS Long Term Plan Implementation Framework: system support offer](#).

Other helpful national, regional and local guidance is likely to be produced in the coming months, such as Healthy London Partnership's [Mental Health in ICS Implementation Tool](#).

## Key theme 1: Purpose and role of ICSs

### *Key messages*

- ICSs provide a real opportunity to improve and join up mental health services with the rest of the health and care system. But there is a risk that ICS leaders' attention will be drawn to organisational and governance structures with not enough focus on improvements in patient care. ICSs need to improve outcomes that matter most to patients.
- As well as being the vehicle used to deliver the mental health commitments from the *Five Year Forward View for Mental Health* and the *NHS Long Term Plan*, ICS leaders should also think in an innovative way about mental health and act as exemplars for the rest of the system.
- The ICS model needs to create an opportunity to work in partnership with others in ways local leaders would not be able to do otherwise.
- ICSs provide an opportunity to build the resilience of the wider system when under strain from unmet need and unexpected demand.
- The purpose and focus of ICSs must be regularly reviewed.

We heard from local leaders that a key purpose of ICSs is to develop a shared vision that is everyone's business. This can lead to greater awareness of what is happening across the system and foster new relationships, providing an opportunity to improve and join up mental health services with clear interfaces with specialised commissioning, primary care, community, acute and social care.

Better integration and coordinated care will support expansion in access and effectively meeting multiple needs across agencies. This will be particularly important when dealing with patients with complex needs, such as older people and individuals with learning difficulties. It also extends to public health and prevention too. When thinking about the mental health offer to a population of 30-50,000 people, ICS leaders can make plans that go beyond care delivery into prevention and the option for pooled budgets across NHS and local authority services can support this further. With the level of innovation that already exists in the mental health sector, there is the opportunity for ICS leaders to learn from these experiences of streamlining co-ordination between local organisations and redesigning services (e.g. the development of an integrated mental health care pathway in North East London NHS Foundation Trust and the National Rapid, Assessment, Interface and Discharge Network launched by Birmingham and Solihull Mental Health NHS Foundation Trust).

But there is a risk that ICS leaders focus too much on organisational and governance structures and not enough on improvements in patient care and outcomes. We heard that local leaders should consider whether it matters if services are provided through different organisations, as opposed to a single provider if the outcome is still the same.

As such, the first and most important principle of ICSs should be continuity of care. This must involve connectivity with other services, including for patients with complex needs. Mental health can be really general, but it can also be really complex. Therefore, ICS leaders should consider whether the changes will lead to a smoother patient journey. Some flows and connections for children and young people and adult mental health are really complex and while there is great potential for these transitions and patients' experiences of them to be improved, the complexity involved must not be overlooked.

We also heard that having enough time and capacity are significant the barriers to system-level working which mental health leaders are experiencing. The organisational culture and institutional fault lines in the health and care system (non-interoperable information systems, information governance issues, difficulties pooling budgets across sectors, and difficulties finding shared premises for integrated teams) were also considered major issues. We heard that the return on investment argument in mental health and the pressure to demonstrate in-year savings were also having a negative impact. To support Long Term Plan delivery significant growth in investment must be delivered in line with the additional funding which has been committed for mental health.

Another concern voiced was that ICSs might give the wider system an excuse for implementing what they were already supposed to be doing on mental health but badged as 'transformation'. If ICSs provide a vehicle for delivering the existing commitments on mental health that would not have ordinarily been delivered, then that is a positive step. However, we heard a desire for ICSs to innovate in mental health and act as exemplars for the rest of the system. By shifting the focus to population-based health ICSs should recognise mental health as a core priority for addressing unmet needs in their population and succeeding in delivering the triple aim.

We heard that another benefit of system-level working in ICSs is the collaboration between NHS providers, the independent sector and voluntary sector. This can help build the resilience of the system for when unmet need/demand presents.

Overall, ICSs' key purpose should be helping those with the poorest outcomes improve the fastest and their evolution should be regularly reviewed.

## Recommendations for national bodies:

### ***Capture learning and share best practice***

- NHS England & NHS Improvement should systematically capture and share learning from ICSs that are furthest ahead, including their governance arrangements, workforce plans and service models (specifically including mental health), to support and accelerate progress in other areas and to provide clarity about what is permissible and effective within the current legal framework.
- NHS England & NHS Improvement and Public Health England should require all 'Healthy New Towns' to report on their progress to promote mental health and wellbeing (amongst other priority areas) annually and take action accordingly.
- By spring 2020, NHS England & NHS Improvement to share annual GIRFT reports on mental health with ICS leaders.
- Mental health trusts exceeding core expectations in ICSs should work with those who are struggling through a peer-learning approach, beginning spring 2020

### ***Securing mental health services within a shifting health and social care landscape***

- We support NHS England & NHS Improvement's proposal that the Government should give CCGs and NHS providers shared new duties to promote the 'triple aim' of better health for everyone, better care for all patients, and sustainability, both for their local NHS system and for the wider NHS. This should also include an explicit requirement to achieve parity of esteem between mental and physical health care.
- Furthermore, the Government should introduce an obligation in primary legislation to reduce inequalities, including amending the statutory duties placed on CCGs, NHS England & NHS Improvement, local authorities and the Secretary of State. This should include:
  - an explicit requirement to assess the gap between people illness across the spectrum accessing health and care services and the rest of the population
  - a plan to improve and/or integrate services to close this gap year-on-year, and
  - an explicit requirement on the Secretary of State for Health and Social Care to assess how well NHS England & NHS Improvement and Public Health England have fulfilled these legal duties and respond publicly each year.

## Advice for local system leaders:

### ***Implement national policy commitments***

- Mental health and Long Term Plan ambitions to improve mental health to be reflected as a top priority with the full programme delivery supported and tracked at ICS board level. This should align with the national NHS Mental Health Implementation Plan.<sup>52</sup>

- As ICSs and STPs develop their 5-year strategies to reflect the mental health commitments in the *NHS Long Term Plan* and its implementation framework and supplementary guidance, the commissioning, design and implementation of any new models of care should be consistent with the requirement to deliver parity of esteem.

## Key theme 2: Planning process - engaging and collaborating

### *Key messages*

- Mental health needs to be a standalone ICS workstream as well as be embedded throughout other relevant workstreams.
- Local leaders should begin with planning mental health services at 'place', which should translate to ICS level if there is good evidence and reason to do so at scale.
- Leaders need to know how to co-produce and then communicate changes to the public. Patient and carer engagement needs to be meaningful and sustained.
- All plans made in ICSs will succeed or fail depending on the workforce. ICSs present an opportunity for workforce planning and joint training across a wider geography spanning multiple providers, as well as improving clinical leadership.

We heard that, in addition to Mental Health being embedded into other ICS workstreams, it also needs a separate standalone workstream to prevent dilution and to stay on the wider ICS agenda. It was seen as very important for mental health to have its own identity to maintain momentum and profile. As the NHS Confederation and NHS Providers' Community Network have highlighted, the full involvement of community services at the heart of the development of the future system architecture is also needed to effectively redesign care around the health of a population.

We heard that in many areas, the conversation between CCGs and acute providers continues to dominate the narrative at ICS level but often at place-based level, conversations between pressures on acute as well as mental health are fairly balanced. It is vital that the larger acute component of new integrated models does not overshadow the voice of community and mental health or affect the ability of some providers to operate smaller scale specialised services.

ICSs provide an opportunity for commissioners and providers to come together to own system-level problems in their areas. Advice from system leaders suggests that ICSs should first consider all their current activities at a place-based level, and how they can learn from them.

Secondly, ICSs should work out where their clinical expertise sits and find ways to share expertise across their patch. Thirdly, ICSs should consider what is most effective and efficient to replicate at ICS level to define their mental health strategy and delivery model, including building on the emerging NHS-led provider collaboratives. Essentially, place-based

planning is where the majority of work should be happening, and it should translate to ICS level if there is good evidence and reason to do so at scale.

Therefore, one of the critical tasks for ICSs is considering what this approach means for mental health provision and how services are organised (e.g. which services can be delivered in neighbourhoods, which services need to be provided at borough level or which could span different boroughs etc). This will determine how best to deploy resources, and how staff will need to work in the future.

We also heard about a need to put more emphasis on patient and public sector engagement – some local areas are not engaging well with patients which is either because they are not competent to do this, or it is just not seen as core business. ICS leaders need to know how to co-produce and communicate. There are four building blocks to this: statutory, voluntary, co-production and an asset-based community development approach. We heard that ICSs will have failed if they have not stitched these elements together.

All plans made in ICSs will succeed or fail depending on the workforce. ICSs present an opportunity for workforce planning across a wider geography as well as joint training opportunities. Local leaders said they need to consider how ICSs can better promote workforce wellbeing and resilience that goes beyond individual organisation level. We also heard about the need to train junior doctors to understand the healthcare landscape and how mental health can fit into this.

But we heard that a narrative is beginning to develop in relation to the workforce that due to difficulties in recruiting perhaps alternatives could be used. There is clearly a role to play for peer workers and volunteers, but they do not replace the need for professionally qualified staff. There was, however, a great deal of support for the creation of new roles in mental health, such as care navigators, nursing associates and physician associates. Some areas are also considering a new joint health and social care role.

We also heard that it has been a huge challenge to find the staff to work in new specialised mental health services developed through provider collaboratives. But working in conjunction with ICS partners, the independent sector has not poached staff from NHS services and there is a genuine sense of working in collaboration.

As we move towards planning healthcare services around neighbourhoods, there will be different workforce challenges and requirements. ICSs, working in partnership with providers across their area, need to develop workforce strategies that build on existing knowledge and expertise in their local areas, as well as national tools and guidance, to address the workforce challenge. This will require capacity and capability. But we heard that there

has been a lack of clarity on what the ICS requirements are in terms of delivery from the centre. Some leaders were also surprised at the lack of detail in the *NHS Long Term Plan* about what needs to be done at the neighbourhood level, as this is a key building block.

As noted under Key theme 5, when workforce planning, there is also a need to consider leadership capability and competency in mental health. This must ensure leaders in mental health are trained and comfortable in engaging leaders across the local system in a way that is mutually beneficial and improves population health outcomes.

### Recommendations for national bodies:

#### ***Ensure transparent and accountable care***

- All ICS should have an identifiable lead Mental Health Provider and a regional mental health Senior Responsible Officer (SRO).
- NHS England & NHS Improvement should publish and keep updated an organogram with contact information of each mental health SROs at the regional level, as well as ICS leads, mental health leads and workforce leads, to increase visibility and accountability.
- Building on earlier published details, NHS England & NHS Improvement regional teams should clarify how they will support ICSs to work in collaboration with their partners, and what action they will take if relationships break down.
- By end of 2019, NHS England & NHS Improvement should review each STP/ICS on their mental health plans, level of planned integration, and mental health leadership representation (including people who use services) and support those that need further development. This should form part of a more sophisticated approach to assessing and supporting the performance of STPs and their readiness to progress to an ICS or ICP as directed by a joint national transformation strategy.

#### ***Workforce and training for ICSs***

- NHS England & NHS Improvement should hold regions and local areas to account for developing and implementing local 'people plans' which fulfil the requirements set out in the NHS Mental Health Implementation Plan, the interim NHS People Plan as well as Stepping Forward to 2020/21: Mental Health Workforce Plan for England.
- NHS England & NHS Improvement and Health Education England should provide greater clarity about the roles and functions of their organisations in national workforce planning and how they will work more strategically and cooperatively with employers and universities.
- By autumn 2019, NHS England & NHS Improvement should clarify the role and governance arrangements of newly formed regional teams for mental health and regional mental health SROs.
- By the end of 2019, NHS England & NHS Improvement and Health Education England should publish the final *NHS Long Term Workforce Plan (People Plan)* including a strategy for the next 10 years that aligns



with the mental health commitments in the *NHS Long Term Plan*. This should include mental health workforce numbers required to deliver service expansion, the number of new medical school places required over the period, as well as a transparent process to allocate those places to medical schools that have a strategy in place to help tackle the shortage specialties issue. a strategy for recruitment and retention of the mental health workforce and plans to introduce new roles and ways of working that promote integrated care for people with mental illness.

- By end of 2019, Health Education England’s regional leads should assess the quality of mental health workforce plans at ICS level for 2019/20 and beyond, with feedback made available to the public.
- To bring together commissioning and workforce activity we strongly recommend that the Government revisit whether national responsibilities and duties for workforce functions are sufficiently clear, as proposed by NHS England and NHS Improvement.
- Health Education England should ensure that a substantial proportion of the CPD budget is ring-fenced for mental health, in line with the size of the mental health workforce with an additional sum to reflect past disparity.

### Advice for local system leaders

#### **Engage and collaborate**

- Engage with patients, public and local Healthwatch to develop a shared understanding of patient needs and work together to design services to meet these needs.
- Engage with the NHS workforce, including psychiatrists, nurses, psychologists, allied health professionals and other mental health professionals to ensure a shared understanding of patient needs and system challenges, and improvements are designed to meet them in a collaborative way.
- Work with local health and social care partners, including local authorities, the voluntary sector and the independent sector considering needs identified through the Joint Strategic Needs Assessments (JSNAs) and the Joint Health and Wellbeing Strategies (JHWSs) to improve public mental health, including addiction services, children and young people’s mental health services, supported housing, employment support as well as suicide prevention programmes.

#### **Workforce planning and training**

- Develop a credible mental health workforce plan (as part of the local people plan) - including recruitment, training, retention & wellbeing schemes – that will allow recruitment and retention of the necessary workforce to meet the mental health priorities of the local population. This should be consistent with the ICS level workforce trajectory to implement the remainder of *Stepping Forward* plus the additional mental health workforce requirements that have been set

out in the NHS mental health implementation plan). This should be made available to the public.

- Fully understand the current mental health workforce and required expansion numbers, drawing on national guidance and tools consider how this translates into provider-level expansion plans, including key local pressure points for service areas or staff groups, and mechanisms to mitigate these issues.
- Ensure workforce information is accurately recorded in the Electronic Staff Record.
- All frontline staff should receive appropriate training in mental health.
- ICSs should ensure opportunities for joint training for all staff across organisations.

## Key theme 3: Population health management, data and outcomes

### *Key messages*

- ICS leaders should prioritise work with local government and the voluntary sector to help disadvantaged neighbourhoods; population health management and better data allow the system to target areas requiring most attention.
- ICSs provide an opportunity to develop better data and analytics for mental health as part of their work on population health management.
- There is an opportunity for greater alignment between ICSs and the statutory Health and Wellbeing Boards that operate at place level to improve outcomes for the population.
- There is a wealth of information in the system, but this can be overwhelming, and leaders can find it difficult to make the best use of it.
- Leaders need to identify how they can get data and outcomes right at a system level, not just an organisational level. This involves anticipating system-level benefits and being able to measure them effectively.
- Consideration should be given to what a population health orientated approach means for the role of psychiatrists, and other health professionals, including future training requirements.

We heard that ICSs can do one of two things: take the assumption of implementing the *Five Year Forward View for Mental Health* and the *NHS Long Term Plan* and, now, build on the information provided to them through the mental health implementation plan, or try to model the actual cost locally by reaching out to CCGs and map out what the level of activity is, what workforce is required and how much it will cost. This requires anticipating system-level benefits and being able to measure them effectively. To do this, local areas need access to rigorous and validated population health management capabilities. However, we heard that mental health is often absent from population health analytics. To support this, ICS leaders need to focus on how we can get mental health data and outcomes right at a system level, not just at organisational level.

Another issue is population analytics capability. This was seen as an ICS responsibility, rather than the responsibility of those working at place or borough level as it is not efficient and areas lack capability. Questions were raised about how this can best work when mental health providers span multiple ICSs.

In areas that are quite advanced in mental health population health management approaches, we heard that ICSs need to consider how best to segment the mental health population, before considering what it means for services and care pathways. We also heard that a priority should be to work with local government and the voluntary sector to help disadvantaged neighbourhoods. Population health management, supported by better data, should allow the system to target areas requiring most attention. Greater alignment between ICSs and Health and Wellbeing Boards will help improve outcomes, utilising how the latter as statutory bodies operate well at place level. The potential to improve preventive services is also particularly interesting, such as understanding the impact of mental health providers supporting GPs.

But we also heard the system can feel overloaded with information and it is not used to plan services in an intelligent way. The collection of data is increasing, but we are not making the best use of the data.

The intention to get CCGs to set high-level outcome-based objectives on population management analytics and then facilitate coordination between providers is a very different way of working and will require a culture change. It is essential that we are able to show the benefits of integrated and accountable care, but in order to do this outcome measures have to improve. We also need shared access to data. Of course, a lack of a single patient record is a huge barrier to this.

We also heard that we need to consider what a population health orientated approach means for the role of psychiatrists and other health professionals, particularly in terms of the new competencies that they might require to work in a population-health orientated way. Clinicians must find the time to engage with this work and we need to create the capacity within the trust.

#### **Recommendations for national bodies:**

##### ***Support local areas with population health management***

- When considering NHS England and NHS Improvement's proposals for an "NHS Bill" the Department of Health and Social Care and the Ministry of Housing, Communities and Local Governments should evaluate the effectiveness of Health and Wellbeing Boards and review their powers.
- Public Health England should be resourced to further support and strengthen Health and Wellbeing Boards to ensure they are able to drive local improvements in mental health care.
- By Spring 2020 the Department of Health and Social Care should commission NHS Digital to link mental health services (MHSDS), community services, and acute services (HES) data so that it can be used by ICS leaders to understand the local population health needs more accurately.

- NHS England & NHS Improvement and Public Health England should provide local systems with guidance and examples of good practice that demonstrate how population health management approaches can help address mental health issues as well as wider public health issues.

### **Advice for local system leaders**

#### ***Invest in population health management***

- Develop a population health management workstream with mental health expertise.
- Develop a system-wide outcomes framework, including mental health and wellbeing outcomes, which defines the partners' collective ambition for improving outcomes for local people to monitor performance against the outcomes framework annually.
- Address and measure outcomes that are important to patients and service users, identified through a process of co-design.
- Work towards ensuring everyone in need of support from mental health services has equitable access to effective early interventions and equitable experiences of care and outcomes across all protected characteristics.
- Incentivise and hold providers to account through system-wide outcome and performance measures covering performance, experience, and integration.
- Commissioners should ensure all providers, including third and independent sector providers, submit comprehensive data to the Mental Health Services Dataset (MHSDS) and IAPT dataset.
- Promote a culture which enables clinicians to collect and report patient outcome measures routinely.
- Streamline data collection to reduce clinical burden while also improving clinicians' access to key information and empowering people who use the services to self-monitor.

## Key theme 4: High quality care using new contractual models

### *Key messages*

- Integration of mental health with physical health and community services is likely to be the dominant model but providers are all on different trajectories. ICS leaders can choose to start with how services are delivered, or how services are contracted.
- Provider collaboratives were considered to enable strengthening the mental health providers' position within the local health economy. But there was also an awareness that provider collaboratives are not population health models so do not in themselves incentivise the rest of the system to improve mental health services.
- Contract key performance indicators need to be simplified and reworked around outcomes.
- Alliance models provide an opportunity for shared targets on mental health, which could support other areas of the system to look at mental health.
- Local areas need to consider how best services from within one organisation can be split to get all the positive benefits of integrating with another organisation without impacting negatively on patient care and outcomes (e.g. uncoupling a mental health trust's community mental health services from acute inpatient beds without loss of continuity of care). Joining one element of mental health services with other health services at the expense of fragmenting mental health services is likely to be detrimental.
- There are concerns of asset stripping from mental health trusts by bigger acute trusts involved in mergers or acquisitions.
- Many mental health trusts are too small to have their voice heard effectively in the ICS agenda and might face re-organisation. These trusts are most likely to need to form a partnership with other providers to maintain viability as ICSs develop.

In general, we heard that service contracts need to be simplified - some areas have more than 500 key performance indicators in their contract. The prevailing view was that contracts should be reworked around key outcomes.

