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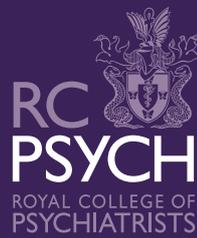
Mental health and new models of care

Lessons from the vanguards

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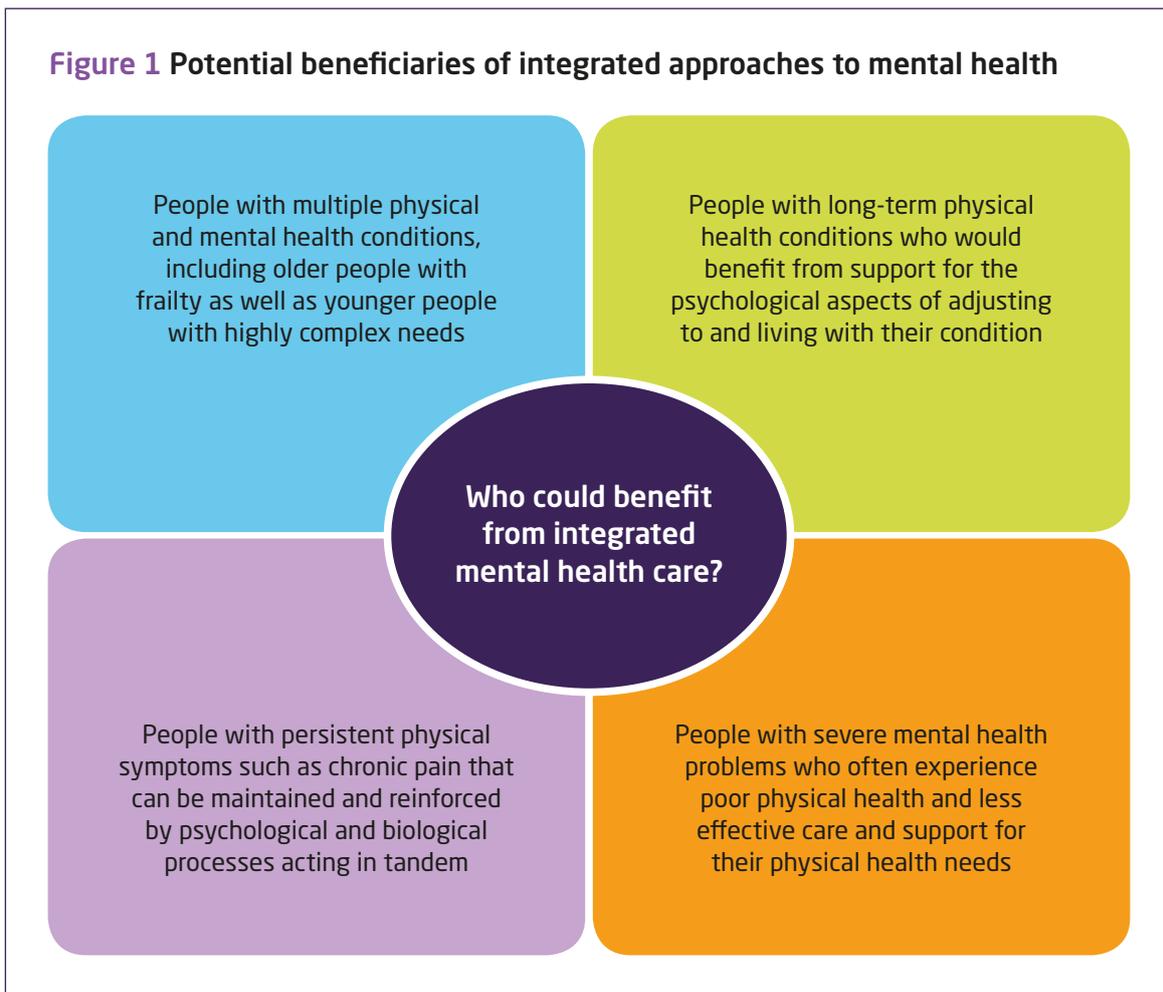**Anna Charles**

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Contents

Key messages

- The new models of care introduced by the *NHS five year forward view* (Forward View) create an important opportunity to deliver whole-person care that responds to mental health, physical health and social needs together.

- Developing more integrated approaches to mental health should be a key priority given the close links between mental health and physical health outcomes, and the impact these have on the quality and costs of care. It is now well established that when the mental health needs of people with physical health conditions are not adequately addressed, this increases costs and undermines patient outcomes.

- Many of the vanguard sites have included some mental health components in their care models, with several reporting promising early results and some emerging lessons that other areas may benefit from. For example, in areas that have incorporated mental health expertise into integrated care teams, team members report that the contribution of their mental health colleagues has been highly valuable in improving the support delivered to people with complex and ongoing care needs.

- Despite these positive steps, our overall assessment is that the full opportunities to improve care through integrated approaches to mental health have not been realised. The level of priority given to mental health in the development of new models of care has not always been sufficiently high. This is not consistent with the spirit of the commitment in *The five year forward view for mental health* (Forward View for Mental Health), which identified integrating physical and mental health as one of its three key priorities.

- The critical measure of success is that when taken together, the work done in the vanguard sites allows adequate testing of hypotheses about the potential impact of integrating mental health within new models of care. Our concern is that the service changes brought about to date may not be sufficiently ambitious to allow for this.

- In developing the multispecialty community provider (MCP) and primary and acute care system (PACS) models further, there is significant scope to make more progress in the following areas:
  - ensuring that integrated care teams designed to support people with complex and ongoing care needs can make full use of mental health expertise, with mental health capacity and capabilities sufficient to meet the needs that exist
  - making new forms of mental health support a core component of enhanced models of primary care, so that primary care teams are better equipped to address the wide range of mental health needs in general practice, and to meet the physical health care needs of people with long-term mental health problems
  - further strengthening mental health components of urgent and emergency care pathways in accident and emergency (A&E) departments and elsewhere
  - making public mental health and wellbeing central to population health management approaches, including through a focus on perinatal mental health, children and young people, where some of the greatest opportunities for prevention lie.

- As new models of care are developed in other areas beyond the vanguard sites, two things will need to be done to ensure that the opportunities relating to mental health are not missed. First, testing the mental health components of existing vanguard sites must be a central part of local and national evaluations of new care models. Second, other local areas rolling out MCPs, PACS and related care models should aim to go further than the vanguard sites in the four areas listed above.

- Sustainability and transformation plans (STPs) are the main mechanism for delivering the Forward View. It is essential that all STPs set out ambitious but credible plans for improving mental health and integrating mental health into new models of care.

- In *Next steps on the NHS five year forward view* NHS England (2017) sets an ambition to 'make the biggest national move to integrated care of any major western country'. Progress in developing integrated approaches to mental health care must be an essential success criterion for achieving this ambition. While the commitment to parity of esteem between mental and physical health is hugely significant, it is time to turn the rhetoric into reality.

1 Introduction

Mental health care is often disconnected from the wider health and social care system – institutionally, professionally, clinically and culturally. Artificial boundaries between services mean that many people do not receive co-ordinated support for their physical health, mental health and wider social needs, and instead receive fragmented care that treats different aspects of their health and wellbeing in isolation. Figure 1 illustrates some of the groups of people who frequently suffer as a result.

Figure 1 Potential beneficiaries of integrated approaches to mental health

People with multiple physical and mental health conditions, including older people with frailty as well as younger people with highly complex needs

People with long-term physical health conditions who would benefit from support for the psychological aspects of adjusting to and living with their condition

Who could benefit from integrated mental health care?

People with persistent physical symptoms such as chronic pain that can be maintained and reinforced by psychological and biological processes acting in tandem

People with severe mental health problems who often experience poor physical health and less effective care and support for their physical health needs

Previous research has argued that integrated care initiatives in England and elsewhere have not yet focused enough on the opportunities to overcome these boundaries and develop more integrated approaches towards mental health (**Naylor et al** 2016). This is despite evidence indicating that there is significant scope both to improve the quality of care and to use available resources more efficiently by doing so. For example, it is now well established that mental health problems are very common among people with long-term physical health conditions, and that when these mental health needs are not adequately addressed, the effect is often to drive up the costs of care and undermine outcomes (**Naylor et al** 2012). In the case of people with severe mental illnesses, poor physical health and barriers to accessing physical health care have led to a situation where they are likely to die 10 to 20 years earlier (on average) than the wider population – one of the starkest health inequalities seen in the UK (**Working Group for Improving the Physical Health of People with SMI 2016**).

Figure 2 (p 7) provides a summary of key facts and figures illustrating the case for change in terms of patient outcomes, system pressures and the financial costs of the current situation, while Figure 3 (p 8) illustrates some of the mechanisms through which physical and mental health interact.

Figure 2 The case for developing integrated approaches to mental health: summary of key facts and figures

Patient outcomes

- Poor mental health is a major risk factor for a wide range of physical health conditions, and can also be a consequence of physical illness. Around 30 per cent of people with one or more long-term physical health conditions also have a mental health problem; this figure is higher among people with multiple conditions (Naylor *et al* 2012).
- Depression and anxiety disorders lead to significantly poorer outcomes among people with diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD) and other long-term conditions (Jünger *et al* 2005; Katon *et al* 2005; Blumenthal *et al* 2003; Lespérance *et al* 2002).
- Compared to the general population, people with severe mental illnesses are 4.7 times more likely to die from liver disease, 4.6 times more likely to die from respiratory disease, 3.2 times more likely to die from cardiovascular disease, 1.7 times more likely to die from cancer, and overall die 10–20 years earlier on average (Taggart and Bailey 2015; Brown *et al* 2010).
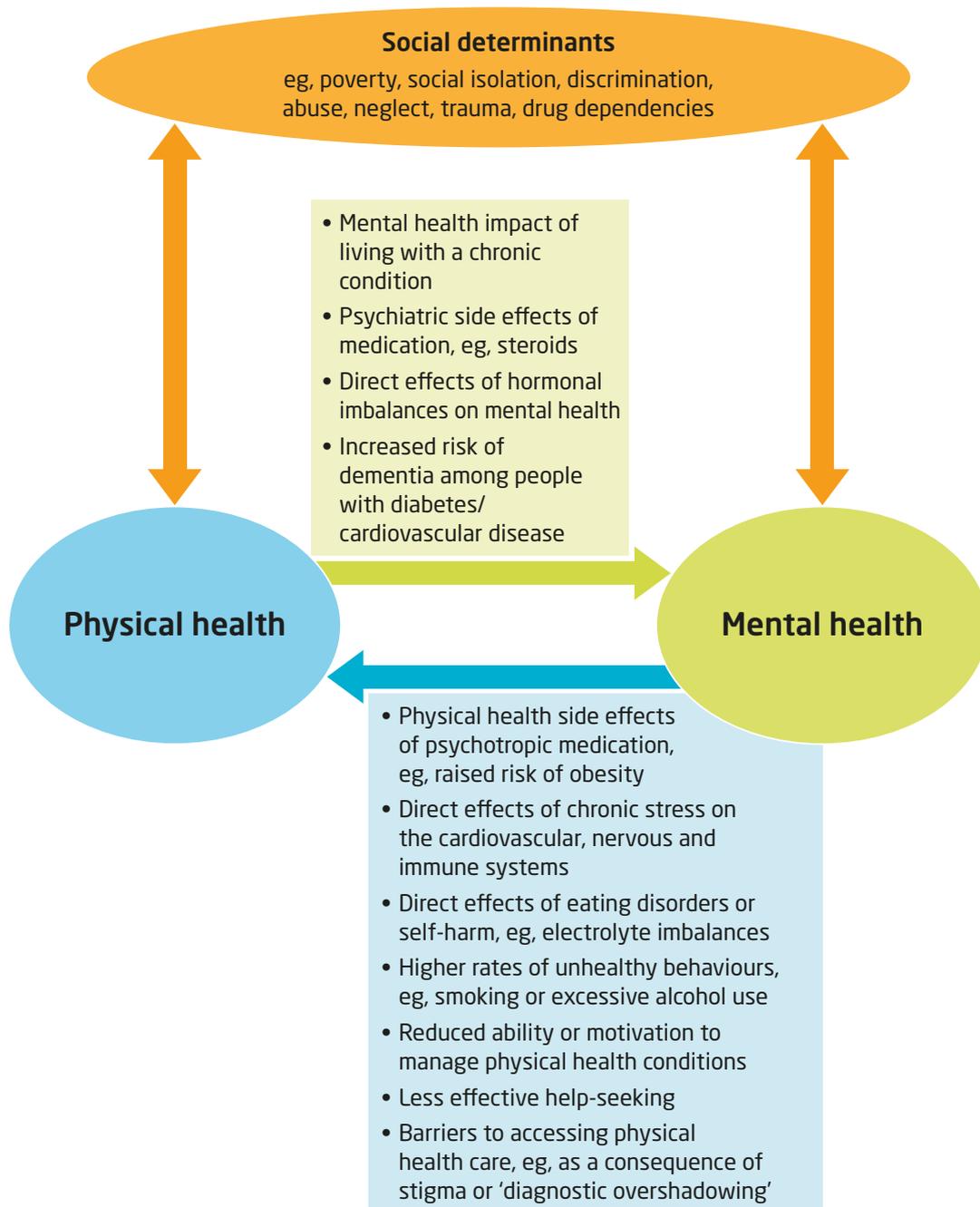
System pressures