### ***Provider collaboratives***

The overall direction of travel is towards provider collaboratives given the ambition set by the Long Term Plan for all appropriate specialised mental health services and learning disability and autism services to be managed through NHS-led provider collaboratives over the next five years. However there is a range of contractual forms that can support this development, population-health thinking and commissioning.

There was wide support for provider collaboratives, which were considered to be an enabler to strengthening the mental health providers' position within the local health economy. They were found to have a clear focus on standardisation and quality improvement for mental health services, as well as reducing out of area placements.

But there was also an awareness that provider collaboratives are not population health models and, therefore, do not incentivise the rest of the system to improve mental health services, nor do they necessarily incentivise mental health providers to work with colleagues in acute, community and primary care settings.

Provider collaboratives also tend to cover a much larger population, often operating at the regional level as opposed to ICS level. There is a clear rationale for this when planning specialised services, although this role will need to be expanded to deliver whole pathway commissioning (where services and interventions are an integral part of a commissioned pathway across primary, secondary and tertiary care). We heard that the communication and overlap between provider collaboratives and ICS planning are happening via the mental health trusts, but this could be strengthened further to ensure alignment. As provider collaboratives develop further there will be a need to define how they can best work with and across different levels within ICSs.

Specialist mental health care is a component of local services – from community mental health teams right up to high secure care units. Patients requiring specialist mental health services need 'step-down' care available in their local area. Therefore, care becomes fragmented if provider collaboratives and ICSs do not communicate well and plan services in conjunction. There might be 4-5 ICSs per region, so we need local services within ICSs to be providing comparable care. Networks around specialist services mean that leaders feel part of something bigger than themselves, which fosters a move away from isolated units focused on care for its immediate local area. ICSs need a closer relationship with secondary and tertiary providers and align their plans to make sure they work together to streamline commissioning for people within the same population footprint and improve continuity in patient care.

We heard that the role of the independent sector should not be undervalued in achieving this, though the debate between “privatisation” of the NHS and losing the ability to receive NHS care free point of delivery can be conflated.

Another point raised was that clinical leadership is a unique value of a CCG, as well as their expertise and local knowledge of their communities (neighbourhood and place-based). CCGs will be reconfigured to work at scale, but they will retain CCG boards. We need to consider what type of commissioning is most appropriate at the right level.

CAMHS tier 4 services were cited as an example of fragmentation between the community and inpatient side because of different commissioning bodies with negative consequences. Given the nature of provider collaboratives and the wider geography they tend to serve, clinical commissioning expertise needs to be replicable at ICS/ regional levels.

### ***Alliance models***

We heard that alliance models provide an opportunity for shared targets on mental health, which could support other areas of the system to look at mental health services and prioritise improvements. However, they do not maximise the potential for integrated care between mental health services and primary medical care, and other NHS services. We heard this could work well in ICSs where NHS providers are financially challenged and the introduction of whole population budgets or pooled budgets would threaten the funding available to mental health services.

### ***Integrated care providers***

Integrated Care Providers are likely to become more popular in future years. As seen in Dudley, we might be more likely to see far more community facing mental health services as a result.

We heard that ICPs provide an opportunity to join up community mental health services with primary medical care and community physical health. This can be really beneficial for patients, particularly those with multiple health needs. We also heard that GPs really like this approach as it brings expertise all within the same organisation. ICPs can also improve the efficiency and sustainability of the local health system by transferring some of the risks from the commissioner to the provider side.

But for those areas considering this approach, there is a major concern about how leaders can split services from within a mental health trust, such as community mental health services from acute inpatient beds, to get all the positive benefits but with the least negative consequences. If community services are uncoupled from inpatient services, they will lose continuity of care.



It is unclear how mental health trusts can best integrate services without fragmenting services even further. The risk of a 'specialist carve-out' could mean the remaining services provided by the mental health trust become clinically and financially unviable.

As discussed in key theme 1 (Purpose and role of ICSs), local leaders should carefully consider the purpose of creating an ICP in terms of continuity of care, quality of care and patient outcomes. Organisational disruption, which can have an impact on patient care as well as the morale of NHS staff. This should not be underestimated. We heard that even within a single organisation, there is still an issue of high numbers of rejected referrals and poor patient flow; bringing services into one organisation is not necessarily going to change that.

More generally, there is much anxiety about large NHS providers taking over mental health services from mental health trusts because of the risk of being sucked into acute work and the mental health elements being diluted. This might lead to mental health professionals tackling mental distress and 'difficult patients' rather than their core business. While we heard that many ICSs still want a strong specialist mental health trust in their patch., this might mean the opportunities and risks for smaller mental health trusts are greater than for larger specialist mental health trusts. There will also be implications for other mental health providers that are not trusts.

### ***Mergers and acquisitions between NHS trusts***

We heard a variety of views about the merging of mental health trusts with other NHS trusts, predominantly acute trusts. On the one hand, we heard significant concern about acute trusts merging with mental health trusts because it was a huge process to separate the two in the first place. In fact, many people said one of the most significant steps taken was when mental health was separated from district hospitals, which had huge benefits for patient outcomes and the workforce. Instead, we heard that local leaders should be pulling in expertise from the relevant services without needing to bring them into the same organisation. We also heard fears relating to asset stripping of mental health trusts by bigger acute trusts.

But on the other hand, we heard that mental health services are in a different place now. They were given prominence and respect in the *NHS Long Term Plan* and the *Five Year Forward View for Mental Health*, which was not the case historically. Local leaders said the discourse feels very different. As such, some leaders think there can be positive opportunities when a mental health trust merges with an acute trust. This includes truly integrated care pathways, joint targets/ outcomes for physical health and mental health, and joint training opportunities – e.g. smoking cessation, A&E staff working with people with personality disorders, assessing ligature risks etc. More generally, there was a view that merging trusts might allow for

workforce challenges to be more effectively addressed, enable better patterns of service delivery and drive efficiencies.

Again, coming back to the purpose of ICSs, local leaders should consider how organisational mergers will help in terms of patient experience, morbidity and mortality and if it doesn't, why do it?

### Recommendations for national bodies:

#### ***High quality care using new contractual models***

- By end of 2019, NHS England & NHS Improvement should require all CCGs using an ICP contract to report their performance on mental health in a way which is comparable to other CCGs without ICP contracts. This will allow sufficient benchmarking across England to ensure the *Five Year Forward View for Mental Health* performance standards are being delivered and ICPs are having a positive impact.
- Further to the proposals for legislative change, the College recommends that the Government should enable NHS trusts acting as lead providers of provider collaboratives to act as statutory NHS bodies to commission specialised services for mental health, where clinically appropriate.
- NHS England & NHS Improvement should assess the benefits and any unintended consequences of ICPs compared with improving joint working through ICSs, including the scope of the draft ICP contract, particularly whether mental health services should be incorporated, either in a partially integrated or fully-integrated capacity.
- Building on the evaluation strategy for new care model vanguards, NHS England & NHS Improvement should publish an evaluation of the benefits and any unintended consequences of delegating commissioning responsibility to provider collaboratives for mental health programmes, compared with the existing joint working arrangements.
- By autumn 2020, NHS England & NHS Improvement should publish national and local evaluations of New Care Models, including an assessment of their impact on people with mental illness as well as on mental health and wellbeing-related outcomes across the wider population. This should build on a September 2019 evaluation<sup>53</sup> where patient outcome data was not yet available.
- NHS England & NHS Improvement should review all organisational mergers which include mental health services for the risks and benefits in the short- to medium-term given the paucity of evidence of the associated impact, and in the long-term must require a comprehensive risk/benefit analysis.

## Advice for local leaders:

### ***Integrated Care Providers, organisational mergers and acquisitions***

- Where mental health services are within scope, ICPs' priorities should align with the commitment to achieve parity of esteem between mental and physical health and national policies to achieve the *Five Year Forward View for Mental Health* and the mental health proposals in the *NHS Long Term Plan*.
- If an NHS lead provider is awarded an ICP contract which results in them sub-contracting a mental health trust to provide services within scope, this should be required to happen in a mutually beneficial way with agreement from both parties. A CCG should involve mental health trusts throughout this process so that mental health services are not re-procured if this is seen as detrimental or disruptive to service delivery.
- Consider making the ICP contract scope as wide as possible or put in place sufficient measures to mitigate the risks of cost-shunting between providers outside of the ICP. If mental health services are out of scope of an ICP contract and so remain under their standard NHS Contract, local leaders should take steps to prevent cost-shunting as there is a risk that ICPs will be inadvertently incentivised to divert people with mental illness away from their services, even if this is not clinically or financially appropriate. This will add greater pressure to mental health trusts as well as primary medical services.
- STPs/ICS and ICPs to take responsibility for working together to align plans to streamline commissioning for people within the same population footprint, to improve outcomes and ensure funding is used in the most effective way which may require a flexible delivery approach.
- Primary mental health care should be a core requirement of any primary medical services integration agreement, even if the local mental health trust(s) are not part of the ICP.
- If considering an organisational merger or acquisitions, a full risk/benefit analysis should be conducted for providing cost-effective integrated care and ensure they do not unduly disadvantage mental health services and the people who use them at such a critical time.

## Key theme 5: Leadership

### *Key messages*

- As ICSs develop, there is a lot of enthusiasm for mental health trusts to be leaders, not followers. Mental health leaders were clear that their experience of working across complex systems is invaluable in supporting other providers to adapt.
- Consideration should be given to the current leadership capability in mental health in order to maximise this existing resource and how we can support and develop the leaders of the future.
- More must be done to promote clinical leadership across ICSs, but we cannot just expect leaders to fight for mental health; they need to be supported with cogent arguments to be able to influence the wider system.
- A common language is required to ensure that all staff understand the rationale for ICSs and their role within that process.

Mental health leaders were clear that their experience of working across complex systems is invaluable as providers already span many systems and can be agile and responsive. We also know that the mental health sector is known for innovation in terms of service redesign and delivery (as noted under Key theme 1). As such, we heard that mental health trusts do not have a choice to be outside of ICS developments – they still need to be in the room when decisions are made. There is a lot of enthusiasm for mental health trusts to be leader, not followers.

We also heard that there is a risk of Mental Health being junior partners in ICSs, whether because of having less of a voice in governance decisions to specific risks such as the capitated payment approach (see Key theme 7 on page 38). How you engage with others across a system is a leadership skill, but we need to consider the current leadership capability we have in mental health and how we can support and develop the leaders of the future. The pace and scale of change, as well as the often confusing sense of direction from the centre, means that engaging and feeding into all the work happening across ICSs, provider collaboratives, new care models and other NHS England programmes, as well as the core business, is a major challenge.

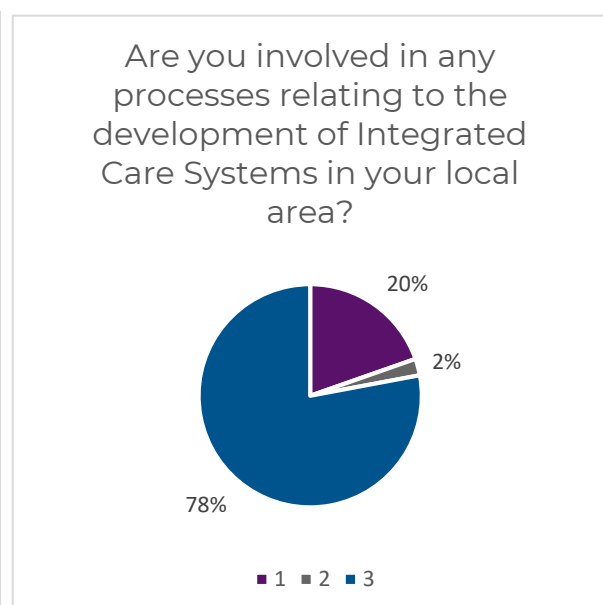
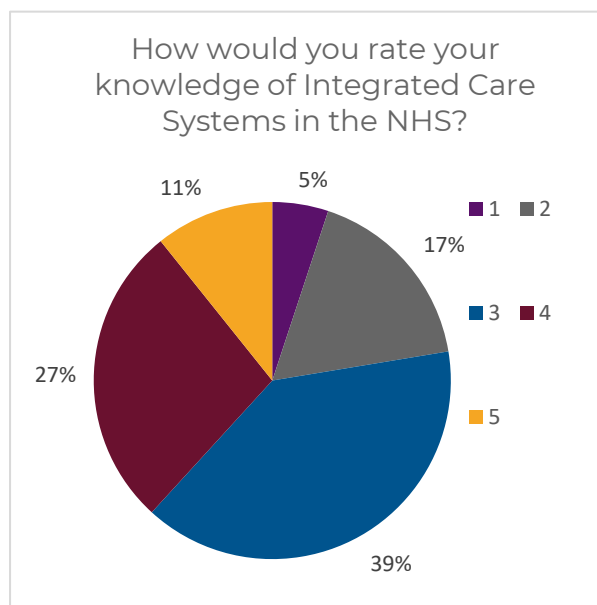
We must also acknowledge that all parties within an ICS are not necessarily equal partners. All have different pressures on them so not everyone will be an equal partner in the room. If a partner has received a cut to their budget but everyone else wants to invest, it can create a strange dynamic around the table. This has implications for mental health services funded by local

authorities. But we cannot just expect leaders to fight for mental health, they need to have effective arguments to be able to influence.

In terms of clinical leadership, we heard about the need for a cultural shift. Mental health leaders were clear that they have a role in working and supporting other clinicians to address health challenges across a system. However, we heard that often other system leaders are most interested in how mental health clinicians and managers can support them with their own challenges, such as getting patients with mental illness out of A&E. This needs to be mutually beneficial to improve population health outcomes; for instance, improving the physical health of people with severe mental illnesses. We heard the reasons behind the success of vanguards was clinical leadership and focus on admission avoidance. ICS leaders need to build on this learning.

But we heard that clinicians need to find the time to engage with this work and we need to create the capacity within the trust, which is patchy. Often clinicians see ICSs as something completely separate to what they do, which is an issue that needs addressed. We need to support clinicians to feel confident to contribute, ensuring they have the right competencies. For instance, many people become consultants without any leadership experience. We heard support for more leadership training opportunities that can be delivered in trusts, not just in London. Securing study leave and funding can be a major barrier to this. We heard there is a leadership vacuum in NHS and more coaching and mentoring schemes would be helpful.

In terms of clinical leadership, the majority of RCPsych members in a recent survey rated their knowledge on ICSs as average (39%) or poor (27%). Only 5% rated their knowledge as very good.<sup>54</sup> The vast majority (78%) of members also reported that they were not at all involved in any processes



relating to the development of ICSs in their local area.<sup>55</sup> Of those respondents who said they were fully involved, the majority were based in RCPsych London divisional region (57%) and the Northern and Yorkshire divisional region (which covers the North, West and East of Yorkshire and the North East of England) (29%).

### Recommendations for national bodies:

#### ***Empower the leaders of the future***

- By autumn 2019, the regional mental health SROs should be linked into every STP/ ICS programme board in their region.
- By spring 2020, Health Education England should establish a Future Mental Health Leaders programme led by the NHS Leadership Academy, in partnership with professional bodies such as RCPsych, building on the similar 'Future Clinical Commissioning Leaders' programme.
- By autumn 2019, the Royal College of Psychiatrists should establish a regional engagement programme across England to support its members in working with ICSs in implementing the NHS Long Term Plan locally.
- By spring 2020, the Royal College of Psychiatrists should work with its members to grow mental health leaders of the future, with a particular focus on gender and ethnic diversity of leadership.

### Advice for local leaders:

#### ***Leadership***

- Mental health leadership should always include people who use services, with appropriate training, development and support. With support from commissioners and other partners, mental health trusts, and other trusts providing mental health services across England should involve people who use services, including those from Black, Asian and minority ethnic groups, in all aspects of their organisation, such as service co-production, planning and delivery of care.
- Clinicians should be supported to engage with ICS developments, particularly where the service encompasses a special group such as older people, children and young people, or those requiring specialised health services.
- Every clinical interaction should be seen as an opportunity to promote mental and physical wellbeing and NHS staff should build relationships and networks to enable them to do this together.

## Key theme 6: Governance

### *Key messages*

- ICSs are not statutory bodies, so they rely on the willingness of local leaders to participate.
- There are challenges associated with setting up joint committees between commissioners and providers and maintaining the integrity of existing governance arrangements. Learning about how these are overcome needs to be gathered and shared.
- ICSs provide an opportunity to collectively manage performance across the system, but trusts are still individually held to account by NHS England and NHS Improvement.
- There is a clear view that governance arrangements need to be agreed with all parties and made simpler and more transparent.

As ICSs are not statutory bodies, they depend on the willingness of local leaders to participate. These relationships are fragile. Some leaders suggested this would need legal changes otherwise there is going to be a postcode lottery. In terms of mental health representation, we heard that ICSs would need some very mature relationships to not need a joint leadership/ programme board arrangement and prevent mental health from being left out. This further emphasises the importance of the previous theme in terms of developing leadership capability in mental health.

We also heard about the challenges associated with setting up joint committees between commissioners and providers, as opposed to committees-in-common, in terms of maintaining the integrity of existing governance arrangements. Some leaders said there is no need to sit in a group structure in order to work in a collaborative way; it can be done without. It will be important to consider how these challenges are being overcome in different areas, and share learning and examples of good practice.

In some areas, a single accountable officer is being introduced, and in some trusts that are merging, it is likely there will only be one medical director post. For mental health trusts, this might lead to a loss in mental health medical directors. We also need to consider where the patient voice is within ICS work, including patient leaders at board level.

Looking to the future, some leaders predicted that in 3-5 years' time, health services might be managed and governed at a 'place-based' level, rather than ICS level. It appears there are some interesting discussions happening in terms of borough-based relationships, such as what governance might look like, joint responsibilities and how that might work in practice.



We also heard that a key benefit of ICSs is the ability to collectively manage performance across the system, but providers are still individually held to account by NHS England and NHS Improvement, which needs to change.

Overall, we heard a desire for governance to be made simpler, more transparent and agreed with all parties.

### Recommendations for national bodies:

#### ***Changes to NHS structure and governance***

- We note that proposals to allow the Secretary of State to set up new NHS trusts to deliver integrated care across a given area will not be progressed. However, appropriate safeguards must be put in place in circumstances where mental health services are within scope (as discussed in earlier recommendations relating to integrated care providers, organisational mergers and acquisitions).
- While proposals for NHS Improvement to have targeted powers to direct mergers or acquisitions involving NHS foundation trusts will not be progressed, it remains critical that appropriate safeguards are put in place in circumstances in cases where mental health trusts are involved.
- We support NHS England’s view that trusts and CCGs should be able to form joint committees in every ICS to exercise functions, and make decisions, jointly. Statutory guidance relating to this should include an explicit requirement to include mental health leaders at an executive level.
- We support NHS England’s view that they should be given the ability to allow groups of CCGs to collaborate to arrange services for their combined populations. CCGs should be able to carry out delegated functions, as if they were their own, to avoid the issue of ‘double delegation’, and that groups of CCGs should be able to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions. This must include an explicit requirement to ensure each CCG within the collaboration is meeting the Mental Health Investment Standard individually, as well as collectively.
- We support NHS England’s view that they should be enabled to enter into formal joint commissioning arrangements with CCGs including providing the ability to pool budgets. This should include a commitment to report spending and activity for mental health in a transparent way.

### Advice for local leaders:

#### ***Governance***

- Senior mental health leaders should be at the heart of all relevant local decision-making structures.
- Ensure at least one senior mental health leader in the programme management team is responsible for overseeing the implementation



for each new model of care and involved in any relevant contract negotiations for ICPs. Also engage or at least have input from specialists where the service encompasses a special group such as older people, children and young people, or those requiring specialised health services.