- People with mental health problems use significantly more unplanned hospital care for physical health needs than the general population, including 3.6 times the rate of potentially avoidable emergency admissions for ambulatory care sensitive conditions (Dorning *et al* 2015).
- Inadequate treatment of mental health problems among general hospital inpatients has been linked to higher rates of re-attendance at A&E after discharge (Joint Commissioning Panel for Mental Health 2013).
- Poor management of persistent physical symptoms adds to pressures in primary care, with these symptoms being present in up to 30 per cent of all GP consultations (Kirmayer *et al* 2004).
- Dementia, depression and other mental health problems can make providing services for older people with multiple health problems significantly more complex.

Financial costs

- Co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem (Naylor *et al* 2012).
- Between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year (Naylor *et al* 2012).
- Persistent physical symptoms are estimated to cost the NHS around £3 billion each year (Bermingham *et al* 2010).
- The lifetime effects of perinatal mental health problems cost the NHS an estimated £1.2 billion for each annual cohort of births (Bauer *et al* 2014).

Figure 3 Mechanisms through which physical and mental health interact

Social determinants

eg, poverty, social isolation, discrimination, abuse, neglect, trauma, drug dependencies

- Mental health impact of living with a chronic condition
- Psychiatric side effects of medication, eg, steroids
- Direct effects of hormonal imbalances on mental health
- Increased risk of dementia among people with diabetes/ cardiovascular disease

Physical health

Mental health

- Physical health side effects of psychotropic medication, eg, raised risk of obesity
- Direct effects of chronic stress on the cardiovascular, nervous and immune systems
- Direct effects of eating disorders or self-harm, eg, electrolyte imbalances
- Higher rates of unhealthy behaviours, eg, smoking or excessive alcohol use
- Reduced ability or motivation to manage physical health conditions
- Less effective help-seeking
- Barriers to accessing physical health care, eg, as a consequence of stigma or 'diagnostic overshadowing'

Source: Naylor *et al* 2016

The new models of care introduced by the Forward View represent the most ambitious attempt yet to dissolve traditional boundaries in the NHS, in particular by bringing together fragmented budgets and services into coherent local systems of care (**NHS England *et al* 2014**). These innovations create an important opportunity to deliver whole-person care that responds to people's mental and physical health needs together.

> *The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three. Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries.*

To put this vision into practice, a number of new care models are being developed and tested in 50 vanguard sites across England, supported by an investment of more than £330 million over three years (ending in 2017/18). These care models create a new platform to support integrated working, including in relation to mental health. Particularly relevant to the goal of developing integrated care are the MCP and PACS models, as well as the related primary care home model (*see* box, p 10). The policy ambition is that most of the population will be covered by a PACS or MCP model or similar within the next few years. These models will be rolled out beyond the vanguard sites through the 44 STPs that have been developed across England (**NHS England 2016f**).

New care models in the vanguard sites and beyond

In the vanguard sites

- **Multispecialty community providers (MCPs).** GP practices in a local area are grouped into a number of neighbourhood clusters, each covering a population of 30,000 to 50,000. In each neighbourhood, a multidisciplinary team is established to allow GPs to work together with other health and social care professionals to provide more integrated services outside of hospitals. These teams might include some specialists currently working in acute hospitals, as well as nurses, mental health professionals, community health services and social workers.

- **Primary and acute care systems (PACS).** A single entity or group of providers takes responsibility for delivering a full range of primary, community, mental health and hospital services for their local population, to improve co-ordination of services and move care out of hospital where appropriate. The PACS model is fundamentally similar to the MCP model but is wider in scope (potentially including a greater range of hospital services) and may also be bigger in scale as a result.

- **Urgent and emergency care models.** These focus on improving the co-ordination of urgent and emergency care services and reducing pressure on A&E departments. Changes include the development of hospital networks, new partnership options for smaller hospitals and greater use of pharmacists and out-of-hours GP services. In 2017, in addition to their existing remit, sites implementing urgent and emergency care models were selected to test new models of mental health crisis care for children and young people, supported by an additional investment of £4.4 million.

- **Acute care collaboration models.** These involve linking hospitals together to improve their clinical and financial viability, reducing variation in care and improving efficiency. Several of the ACC vanguards are focused on developing networked approaches towards a specific clinical area such as cancer, orthopaedics or neurology. There is one ACC vanguard focused on mental health – the MERIT vanguard (*see* 'Aims and methodology' section, p 17).

- **Enhanced health in care homes models.** These involve NHS services working in partnership with care home providers and local authority services to develop new forms of support for older people.

New care models in the vanguard sites and beyond *continued*

Beyond the vanguards programme

- **Primary care homes.** Scaled-up primary care based on multidisciplinary teams serving populations of 30,000 to 50,000. These units also form the basic building blocks of MCP and PACS models, but the primary care home model is often smaller in scale and potentially involves less structural or contractual change. Primary care homes are not formally part of the vanguards programme but are closely related, and are currently being tested in 15 pilot sites across England as part of a programme led by the National Association of Primary Care and the NHS Confederation.

- **New care models in tertiary mental health services.** Six sites across England are trialling a new model of care that enables secondary providers of mental health services to manage care budgets for tertiary mental health services (for example, secure services or specialised services for children and young people). The aim is to improve outcomes and reduce the need for out-of-area placements.

The need to develop more integrated approaches to mental health was reinforced by the Forward View for Mental Health, which placed significant emphasis on integration as part of a national strategy for improving mental health (Mental Health Taskforce 2016) (*see* box, p 12). In response to this, NHS England announced plans to invest in various forms of integrated support, including through mental health liaison services in acute hospitals, integrated perinatal mental health care, psychological therapy services for people with long-term conditions, and improved access to physical health assessment and follow-up for people with severe mental health illnesses (NHS England 2016b). The focus on integration was also included in guidance to STP leaders, which stated that their plans should include work on 'supporting physical and mental health needs in every interaction' across the whole system, including through new models of care (NHS England 2016e).

Parallel to these developments, new opportunities to incorporate mental health in work on integrated care have also been identified in other countries. The rise of accountable care organisations (ACOs) in the United States has created similar opportunities to address mental health, physical health and other needs as part of

the same care pathways. These reforms are intended to provide greater flexibility in terms of how resources are allocated and how different staff groups are used. A number of authors have argued that many of the first waves of ACOs have missed the opportunity to make mental health a central part of their work from the outset, and that there is a lack of adequate policy incentives for them to do so (Kathol *et al* 2015; Lewis *et al* 2014, p 20; O'Donnell *et al* 2013). As new models of care are adopted across increasingly large parts of the English NHS, it is important to ensure that we learn from these missed opportunities and do not repeat them. This is particularly pertinent given the intention to develop accountable care systems (seen as a step towards the ACO model) in a number of areas of the country, with NHS England and NHS Improvement providing support to local systems moving towards this approach (**NHS England 2017**).

Forward View for Mental Health

The Mental Health Taskforce, set up by NHS England in March 2015, was tasked with developing a five-year, all-age national strategy for mental health in England to 2020, aligned to the Forward View. Its final report, *The five year forward view for mental health*, published in February 2016, marked the first time that a shared national ambition for mental health had been set for the arm's length bodies of the NHS, supported by a pledge to invest an additional £1 billion per year by 2020/21.

The report made 58 recommendations on: prevention; improving the quality and accessibility of care; innovation and research; workforce; data and transparency; incentives, levers and payment; and regulation and inspection. The taskforce also recommended a series of access and waiting time standards to be achieved by 2021. Specific commitments include the following.

- 30,000 more women each year will have access to evidence-based specialist mental health care during the perinatal period.

- 70,000 more children and young people will be able to access high-quality mental health care when they need it.

- An additional 600,000 adults with anxiety and depression will have access to integrated evidence-based psychological therapies, resulting in at least 350,000 people completing treatment.

Forward View for Mental Health *continued*

- 60 per cent of people experiencing a first episode of psychosis will be treated with a care package approved by the National Institute for Health and Care Excellence (NICE) within two weeks of referral.

- 280,000 more people living with severe mental illnesses will have their physical health needs met each year through early detection and by expanding access to evidence-based care.

- An additional 29,000 people per year living with mental health problems will be supported to find work or stay in work through increasing access to psychological therapies for common mental health problems and doubling the reach of employment support using the Individual Placement and Support (IPS) model.

- Crisis resolution and home treatment teams will deliver 24/7 care and at least half of all acute trusts will deliver 'core 24' liaison psychiatry.

The Forward View for Mental Health and the subsequent implementation plan (NHS England 2016b) included a significant focus on integrated approaches to mental health, including ambitions to expand access to psychological therapies in primary care for people with long-term conditions, to strengthen liaison mental health services in general acute hospitals, and to develop integrated perinatal mental health services.

2 Aims and methodology

This report explores what an integrated response to mental health in the context of new models of care could look like. It is based on research conducted jointly by The King's Fund and the Royal College of Psychiatrists. Our research focused on a number of issues, including:

- how vanguard sites are developing integrated approaches to mental health

- the relative level of priority being placed on this

- lessons that are applicable to other parts of the country adopting new models of care

- the impact of changes made so far.

The research was based on the following methodological components:

- scoping interviews with leaders from 22 vanguard sites

- in-depth stakeholder interviews in a sub-set of three selected vanguard sites

- an expert workshop and roundtable event

- insights from the Vanguard Expert Reference Group at the Royal College of Psychiatrists.

Scoping interviews

We contacted leaders in all 50 vanguard sites to ask for information on the mental health components of their work. Scoping interviews were then conducted with leaders from 22 sites between December 2015 and October 2016, either by telephone or through a site visit. In January 2017, we also conducted a survey of project managers leading the vanguard sites to gather further evidence of progress made in relation to mental health. In total, we collected information from 29 vanguard sites, listed below.

MCP vanguards

- All Together Better Sunderland

- Better Local Care (Southern Hampshire)

- Dudley Multispecialty Community Provider

- Rushcliffe Multispecialty Community Provider

- The Connected Care Partnership (Sandwell and West Birmingham)

- Tower Hamlets Together

- Wellbeing Erewash

- West Cheshire Way

- West Wakefield Health and Wellbeing Ltd

PACS vanguards

- Harrogate and Rural District

- My Life a Full Life (Isle of Wight)

- North East Hampshire and Farnham

- Northumberland Accountable Care Organisation

- Salford Together

- South Somerset Symphony Programme

- Wirral Partners

Urgent and emergency care vanguards

- Cambridge and Peterborough

- Greater Nottingham System Resilience Group

- Leicester, Leicestershire and Rutland System Resilience Group

- North East Urgent Care Network

- Solihull Together for Better Lives

Acute care collaboration vanguards

- Developing One NHS in Dorset

- Foundation Healthcare Group (Dartford and Gravesham)

- Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT) (West Midlands)

- Moorfields

- The Neuro Network (The Walton Centre, Liverpool)

Enhanced health in care homes vanguards

- Airedale and Partners

- East and North Hertfordshire Clinical Commissioning Group

- Gateshead Care Home Project

In-depth case study interviews

On the basis of our scoping work, we selected three case study sites where initial discussions indicated that there was a relatively substantial focus on mental health integration as part of the vanguard work. These were:

- North East Hampshire and Farnham PACS vanguard

- Tower Hamlets Together MCP vanguard

- West Cheshire Way MCP vanguard.

A profile of each is provided in Appendix B.

In these three sites, we conducted a total of 20 qualitative interviews with a range of stakeholders between September and November 2016. We interviewed clinical and managerial staff, including frontline clinicians as well as individuals in strategic roles. The interviews included mental health and non-mental health staff.

We chose to focus our in-depth research on MCPs and PACS because the emphasis in these care models on dissolving traditional boundaries between hospital, community,

primary, social and mental health care fits most closely with our focus on integrated approaches to mental health. However, in the report, we also draw on material collected through our scoping interviews to describe relevant developments in other vanguard types, including in the urgent and emergency care vanguards, most of which have included a focus on improving mental health crisis care.