## Key theme 7: Funding, whole population budgets and incentives

### *Key messages*

- ICSs should be able to determine the payment approach that matches the issues of the system at a particular time.
- Whole population budgets provide useful flexibility for providers to work together towards outcomes rather than activity, but there is concern about the risk borne by mental health providers because of historic underinvestment and a paucity of activity and outcome data.
- CQUIN and QOF should incorporate broader mental health metrics to ensure quality and outcomes for mental health improvement continue to be incentivised across the system. But there is uncertainty about how an ICS would be able to release cash at scale.
- The enhanced Mental Health Investment Standard is seen as useful, but concerns remain that funding for mental health could be diverted. Mental health trusts' leaders will look to ICS Leads to join them in holding CCGs to account should the mental health investment not be sufficient.
- The new funding is only sustaining the NHS and two major gaps remain: public health and social care. The financial position of local authorities is significant to the success or failure of system-wide transformation. Addressing this is vital to ensuring ICS are able to support strong collaboration between health and social care with partners in local government and the voluntary sector on prevention and recovery.
- A longer-term ICP contract duration can offer the stability needed to incentivise the provider to invest in the new care model and the changes required; however, this will need to take account of the challenges for mental health, including risks of a capitated payment approach and the limited data available to support outcome-based payments.

ICSs should be able to determine the payment approach that matches the issues of the system at a particular time. There are a variety of payment mechanisms suitable for different issues. For instance, if you have a long elective waiting list, then the tariff can incentivise providers to see more patients. But for people with complex and long-term conditions, you need to set the incentive differently.

While whole population budgets are being discussed by a number of local areas, none of the ICSs – except Greater Manchester and Surrey Heartlands where devolution agreements are in place – are currently using a whole population budget. However, some ICSs have advanced plans to use the

forthcoming ICP contract. We heard that bringing together different funding streams into a single budget provides useful flexibility for providers to work together towards outcomes rather than activity, but there is a concern with the risk borne by mental health providers. Capitation is potentially very problematic in a fragmented system, which is especially common in mental health services. This is because the mental health element of the whole population budget is based on historical CCG spend, which has not always been sufficiently high. Furthermore, we heard concerns about outcome-based payments where mental health services are within the scope as data is poor in this area.

Therefore, by their very nature, commissioners may find it harder to disaggregate spending between different programme budgets when a whole population budget is being used. In areas where mental health services are within scope, this means that there may be less transparency about how much money is being invested in mental health and whether this is growing, falling or maintaining in line with national policies. We heard that this will be challenging in mental health as data on outcomes and activity data capturing the breadth of mental health services is, overall, quite poor. We also heard concerns about whether commissioners will be able to adequately assess the performance of mental health services when in the scope of an ICP contract as funding will be less clear.

In terms of incentives through the CQUIN and QOF, we heard that this should incorporate broader mental health metrics to ensure quality and outcomes for mental health improvement continue to be incentivised across the system. Others were uncertain about how this would work in practice as it would be difficult for an ICS to be able to release cash at scale.

More generally, we heard concerns that continuing financial pressures might mean money for mental health services will be diverted so there is strong support for CCGs to continue to be held to account, which needs to go beyond rhetoric. The commitments for a strengthened Mental Health Investment Standard is useful in doing this. We heard that mental health trusts leaders would look to ICS Leads to join them in holding CCGs to account should the mental health investment not be sufficient. Long Term Plan implementation guidance states that it expects local health systems to work jointly to develop and confirm CCG Mental Health Investment Plans across the five years including with a lead mental health provider, in line with the planning requirement for 2019/20. It is important that there is a thorough planning process incorporating all organisations involved, ensuring commissioning is in line with population needs and the delivery of the mental health.

In general, local leaders were pleased we are moving away from the return on investment argument in mental health. We also heard that access to shared capital funding for mental health is important.

Another strong message was that the financial position of local authorities is significant to the success or failure of system-wide transformation, but this has not really been addressed. This is extremely important given how an individual's mental health is strongly linked to the circumstances within which they are born, grow up and live. Strong collaboration, supported by an ICS framework, is needed to enhance the way the health and social care system works with partners in local government and the voluntary sector on prevention and recovery.

### **Recommendations for national bodies:**

#### ***Protect funding in mental health***

- The Department for Health and Social Care and NHS England & NHS Improvement should fairly apportion any additional capital funding to mental health trusts based on ICS estates and capital plans.

### **Advice for local leaders:**

#### ***Funding, whole population budgets and incentives***

- Jointly agree a mental health investment strategy, taking account of the NHS Operational Planning and Contracting Guidance 2019/20, *NHS Long Term Plan* implementation framework and supplementary guidance, signed off by the ICS board, and in place across partners in the ICS, including:
  - plans for the use of additional baseline mental health funding commissioning services that deliver improved services set out in the NHS Long Term Plan
  - Delivering of the Mental Health Investment Standard to ensure it covers all priority areas for the programme and related workforce requirements
  - quality assurance of mental health delivery, including evaluating the value and return on investment of mental health programmes to facilitate forward planning,
  - agreement across the health system that efficiencies delivered through mental health initiatives will be reinvested back into mental health services to promote sustainability.
- Fairly apportion additional capital funding to mental health trusts based on ICS estates and capital plans.
- For whole population budgets, the capitation population needs to be defined carefully and in detail and must be linked to the existing funding formula method to ensure that patients with mental illness are not disadvantaged. Deprivation must be adequately adjusted for within budgets and should be if existing formula rules are applied. Attributing outcomes (i.e. a share of a capitation payment) to one of several providers in a fragmented market or pathway will be extremely difficult in mental health.

- When outcomes are linked to payment, as in an alliance contract or an ICP contract, careful consideration should be given to fair payment as many of these factors may be out of the sphere of influence of local providers and commissioners, especially social care provision.
- In ICP contracts, include long-term proxy outcomes measures on public mental health and prevention, so that improvements are tracked when contracts span years/decades. This must be balanced with local services, access and waiting time standards and delivering outcomes for those who use services and these outcome measures operate within a different time scale.
- CQUIN and QOF should incorporate broader mental health metrics to ensure quality and outcomes for mental health improvement continue to be incentivised across the system.

## 5. Lessons and next steps

In summary, we heard that ICSs have potential to improve patient experience, reduce morbidity and mortality rates, reduce the unmet need in mental health and innovate, going further faster.

Through system-wide collaboration, there is a real opportunity to improve and join up mental health services with the rest of the health and care system, including greater alignment with Health and Wellbeing Boards and better data and analytics for mental health. To support this, there is an opportunity for robust workforce planning across a wider geography.

Mental health trusts should be leaders, not followers, as their expertise in moving care from hospital settings into the community and working across complex health and care systems is invaluable. ICSs provide an opportunity to develop system-wide incentives to improve mental health care, linked to outcome-based payments, either through alliance or ICP models.

In addition, there is a need to consider the current leadership capability in mental health and how we can support and develop the leaders of the future. All plans made in ICSs will succeed or fail depending on the workforce and there is currently a lack of certainty about how workforce planning and joint training can be optimised across a wider geography spanning multiple providers.

Major challenges remain. Predominantly, this revolves around the viability of mental health trusts, many of which might be too small to have their voice heard in the ICS agenda and might face re-organisation.

Thought needs to be given on how NHS-led provider collaboratives can work with services at all levels of ICSs, including services beyond mental health. Joining one element of mental health provision with another provider can be beneficial but not if it comes at the expense of fragmenting mental health services. The benefits and risks need to be carefully balanced when thinking about the impact on continuity and quality of patient care.

The pace and scale of change is also a considerable challenge and local leaders should be conscious of this when thinking about complex organisational change. We must also acknowledge that we are only sustaining the NHS with new funding and the financial position of local authorities is significant to the success or failure of system-wide transformation.

Centrally, change should be supported by systematic capturing and sharing of learning of areas further ahead to spread understanding on what is permissible and effective. However there is, to date, a lack of consensus around how we should evaluate change within these integrated models of

care.<sup>56</sup> It is essential that the purpose and focus of local ICSs must be regularly reviewed to ensure that they are working effectively towards improving outcomes that matter most to patients.

**To keep up to date with RCPsych's our work on this areas please visit:  
[www.rcpsych.ac.uk/mental-health-ICS](http://www.rcpsych.ac.uk/mental-health-ICS)**

## **Appendix 1: About the Royal College of Psychiatrists and acknowledgements**

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and for setting and raising standards of psychiatry in the UK.

The College aims to improve the outcomes for people with mental illness and the mental health of individuals, their families and communities. To achieve this, the College: sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; and works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

### **Acknowledgements**

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The findings are based primarily on the information gathered from people working across 14 Integrated Care Systems, Sustainability and Transformation Partnerships and Provider Collaboratives in England. We also draw on the expertise of colleagues working for RCPsych in Wales and Scotland. We are extremely grateful to those who contributed to this work.

We would also like to thank the frontline staff, service users, carers, providers and commissioners who attended our Sustainability and Transformation Partnerships engagement workshop in autumn 2017 and to all those who have kindly contributed feedback to this project, including NHS Confederation and NHS England.



## Appendix 2: Terminology and acronyms

There are numerous acronyms used to describe the changes happening in the NHS across England. There are also multiple programmes that are seeking to help local areas make improvements in care. A brief explanation is given below on the pertinent systems, models and programmes relevant to this report.

### *Systems and models of care*

**Devolution agreements** are when NHS organisations and local authorities sign an agreement with the government to take charge of health and social care spending and decisions in the region. The partnership can include NHS organisations, councils, primary care, NHS England, community and voluntary social enterprise organisations, Healthwatch, Police and the Fire and Rescue Service. Greater Manchester Health and Social Care Partnership is an example of this, with responsibility for the devolved £6 billion health and social care budget for Bolton, Bury, Oldham, Manchester, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan.<sup>57</sup> Similarly, Surrey Heartlands Integrated Care System has a devolved budget.<sup>58</sup>

**GP federations** are a group of practices that come together to deliver services in a local area. There are different ownership, governance and management structures depending on the local requirements. In all models, individual practices remain independent organisations, but profit, contractual and pension arrangements will vary according to the model chosen. This includes whether practices or the federation holds GMS/PMS/APMCs contracts.<sup>59</sup> Other models that involve GP practices include primary care networks, multispecialty community providers and primary and acute care systems.

**Integrated Care Providers (ICP)** are organisations that are responsible for the integrated provision of general practice, wider NHS and potentially local authority services, which enters into an ICP contract with the commissioner(s) of those services. The ICP (which is sometimes referred to as a multispecialty provider or integrated services provider) would be a 'lead' provider organisation, and so would be contractually responsible for delivering integrated services for local people. An ICP is not a new type of legal entity, but simply the name for a provider organisation awarded an ICP Contract. These were formally known as Accountable Care Organisations (ACOs).<sup>60</sup>

**Integrated Care Systems (ICS)** are partnerships between NHS organisations, local councils and others, which take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. They have greater freedoms to manage the operational and financial performance of services in their area. There are

currently 14 ICSs across England.<sup>61</sup> These were formally known as Accountable Care Systems (ACSs). By April 2021, it is anticipated that ICSs will replace all STPs across the country.<sup>62</sup>

**Multispecialty community providers (MCP)** is a population-based health and social care model of care that joins up GP, community health services and social care. Fourteen multispecialty community provider vanguards were chosen to develop these models of care in March 2015.<sup>63</sup> As with primary and acute care systems and primary care networks, general practice is integral to this model.

**Primary and acute care systems (PACS)** is a model of care that joins up GP, hospital, community and mental health services. The aim of a PACS is to improve the physical, mental, social health and wellbeing of its local population. It achieves this by bringing together health and care providers with shared goals and incentives, so they can focus on what is best for the local population. Nine vanguards were chosen to develop these models of care in March 2015.<sup>64</sup> As with primary care networks and multispecialty community providers, general practice is integral to this model.

**Primary care networks** are broader collaborations of GP practices and other health and care partners. Together, general practices work closely with other primary and community care staff and health and care organisations, providing integrated services to their local populations. This model helps rebuild and reconnect the primary healthcare team across the area they cover through the network, providing workload support for practices at the same time.<sup>65</sup> As with primary and acute care systems and multispecialty community providers, general practice is integral to this model.

**Provider collaboratives or partnerships** are where similar NHS trusts, such as mental health trusts, come together to form a partnership to deliver services to a wider population. These partnerships often bring together clinical expertise, experience and innovation, aiming to improve quality, use resources most effectively, and deliver best practice consistently to all patients.<sup>66</sup> In some areas of the country, provider collaboratives focus solely on specialised services which historically would have been commissioned by NHS England, such as secure services or child and adolescent mental health services (CAMHS) tier 4 services. In other areas of the country, provider collaboratives are working together to redesign the whole system pathways of care, such as South London Mental Health and Community Partnership.

Some of this work builds on the Acute Care Collaborations (ACCs) vanguards selected in September 2015, to focus on either (i) accountable clinical networks (collaborations covering a range of acute services to optimise patient pathways for services covered by the network, and identifying and

implementing best practice at each stage along those pathways), (ii) NHS foundation groups (flexible membership model that allows a number of hospitals to operate as part of a single group with a central headquarters) or (iii) speciality franchises (local areas developing a toolkit that codifies the clinical, financial and operating model for specialty franchises in the NHS).<sup>67</sup>

**Sustainability and Transformation Partnerships (STP)** cover the whole of England and are where NHS and local councils came together to develop proposals to improve health and care – to run services in a more coordinated way, to agree on system-wide priorities. There are currently 41 STPs across England.<sup>68</sup>

### **Programmes**

**Establishing Steady State Commissioning programme** aims to reduce the length of stay and the number of patients who are out-of-area in a number of specialised mental health services. It delegates responsibility for the budget for in-patient services to local provider partnerships, so they can ensure funding is spent as effectively as possible.<sup>69</sup> This covers adult low and medium secure services, adult eating disorder services and CAMHS tier 4 services. There are 15 sites across the country, which went live in April 2017.<sup>70</sup> These local areas are now being referred to as NHS- led Provider Collaboratives.

**Getting It Right First Time (GIRFT)** is a national programme, led by frontline clinicians, created to help improve the quality of medical and clinical care within the NHS by identifying and reducing unwarranted variations in service and practice. It is a partnership between the NHS Royal National Orthopaedic Hospital Trust (RNOH), which first hosted the pilot programme and the Operational Productivity Directorate. GIRFT covers ten medical specialities, including mental health.<sup>71</sup>

**Global Digital Exemplars** are NHS providers delivering improvements in the quality of care, through the world-class use of digital technologies and information. Exemplars will share their learning and experiences through the creation of blueprints to enable other trusts to follow in their footsteps as quickly and effectively as possible. NHS England is currently supporting selected digitally advanced mental health, ambulance and acute trusts, to become Exemplars. These trusts are partnered with international healthcare organisations to help ensure they learn from those that have already achieved significant benefits from employing digital technology.<sup>72</sup>

**Healthy new towns** is a programme comprised of 10 housing developments across England that are seeking to shape the health of their communities and to rethink how health and care services can be delivered on NHS land.<sup>73</sup> For example, on old Ministry of Defence brownfield land in Hampshire, Whitehill and Bordon are building 3,350 new homes, a new town centre with new leisure centre, secondary school, cinema and health hub and 80 hectares of suitable alternative natural greenspace. They are

seeking to reduce the incidence of poor mental health through their plans with better access and connectedness of health services and a better-built environment. The project will be complete by 2036.

**New care models programme** was initiated in January 2015 by NHS England. Individual organisations and partnerships were able to apply to become ‘vanguard’ sites and in March 2015, the first 29 vanguard sites were chosen – integrated primary and acute care systems (PACS); multispecialty community providers (MCPs), and enhanced health in care homes. Following this, 8 urgent and emergency (UECs) vanguards and 13 acute care collaborations were announced.<sup>74</sup>

**Test Bed Programme** brings NHS organisations and industry partners together to test combinations of digital technologies with pathway redesign in real-world settings. The goal is to use the potential of digital technologies to positively transform the way in which healthcare is delivered for patients and carers.<sup>75</sup>

ACC	Acute care collaboration
ACO	Accountable care organisation
ACS	Accountable care system
CCG	Clinical commissioning group
CQUIN	Commissioning for quality and innovation
GIRFT	Getting it right first time
IAPT	Improving access to psychological therapies
ICP	Integrated care provider
ICS	Integrated care system
MCP	Multispecialty community provider
PACS	Primary and acute care system
PCN	Primary care network
QOF	Quality and outcomes framework
STP	Sustainability and transformation partnership
UEC	Urgent and emergency care



# Appendix 3: NHS England ICS system maturity matrix – five domains, four stages

*System progression* →

	Emerging	Developing	Maturing ICS <i>System formally named an ICS and minimum level of maturity for all systems to reach by April 21</i>	Thriving ICS
<b>System leadership, partnerships and change capability</b>	<ul style="list-style-type: none"> <li>Leadership team that lacks authority with no collectively-owned local narrative or sense of purpose.</li> <li>Lack of transparency in ways of working.</li> <li>Little progress made to finalise system vision and objectives or embed these across the system and within individual organisations.</li> <li>Minimal meaningful engagement with primary care, local government, voluntary and community partners, service users and the public.</li> </ul>	<ul style="list-style-type: none"> <li>All system leaders signed up to working together with ability to carry out decisions that are made.</li> <li>An early shared vision and objectives, starting to build common purpose and a collectively-owned narrative among the broader leadership community including primary care.</li> <li>Plans to increase the involvement of local government, voluntary and community partners, service users and the public in decision-making at system, place and neighbourhood.</li> </ul>	<ul style="list-style-type: none"> <li>Collaborative and inclusive multi-professional system leadership and governance; including local government and the voluntary sector.</li> <li>Clear shared vision and objectives, with steady progress made visible to stakeholders and staff.</li> <li>Dedicated capacity and supporting infrastructure being developed to help drive change at system, place and neighbourhood level (through PCNs).</li> <li>Effective ongoing involvement of voluntary and community partners, service users and the public in decision-making at system, place and neighbourhood levels.</li> <li>A culture of learning and sharing with system leaders solving problems together and drawing in the experiences of others.</li> </ul>	<ul style="list-style-type: none"> <li>Strong collaborative and inclusive system leadership, including local government and the voluntary sector, with a track record of delivery.</li> <li>Transparent and robust governance, with multi-professional leadership aligned around the system and system working closely with health and wellbeing boards.</li> <li>A proactive approach to the identification and development of future system leaders at all levels.</li> <li>Dedicated clinical and management capacity and infrastructure to execute system-wide plans.</li> <li>A narrative that is well understood and strongly supported by the public and staff, outlining how integrated care is delivering on the ambitions of communities, with demonstrable impact on outcomes.</li> </ul>
<b>System architecture and strong financial management and planning</b>	<ul style="list-style-type: none"> <li>Limited understanding of system architecture across the footprint and limited plans to organise delivery around neighbourhood, place and system.</li> <li>Fragmented commissioning landscape with few agreed plans to streamline arrangements.</li> <li>System not in financial balance and unable to collectively agree recovery trajectory.</li> <li>Lack of system wide plans on workforce, estates and digital.</li> </ul>	<ul style="list-style-type: none"> <li>Clear plans to organise delivery around neighbourhood, place and system.</li> <li>Plans to streamline commissioning, typically with one CCG that is leaner and more strategic.</li> <li>Good understanding of system financial drivers and efficiency opportunities, with a shared plan to address issues.</li> <li>System wide plans being developed to address workforce, estates and digital infrastructure.</li> </ul>	<ul style="list-style-type: none"> <li>System is working with regional teams to take on increased responsibility for oversight.</li> <li>Plans to streamline commissioning are underway.</li> <li>System has credible plans for meeting system control total and, where not already achieved, for moving towards system financial balance.</li> <li>System wide plans for workforce, estates and digital infrastructure being implemented.</li> <li>System is managing resources collectively and signed up to the ICS financial framework.</li> </ul>	<ul style="list-style-type: none"> <li>System has progressed to the most advanced stage of oversight progression – i.e. self-assurance, with clear communication and relationships with regional team.</li> <li>Streamlined commissioning arrangements fully embedded across all partners.</li> <li>System is in financial balance and is sharing financial risk using more sophisticated modelling of current and future population health and care needs.</li> <li>Incentives and payment mechanisms support objectives and maximises impact for the local population.</li> <li>Improvements in workforce, estates and digital infrastructure being seen across the system.</li> <li>System is managing resources collectively and signed up to the ICS financial framework.</li> </ul>
<b>Integrated care models</b>	<ul style="list-style-type: none"> <li>Limited use of national and local data to understand population health and care needs.</li> <li>Limited thinking about how to scale up primary care and how to integrate services at neighbourhood or place</li> <li>Minimal collaboration or engagement across providers.</li> </ul>	<ul style="list-style-type: none"> <li>Early development of the 5 service changes within the LTP, and care models aiming to:                             <ul style="list-style-type: none"> <li>address unwarranted clinical variation;</li> <li>integrate services around the needs of the population in neighbourhoods;</li> <li>integrate services vertically at place;</li> <li>collaborate horizontally across providers at the system and/or place level.</li> </ul> </li> <li>PCNs developing clear vision for integrated care models and transforming population health.</li> <li>Some understanding of current and future population health and care needs using local and national data.</li> <li>Plans in place to support interoperable access to care records across health and social care providers.</li> </ul>	<ul style="list-style-type: none"> <li>PCNs implementing new or redesigned care models with partners to meet population need – that is enabling integrated provision of health and care within neighbourhoods.</li> <li>Integrated care teams operating at neighbourhood and place bringing together PCNs, mental health, social care and hospital services as per the triple integration set out in the LTP.</li> <li>Starting to implement plans to:                             <ul style="list-style-type: none"> <li>address unwarranted clinical variation;</li> <li>deliver the 5 service changes in the LTP;</li> <li>tackle the prevention agenda and address health inequalities.</li> </ul> </li> <li>PHM capability being implemented including segmenting and stratifying population using local and national data to understand needs of key groups and resource use.</li> </ul>	<ul style="list-style-type: none"> <li>Integrated teams demonstrating improvement in outcomes.</li> <li>Fully mature PCNs across the system delivering care with partners that meets population needs.</li> <li>Implementing priorities in prevention and reducing health inequalities as part of care model design and delivery.</li> <li>Full population health management capability embedded at neighbourhood, place and system levels which supports the ongoing design and delivery of proactive care.</li> <li>Implementation of the 5 service changes set out in the LTP demonstrating improvement in health outcomes.</li> </ul>