There is one vanguard in England (an ACC vanguard) that is specifically focused on mental health – MERIT. Through a partnership of four mental health providers serving a combined population of more than 3 million people, this alliance aims to improve acute mental health services by sharing best practice and developing new ways of working that are more effective, efficient and consistent. The vanguard is focusing on areas including co-ordinated emergency response, improved discharge from inpatient care and more support for recovery and relapse prevention in the community. In this report, we describe elements of the MERIT programme that relate most closely to the main themes addressed in our research, particularly those around integrated care and the relationship between mental health services and the wider system.

We did not conduct in-depth research on the 'enhanced health in care homes' vanguards, but acknowledge that many of these sites are conducting work intended to improve the way people with dementia are supported in care homes.

Stakeholder engagement

In August 2016 we held an engagement workshop involving service users and carers, a range of mental health professionals, other health and care professionals (including GPs), senior managers from provider organisations, commissioners and other stakeholders. This workshop explored what good practice might look like – including from a service user and carer perspective – and underpins the nine principles for success described in the next section.

In November 2016 a roundtable event was held at the Royal College of Psychiatrists focusing on the mental health components of urgent and emergency care vanguards. The event was attended by leaders of some of those vanguard sites, and provided a way of gathering further intelligence and testing emerging findings.

Our work was also informed by the Vanguard Expert Reference Group at the Royal College of Psychiatrists, which includes representation from the College's faculties and divisions, specialist advisers and college leads as well as from service users and carers, the Academy of Medical Royal Colleges, the Royal College of General Practitioners and the National Collaborating Centre for Mental Health.

Further to this, in January 2017 we contacted clinical associates working in the new care models team at NHS England, as well as mental health leads in strategic clinical networks across England, in order to gather further information about mental health plans across the vanguard programme.

3 Nine principles for success

We wanted to start with an understanding of what, in principle, successful integration of mental health within new models of care would look like. The engagement workshop with frontline staff, service users, carers, providers, commissioners and relevant national stakeholders (held in August 2016) aimed to identify design principles to guide the development of integrated approaches to mental health through new models of care.

Drawing on the views and experiences of workshop participants, we identified nine key principles for successful integration of mental health in new models of care. Local system leaders can use these principles to help ensure that integration of mental health is a core part of the development of new care models, and to capitalise on the opportunities this presents.

1. The commissioning, design and implementation of new models of care should be consistent with the requirement to deliver parity of esteem.

The requirement to deliver parity of esteem, defined as 'valuing mental health equally with physical health', has been laid out in legislation and numerous policy documents over recent years. It is characterised by: equal access to the most effective and safest care and treatment; equal efforts to improve the quality of care; the allocation of time, effort and resources on a basis commensurate with need; equal status within health care education and practice; equally high aspirations for service users; and equal status in the measurement of health outcomes (**Royal College of Psychiatrists 2013**). These principles must be reflected throughout the development of new models of care.

2. Mental health should be considered from the initial design stages of new models of care.

The fundamental changes needed are likely to be harder to achieve if mental health is added onto pre-existing plans that have not considered it from their inception. To achieve meaningful integration of mental health in new care models, it must be a key consideration throughout the entire development process, including during the early design phases.

3. New care models should address and measure outcomes that are important to patients and service users, identified through a process of co-design.

It is important that new models of care address outcomes that are important to service users and carers, in addition to outcomes designed to bolster the financial sustainability of the system. Co-designing the care model with people using services and the wider local population is an essential part of this. Meaningful public engagement is necessary to identify the outcomes that are most important to the population being served, and the design of new care models should then follow from these priorities. Once the care model is implemented, progress against these outcomes should be measured systematically and include patient-reported measures.

4. New care models should take a whole-person approach spanning an individual's physical, mental and social needs.

New models of care should focus on delivering whole-person care that supports mental health alongside other aspects of health, rather than being addressed in isolation. This requires attention to the full range of an individual's needs, including their psychological and social needs – regardless of whether their primary health need is mental or physical in nature. As part of this, there needs to be a clear understanding among those involved in developing new models of care that mental health is about more than mental illness; good mental health is a key determinant of other outcomes and should be considered as a routine part of care.

5. New models of care should extend beyond NHS services to include all organisations that may impact on people's health and wellbeing.

Relationships and networks should be built with a variety of partners, not only those delivering NHS-funded services. Key partners include social care, housing and voluntary sector organisations as well as employers and the education system, all of which can play an indispensable role in relation to mental health. Through bringing together parts of the wider system, new models of care can capitalise on the full range of assets in an area.

6. Invest in building relationships and networks between mental and physical health care professionals.

New care models should be designed in a way that helps to break down the barriers between organisations and individuals. This will require an explicit focus on strengthening relationships at all levels, including between senior leaders from different organisations as well as between frontline staff from different professions and provider organisations.

7. New models of care should enhance the provision of upstream, preventive interventions to improve mental health and wellbeing.

Strengthening prevention should be a key focus for new care models, including primary, secondary and tertiary prevention. For example, integrated care teams established as part of new care models should aim to address the range of factors (including social and environmental factors) that shape the mental and physical health and wellbeing of the people they are serving.

8. Every clinical interaction should be seen as an opportunity to promote mental and physical wellbeing.

All interactions between health care professionals and members of the public represent valuable opportunities to help people improve their mental and physical wellbeing. Staff should be equipped with the necessary knowledge, information and skills to initiate conversations with people about their mental wellbeing, to encourage positive behaviour change, and to signpost to local support resources.

9. All frontline staff should receive appropriate training in mental health, regardless of the setting in which they work.

Training should equip staff to recognise and manage common mental health problems at different stages in the life course, and to understand the psychological components of physical illness. Where appropriate, education and training should be conducted on an inter-professional basis, bringing together staff working in physical and mental health care settings to share their knowledge and expertise.

These nine principles provide an overview of the approach to mental health integration that key stakeholder groups would like to see implemented through new models of care. In the next section, we explore the approaches being taken to mental health integration in a number of vanguard sites, providing insights into how some of these principles may be applied in practice.

④ Mental health in new models of care: examples from the vanguard sites

This section describes examples of how mental health is being incorporated into new models of care, primarily drawing on our research in two MCP vanguards and one PACS vanguard (*see* Aims and methodology section, p 16). Where relevant, we also include intelligence gathered from other vanguard sites, including some of the urgent and emergency care vanguards.

This section has been structured according to the framework that MCPs and PACS are expected to operate within (**NHS England 2016c**, **2016g**). The framework describes how successful MCP and PACS models involve making changes at four levels, as shown in Figure 4.

Figure 4 **The four levels of the MCP and PACS care models**
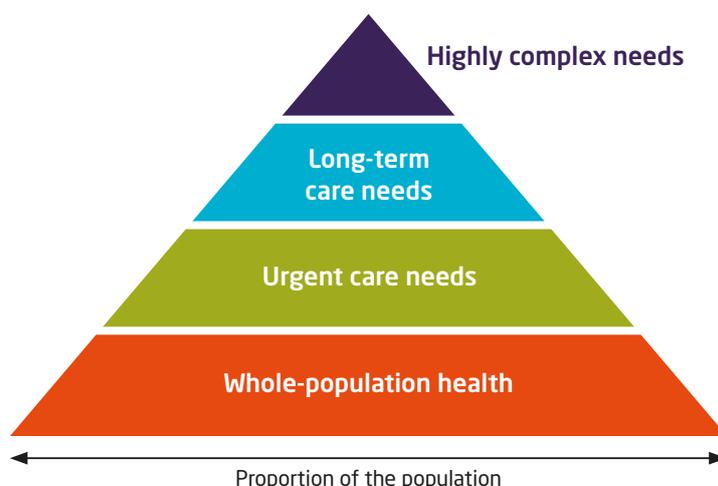
Source: Adapted from NHS England 2016c, 2016g

The section concludes by describing the supporting infrastructure that has been developed to enable changes at each of these levels. Our intention is not to provide a comprehensive stocktake of all relevant developments, but rather to illustrate the range of work being done on mental health in vanguard sites, and to highlight some of the most common components.

Highly complex needs

A major focus of work on new models of care has been the development of improved support in the community for people with highly complex care needs. This often includes older people with frailty, people with multiple long-term conditions and high social care needs, and people receiving end-of-life care. Services being developed for these groups are typically targeted at a small fraction (2–5 per cent) of the population who use health and social care services most frequently.

The main approach seen in the vanguard sites and elsewhere to improve care for people with highly complex needs is the development of integrated care teams covering a local area or 'neighbourhood'.

Neighbourhood or locality-based integrated care teams form the mainstay of MCP and PACS models, and are also the basis of the primary care home model. These multidisciplinary teams typically cover populations of 30,000 to 50,000, and bring together a range of community health and social care professionals working alongside a cluster of GP practices. In most MCPs and PACS there is some form of mental health input into these teams, but arrangements vary considerably. Some sites have chosen to fully embed mental health professionals into integrated care teams, whereas others have arrangements in place for consultation and liaison with staff in separate mental health teams.

Many integrated care teams focus primarily (although often not exclusively) on older people. As such, there has been a particular emphasis on securing expertise in relation to older people's mental health. This includes advice about dementia management as well as other conditions common among older people, such as depression.

In North East Hampshire and Farnham PACS, mental health expertise is directly embedded in locality integrated care teams. There are currently 2.3 full-time equivalent (FTE) mental health professionals (two nurses and one occupational

therapist) working across five integrated care teams. These individuals are involved in discussion of all cases at weekly referral meetings and multidisciplinary team meetings, and carry their own caseload. Their primary focus is on older adults with co-morbid physical and mental health conditions, but the intention is that the client group served will widen as the care model develops. They receive monthly clinical supervision from a consultant psychiatrist, who they can also contact for specific advice (eg, in relation to medications).

Similar arrangements have been developed in Harrogate and Rural District PACS, where each community care team includes a mental health practitioner working alongside two district nurses, two physiotherapists, two occupational therapists, a pharmacist and a social care assessor.

In Tower Hamlets Together MCP, a senior community mental health nurse is included in each integrated community health team. Linked with GP practices, these teams provide co-ordinated health and social support to all patients over the age of 18 identified as having complex needs. This includes anybody on the primary care registers for dementia, palliative care or living in a care home, as well as people who have been identified by their clinician as needing a multidisciplinary approach. The mental health nurses are supported by a half-time consultant psychiatrist working specifically as part of the integrated care programme. The nurses attend practice-based multidisciplinary team meetings to help identify patients who potentially have a mental health problem that may be exacerbating their physical illness. They also provide brief support and treatment to patients requiring additional input, along with consultation and training to community health teams and primary care professionals. The teams also support care homes in the borough to deliver person-centred care for people with dementia.

West Cheshire Way MCP is using a different model, involving link worker arrangements designed to enable the integrated care teams to work in liaison with mental health professionals. Two main sources of support are available. First, for older adults, each locality is supported by a designated mental health nurse in the local older people's mental health team. Members of the integrated care team can contact their named clinical lead by phone for advice, and the lead may be invited to participate in a case discussion in a multidisciplinary team meeting. Second, for working-age adults, each of the integrated care teams has a link worker in the primary care mental health service (*see* below).

A related approach used in some vanguard sites is the 'extensive care' model, developed for supporting people with the very highest levels of care needs. The model involves an 'extensivist' (usually a community geriatrician or GP) assuming overall clinical responsibility for a person's care from their general practice. The extensivist works alongside a multidisciplinary team to address all aspects of a person's care in a co-ordinated way. As part of the Fylde Coast MCP an extensive care service has been developed in Blackpool aimed specifically at people with complex mental health needs, substance abuse and/or social problems.

Long-term care needs

A central concern of work on new models of care has been to improve care for people with long-term conditions and other ongoing care needs. These services are typically targeted at the 20 per cent of the population who use health and social care services most frequently (ie, a broader group than those with highly complex needs, focused on in the previous section).

The aim is to provide a broader range of services in the community that integrate primary, community, social and acute care services, and bring together physical and mental health. In addition to the integrated care teams described earlier (which often focus on both complex and long-term care needs), other approaches being implemented include enhanced mental health provision in primary care, social prescribing, and programmes to support personal recovery.

Enhancing mental health provision in primary care

A number of vanguards are enhancing the mental health support and expertise available in primary care. For example, one component of the West Cheshire Way MCP has involved strengthening the local primary care mental health service. This service is delivered primarily by community psychiatric nurses, nurse therapists and psychologists. As part of the vanguard programme a consultant liaison psychiatrist has been added to the team, who splits their time between the primary care and acute hospital liaison services. This has enhanced the service's ability to support people with co-morbid physical and mental health problems, chronic pain and other persistent physical symptoms. The vanguard work has also involved setting up a link worker arrangement with local integrated care teams, as described earlier in this section.