<b>Track record of delivery</b>	<ul style="list-style-type: none"> <li>• Slow progress towards delivering national priorities especially the 5 service changes set out in the LTP.</li> <li>• Lack of relative progress in delivering constitutional standards without system agreement to work together to support improvements.</li> <li>• Weak system operating plan developed and system unable to make collective decisions around system funding.</li> </ul>	<ul style="list-style-type: none"> <li>• Evidence of progress towards delivering national priorities especially the 5 service changes set out in the LTP.</li> <li>• Improved delivery of constitutional standards.</li> <li>• System operating plan in place that demonstrates a shared set of principles to start to manage finances collectively.</li> </ul>	<ul style="list-style-type: none"> <li>• Evidence of tangible progress towards delivering national priorities especially the 5 service changes set out in the LTP.</li> <li>• Consistently improving delivery of constitutional standards with credible system plans to address risks.</li> <li>• Robust system operating plan and system financial management in place, with a collective commitment to shared financial risk management.</li> <li>• Robust approach in place to support challenged organisations and address systemic issues.</li> </ul>	<ul style="list-style-type: none"> <li>• Evidence of delivering national priorities especially the 5 service changes set out in the LTP.</li> <li>• Delivery of constitutional standards including working as a system to mitigate risks.</li> <li>• Demonstrating early impact on improving population health outcomes.</li> <li>• Consistently delivering system control total with resources being moved to address priorities.</li> <li>• As issues emerge, leaders join forces to tackle them as a system including when under pressure.</li> </ul>
<b>Coherent and defined population</b>	<ul style="list-style-type: none"> <li>• A meaningful geographical footprint that respects patient flows</li> <li>• Where possible contiguous with local authority boundaries; where not practicable has clear arrangements for working across local authority boundaries</li> <li>• Covers an existing STP of sufficient scale (~1m pop or more)</li> </ul>	<ul style="list-style-type: none"> <li>• A meaningful geographical footprint that respects patient flows</li> <li>• Where possible contiguous with local authority boundaries; where not practicable has clear arrangements for working across local authority boundaries</li> <li>• Covers an existing STP of sufficient scale (~1m pop or more)</li> </ul>	<ul style="list-style-type: none"> <li>• A meaningful geographical footprint that respects patient flows</li> <li>• Where possible contiguous with local authority boundaries; where not practicable has clear arrangements for working across local authority boundaries</li> <li>• Covers an existing STP of sufficient scale (~1m pop or more)</li> </ul>	<ul style="list-style-type: none"> <li>• A meaningful geographic footprint that respects patient flows</li> <li>• Where possible contiguous with local authority boundaries; where not practicable has clear arrangements for working across local authority boundaries</li> <li>• Covers an existing STP of sufficient scale (~1m pop or more)</li> </ul>

Source: NHS England. Designing integrated care systems (ICSs) in England. 2019. Available from: <https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf>

## Appendix 4: Mental health deliverables for ICSs/ STPs in 2019/20

The 2019/20 operational planning and contracting guidance for the NHS sets out the service deliverables as well as the trust financial regime. NHS England & NHS Improvement has instructed CCGs and trusts to take action from April 2019.

The 2019/20 deliverables for mental health include: <sup>76</sup>

- By March 2020 IAPT services should be providing timely access to treatment for at least 22% of those who could benefit (people with anxiety disorders and depression).
- At least 50% of people who complete IAPT treatment should recover.
- At least two thirds (66.7%) of people with dementia, aged 65 and over, should receive a formal diagnosis.
- At least 75% of people referred to the IAPT programme should begin treatment within six weeks of referral.
- At least 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral.
- At least 56% of people aged 14-65 experiencing their first episode of psychosis should start treatment within two weeks.
- At least 34% of children and young people with a diagnosable mental health condition should receive treatment from an NHS-funded community mental health service, representing an additional 63,000 receiving treatment each year.
- By March 2021, at least 95% of children and young people with an eating disorder should be seen within one week of an urgent referral.
- By March 2021, at least 95% of children and young people with an eating disorder should be seen within four weeks of a routine referral.
- Continued reduction in out of area placements for acute mental health care for adults, in line with agreed trajectories.
- At least 60% of people with a severe mental illness should receive a full annual physical health check.
- Nationally, 3,000 mental health therapists should be co-located in primary care by 2020/21 to support two-thirds of the increase in access to be delivered through IAPT-Long Term Conditions services.
- Nationally, 4,500 additional mental health therapists should be recruited and trained by 2020/21.

## Appendix 5: Mental health deliverables for STPs/ICS by 2023/24

Core planning and delivery requirements for local systems by 2023/24, as set out by NHS England and NHS Improvement:

### **Specialist Community Perinatal Mental Health**

- At least 66,000 women with moderate to severe perinatal mental health difficulties will have access to specialist community care from pre-conception to 24 months after birth with increased availability of evidence-based psychological therapies
- Partners of women accessing specialist community care will be able to access an assessment for their mental health and signposting to support as required
- Maternity Outreach Clinics will be available across the country, combining maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience

### **Children and Young People's (CYP) Mental Health**

- 345,000 additional CYP aged 0-25 will have access to support via NHS-funded mental health services and school- or college-based Mental Health Support Teams (in addition to the FYFVMH commitment to have 70,000 additional CYP accessing NHS services by 2020/21)
- There will be 24/7 mental health crisis provision for children and young people that combines crisis assessment, brief response and intensive home treatment functions
- There will be a comprehensive offer for 0-25 year olds that reaches across mental health services for CYP and adults
- The 95% CYP Eating Disorder referral to treatment time standards achieved in 2020/21 will be maintained
- CYP mental health plans will align with those for children and young people with learning disability, autism, special educational needs and



disability (SEND), children and young people's services, and health and justice [from 2022/23]

### **Adult Common Mental Illnesses (IAPT)**

- Access to IAPT services will be expanded to cover a total of 1.9m adults and older adults
- All areas will maintain the existing IAPT referral to treatment time and recovery standards
- All areas will maintain the existing requirement to commission IAPT-LTC services

### **Adult Severe Mental Illnesses (SMI) Community Care**

- New integrated community models for adults with SMI (including care for people with eating disorders, mental health rehabilitation needs and a 'personality disorder' diagnosis) spanning both core community provision and also dedicated services will ensure at least 370,000 adults and older adults per year have greater choice and control over their care, and are supported to live well in their communities
- A total of 390,000 people with SMI will receive a physical health check
- A total of 55,000 people a year will have access to IPS services
- The 60% Early Intervention in Psychosis access standard will be maintained and 95% of services will achieve Level 3 NICE concordance

### **Mental Health Crisis Care and Liaison**

- There will be 100% coverage of 24/7 age-appropriate crisis care, via NHS 111, including:
  - 24/7 CRHT functions for adults, operating in line with best practice by 2020/21 and maintaining coverage to 2023/24;
  - 24/7 provision for CYP that combines crisis assessment, brief response and intensive home treatment functions;
  - A range of complementary and alternative crisis services to A&E and admission (including in VCSE-/local authority-provided services) within all local mental health crisis pathways;
  - Mental health professionals working in ambulance control rooms, Integrated Urgent Care services, and providing on-the-scene response in line with clinical quality indicators
- All general hospitals will have mental health liaison services, with 70% meeting the 'core 24' standard for adults and older adults

### **Therapeutic Acute Mental Health Inpatient Care**

- The therapeutic offer from inpatient mental health services will be improved by increased investment in interventions and activities, resulting in better patient outcomes and experience in hospital. This will contribute to a reduction in length of stay for all services to the current national average of 32 days (or fewer) in adult acute inpatient mental health settings

### **Suicide Reduction and Bereavement Support**

- The current suicide prevention programme will cover every local area in the country
- All systems will have suicide bereavement support services providing timely and appropriate support to families and staff

### **Problem Gambling Mental Health Support**

- There will be a total of 15 new clinics providing NHS specialist treatment for people with serious gambling problems. This will include piloting provision for under 18s

### **Rough Sleeping Mental Health Support**

- 20 high-need areas will have established new specialist mental health provision for rough sleepers

### **Provider Collaboratives (formerly 'New Care Models') and Secure Care**

- All appropriate specialised mental health services, and learning disability and autism services, will be managed through NHS-led provider collaboratives over the next five years
- NHS-led Provider Collaboratives will become the vehicle for rolling-out specialist community forensic care

### **Digitally enabled Mental Health Care**

- 100% of mental health providers meet required levels of digitisation
- Local systems offer a range of self-management apps, digital consultations and digitally-enabled models of therapy
- Systems are utilising digital clinical decision-making tools

### **Improving the quality of mental health data**

- All mental health providers will achieve Data Quality Maturity Index scores of or above 95%

## Appendix 6: Mental health in systems of integrated and accountable care in other countries

The stark inequities in health outcomes for people living with severe mental illnesses is a global challenge.<sup>77</sup> Addressing this via better integration with wider health and social care services is a priority for many health systems. Given the similarities between ICSs and other models of care, we briefly consider the health system reforms in the United States, Scotland and Wales and the likely impact on services, although, this report does not aim to provide a comprehensive cross-country comparison.

### *Accountable Care Organisations in the USA*

The 300 million people living in the United States have four options for accessing healthcare. The first option is where patients pay money direct to healthcare providers for their care, out of pocket: around a third of Americans are uninsured and fall into this group. The second option is for patients to pay premiums directly to insurance companies. This means everyone on the plan pays a healthcare premium to an insurer to offset rare and serious illnesses, which is a way of pooling risk across a defined population. Patients, therefore, pay a smaller amount on receipt of services (co-pay or a deductible) and the majority of funding comes from the insurance company. A small proportion of Americans access healthcare in this way. The third option is an employer-sponsored insurance, which is the route approximately half of Americans use when accessing healthcare services. In this case, employers pay a premium to an insurance company to provide employees with health insurance as part of a benefit package. Finally, the fourth option is to access healthcare through a tax-payer funded government-run programme. The major programmes include Medicare, Medicaid and military health and around a third of Americans access health in this way.

In the United States, Accountable Care Organisations (ACOs) have gained significant momentum and much research has considered their integrity and ability to deliver high-value care for vulnerable and minority populations.<sup>78 79 80 81</sup> ACOs were offered as a solution to address the issues of fragmentation, as well as broader issues relating to the 'triple aim'.

As with ICPs in the English NHS, primary care is integral element to an ACO with hospitals, specialist services, community care, nursing and care homes (post-acute providers) and private and voluntary sector providers wrapping around. Moreover, there is clear accountability for the totality of care, financial risk-sharing, a capitated budget and an outcome-based contract.<sup>82</sup> Whilst not compulsory, the inclusion of hospitals in ACO networks appears to be associated with urban areas, non-profit organisations, and areas with a relatively small share of Medicare patients.<sup>83</sup> An estimated 23.5 million Americans are now being served by an ACO and 8.9 million people are Medicare beneficiaries.<sup>84 85</sup>

Across the United States, there are many different examples of ACOs. Integrated delivery systems are regarded as the most formal and organised ACO structure. This is where organisations are brought together within a single system and payment mechanisms encompass all care across organisational boundaries.<sup>86</sup> These typically include hospital services as well as multispecialty group practices (enhanced primary care similar to England's federated GP model and primary care networks). These ACOs take a system-wide approach to care. Kaiser Permanente, for instance, operates in eight states and the District of Columbia and is the largest managed care organisation in the United States.<sup>87</sup> Intermountain Healthcare in Salt Lake City is another example of this.<sup>88</sup>

For Medicare and Medicaid beneficiaries, the Commonwealth Care Alliance, in Massachusetts, for instance, provides enhanced primary care and care coordination through multidisciplinary teams that include physicians, nurses, mental health and geriatric specialists. Approximately 80 per cent of their patients has mental health problems, multiple chronic health conditions, or functional limitations due to physical and developmental disabilities.<sup>89</sup> There are other examples, such as Crystal Run Healthcare ACO in New York<sup>90</sup>, and Essentia Health<sup>91</sup>, which have developed an integrated model that embeds several mental health specialists within primary care teams and co-locates providers.

Despite this, the involvement of a mental health provider in ACOs is variable across the United States. For instance, the majority of ACOs have responsibility for mental health services and some mental health care costs but only one-third of all ACOs have no formal relationships with mental health providers.<sup>92-93</sup> Furthermore, evidence suggests there has been limited scope for mental health providers to participate in an ACO, either as a lead entity or as participants in ACO networks.<sup>94</sup>

Consequently, integration of mental health remains low with most ACOs pursuing traditional fragmented approaches.<sup>95</sup> However, there are examples, albeit relatively few, of Medicaid ACO models seeking to do this in four ways: (i) including mental health services in ACO payment models; (ii) requiring ACOs to report mental health quality metrics and tying some of these metrics to payment; (iii) including mental health providers in ACOs and/or ACO governance structures; and (iv) improving information-sharing and health information technology.<sup>96-97</sup> But, ultimately, researchers and policy-makers have argued that many ACOs have failed to integrate mental health and medical services, thus far.<sup>98-99</sup>

The driver for developing ACOs in the United States has been greater than in England, simply because the degree of inequity and the challenge in creating value outweighs the experiences in the English NHS. However, there are some interesting lessons for ICSs and ICPs when seeking to collaborate with mental health providers.

## ***Integrated Authorities and Integrated Joint Boards in Scotland***

Healthcare is devolved across the UK, which has led to variation in health system design. In Scotland, the Public Bodies (Joint Working) (Scotland) Act in 2014 was introduced to ensure that health and social care services are well integrated, so that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care.

The Act required councils and NHS boards to work together to form new partnerships, known as Integration Authorities. There are now 31 Integration Authorities, established through partnerships between the 14 regional NHS boards and 32 councils in Scotland.<sup>100</sup> Each Integration Authority differs in terms of the services they are responsible for and local needs and pressures. At a minimum, Integration Authorities need to include governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults. In some areas, partners have also integrated children's services and social work criminal justice services, as well as acute health services.<sup>101</sup>

Integration Joint Boards are separate legal entities, responsible for the strategic planning and commissioning of the wide range of health and social care services across a partnership area. They were established to integrate health and care systems across the country. Currently, local authorities and health boards jointly delegate certain responsibilities to Integration Joint Boards, to be delivered through a local strategic plan. This includes planning and resourcing community service provision.<sup>102</sup>

A report by Audit Scotland found that, since 2016, Integration Authorities have begun to introduce more collaborative ways of delivering services and have made improvements in several areas, including reducing unplanned hospital activity and delays in discharging people from hospital. However, they find that financial planning is not integrated, long-term or focused on providing the best outcomes for people who need support.<sup>103</sup>

Audit Scotland argue that financial pressures across health and care services make it difficult for Integration Authorities to achieve meaningful change. For example, Integration Authorities were designed to control some services provided by acute hospitals and their related budgets this has not been enacted in most areas.<sup>104</sup>

Furthermore, they argue that strategic planning needs to improve, and several significant barriers must be overcome to speed up change. These include a lack of collaborative leadership and strategic capacity; a high turnover in leadership teams; disagreement over governance arrangements; and an inability or unwillingness to safely share data with staff and the public. Local areas that are effectively tackling these issues are making better progress.<sup>105</sup>

The Royal College of Physicians of Edinburgh have also highlighted that the complexity of Integration Joint Boards can lead to confusion around roles and responsibilities, and even make accountability unclear, particularly when there is service failure. They urge that Integration Joint Boards must understand the needs of their local population for integration to work, and that “staff on the ground” require more support to deliver health and care objectives.<sup>106</sup>

While there are differences between the Integration Authorities and Integrated Joint Boards in Scotland and the ICSs in England, notably in terms of the commissioner and provider role, there is much to learn about the experiences of integrating health and social care.

### **Local Health Boards in Wales**

As in Scotland, healthcare is devolved in Wales. In 2009, the NHS in Wales underwent major reorganisation to equip it to deliver better healthcare to its population. The Government's *One Wales* strategy document determined that the delivery of the NHS in Wales needed to be redesigned to improve health outcomes and ensure that the NHS delivers care effectively with its partners.<sup>107</sup> As with the *Five Year Forward View* in England, the Welsh Government aimed to provide more care closer to people's homes and more self-care programmes to help people live more independent lives, provide more joined up services between health and social care, and increasingly focus on public health.<sup>108</sup>

The reorganisation created single local health organisations that are responsible for delivering all healthcare services within a geographical area, rather than the internal market that existed previously. The NHS in Wales now delivers services through seven integrated Local Health Boards and three NHS Trusts, which replaces the 22 Boards and 7 NHS Trusts which performed these functions in the past. Local Health Boards are responsible for assessing the needs of their population and to plan, secure and deliver healthcare services in their areas, meaning there is no purchaser-provider split. These boards provide a range of primary, community, mental health and acute hospital services for a defined population ranging from 350,000 to 700,000 people. Local Health Boards have also established 64 primary care clusters serving a population of 25,000 to 50,000 per cluster.<sup>109</sup> The 3 NHS Trusts in Wales that provide services nationally include the Welsh Ambulance Services Trust for emergency services, Velindre NHS Trust offering specialist services in cancer care and a range of national support services, and Public Health Wales.<sup>110</sup>

Progress is monitored through annual reports to the Welsh Government and through the Integrated Medium Term Plans (IMTPs) of Health Boards and Trusts. These plans set out projected activities for the following three years and are signed off by the Minister.<sup>111</sup>

Anecdotally from RCPsych members working in Wales, Local Health Boards are viewed as a generally positive step for mental health services. It is felt to have helped embed the ambition to achieve parity of esteem between a range of local leaders across health boards, and from a clinical perspective, it has supported multi-disciplinary team working. Members also report having a lot of input and influence over the developments happening at health board level generally. However, it has been argued that a mental health lead should be required in each Local Health Board at the executive level to keep mental health high on the agenda.

In Wales, there is also an ongoing issue with the ability to retain psychiatric trainees. Anecdotally, Local Health Boards are viewed more positively by members than smaller organisations, perhaps because of the flexibility and greater number of job opportunities when working for a larger organisation.

Ensuring that sufficient funding flows through the Local Health Boards to mental health services has been another matter of concern. As such, the Welsh Government in 2008 ring-fenced mental health revenue allocations to Local Health Boards with the aim of protecting investment in mental health services.<sup>112</sup> But despite this, Local Health Boards traditionally overspend each year and when this happens, the gap between spending on mental and physical health services usually widens. This is because overspending tends to happen for physical health services. The Welsh Government's draft budget report for 2018/19 indicated that government should undertake a further review of the mental health ring-fence to assess whether it has led to effective and appropriate expenditure on mental health and ensuring improved outcomes for patients.<sup>113</sup>

These three brief examples of health system reform in the United States, Scotland and Wales share similarities with the development of ICSs and ICPs across England. All of the changes are linked to a policy objective to shift focus from treatment to prevention, reduce reliance on hospital care and improve the financial viability of the health service. These models also have a much greater focus on population health management approaches, thereby planning and delivering services fit for the population within a defined geography or specific programme or plan. There is also an element of local flexibility to determine how national priorities should be delivered. In each of these examples, there is a convergence of the commissioning and provider function, which provides useful lessons for ICSs and ICPs. While clinical commissioning groups (CCGs) will retain their statutory duty in England to plan and commission services, there is an expectation that this will be much more closely linked with providers.

### ***Lessons from other countries***

There are useful lessons to be drawn from reforms elsewhere for emerging ICSs in England. Opportunities and challenges identified by health system leaders working across established and evolving ICSs and similar developments from other countries are found below.

When considering how health system reform in the United States, Scotland and Wales could inform the development of ICSs and ICPs across England, it is clear all the changes were linked to a policy objective to shift focus from treatment to prevention, reduce reliance on hospital care and improve the financial viability of the health service.

- **Agree a clear view of the model of care best for their population** - although models of integrated care share a common goal, a great deal of variation exists between delivery models.
- **Consider how ICSs will coordinate with existing infrastructure** to reduce disruption and maintain continuity of care. Building on existing assets and opportunities to deliver change needs to be weighed up against the capacity and need for new approaches or structural change.
- **Consider how the ICS will integrate with the wider sector** – including other types of NHS providers, social services, children’s services, voluntary and independent sectors.
- **Ensure ICSs successfully engage and co-produce plans with patients and the public and help them shape what services and communities work locally** – patient engagement should be a priority with clear and consistent messages.
- **Ensure models are clinically led** – ensure clinicians’ input and influence over changes to ensure buy-in and support and integrated multi-disciplinary team ways of working.
- **Consider how to best link financial incentives to provider outcomes** – are current financial incentives strong enough to change provider behaviour? Aligning financial incentives towards high-value care-versus high-volume care.
- **Consider which metrics will effectively measure the quality of care** – invest in data.
- **Workforce** – larger organisations might be more appealing to health professionals compared to smaller health providers, perhaps because of the flexibility and greater number of job prospects when working for a larger organisation.
- **Governance** – should be simplified and leadership should focus on strategic goals.
- **Ensure security of funding for mental health services** – population health budgets can mean the gap between spending on mental and physical health services widens.



- **Leadership development** – ensure appropriate leadership capacity is in place to support integration and increase opportunities for joint leadership development across the health and care system to help leaders to work more collaboratively.
- **Share learning** – share learning from successful integration approaches.

## Appendix 7: Proposed legislative change relating to ICSs

Following a consultation process, NHS England & NHS Improvement have proposed to Government and Parliament that legislative change is made through an NHS Bill.<sup>114</sup> An overview of relevant proposals is below:

### *Promoting collaboration*

- The Competition and Markets Authority function to review mergers involving NHS foundation trusts should be removed.
- NHS Improvement's competition powers and duties should be removed.
- The need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the Competition and Markets Authority should be removed.

### *Getting better value for the NHS*

- The regulations made under section 75 of the Health and Social Care Act 2012 should be revoked and the powers in primary legislation under which they are made should be repealed and replaced with a 'new NHS procurement regime'.
- The arrangements between NHS commissioners and NHS providers should effectively be removed from the scope of the Public Contracts Regulations and that NHS commissioners are instead subject to a new 'best value' test when making such arrangements, supported by statutory guidance.

### *Increasing the flexibility of national NHS payment systems*

- Once ICSs are fully developed, the power to apply to NHS Improvement to make local modifications to tariff prices should be removed.
- Primary legislation should be changed so that the national tariff can include prices for 'section 7A' public health services.

### *Integrating care provision*

- The law should be clarified so that the Secretary of State can only establish a new trust to secure the provision of integrated care across a given area; Or as may be specified in regulations.

### *Managing the NHS's resources better*

- An initial recommendation giving NHS Improvement targeted powers to direct mergers or acquisitions involving NHS foundation trusts, in

specific circumstances only has been replaced with granting NHSE/I the power in some circumstances to consider whether or not the board is complying with its licence conditions relating to governance and if appropriate can use regulatory powers to intervene.

- Initial proposals for NHS Improvement to have powers to set annual capital spending limits for NHS foundation trusts, as it can currently for NHS trusts have been revised, so that NHSI's power to set annual capital spending limits for the NHS FTs should be circumscribed, on the face of the Bill, as a narrow 'reserve power'.

### *Every part of the NHS working together*

- Organisations should be given the ability to create both joint committees of CCGs and NHS providers and also joint committees of providers only. Joint committees would be subject to statutory guidance stipulating core requirements about governance, the use of public funds and addressing conflicts of interest.
- A restriction should be removed to allow the designated nurse and secondary care doctor appointed to CCG governing bodies to be clinicians who work for local providers.
- Express provision should be made in legislation to enable CCGs and NHS providers to make joint appointments. To combat concerns around this recommendation and the difficulty of managing conflicts of interest, NHSE/I would consult on the application of guidance for joint appointments.

### *Shared responsibility for the NHS*

- A new shared duty should be introduced that requires those organisations that plan services in a local area (CCGs) and NHS providers of care to promote the 'triple aim' of better health for everyone, better care for all patients, and efficient use of NHS resources, both for their local system and for the wider NHS.

### *Planning our services together*

- NHS England should be given the ability to allow groups of CCGs to collaborate to arrange services for their combined populations. CCGs should be able to carry out delegated functions, as if they were their own, to avoid the issue of 'double delegation', and that groups of CCGs should be able to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions.
- Enable NHS England to jointly commission with CCGs the specific services currently commissioned under the section 7A agreement or to delegate the commissioning of these services to groups of CCGs.
- Enable NHS England to enter into formal joint commissioning arrangements with CCGs including providing the ability to pool budgets.

### *Joined-up national leadership*

- NHS England and NHS Improvement should be brought together more closely beyond the limits of the current legislation, whilst clarifying the accountability to the Secretary of State and Parliament.
- Initial proposals to establish new powers for the Secretary of State to transfer, or require delegation of, ALB functions to other ALBs, and create new functions of ALBs will not progress and NHSE recommends that the Government revisits with partners whether national responsibilities in relation to workforce functions are sufficiently clear.

## Appendix 8: Case studies

### Case study 1: Bexleycare, Oxleas NHS Foundation Trust, South London Partnership

#### Overview

'Bexleycare' is a new model of care for the London Borough of Bexley. It brings together one part of Oxleas NHS Foundation Trust (which also provides care to the boroughs of Greenwich and Bromley) and Adult Social Care in Bexley's Local Authority. This sits underneath the South East London STP and is also part of the strategic alignment of the South London Mental Health and Community Partnership.

Providing care for a local population of just under a quarter of a million people, it integrates mental health, community physical health (excluding primary care), and social care for those aged eighteen and over. A single point of contact and triage service take all referrals, passing those appropriate to one of three Local Care Networks (LCNs) that are geographically split within the borough to GP practices.

The vision is to provide better 'joined-up' care for residents, by dissolving barriers between physical health, mental health, and social care, as well as reducing wastage, bureaucracy and expense that previous models created through duplication and inefficiencies. It is anticipated that this will also lead to positive career development opportunities for staff working under a unified management structure to 'do things differently', helping with recruitment, retention, and job satisfaction.

#### The changes being made

The population of Bexley is projected to continue to rise in the coming years, and, moreover, life expectancy and the percentage of residents over 65s is increasing. The population's health and social care needs strain the existing model, not least in those with multiple needs, with individual and professional frustration at systems that could, at times, feel barriered. It was clear that a new approach was required, from public health preventative work, through more integrated approaches to care in those who needed it, to an emphasis on supporting and empowering self-management where this was appropriate.

Oxleas NHS Foundation Trust provides both secondary mental health and community physical health (district and specialist nursing, community physio- and occupational therapy, but not primary care). The relationship with the Local Authority and CCG has been a constructive and positive one, with the commissioners and providers committed to better align and design more thoughtful services.

'Bexleycare' was the result of this, formed in 2017; a virtual merger of adult social care, adult mental health, older persons' mental health, and community physical health. The first iteration involved merging the senior management team, so that service managers, associate directors, the clinical director, and the service director worked in a single team covering all of these services. Financing was split between the Local Authority and the NHS in a ratio proportional to services provided, with now aligned budgets to manage and the flexibility to move resources to ensure best value and use of resources. Both 'parent' organisations remain jointly responsible, with Bexleycare reporting to the Board the Trust and Council's Cabinet, and joint Oxleas-Local Authority meetings are regularly held to assure a single agreed approach.

The second phase, currently being implemented, is the formation of a single point of contact and 'triage' service for the borough, as well as three 'Local Care Networks' or LCNs, aligned to primary care practices. The Single Point of Contact services acts as a primarily administrative centre, though with rapid access to clinical support, for initial information taking on a single assessment form covering all services, and initial allocation to a next tier, or signposting to external agencies. The triage service has the ability to same-day assess any health or social care crisis, and rapidly escalate as required.

The Local Care Networks consist of elements of each of mental health, physical health, and adult social care working together under a single manager, trying to provide better joined-up care to local individuals. The Local Care Networks are 'virtual' insofar as the teams have not moved location at this time. Further, after much debate about which services 'should' be integrated, it was determined, for now, to keep early intervention and rehabilitation psychiatry outside of, but working with, the Local Care Networks (as are home treatment and inpatient services) though this may change as integration matures. A challenge is that IT and email systems remain separate for health and social care, with the workaround that key staff have access to both, and that the systems can read from each other.

Longer-term challenges include determining if this 'virtual' model is optimal, or if physical co-location is preferable, mindful of the workforce challenges of such moves, and staff preferences. The Local Care Networks are seen as offering opportunities for new ways of working and interesting professional development, but equally, it is recognised how this can be challenging for staff.

## **Looking ahead to 2021**

At this time, the Local Care Networks are 'virtual'; they operate under a single management structure, but physical health, mental health, and social care teams are located at different sites. The directorate is exploring how best to optimise the LCNs, including if physical co-location would

improve this, or if that is not necessary. It is envisioned that there will be increased working with the voluntary sector, utilisation of community assets including through the single point of contact, and enhanced joint working with primary care through social prescribing. Likewise, “place based” locality working will inevitably improve the ability of the whole health and care system to provide more timely and appropriate early intervention that not only improves outcomes for people who need services, but also help reduce demand.

### **Contact and further information**

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## Case study 2: Dudley MCP

### Overview

The Black Country Sustainability and Transformation Partnership serves five distinct local communities – Birmingham (West), Dudley, Sandwell, Walsall and Wolverhampton.

Across the region, depression rates (7.4%) are higher than the England average (7.3%), diabetes prevalence is much higher, with Sandwell and West Birmingham reaching over 9% (England 6.4%), the proportion of physically inactive adults is 32.6% (England 27.7%) and the infant mortality rate is also much higher in the Black Country and West Birmingham compared to England overall.<sup>115</sup> Specifically, in Dudley nearly 20% of the population have a limiting long-term illness or disability and the gap in life expectancy for the least and most deprived areas has widened, mostly due to heart disease, chronic obstructive pulmonary disease and lung cancer in men.

In 2015, Dudley CCG was selected to join NHS England's Vanguard Programme with the intention to develop a new care model – the Multispecialty Community Provider (MCP). The aim is for the MCP to deliver:

- **improved access to care** - which would result in improved patient experience and ultimately healthier lifestyles
- **continuity of care provision** – which would support stable management of long-term conditions, reducing variation in care and ultimately reducing inequalities, and
- **coordination of care** - which would enable people needing care or support to remain in their own homes, reducing social isolation and ultimately remaining connected to their community.

Through a series of multi-disciplinary teams, the MCP will support people in their homes and communities, working with all partners to enhance individual independence, prevent unnecessary admissions and facilitate speedy discharges. This will redefine the relationship between commissioner and provider, with the ultimate aim of delivering better, more integrated care and reducing health inequalities.

This new approach to continuity of care and standardising access to services will provide a return on investment as it will: improve the efficiency and effectiveness of primary care; improve self-determination by the public; contain the rising demand for emergency & planned secondary care - and thus improve the efficiency of the overall system.

Currently, primary medical care, mental health, community health and hospital services are provided by:



- Primary Medical Services from 46 GP Practices
- Dudley and Walsall Mental Health Partnership NHS Trust - hospital and community mental health services
- Black Country Partnership NHS Foundation Trust - hospital and community mental health services, community children's services, learning disability services
- Dudley Group NHS Foundation Trust - hospital planned / urgent care and community physical health services.

The MCP seeks to combine the delivery of primary care and community-based health and care services, not just planning and budgets.

## **The changes being made**

### *Re-procuring services under an MCP/ICP contract*

Dudley CCG and Dudley Metropolitan Borough Council are commissioning an MCP (also called an ICP) which will bring together services in an integrated manner. It will:

- hold a single contract of up to 15 years' duration worth between £3,495.0m - £5,445.0m
- manage a single, whole-population budget for 315,000 people registered with a Dudley GP
- transform the access to and delivery of community health and care services with primary care at the centre, and
- meet a defined set of outcome and performance measures.

The aim of the CCG is for a single entity to run the MCP, delivering a range of services including:

- community-based physical health services for adults and children
- some outpatient services for adults and children,
- urgent Care Centre and GP services including GP out-of-hours care
- community mental health and learning disability services,
- intermediate care services and NHS Continuing Healthcare
- end of life services
- voluntary and community sector services, and
- services commissioned by Dudley Metropolitan Borough Council's Office of Public Health including health visiting, family nurse partnerships, sexual health and substance misuse services.

It is expected that adult social care services could be phased in at a later date.

The building blocks of the MCP are the 'care hubs' of integrated teams. These serve approximately 30,000 people (2 per locality subject to prevalence) and are the core operational delivery and management structures with matrix management to support all professional requirements. The care hubs allow a move from 'MDT meetings' to 'MDT teams'. A shared clinical record will also be used across the MCP.

In order to provide the services within scope, this will involve the MCP sub-contracting with other service providers in order to maintain service stability. Other services will be phased in over time, depending upon the expiry date of existing contracts and subject to the agreement of a suitable mobilisation plan.

### *Mergers and split-ups*

In order to create the MCP, the CCG will split The Dudley Group NHS Foundation Trust, (main acute trust) in two, leaving a residual acute trust and the MCP.

The Black Country Partnership NHS Foundation Trust and Dudley and Walsall Mental Health Partnership NHS Trust also plan to merge in early 2020.

### *Integration agreement with GPs*

It is expected that the vast majority of GP practices will partially integrate with the MCP, meaning core GP services retain their existing contract. Instead, the MCP provider would sign an integration agreement with the practices.

### *Mental health services and link with primary care*

The Black Country Partnership NHS Foundation Trust and Dudley and Walsall Mental Health Partnership NHS Trust currently provide mental health services in community and hospital settings. The adult mental health team cover both inpatient and community services so there is continuity of care.

Dudley has an integrated model between adult mental health and primary care, which started as a pilot and has now expanded to the whole of Dudley.

The adult mental health medical teams led by consultant psychiatrists provide both inpatient and community mental health services serving defined catchment areas and population on the basis of GP clusters, thus ensuring continuity of patient care across inpatient and community mental health services. The consultant mental health team is split into eight teams which serve four community recovery teams. These teams link up with primary care practices and each visit primary care practices every 1-2 months for a couple of hours. They discuss new referrals to secondary care

(consultant liaison model) which can sometimes avoid the referral being made. They can jointly formulate a care plan if the patient is to be managed in primary care. Similarly, psychiatrists can discuss stable patients they wish to discharge back to primary care. This model has been very successful in creating a good dialogue between GPs and psychiatrists and is well received.

### *Governance*

The MCP is expected to have clear accountability to the public for the delivery of high-quality care within the resources available; emphasis on co-production of care and maximising the potential of the individual; and promoting responsibility for individuals to manage their own health and wellbeing and to access services appropriately.

### **Looking ahead to 2021**

The CCG has almost completed the procurement phase and it is expected to award its integrated care contract in April 2020.

### **Contact and further information**

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Further information: <http://www.dudleyccg.nhs.uk/mcp-procurement/>

## **Case study 3: North East and North Cumbria ICS**

### **Overview**

The Mental Health work stream was initially one of sixteen in the overarching North East and North Cumbria ICS.

A review in March 2019 by the overseeing Health Strategy Group decided to focus on the following 6 priority areas:

- Population health and prevention
- Optimising health services
- Digital transformation
- Workforce transformation
- Mental health
- Learning disabilities.

The overarching ambition is for sustainable, joined up high-quality health and care services that maximise the mental health and well-being of the local population.

The purpose of the North East and North Cumbria mental health ICS programme is to:

- ensure that mental health is fully integrated across the 'whole system' in order to progress the delivery of the national mental health strategy
- support the transformation process through communication, information, sharing best practice, reducing duplication and progressing system-wide engagement
- inform locality arrangements to progress ICSs aligned to needs profile, and
- understand variation and promote innovation and evidence-based practice to address gaps.

Seven priority areas have been identified by the Mental Health Steering Group. These are:

- Child health
- Zero suicide ambition
- Employment
- Optimising Health Services
- Long-term conditions and persistent physical symptoms
- Older people
- Improving the physical health of people in receipt of treatment for a mental health or learning disability condition.

The working groups are progressing implementation plans that consider the benefits of integrated services and are linking with system partners including, primary care, community and urgent care. 'Core' and 'transformational' services will be identified through a collaborative review of current delivery arrangements. Specialised commissioning aspects will be considered as part of the pathway review and in form recommendations. Quality improvement via continuous improvement is the focus of the work streams and the provision of informed baseline data has supported the aim of reducing unwarranted variation.

The Five Year Forward View metrics have been mapped to the 7 priority areas and a further mapping exercise has recently been completed to align the activity occurring in the priority area work streams with the outcomes described in the NHS 10-year plan, so any gaps can be identified.

*Population: demographic info for area*

<b>CCG</b>	<b>Local Authorities</b>	<b>County Councils</b>
Darlington	Darlington	
Durham Easington Sedgefield	Dakes, and County Durham	
Hartlepool Stockton on Tees	and Hartlepool Stockton	
South Tees	Middlebrough Redcar and Cleveland	
Hambleton, Richmonshire Whitby	and Hambleton Richmonshire	North Yorkshire
Newcastle Gateshead	Gateshead Newcastle	
North Tyneside	North Tyneside	
South Tyneside	South Tyneside	
Sunderland	Sunderland	
Northumberland	Northumberland	
North Cumbria	Allerdale Carlisle Copeland Eden	Cumbria

**Notes:**

- Cumbria and North Yorkshire both include districts that are outside of the North East and North Cumbria STP/ICS.
- Cumbria has a further 2 districts (Barrow-in-Furness and South Lakeland) that are within the Lancashire and South Cumbria STP/ICS.
- North Yorkshire has 5 districts (Craven, Harrogate, Ryedale, Scarborough and Selby) that are not in the NENC STP/ ICS.