Tower Hamlets Together MCP, working with partners in neighbouring boroughs, has developed a primary care mental health service supporting the discharge of people with stable serious mental illness to primary care, and providing step-up support to people from primary care. The service includes a contract with practices to provide additional support for service users with a focus on healthy lifestyles, along with a team of primary care-based mental health professionals. The model is reported to have brought about a significant improvement in communication between secondary and primary care, with regular practice-based multidisciplinary team meetings attended by consultant psychiatrists.

North East Hampshire and Farnham PACS is expanding its improving access to psychological therapies (IAPT) programme as part of the national policy drive to extend the scope of these services and to integrate them more closely with primary care. The area is one of 22 'early implementer' sites being supported to lead the way in integrating IAPT services with physical health care. The care pathways being focused on include those for persistent physical symptoms and for COPD. This does not fall directly under the vanguard, but is viewed locally as being part of the same drive to bring mental and physical health pathways together.

As part of its vanguard programme, Rushcliffe MCP in Nottinghamshire has developed a primary care psychological medicine service. This focuses on supporting people with persistent physical symptoms and others who frequently attend primary care, and is delivered by experienced liaison nurses and a liaison psychiatrist who also works in the local acute trust. Common input includes: case management; diagnosis of mixed medical and psychiatric morbidity; training, supervision and support for GPs and other professionals; and educating patients.

Accessing community resources

There has been a growing interest across the country in the use of social prescribing and related approaches to connect people with resources in their local community aimed at improving health and wellbeing, with some evaluations reporting positive results in terms of patient outcomes and service use (**Dayson _et al_ 2013**; **Kimberlee 2013**). Social prescribing allows health care professionals to refer people to a range of non-clinical services to address their needs in a holistic way, and often focuses on improving mental health and wellbeing. Vanguard sites have developed various approaches towards supporting people to access these kinds of resources.

1 2 3 **4** 5 6 7

In North East Hampshire and Farnham PACS, the Making Connections programme includes Making Connections workers (a new role delivered through the voluntary sector) based in general practices. These individuals act as navigators and can connect people to local resources as well as helping them to identify and access voluntary services in the community that may improve their health and wellbeing. This enhances the non-clinical support available to patients and service users, and provides GPs and professionals in the integrated care teams with an additional type of support to offer.

West Cheshire Way MCP has introduced a similar role – that of wellbeing co-ordinators – in each integrated care team. These staff are reported to play a critical role in promoting positive mental health and wellbeing among the people supported by the team. Their main role is to help connect people with local voluntary and community sector services – particularly people who are at risk of social isolation and are in need of some extra support, or who are known to be experiencing emotional distress. The intention is both to prevent the development of mental health problems, and to support the recovery of those with existing mental health problems. The aspiration is to widen the wellbeing offer in the integrated care teams over time, with the addition of peer-coaches, self-management courses and (potentially) other resources such as dementia care navigators.

Tower Hamlets Together MCP is establishing four 'wellbeing hubs' across the borough to provide a single point of access to information on health, wellbeing, social and other resources available within the local community, as well as providing links to key services such as public health, social care, and voluntary and community sector organisations. Once established, it is expected that these hubs will hold detailed information on local mental health provision and will be able to direct people to appropriate services. Similarly, professionals in mental health services will be able to signpost their clients to the wellbeing hubs for support in addressing their wider needs, including lifestyle services, health trainers and employment support among a range of other services.

A related approach is 'local area co-ordination', currently being used by the My Life a Full Life (Isle of Wight) PACS vanguard. Co-ordinators are recruited from the local community and are responsible for developing detailed knowledge of the

various assets available in an area (usually covering a population of around 12,000). Co-ordinators work with people with mental health needs, disabled people and older people at risk of loneliness and isolation. They help people to identify their strengths and skills and make use of these in their local community, reinstate their social networks and build new relationships, and explore what a 'good life' would look like for them.

Supporting personal recovery

The concept of 'recovery' in mental health has been defined as 'living a satisfying, hopeful and contributing life even with the limitations caused by illness' (Anthony 1993). Enabling personal recovery has been a focus for mental health services for many years, and some vanguards are building on this by introducing or expanding services that focus on support for recovery.

One increasingly common approach is the development of peer-led 'recovery colleges' to share knowledge and evidence about recovery, self-care and self-management (Burhouse *et al* 2015). In North East Hampshire and Farnham PACS, the recovery college model has been expanded as part of the vanguard's work. Originally developed for individuals living with long-term mental health problems, the remit of the college has extended to focus on both mental and physical health, and there is a dedicated course exploring the links between the two. Work is ongoing to further develop the offer, particularly to enhance the focus on physical health, wellbeing and prevention.

Developing more effective ways of supporting recovery is also a component of the work being done by the MERIT vanguard, with the aim of preventing relapse and readmission wherever possible. The alliance is exploring how resources and assets in local communities can be mapped more systematically and used to help people in their recovery. Part of this involves thinking about the role of employers in supporting people back into work, including through the provision of mental health first aid training to local employers.

Urgent care needs

In addition to improving services for people with highly complex and ongoing care needs, many of the vanguards are redesigning urgent and emergency care services. This is obviously a key focus in the urgent and emergency care vanguards but has also been given attention in some MCP and PACS sites.

Many of the urgent and emergency care vanguards are expanding their psychiatric liaison service to meet the 'core 24' standards, making the service available 24 hours a day, 7 days a week (**Aitken** *et al* **2014**). While this is a requirement of the Forward View for Mental Health (**Mental Health Taskforce 2016**), some of the urgent and emergency care vanguards are using this as an opportunity to expand psychiatric liaison services further. For instance, the Leicester, Leicestershire and Rutland System Resilience Group urgent and emergency care vanguard is incorporating consultant psychiatrists into its mental health triage nurse service and the frail older people's assessment and liaison service. The liaison psychiatry service will also align with the alcohol team based in the emergency department.

Other developments seeking to better integrate mental health into urgent care pathways include the following.

- Safe Havens in North East Hampshire and Farnham were initially introduced as a short-term pilot in 2014 but have now been expanded through the vanguard programme. These services provide a safe space for people who are at risk of a mental health crisis, seven days a week, in community settings. The model is also being adopted in the Isle of Wight vanguard and elsewhere.

- Cambridgeshire and Peterborough urgent and emergency care vanguard has developed a First Response Service that directs 111 callers to 24/7 support and mental health crisis response. The service consists of: experienced psychological wellbeing coaches who provide initial assessment via telephone; a co-ordinator who oversees the coaches and co-ordinates calls from emergency services; and first responders (mental health nurses or social workers) who provide face-to-face assessment and crisis management.