*System partners*

System partners include CCGs, providers, the voluntary sector and social care.

Senior leaders and senior clinicians from the region are engaged in the Mental Health Steering Group and supporting infrastructures. There is ongoing activity occurring to further progress links with primary care, acute

care and local authorities at a steering group and priority area sub-group level.

Engagement with service users, carers and the voluntary sector is occurring through the priority area working groups. The mental health work stream has arranged four regional events in 2018/19 and a number of workshops have been progressed by the priority area work stream sponsors to take forward the work plans. A further regional engagement event is planned for spring 2020.

## **The changes being made**

### *Population health management*

An evidence and evaluation group prepared locality demographic profiles to inform initial population health management discussions. Information has also been sourced to inform ongoing decision-making through collaboration with, for example, public health colleagues and academic partners. A review and summary of the NHS England commissioned Strategy Unit reports for the region and reference to other contemporary publications has further informed the mental health plan.

Discussions are occurring with North of England Commissioning Support Business Intelligence Unit to progress 'one version of the truth' in terms of the baseline information provided for the North East and North Cumbria. The need to 'link up' data sources has been recognised and arrangements are progressing to bring together key agencies to develop an informed central data set.

An evidence and evaluation framework has also been developed to inform the approach to outcome measurement. The seven priority area working groups have identified collectively agreed deliverables and the criteria for measuring impact is being progressed in accordance with the framework.

### *Care redesign*

The multi-agency evidence and evaluation working group completed a literature search to understand 'what good integration looks like' and thematically reviewed the findings to inform the structure of the implementation plan. This process has:

- provided evidence based guidance for mental health system leaders
- informed the mental health steering group principles and purpose
- supported the implementation and review process for the seven priority areas
- helped to convey a clear message to partners, patients and carers, and
- ensured the focus on what it feels like for people in the system is maintained.

## *Principles*

A 'call to action' launch event took place in April 2018 and following this the nominated sponsors for each of the priority area working groups commenced a process of engagement and intelligence gathering to inform the developing work plans. The initial focus was on securing multiagency relationships and agreeing shared principles in order to progress a delivery plan that is jointly owned by the system leaders and informed by the people using and providing services. Agreement on the principles and the shared values that underpin the work plans were agreed for each of the 7 priority areas.

## *Purpose*

The emerging ICS arrangements were not determined by an existing 'blueprint' and discussions have progressed to 'make sense' of the task for our region. There is recognition that a continuous improvement process is required, and identification of some initial objectives is a necessary first step to move from planning to action. The priority groups have identified 3 initial key objectives that will be progressed and monitored via the Mental Health Steering Group Delivery Plan for 2019/20. As each one of the objectives are met, the working groups will agree 'what next' to ensure a managed system of continuous improvement work is in place.

## *People*

Engagement with wider system partners and people using and providing services is a primary driver for successful integration. Since the Mental Health Programme 'call to action' launch event in April 2018 there has been a focus on making, maintaining and expanding connections to engage system partners at every level. Involvement of service users and carers to develop plans through active participation and co-produced solutions remains a primary objective.

The seven priority areas have differing infrastructures that enable progress and each group has reviewed the communication and engagement arrangements in place recognising that involvement is an ongoing developmental aspect of the service improvement process. Working relationships are in place with public health to embed the principles of prevention and promote community well-being. Informal relationships with academic partners across the region are well established and work is progressing to map out the existing relationships and agree formal links to ensure maximum benefit is gained from partnership working.

## *Practicalities*

The ICS arrangements are evolving, and the practical aspects of the implementation process have been considered by the working groups. A thematic review of the feedback on the practicalities identified has

highlighted a number of issues to be addressed via the steering group and regional oversight groups.

### *Positive Impact*

Work is occurring to formalise links with the regional and national universities to maximise opportunities for joint working and increase access to expertise and resources to support evaluation and research. A joint working discussion has occurred with the National Institute for Health and Care Excellence to consider utilising the quality standards as an evidence-based benchmark for continuous improvement.

### *Precautions*

One of the main risks identified is that many of the solutions required to progress implementation are 'whole system solutions' and ongoing action to engage third sector and Local Authority organisations is crucial.

The identified risks that will require a whole system solution include:

- uncertainties with regard to funding
- information sharing and risk sharing issues
- consistency and reliability of data
- decision-making, governance and accountability aspects, and
- managing workforce implications

### *Informatics and digital*

Each working group is considering opportunities to implement digital solutions to enhance care in accordance with the agreed delivery plans. The steering group membership includes a digital care lead who can provide advice and links into the overarching enabling work stream for digital care.

### *Contract reform and mergers*

Discussions are underway at ICP and place level with regard to future contracting arrangements. Whole pathway commissioning is being progressed in some areas.

Cumbria Partnership NHS Foundation Trust currently provides mental health services, community health services, services for children and families and specialist physical health services.

Later this year, Cumbria Partnership NHS Foundation Trust (CPFT) and North Cumbria University Hospitals NHS Trust (NCUH) are set to merge together to form a single organisation. Following this, adult mental health services, CAMHS and learning disability services will be transferred from



Cumbria Partnership NHS Foundation Trust to Lancashire Care NHS Foundation Trust for the south of the county.

The new arrangements will provide a renewed focus on improving mental health services in south Cumbria and taking the next steps towards integrated physical, mental and social care services across the Bay.

In the north of the county, mental health services will be transferred from Cumbria Partnership NHS Foundation Trust to Northumberland, Tyne and Wear Foundation Trust and form part of the developing North East and North Cumbria ICS.

### *Payment systems*

The Mental Health Steering Group has been monitoring the investment required to support the delivery of the mental health programme since January 2018. A paper outlining the workforce commitment, expenditure and the contributions from the organisations and individuals leading and supporting the delivery has been prepared to inform 2019/20 funding arrangements. A process is also in place to support and monitor funding bids across the North East and North Cumbria area. Discussions are underway at ICP and place level with regard to contract payment arrangements.

### *Single operating plans*

Work is ongoing at ICS level to develop a longer-term plan by autumn and the mental health steering group will contribute to the narrative. The key task is to demonstrate purpose and value of ICS through, for example, reducing duplication, economies of scale, sharing positive practice and informing improvement. There are recognised challenges identified in terms of both the size and complexity of the North East and North Cumbria region and it will be crucial to share ownership of longer-term ICS strategy and ensure providers and commissioners align plans.

### *Leadership and governance*

The joint senior responsible officers for the ICS mental health work stream are chief executive of Northumberland, Tyne and Wear Foundation NHS Trust, John Lawlor and chief officer for South Tyneside Clinical Commissioning Group, Dr David Hambleton.. The seven priority area work streams are chaired by system leaders from health and social care . – Membership of the groups is multiagency with clinical and expert by experience representation. The working groups and supporting evidence and evaluation group report progress, and any issues arising, through the Mental Health Operational Management Group and escalate, as required, to the North East and North Cumbria ICS Mental Health Steering Group. A monthly highlight report is submitted to inform the wider ICS system delivery arrangements.

The Mental Health Steering Group meets every two months and reports to the North East and North Cumbria Health Management Group. Performance management aspects of delivery are monitored via the NHS England North Regional Mental Health Programme Board and Quality Assurance, Delivery and Improvement meeting. The mental health leads are actively engaged in the governance and oversight structures.

## **Looking ahead to 2021**

During 2018/19 the Mental Health Programme has made progress and a year one report has been prepared outlining achievements to date and describing the ongoing commitment to engage with service users, carers, staff and partners to take forward the 2020/21 delivery plan.

It is recognised that 2020 will be a transitional year, allowing ongoing work with partners to shape local the implementation plans in order to ensure that they meet the needs of the population.

The North East and North Cumbria mental health delivery plan focuses on a commitment to doing what is best for the health and wellbeing of the people by working together. Work with partners will continue to support the move towards creating an ICSs by April 2021 in line with the national timeline.

## **Contact and further information**

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## **Case study 4: Northamptonshire Health and Care Partnership**

### **Overview**

Northamptonshire Health and Care Partnership (NHCP) (formerly known as Northamptonshire STP) is evolving as an ICS with health and care providers in the county working together to support a vision of ‘a positive lifetime of health, wellbeing and care in our community.’

Northamptonshire Health and Care Partnership serves a population of 700,000, with the proportion under 18 (22.6%) slightly higher than the England average (21.3%) and 65+ (17.6%) slightly lower than the England average (17.9%). About 14% (19,300) of children live in low-income families. Life expectancy for men and women is similar to the England average.

Members of the Partnership include: general hospitals – Northampton General Hospital (NGH) and Kettering General Hospital (KGH); Northamptonshire Healthcare NHS Foundation Trust (NHFT); GP federations (3Sixty Care, GP Alliance and PML); Lakeside Healthcare Group (a single-partnership 'super-practice) in Northamptonshire; Northamptonshire County Council and district and borough councils; voluntary and community service providers; East Midlands Ambulance Service; and Nene and Corby CCGs.

## **The changes being made**

Partners across Northamptonshire established a new Mental Health Transformation Board which first met in late 2016. The Board includes service users, health and care organisations, other public sector organisations and the third sector. It was tasked with setting the vision and strategic direction for the future of mental health services in Northamptonshire and has overall responsibility for overseeing transformation.

In January 2017 the Board agreed a project initiation document (PID) which set out practical approaches to undertaking this work. The PID covers all in-county mental health services and the life-long pathway, whilst prioritising work according to the capacity within the system. This is one of the key workstreams of the Northamptonshire Health and Care Partnership, the Chair and Executive Sponsor of the Mental Health Transformation Board sit on the Northamptonshire Health and Care Partnership Board ensuring mental health leadership within the system.

The Mental Health Transformation Board committed to reviewing the full mental health and care profile for Northamptonshire, designed to support the development of a long-term commissioning and market development strategy.

Following this review, the Outcomes Framework has been co-produced over a 12-month period and has been defined by the valued input from service users, carers, practitioners, clinicians and managers from statutory, independent and third sector organisations in Northamptonshire, it is very much a user-defined framework.

### *What is the arrangement?*

A move to Outcome-based commissioning for Mental Health services that support the delivery of better outcomes that are important to service users. Working with clinicians and stakeholders across a health and care economy, and engaging service users to find out what outcomes they want and provide services that deliver them. Outcome-based commissioning creates the circumstances and incentives that allow innovation and re-investment from success.

## *Deliverables and measures of success*

### **Outcomes that matter to the individual:**

- Holistic health needs met
- New employment/sustained employment
- Sustained housing
- Empowered to access services as needed (referral not professional led)
- Timely and adequate crisis avoidance/intervention

### **Influencing the system:**

Increasing:

- People returning home after admission to a mental health unit
- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well/preventing a future crisis
- Offer to Primary Care through prevention and low-level input
- Ability to meet IAPT/EIP targets

Reducing:

- Acute hospital attendances
- Mental health admissions
- Section 136/police time

## *Benefits and challenges of the arrangement so far*

To date, the greatest benefit has been a system focus on recovery for the service user and carer based on hope, control and opportunity. This has generated a cultural change across organisations with the common language being “what can we do to develop and improve together” and even before the framework is translated into a contract we have seen the development of innovative services across the system. We truly feel the partnership working in everyday work lives.

It has not been easy and there have been challenges as with any cultural change, there has been a period of settling into recovery based working and gaining a shared understanding of hope, control and opportunity.

## **Looking ahead to 2021**

Key focus until 2021 is to:

- Define the scope of the framework delivery
- Build the provider alliance across the county with key individual and organisational stakeholders
- Agree on the contracting framework for delivery
- Confirm Outcome-Based Commissioning Framework
- Set out Outcome-Based Commissioning Framework in shadow form to run alongside 2019/20 contracts, including KLOEs, reporting requirements and reporting & review points
- Outcome-Based Commissioning Framework: Review the effectiveness of KLOE and reporting requirements for reviewing
- Outcome-Based Commissioning Framework: Format 2020/21 and contract and confirm final format for OBCF, KLOEs, reporting requirements and reporting & review points
- Deliver sustainable transformation plans within the new framework.

## **Contact and further information**

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## Case study 5: South West London Health and Care Partnership

### Overview

South West London Health and Care Partnership is evolving as an STP to provide care for a population of 1.4 million. It comprises six local health and care partnerships in Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth. This local approach reflects the distinct area health profiles. Compared to the average Londoner, people in Croydon are more likely to be obese as children, have higher rates of diabetes and heart disease and experience inequalities in life expectancy; residents of Kingston, Richmond, Merton and Wandsworth are, on average, less deprived compared to other London boroughs, but they have an increasingly older population (over 65) with increasing rates of long-term conditions; and Sutton residents live in one of the healthiest English boroughs with an increasingly young population.

The system partners include its six CCGs and local authorities; acute and community providers in the area; the two mental health providers; GP Federations; London Ambulance Service and Healthwatch.

Its vision is based on a local approach to planning, supported by Local Transformation Boards, focused on delivering care where it is best for people to receive it, strengthening the focus on prevention and helping keep people out of hospital.

The programme was originally awarded £1.85m of national funding in December 2018 to develop mental health support teams in clusters of schools in Merton, Wandsworth and Sutton. A further £4.3m was announced in July this year. The funding was in part to expand existing mental health support teams in clusters of schools in Croydon, Kingston and Richmond which are focusing on building emotional resilience of children and young people through early intervention. The money is also being used to create new teams in additional schools with new areas of focus around reducing inequalities in health:

- Reducing serious youth violence in schools in Croydon
- Mental health early intervention for special educational needs and disabilities (SEND) in selected special schools in Merton and Sutton
- Supporting young people from a BAME background who have suffered trauma in Wandsworth.

### *Ambition*

South West London (SWL) Health and Care Partnership (HCP) have made a commitment to champion the emotional wellbeing of children and young people (CYP). The ambition is that CYP will have the best start in life so that they achieve their full potential and have good mental health into

adulthood. They have listened to young people, their families and front-line professionals.

Using the results of that engagement, they are now taking three actions for each SWL borough to create: “school clusters” to develop a whole schools approach with their teachers and pupils; an enhanced single point of access; and a directory of emotional wellbeing and support services to bring together the tapestry of different services that are available. In support of this, their STP, SWL Health and Care Partnership’s , health promotion and prevention priority is children and young people emotional wellbeing and resilience.

Building on this work, they have used their guiding coalition to oversee the development of trailblazer Mental Health Support Teams (MHST) in Merton, Sutton and Wandsworth funded by NHS England and the Department for Education. For their non-trailblazer boroughs of Croydon, Kingston and Richmond the local CCGs have invested in mental health support workers who will support the development of a whole school approach.

### *System Leadership*

They have already started a system-wide programme, supported by Yale School of Public Health, to reduce self-harm. The four programme leaders are a GP CCG Chair, Local Authority Chief Executive, Hospital and Mental Health Trust Chief Executives.<sup>116</sup> They have built a small guiding coalition including head teachers, children and young people and stakeholders from the CAMHS partnership boards in each borough.

They have worked with teachers; school counsellors; GPs; mental health, local authority and social care professionals; children and young people advocates and the voluntary sector to develop a range of joint actions to address the root causes of self-harm by ensuring consistent early and effective support for emotional wellbeing. They have then asked children, young people, parents and carers in each borough to prioritise the actions.

### **The changes being made**

They have been successful in attracting external funding from NHS England, HIN and HEE well as internal CCG funding because:

- they have a strong coalition of cross-sector senior leaders in place to lead and drive forward this priority programme across health, care and education with oversight and support from the NHS Strategic Leadership Programme (including Yale School of Public Health)
- they have already undertaken significant work across SWL to look at how they support children and young people’s mental health and build their resilience. They have developed strong relationships with the health,

care and education sectors which has accelerated delivery of their service model

- they have already undertaken significant engagement with children, young people and their parents and carers and will continue to build on this
- children and young people, their parents and carers as well as teachers and health professionals, have told them that current services are not meeting need and that too many children continue to present in mental health crisis to mental health services or to A&E
- they have a track record of implementing and spreading good practice, e.g. the South London new models of care pilot for CAMHS crisis care and CAMHS tier 4 services
- their approach enables them to test a very mixed demographic including inner and outer city schools from which they can share learning, and
- all boroughs in SWL have been actively involved in this programme, their cluster schools have already begun making significant changes in implementing the whole school approach.

### *Assessment of need*

There are approximately 228,432 children and young people at school in the boroughs of SWL. This comprises a very mixed demographic as it represents both inner and outer city children. Their population comprises some of the more deprived wards (for example 3 wards in Merton and 5 in Sutton) nationally as well as some of the most affluent. Boroughs are ethnically diverse. Further detail is given below:

	<b>Merton</b>	<b>Sutton</b>	<b>Wandsworth</b>	<b>Croydon</b>	<b>Kingston</b>	<b>Richmond</b>
<b>School population</b>	34,000	39,000	38,000	64,605	25,599	27,228
<b>Number of children with a Child Protection Plan</b>	220	265	322	794	155	142
<b>Number of children with a care plan</b>	1,679	1,658	1,405	694	411	300
<b>Number of looked after children</b>	160	215	300	783	127	117



<b>Number of children with pupil premium</b>	6,163	6,256	9,234	17,678	3,837	3,983
<b>Proportion of Black and Ethnic Minority children</b>	44%	36%	72%	44.9%	36%	37.6%
<b>Mild to moderate need</b>	3,900	3,800	5,000	1,351	2,884	2,713

In addition, across all 6 boroughs, there has been an increase in Special Educational Needs and Disabilities (SEND) characterised by an increase in the number of children requiring a diagnosis for Autism Spectrum Disorder (ASD)/ Attention Deficit Hyperactivity Disorder (ADHD). This increase in children with challenging behaviour in the school settings has an adverse impact on exclusions with ongoing societal implications such as involvement in crime and gangs. In 16/17 there were 154 permanent exclusions and 6,253 temporary exclusions across Croydon, Merton, Sutton, Kingston, Richmond and Wandsworth boroughs. A significant proportion of these children were not known to authorities prior to their exclusions and as such had little or no professional mental health support prior to this.

### ***Targeted Support for children and young people with mild to moderate mental health conditions***

The mental health support teams in the trailblazer sites will deliver consultation for teachers and assessments and treatment of pupils for mild to moderate mental health conditions in primary and secondary schools. Treatments will comprise:

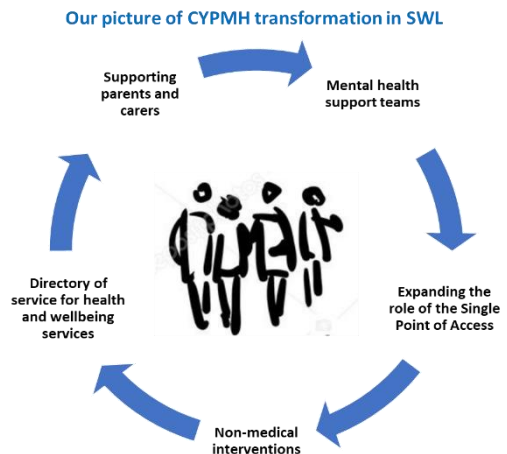
- 1:1 interventions
- group treatment programmes

Their teams will be trained in evidence-based practice including low-level cognitive behaviour therapy, parenting work including multi family therapy group work. They will work with the single point of access to refer those children who require longer-term work and equally support those children from CAMHS who require a step-down approach.

In their non-trailblazer sites, the mental health support worker will deliver consultation to teachers and parents and provide group work for children, signposting those children who have greater needs to other CAMHS services.

In addition to delivering on the core requirements of the mental health support teams, the SWL whole school approach will include the following elements that support wider proposals within the green paper:

- **Supporting parents and carers** – such as peer parenting support.
- **Directory of Services** – which clearly describes health and wellbeing services that are available in each borough to support children and young people. They have commissioned additional online peer to peer support and online counselling for children and young people 7 days a week until 10 pm.
- **Non-medical intervention** – they plan to commission evidence-based non-medical interventions for children and young people who have emotional wellbeing issues that do not meet the CAMHS criteria.
- **Expanding the role of the Single Point of Access** - to ensure that it signposts children and young people into early help and non-medical interventions services. They plan to convene workshops and task and finish groups that will oversee the transformation of their existing single point of access.



### *Informatics and Digital*

SWL STP has an established digital strategy that will enhance the operability of IT systems. Phase 1 which is underway will link all GP practices and the 4 acute hospitals so that there is a shared health record. For Kingston, there is already a shared record with Achieving for Children and SWL and St Georges Mental Health Trust which means that CAMHS clinicians and education and early year's colleagues are able to see each other's records.

Phase 2 will link community, adult social care, mental health, NHS 111 and GP out of hours. There will be a shared record for those patients with complex needs and long-term conditions.

Phase 3 will include Local Authority services and care homes.

### *Contract reform*

Sutton CCG and the London Borough of Sutton already commission their CAMHS tier 2 service using an alliance contract. Across SWL they will use the learning from this to develop an alliance contracting model for the emotional wellbeing digital providers.

They have signed an MOU with schools, the CCGs and all NHS providers on the programme setting out how they will work together to deliver the programme outcomes. They see their programme as an enabler to the development of a functional ICS. They know that for the ICS to be successful, they require behavioural change in the way in which services are provided and commissioned. They are working in partnership to break down the organisational boundaries that have existed, their approach is to create seamless care pathways that enable children and young people to access the most appropriate support early and consistently across SWL.

### *Developing a new workforce*

They are working with Kings College University to train a new workforce of Education Wellbeing Practitioners who are being trained in evidence-based approaches to support children with mild to moderate mental health needs in education settings. This is building on the success of their established Children and Wellbeing Practitioners in Kingston, Richmond, and Sutton with an additional cohort being trained for Wandsworth. They have senior clinical psychologists who provide clinical supervision and training for this new workforce.

### *Support for teachers*

In addition, they are supporting teachers and school staff by providing mental health first aid training for all staff to equip them with the skills to support children and young people who may present with mental health conditions. They have identified a designated mental health lead in each of the schools in the programme who will be supported with additional development to undertake the role in leading the whole school approach. They are also working with their schools to support the emotional wellbeing of teachers, they have rolled out the Good Thinking website to all the schools in the programme, and some of their schools have introduced mindfulness and yoga to improve the emotional wellbeing of the staff.

### *Support for parents*

They are expanding their capabilities and capacity by training parents in an evidenced based peer parenting programme (Empowering Parents Empowering Communities) working in collaboration with SLAM (South London and Maudsley NHT Trust) and Kings College University. Once trained, these parents will deliver peer universal parenting programmes to other parents with the aim of building emotional resilience

### *Support for staff in acute medical settings*

They are in the early stages of working with Healthy Teen Minds to embark on a programme called 'we can talk' that aims to train all staff in acute medical settings to enable the staff to identify mental health conditions in acute settings and provide appropriate support.

### *Governance and Accountability*

They have a track record of delivery; their programme will build on previous successes across their system which include:

- delivery of South London Mental Health and Community Partnership new models of care for CAMHS tier 4 service which has reduced out-of-area occupied bed days for children and young people by 38%
- implemented co-located teams offering integrated provision between social care and health such as psychologists in the Youth Offending Teams and Looked After Children teams, CAMHS workers in social care and education teams and joint provision of early help and parenting services
- implementation of Emotional Literacy Support Assistants who have been trained in a range of interventions for emerging emotional wellbeing issues
- implementation of a new self-harm prevention service in Sutton resulting in reduced numbers of children attending A&E - including a multi-agency self-harm protocol, bi-weekly MDT meetings with schools to agree on joint actions for the most vulnerable children who self-harm
- review of training needs resulting in the development of training programmes e.g. trauma and domestic violence in Sutton
- implementation of a programme to support children and young people and their parents with exam stress which has resulted in a reduction in the number of children requiring CAMHS intervention during exam period, with the majority being sign-posted early to self-referral voluntary sector services for emotional wellbeing
- implementation of single points of access for CAMHS referrals which has resulted in reduced waiting times and improved access in all 6 boroughs, and
- implementing a new community neurodevelopmental pathway in Richmond and Sutton which has reduced waiting times for new diagnostic assessments. This scheme is currently being extended to Kingston.

### *Evaluation commitment*

To ensure a rigorous evaluation of the transformation work, they have commissioned CORC to undertake baseline school surveys which will be repeated after a year.

### *Success measures*

Their project to reduce self-harm in children and young people was created and developed in conjunction with the Yale School of Public Health which

means that they have benefitted from their academic expertise as they have developed an approach to complex problem solving, particularly in terms of developing interventions with the greatest impact, strong metrics and evaluation processes.

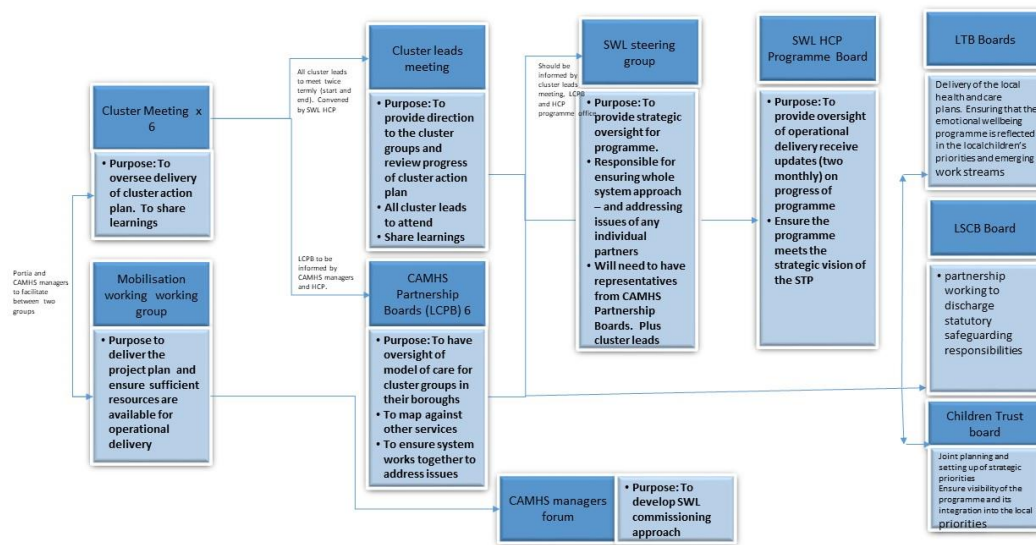
Their mental health support teams will collect children and young people's IAPT paired measures, using the same measures across all providers and pathways to make sure they can track improvements and also ensure that they have a consistent approach across SWL. They will also use school surveys and other evidence-based measures to track the impact of interventions and make changes where things are not working.

They will measure success based on both qualitative and quantitative measures. The measures will include:

- Number of interventions delivered per mental health support team (target 500 per year)
- Number of children and young people who attend A&E as a result of self-harm per year (target to reduce by 20% per year from year 2)
- Pre and post intervention score using the CORC school surveys
- BAME access to services and experience of CAMHS
- Time from referral to treatment for children and young people referred to specialist CAMHS services
- Pre and post intervention questionnaires to assess an increase in confidence of young people to manage emotional wellbeing
- Pre and post intervention questionnaires to assess improved knowledge and confidence from teachers and parents on supporting children with emotional wellbeing issues
- School/college time lost

### *Structures in place to succeed*

- The SWLHCP have agreed on a joint commitment to champion and improve children and young peoples' mental health and well-being and have committed to working as a system to improve the support that children and young people with mental health needs receive.
- This system-wide commitment means that they have established structures and leads in place to support implementation and drive delivery of the trailblazer - summarised below:



## Looking ahead to 2021

Their plans for the next two years are to fully implement the comprehensive MHSTs in the trailblazer sites with a view to expanding the mental health support teams to Kingston, Richmond and Croydon as fast followers. They will use the data from their year 1 evaluation to inform future commissioning intentions.

## Contact and further information

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## Case study 6: South West Regional Secure Services

### Overview

South West Regional Secure Services are a part of the first wave of NHS England's 'New Care Models in Tertiary Mental Health' programme. They are piloting a new approach to commissioning secure mental health provision for a regional population to provide care for people as close to home as possible, for the shortest appropriate period and in the least restrictive setting.

As the accountable provider, Devon Partnership NHS Trust is leading eight organisations to commission and deliver medium and low secure mental health services for adults. The partners include five NHS organisations, two independent sector organisations (Elysium and Cygnet), and one community interest company (Livewell Southwest). The partnership covers 22,000 square kilometers, a population of five million people, within a budget of around £71 million. Following a shadow period that commenced in October 2016, the programme went live in April 2017.

The long-term vision for the partnership is to stop inappropriate out-of-area placements altogether and to reduce reliance on inpatient services, by investing in community forensic services. There are currently limited community forensic services across the region and the aim is to have a total of seven fully-commissioned teams over the next five years.

### The changes being made

The members of the partnership developed a shared vision, clinical model and business model for a comprehensive secure mental health pathway, supported by its senior clinicians and leaders. This helped to embed a culture of working together and planning across the whole region in real-time. They have introduced the following key actions:

- introducing a single point of access across the region, standardising the assessment and acceptance criteria - ensuring the right people access the right services in a timely manner
- implementing a regional approach to bed management to optimize in-region bed occupancy, ensuring more people are treated closer to home, instead of having to access care with out-of-region providers
- implementing a regionally coordinated repatriation plan for those people placed out-of-region – more than 140 people have already been returned to in-region services
- developing clinical networks standardising delivery of inpatient care and developing a shared set of clinical and patient-rated outcomes
- engaging with patient networks to ensure co-design

- successfully proposing the commissioning of additional specialist beds in the region, helping to address the historical under-provision of services locally
- identifying the need for improved services for women, addressing this by re-profiling the use of some in-region beds to provide women's services, commissioning additional female secure beds and planning to introduce more women's services
- developing inpatient care pathways to reduce length of stay and address barriers to timely discharge
- developing community alternatives to support people in the community by developing a specification for comprehensive community forensic teams and successfully bidding for national monies to invest in a community forensic service across one county
- developing integrated working partnerships with accommodation providers to support people with secure mental health needs in community settings
- enhancing existing specialist community forensic teams, namely Pathfinder services (which provide services for people with a Personality Disorder needing secure mental health care) and FIND services (which provide services for people with Forensic Intellectual and Neuro-developmental Disorder needing secure mental health care)
- engaging with and develop integrated solutions with commissioners and providers across Criminal Justice pathways, for example Health and Justice commissioning, and
- contributing to the national design workstreams for community forensic teams, prison healthcare and women's services.

Learning and experience gained by the partnership in delivering this New Care Model programme is being used to further extend our secure cohort to include people with a learning disability and autism, and also to develop Tier 4 child and adolescent mental health services (CAMHS). This will focus on providing new services for children and young people with more complex mental health needs who may require inpatient treatment (including addressing the under-provision of CAMHS Tier 4 beds in the south west).

Initial work has begun to identify the level of need. The partner organisations will work together to ensure CAMHS services are designed to be as clinically-effective and as close to home as possible. The aim is to go live with the CAMHS Tier 4 service in mid-2019, subject to approval by the Regional Partnership Board and the boards of individual organisations within the partnership.



## **Looking ahead to 2021**

It is the intention of the partnership to extend the New Care Model to include Adult Eating Disorders and Perinatal Services for people in the south west.

Their partnership is represented in both the national delivery group and national oversight group in Establishing Steady State Commissioning. This involves the delegation of Specialised Mental Health commissioning from NHS England to provider collaboratives through a lead provider framework, commencing in April 2020.

## **Contact and further information**

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## **Case study 7: West Yorkshire and Harrogate Health and Care Partnership**

### **Overview**

The West Yorkshire and Harrogate partnership was created in March 2016 and joined the second wave of the ICS development programme in shadow form in May 2018. It has brought together local system partners, including local CCGs, Councils, NHS trusts and foundation trusts (acute and mental health) and others (voluntary and community partners, NHS England, NHS Improvement, Yorkshire Ambulance Service, Public Health England, Health Education England, Healthwatch and GP Federations).

The area population (2.6 million) has a higher mortality rate for people with severe mental illness compared to other parts of England, and significantly worse rates of cardiovascular disease. The area has 260,000 unpaid carers and a fifth of adults have a disability.

Their vision is for everyone to have the best possible outcomes for their health and wellbeing based on living in 'healthy places' (including a greater focus on preventing illness, self-care and joined up community and social care services), having access to 'high-quality and efficient services' (including integration of physical and mental healthcare services, single commissioning arrangements and better use of resources), and 'a health and care service that works for everyone' (work with people to make the areas a great place to work).

### **The changes being made**

Mental Health, Learning Disabilities and Autism are all national priorities and a local West Yorkshire and Harrogate Health and Care Partnership priority. We have a dedicated work stream within our ICS led by Dr Sara Munro (Chief Executive Leeds and York Partnership NHS Trust). The NHS providers of secondary mental health services in WY (Bradford District Care Foundation Trust, Leeds and York Partnership Foundation Trust, Leeds Community Healthcare NHS Trust and South West Yorkshire Partnership Foundation Trust) have come together to form a provider collaborative (West Yorkshire Mental Health Services Collaborative) to ensure consistent outcomes for people accessing services based on integrated and standard operating models for acute/specialist mental health services. This will ensure services are planned and delivered according to the needs of the population, through networked models of care and not an individual organisation.

Shared and aligned governance has been put in place to allow the four trusts to make timely decisions together to support service delivery and change, within a robust and challenging governance framework. This includes Committees in Common (C-I-C), where the Chair and Chief

Executives of the four trusts meet quarterly to oversee and make decisions relating to the programme. The C-I-C does not undermine the statutory responsibilities of the trust Board and its directors who remain accountable for the services and the care provided by their trust.

The collaborative is underpinned by a programme board which also includes third sector, local authority, commissioners and HEE. This joint approach supports relationships with the WYH Joint CCG Committee.

The partnership has agreed a number of priority service areas; covering both specialist/secondary care mental health and learning disability/autism services and work on early intervention/wider determinants of health—where it makes sense to take a WYH HCP approach and undertake the transformation work once as part of the MH& LD Programme (see Figure 1). This has primarily been influenced by the scale of the service and where something is challenging all local places.

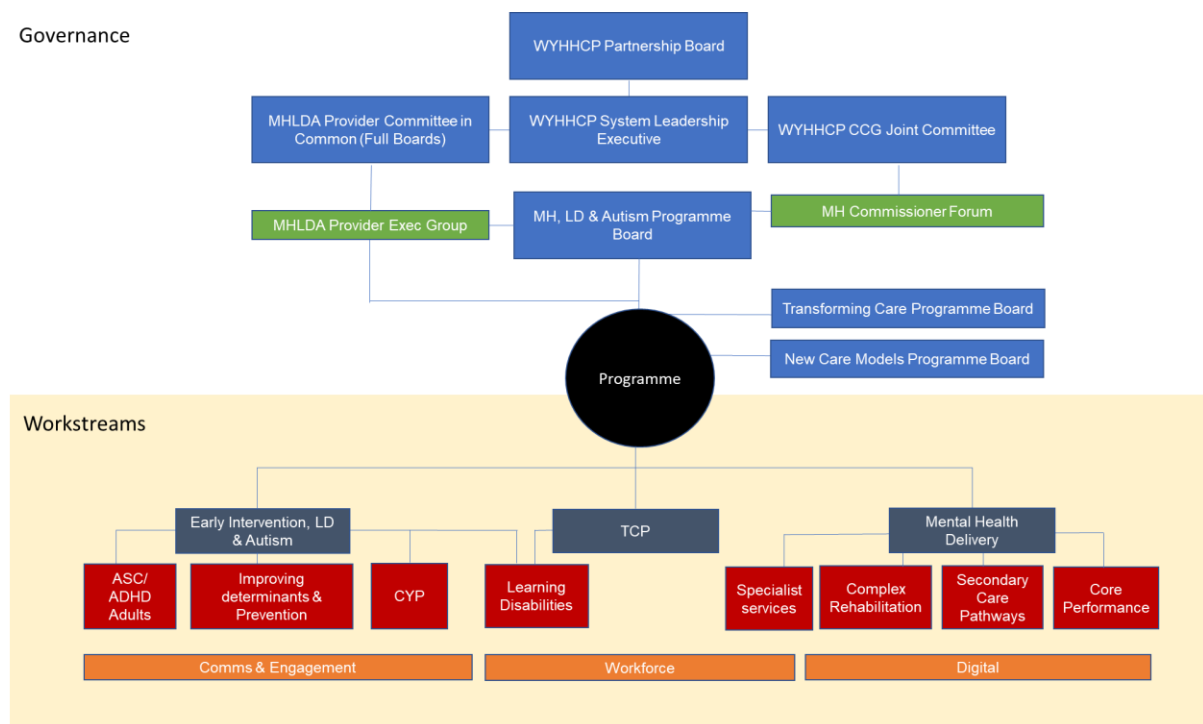
The programme has the following objectives.

- Improve the mental health of our population; promoting good mental health for everyone, with a particular focus on those who we know might need more support to stay healthy.
- Invest more money into mental health services; for people in crisis, mothers and partners post the birth of a child, children and young people, and for a range of common and severe mental illnesses.
- Eliminate the need for people with a mental health condition or learning disability needing to stay in hospital beds outside of West Yorkshire & Harrogate.
- Reduce the number of people with a mental health condition, learning disability or autism who unnecessarily attend A&E or who must be taken to a 'place of safety' by police.
- Reduce our suicide rates through a targeted approach to prevention.
- Develop new ways of providing specialist services, such as eating disorders, specialist care for children and young people with emotional, behavioural or mental health difficulties or services for criminal offenders and those at risk of offending.
- Reduce waiting times for Autism/ADHD assessments so that people get the support they need more quickly.
- Increase the number of people with a learning disability who can live in the community with support, rather than in hospital settings.
- Provide complex mental health care and rehabilitation in our communities so people no longer go far away from home for care.

- Ensure that when people with a learning disability require hospital care and treatment that this care is based on their needs and of the highest standard.
- Improve the physical health of people with mental health problems and people with a learning disability/autism; reducing the incidence of early death or poor health compared with the wider population.

The majority of service transformation and delivery of the *NHS Long Term Plan* and *Five Year Forward View for Mental Health* will be in the West Yorkshire and Harrogate Health and Care Partnership local places. To support this, the West Yorkshire and Harrogate Health and Care Partnership programme is developing its approach to undertaking a strategic oversight role (alongside the direct delivery of transformation) for mental health, learning disabilities and autism across the West Yorkshire and Harrogate Health and Care Partnership. This will ensure there is a system perspective to delivering all the change and improvements needed and investing in frontline mental health and learning disability services. It will also ensure they are spreading proven best practice and supporting each other through a process of peer review and mutual aid to improve services for the local population.

**Figure 1: Programme Overview**



Key highlights for the Connect Eating Disorder Service.

- The model was based on increasing the scope of community provision to reduce admissions and the service is working as expected.

- All posts have been recruited to.
- There have been no patients placed out of area since the beginning of September, which is significantly ahead of the forecast trajectory.
- The number of bed days for April – October 2018/19 is 3,504, compared to a baseline of 4,596 (pro rata), a reduction of 24%.
- Admissions have reduced from 81 in 2017/18 to 24 for April – October 2018/19.
- The average length of stay for patients admitted and discharged since the community team has been in place is 38 days, compared to an average of 85 days for 2017/18.
- Financial reconciliation has been agreed with NHS England and therefore they do not anticipate any issues.

### **Looking ahead to 2021**

We have developed a strategy for the next five years that underpins commitments in the overarching ICS 5-year strategy described in the *NHS Long Term Plan*. Our priority areas include:

- Establishing a new care model for forensic service provision
- Redesigning and improving learning disability services including the provision of better out of hospital care and ATU provision
- Investing in better and more comprehensive rehabilitation services for people with complex mental health needs to enable people to remain close to home and thereby reducing out of area placements
- Eliminating out of area placements for acute care
- Building a new 22 bedded tier 4 CAMHS unit for West Yorkshire.
- Developing a shared workforce strategy to support the development of the specialist mental health workforce
- Taking a ‘whole pathway’ approach to provision for children and young people pre and post diagnosis of a mental health condition, with a particular emphasis on crisis care, looked after children and those with a learning disability and/or autism.

### **Contact and further information**

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## Appendix 9: Details and examples of contractual models for greater cooperation and integration

### Greater cooperation

The vision behind STPs was for NHS services and local councils to come together to develop proposals to improve health and care – to run services in a more coordinated way. In these cases, commissioners maintain their existing service contracts with their providers, but system leaders develop a joint plan for improving the health of the local population.

#### ***Northamptonshire Health and Care Partnership***

Northamptonshire Health and Care Partnership (formerly known as Northamptonshire STP) is evolving as an ICS with health and care providers in the county working together to support a vision of ‘a positive lifetime of health, wellbeing and care in our community.’ Members of the partnership include: general hospitals – Northampton General Hospital (NGH) and Kettering General Hospital (KGH); Northamptonshire Healthcare NHS Foundation Trust (NHFT); GP federations (3Sixty Care, GP Alliance and PML); Northamptonshire County Council and district and borough councils; voluntary and community service providers; East Midlands Ambulance Service; and Nene and Corby CCGs.

Partners across Northamptonshire established a Mental Health Transformation Board, which first met in late 2016. The Board includes service users, health and care organisations, other public sector organisations and the third sector. It was tasked with setting the vision and strategic direction for the future of mental health services in Northamptonshire and has overall responsibility for overseeing transformation.

The emerging ICS is moving towards outcomes-based commissioning for mental health services that support the delivery of better outcomes that are important to service users. Working with clinicians and stakeholders across a health and care economy, and engaging service users to find out what outcomes they want and then design services that deliver them. Outcomes-based commissioning creates the circumstances and incentives that allow innovation and re-investment from success.

### **Leeds Providers' Integrated Care Collaborative**

Leeds Providers' Integrated Care Collaborative has been established as Committees in Common across the following organisations:

- Leeds and York Partnership NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- Leeds Teaching Hospitals NHS Trust
- Leeds GP Confederation

Its role is to bring providers together to coordinate decision-making, in order to secure more integrated services for the people of the city. Leeds City Council as a provider of Social Care Services and third sector representatives also attend the Committees in Common.

Leeds Providers' Integrated Care Collaborative has a work programme with a number of projects, including implementation of the new model for frailty, ensuring the successful development of Local Care Partnerships in the city and ensuring that providers collaborate in proposals for new services (examples include weight management and IAPT). One of the key projects which will underpin the work of Leeds Providers' Integrated Care Collaborative is the production of a 'blue print' for service delivery in the city in the next 5 years. This will enable them to have a picture of what 'good' integrated services should look like based on evidence of what can be achieved, which in turn will drive workforce and estate requirements and give direction to providers to work together to deliver this.

### **Provider alliances**

Provider alliances are when different organisations within a patch come together to agree on a common aspiration for their population. This can include NHS organisations, primary medical services, local authority services etc. It goes beyond greater cooperation as it allows local systems to agree on a risk and gain share mechanism, which sets out how providers within the alliance will benefit where demand management activities are successful in reducing secondary care activity. An Alliance Agreement does not seek to replace or in any way override existing services contracts and individual providers will be responsible for their own costs.<sup>117</sup>

## ***East London Health & Care Partnership (North East London STP)***

North East London has a diverse and rapidly expanding population: currently 1.95 million people live within eight boroughs, and a significant number of commuters come into The City and Canary Wharf to work. There is significant deprivation across the boroughs and health inequalities remains a significant issue with diabetes, dementia and obesity disproportionately affecting people living in poverty. North east London has amongst the highest prevalence of serious mental illness in the country.

Within ELHCP, seven North East London CCGs – City and Hackney, Newham, Tower Hamlets, Waltham Forest, Barking and Dagenham, Havering and Redbridge – have come together with the seven local authorities and the Corporation of London, two mental health and community providers, and three acute providers, to develop a partnership with the aim of improving outcomes, quality and value for the population they serve. This includes an STP mental health workstream, and work to develop place based commissioner and provider partnerships.

Mental health services have undergone significant transformation in north east London over recent years, for example through a programme to develop primary care mental health services in inner north east London, which has now provided recovery-orientated support for several thousand service users, and delivered some of the best performance on primary care physical health checks in the country, alongside work in outer north east London to develop the Open Dialogue approach. The STP programme has successfully supported cross CCG and provider learning, with a mature pan-provider perinatal network in place, and work to develop primary care mental health services. The programme has blended leadership across commissioners and providers, with high visibility in the STP programme more generally. The programme is also using linked data across primary, secondary mental health and acute care to understand how mental health conditions and learning disability are associated with system activity and spend, to support the development of more preventative integrated mental and physical health pathways. Crisis services too have been modernised with street triage, crisis cafes and a local crisis line providing community based support for those in crisis. As one of the first commissioners of liaison psychiatry, our work has shaped innovative pathways in acute services including a novel MDT for High Intensity Users in City and Hackney which includes an alliance of ELFT, Homerton, Tavistock and Portman and the Volunteer Center.

Within ELHCP there is also a significant programme of work to develop the infrastructure of an Integrated Care System, with mental health at the heart of it. Learning from the MCP Vanguard in Tower Hamlets, where NHS providers are now delivering an alliance contract for community health services around eight Primary Care Networks; the development of integrated provider and commissioner system governance in Barking, Havering & Redbridge; and City & Hackney work to develop integrated commissioning, where an integrated commissioning board made up of the CCG, the Corporation of London and the London Borough of Hackney already meets in public, there is significant progress being made to respond to the Five Year Forward View and Long Term plan ambition to integrate both service delivery, and service planning. Recent work with communities is leading to the development of a Citizen Panel to help us coproduce our work, and increasingly we are looking at developing networked pathways across providers and communities in NEL.



## **South West London Health and Care Partnership**

South West London Health and Care Partnership is evolving as an STP to provide care for a population of 1.4 million. It comprises six local health and care partnerships in Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.

The system partners include its six CCGs and local authorities; acute and community providers in the area; the two mental health providers; GP Federations; London Ambulance Service and Healthwatch. SWL Health and Care Partnership have identified children and young people's emotional wellbeing as their prevention priority in their health and care plan. They are building a foundation of strong partnerships with schools, the voluntary sector, local authorities, NHS providers and CCGs to improve the emotional wellbeing for CYP.

There are existing examples of alliance contracts; Sutton CCG and the London Borough of Sutton already commission their CAMHS tier 2 service using an alliance contract. South West London will use this learning to develop an alliance contracting model for all emotional wellbeing digital providers as part of the emotional wellbeing programme

As part of implementing the emotional wellbeing programme the health and care partnership have signed a memorandum of understanding with schools and all of their providers setting out how they will work together to deliver the outcomes of the programme. They see their programme as an enabler to the development of a functional ICS with improved partnership working breaking down the organisational boundaries that have existed. The intended outcome is to reduce fragmentation and enhance seamless care pathways that enable children and young people to access the most appropriate support early and consistently across South West London.

## **Integrated Care Providers**

An ICP is an organisation responsible for the integrated provision of primary medical services with wider NHS and potentially local authority services, which enters into an ICP contract with the commissioner(s) of those services. The ICP would be a 'lead' provider organisation, and so would be contractually responsible for delivering integrated services for local people. An ICP is not a new type of legal entity; it is the name for a provider organisation awarded an ICP Contract.<sup>118</sup>

ICPs have a different role in the system compared to other NHS providers as they provide a wider range of services which any one patient may be required to use over the course of their life than they traditionally would, such as primary medical care, community mental health, community physical health. In the likely event that the ICP is unable to deliver all the

services required by the population, it will have the flexibility to sub-contract services from other providers and will have the underpinning payment mechanism to enable it to do so. Either way, the ICP will be held to account for the collective delivery of services, as this provides the incentive for it to think more carefully about the best way to improve quality.<sup>119</sup>

A new ICP was published in August 2019<sup>120</sup> and NHS England expects that ICP contracts would be held by public statutory providers.<sup>121</sup> To use an ICP contract, commissioners and providers must undertake an Integrated Support and Assurance Process (ISAP).<sup>122</sup> This national oversight seeks to ensure both commissioners and providers have the capability and capacity to deliver services required under the contract to the highest possible standard. This considers:

- the relationships the lead providers have with other partners in the system, so they have a shared and coherent vision of how to integrate and improve services
- whether the provider has demonstrated sufficient rigour in their approach to health analytics prior to commencing delivery
- whether there is confidence that the provider will be able to deliver this role properly and plan carefully to meet the current and future needs of the population, and
- whether the assurance from the responsible commissioners that any proposals protect the long-term sustainability of high-quality services, irrespective of where and how they are currently provided, stands up to scrutiny.

## **Dudley**

Dudley CCG and Dudley Metropolitan Borough Council are commissioning an MCP (also called an ICP) which will bring together services in an integrated manner. The provider will:

- hold a single contract of up to 15 years' duration worth between £3,495.0m - £5,445.0m
- manage a single, whole-population budget for 315,000 people registered with a Dudley GP
- transform the access to and delivery of community health and care services with primary care at the centre, and
- meet a defined set of outcome and performance measures.

The aim is for a single entity to run the MCP, delivering a range of services including community-based physical health services for adults and children, some outpatient services, community mental health and learning disability services, sexual health and substance misuse services, the Urgent Care Centre and GP services including GP out-of-hours care. It is expected that adult social care services could be phased in at a later date.

To provide the services within scope, this may involve the MCP sub-contracting with other service providers in order to maintain service stability. Other services will be phased in over time, depending upon the expiry date of existing contracts and subject to the agreement of a suitable mobilisation plan.

In order to create the MCP, the CCG will split the The Dudley Group NHS Foundation Trust, (main acute trust) in two, leaving a residual acute trust and the MCP. The Black Country Partnership NHS Foundation Trust and Dudley and Walsall Mental Health Partnership NHS Trust will also merge in early 2020 to improve the clinical and financial viability.

It is expected that the vast majority of GP practices will partially integrate with the MCP, meaning core GP services retain their existing contract. Instead the MCP provider would sign an integration agreement with the practices.

As well as Dudley, it appears that Manchester, Northumberland and Sunderland are the areas with the most advanced plans to procure a single contract to create an accountable care type organisation.

## **Mergers and acquisitions**

Mergers are when two or more organisations come together to form a single organisation. They have a single governance and decision-making process, single management structure, full pooling of assets which can be redeployed as needed, full pooling of the risks and rewards of different activities within the organisation and are not time-limited. One of the

reasons trusts might decide to merge is to become a lead provider for the local area. They might then sub-contract services outside of their scope to other trusts.

***Bexleycare, Oxleas NHS Foundation Trust, South London Partnership***

'Bexleycare' is a new model of care for the London Borough of Bexley. It brings together one part of Oxleas NHS Foundation Trust (which also provides care to the boroughs of Greenwich and Bromley) and Adult Social Care in Bexley's Local Authority. This sits underneath the South East London STP and is also part of the strategic alignment of the South London Partnership.

Oxleas NHS Foundation Trust provides both secondary mental health and community physical health (that is district and specialist nursing, community physio- and occupational therapy and so forth, but not primary care). The relationship with the Local Authority and CCG has been a constructive and positive one, with the commissioners and providers committed to better align and design more thoughtful services.

'Bexleycare' was the result of this, formed in 2017; a virtual merge of adult social care, adult mental health, older persons' mental health, and community physical health. The first iteration involved merging the senior management team, so that service managers, associate directors, the clinical director, and the service director worked in a single team covering all of these services. Financing was split between the Local Authority and the NHS in a ratio proportional to services provided. Both 'parent' organisations remain jointly responsible, with 'Bexleycare' reporting to the Board of each, and joint Oxleas-Local Authority meetings regularly held to assure a single agreed approach.

The second phase, currently being implemented, is the formation of a single point of contact and 'triage' service for the borough, as well as three 'Local Care Networks' or LCNs, aligned to primary care practices. The Single Point of Contact service acts as a primarily administrative centre, though with rapid access to clinical support, for initial information taking on a single assessment form covering all services, and initial allocation to a next tier, or sign-posting to external agencies. The triage has the ability to same-day assess any health or social care crisis, and rapidly escalate as required.

### ***North Cumbria Health and Care System***

Across North Cumbria Health and Care System, Cumbria Partnership NHS Foundation Trust currently provides mental health services, community health services, services for children and families and specialist physical health services. Later this year, Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NHS Trust (acute trust) are set to merge to form a single organisation. In doing so, adult mental health services, child and adolescent mental health services and learning disability services will be transferred from Cumbria Partnership NHS Foundation Trust to Lancashire Care NHS Foundation Trust for the south of the country as part of the ambitions of the Bay Health & Care Partners. The new arrangements will provide a renewed focus on improving mental health services in south Cumbria and taking the next steps towards integrated physical, mental and social care services across the Bay.

In the north of the county, mental health services will be transferred from Cumbria Partnership NHS Foundation Trust to Northumberland, Tyne and Wear Foundation Trust and will be part of the North East and North Cumbria ICS.

## Appendix 10: Markers of success for ICSs

As part of our research, RCPsych's Research Panel members were asked what they thought the markers of success would be for their ICS in 5 years' time. A range of markers was suggested, with many centring around more joined-up ways of working and patient care pathways:

**Multi-agency working** between a range of service types including: different NHS trusts working together; a single provider for CAMHS services in a local area; health and social care providers working together; and better joint working between: mental health and geriatric services for older people; the NHS and private sector organisations, pharmaceutical companies and insurance companies; psychiatrists and GPs; CAMHS, counselling services, children's social care and education; drug and alcohol services and community mental health services (with one suggestion that addiction services should be run by NHS trusts); and mental health services with housing, education and employment services.

Some specific outcomes were anticipated by the marker of multi-agency working. For example, better joint working between CAMHS and children's social care following self-harm incidents in children and young people were expected to reduce presentations to A&E with self-harm; while better integration between obstetrics, perinatal mental health care and social care was anticipated to improve holistic perinatal support and reduce the incidence of removal of infants at birth.

**More seamless pathways of care**, with better integration between services to ensure people do not fall through gaps and a single point of access to care. This could include transfer from primary to secondary care, or to third sector support services, or following discharge from inpatient care to community or primary care, leading to another suggested marker of fewer delayed discharges from inpatient care.

Some specific care pathways were highlighted as requiring improvement, including secure care and crisis care pathways, which it was suggested needed to be more integrated with emergency departments and outreach from local inpatient units. It was suggested that the medical model of continuity of care must be applied to the mental health service.

Other improvements to care pathways suggested as markers of success was needs-based rather than a diagnosis-based assessment; or, put another way, person-centred rather than disease-led pathways. One way this could be achieved is through a system where services gather around the patient, especially for complex care, rather than the patient undergoing serial referrals.

**Greater focus on the holistic care of patients**, including increased use of social prescribing, particularly relevant for patients with comorbidity or dual diagnosis, but also an important marker for all mental health patients. Reduced homelessness and better quality, more permanent housing for patients, including reduced waiting times for supported accommodation and local authorities addressing housing issues more effectively, were also identified as markers, as were better access to education, training and permanent employment for disadvantaged patients, and rehab services where needed.

**Better interaction between physical health and mental health services** including improved physical health for patients with long-term mental health conditions, and improved mental healthcare for people with physical difficulties, with focus on addressing psychological elements of a person's care for all long-term health conditions. This marker was expected to involve greater psychiatric presence in front line services such as A&E, and in care plans for managing chronic medical conditions. Parity of funding for physical and mental healthcare was also identified as an important element of this marker.

**Improved access to care** including: community mental health specialist services; home treatment teams; inpatient beds; out of area beds; direct access to specialist mental health care; talking therapies; CAMHS clinicians for consultation and advice in schools; NHS services for children in crisis, including those who are suicidal; specialist personality disorder services; eating disorder services, autism services, and local access to care, especially to local inpatient care. Service user groups who were felt to particularly require better access to care included: adults who have children in their care; children and adolescents who currently do not meet the threshold for access to CAMHS; and patients who are currently refused mental health care due to substance misuse or alcohol issues. Referral criteria and thresholds were also considered to be a problem for GPs who feel unable to refer patients below crisis point. There was a view that only a minority of patients with needs are currently assessed and offered support, for example, it was claimed that currently only about 30% of people with depression are seen, with few offered therapy, and about 20% of people with ADHD are seen, with few offered adequate monitoring.

**Reduction in waiting times for care, treatment and care coordination** particularly waiting times for talking therapies outside of the IAPT programme and meeting the four-hour target for accessing urgent mental health care. A single access point for patients to access support and easier navigation of systems by staff and patients were highlighted as key markers of improved access to care.

Other suggested markers of success by panel members included:

- **Better outcomes for patients** including reduced health inequalities, morbidity, mortality and suicide rates and improved patient feedback and satisfaction ratings.
- **Reduced hospital admissions;** particularly fewer short-term crisis admissions, accident and emergency attendances for mental health issues and reduction in re-admissions especially for people with long-term mental health conditions. It was suggested that community rehab, and a long-term intermediate care system for chronic, but controlled, mental health conditions would lead to fewer 'revolving door' patients.
- **Improved cost efficiency;** with more efficient use and improved management of resources, including an absence of duplication and minimal repeat assessments. Reduced time and money spent on commissioning, and more generally, rapid decision-making, alongside a reduction in administrative burden with fewer referral forms in use.
- **A greater level of resource;** involving services staffed to NICE recommended levels and reduced caseloads. Capacity assessments for community and inpatient services were considered key to achieving effective resource allocation.
- **Improved accountability** - including acknowledgement of instances where NICE guidance was not followed; closer accountability in cases where joint care was needed; and improved coordination of quality improvement activities and outcome measures.
- **Early intervention and preventative care,** including a focus on aspects of health such as obesity, smoking, physical health and lifestyle. This would also involve better detection of early warning signs of relapse in the community, and early agreement on a patient's treatment pathway.
- **Full recognition, involvement and support of carers;** including ease of access to and navigation of services to ensure they meet a patient's needs. A carer support evaluation mechanism was suggested as a means to monitor this.
- **Patient involvement in their care,** involving clear mechanisms by which patients can exercise choice over their treatment, and be involved in service design and improvement, with innovations being service-user led.
- **Parity of esteem** for different mental health care services, including older people's mental health care, which it was argued should be retained as a specialist area, and CAMHS. It was suggested that services receiving an equitable share of budgets would be an indicator of the extent to which this marker had been achieved.



- **Improved staff morale;** with staff supported to enjoy their work and feeling confident that they are making a difference; more successful staff recruitment and retention, and less staff burnout.
- **Improved data sharing,** including quicker, more seamless access to medical records in different systems using shared IT systems. This would lead to another marker of improved quality of communication between services, particularly between primary and secondary care.
- Improvements to **funding models** including greater investment in mental health care, including pay increases for staff and ‘proper’ or increased funding of community mental health services; fully integrated funding of health and social care; investment in local area inpatient services; and proportionate spend on different parts of the Intensive Community Service. In addition: greater stability of local finances; consultants having more budgetary control and influence over the design of services; and some shared budgets to enable more proactive multi-agency working were suggested.

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