- Many vanguard sites (and other areas of the country) are seeking to improve the care people receive when in contact with the police. For example, in Cambridgeshire and Peterborough urgent and emergency care vanguard, a mental health practitioner is present in the police control room between

8.00am and 10.00pm (weekdays) and between 1.00pm and 9.00pm (weekends) providing advice to frontline officers.

- In Leicester, Leicestershire and Rutland urgent and emergency care vanguard, a street triage service staffed by police officers, paramedics and mental health nurses operates three days a week (Friday to Sunday). Currently, 50 per cent of the people who are in contact with the service are taken to A&E; the vanguard aims to reduce this to 12 per cent.

- The MERIT vanguard is developing a co-ordinated emergency response system across the four participating mental health trusts, with the aim of reducing the time people who come into contact with mental health services spend unnecessarily in A&E or police cells. This involves the introduction of standard operating procedures as well as making systems more flexible so that crisis care is provided in a consistent and efficient way. One aspect of this is the introduction of a new bed management system that will allow professionals working across mental health services to better manage beds in order to reduce inappropriate out-of-area placements.

Whole-population health

Guidance from NHS England is clear that MCPs and PACS have an important role to play in reducing future demand on services through health promotion activities and the prevention of ill health. However, we found few examples of MCPs and PACS conducting work intended to improve the health of the whole local population, particularly in relation to mental health.

Tower Hamlets Together provides one example of a vanguard site aiming to progress towards a population health management approach involving both mental and physical health. As part of this work, the main mental health provider involved in the vanguard (East London Foundation Trust) has recruited a public health lead to support the development of more integrated preventive pathways, working alongside a public health consultant reporting to the Tower Hamlets Together partnership. The box below provides further detail on some of the work being done to underpin population health management in Tower Hamlets Together.

Wider work being conducted in some vanguard sites may have an impact on population mental health and wellbeing over time. For example, in the Morecambe

Bay PACS vanguard several initiatives are under way aiming to support local people to take part in and lead activities that promote their health and wellbeing, such as community-led 'wellness days' in Barrow-in-Furness. By reducing social isolation and improving general health and independence, initiatives of this kind may also have a positive effect on mental health outcomes.

Population health management in Tower Hamlets Together

Population-level data

In order to understand health inequalities and health service utilisation across the borough, Tower Hamlets has created a linked dataset with patient-level information from acute services, primary care, primary care prescribing, social care, mental health, community services and continuing health care. Other areas of health and social care activity, including public health and specialised commissioning, are to be incorporated in future. This has enabled Tower Hamlets Together MCP 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, COPD, cancer and chronic kidney disease). This analysis is helping to shape the development of new whole-person pathways. For example, the organisations involved are currently developing 'test and learn' pilots of a consultant psychiatrist role within renal outpatients, and health psychologists to support people with diabetes in GP practices.

Realigning incentives through new approaches to reimbursement

The linked dataset in Tower Hamlets was created to support plans for a new contractual approach based on a capitated budget. Local providers are now beginning to use the dataset to help understand how linked data can support clinicians to redesign pathways and services, and to understand the quality, strategic, commercial and financial opportunities and risks of a capitated approach to contracting.

As a first step in testing how financial risks and opportunities might be shared across the provider partnership, the partners have been working together to deliver against a shared

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Population health management in Tower Hamlets Together *continued*

local incentive scheme in 2016/17. This scheme places £1.7 million of provider income at risk and makes available a potential £1 million benefit to providers, dependent on the delivery of 10 outcome goals over the course of the year. Two of these relate to mental health: emergency admissions for people with depression, serious mental illness or dementia; and total bed days for the same groups.

In 2016/17 there was a statistically significant 12.7 per cent reduction in occupied bed days for people with depression, serious mental illness and dementia, while rates of emergency admissions have remained static. The intention now is to incentivise outcomes for emergency admissions through a new community health services alliance contract, and discussions are under way with the clinical commissioning group (CCG) about a reward pool against a similar set of metrics for 2017/18.

System-wide outcomes framework

Tower Hamlets partners are currently working with service users, carers, citizens and clinicians to develop a system-wide outcomes framework, including mental health and wellbeing outcomes, which defines the partners' collective ambition for improving outcomes for people who live in the borough. It is anticipated that the partners will begin to monitor performance against the outcomes framework during 2017/18.

Supporting infrastructure

Vanguard sites have invested in various forms of infrastructure to support the kind of service changes described earlier in this section. This has included redesigning the workforce, and using technology in new ways to improve the delivery of care.

Developing new and extended roles

Many vanguard sites have explored new and extended roles as part of new models of care, including care navigators, case managers, hybrid health and social workers, health and social care co-ordinators, discharge co-ordinators based in acute wards, recovery coaches (with lived experience of mental illness), and a variety of roles provided by voluntary sector partners focused on supporting wider wellbeing. These kinds of workforce innovations are a common feature of work on integrated care,

although in some cases there is a need for more evidence on the impact of these new roles on patient outcomes (**Gilburt 2016a**).

Many of the extended roles identified in our case study sites involved the appointment of senior (band 7) mental health nurses into integrated care teams. Seniority was seen as being important given the need for these professionals to work across different services in a highly autonomous and flexible way.

Tower Hamlets Together MCP has developed a competency set for new and extended roles to define the integrated care skills that mental health professionals need, as well as the mental health skills that community teams need in order to do their job safely and effectively. This includes: history-taking and mental state examinations; engagement skills and principles around building a positive therapeutic relationship; risk assessment and management; recovery-oriented care; and dealing with psychiatric emergencies. Those involved are now working with Bournemouth University to turn these competencies into a training package for GPs and practice nurses with a focus on managing severe mental illness in primary care.

The MERIT vanguard is also reviewing the training needs and skill-mix of its staff in order to deliver mental health services that are more consistent across a number of sites. As part of this they are considering how staff may work more flexibly across the four trusts involved in the alliance.

Informatics and technology

Several vanguards have sought to address issues with informatics and technology – for example, in relation to the interoperability of IT systems. In North East Hampshire and Farnham PACS, the Hampshire Health Record allows GPs to see a more comprehensive picture of a patient's history. This means they can share patient information within the system, and staff in A&E and out-of-hours services can view GP records, past medical history, medication lists and allergies. The vanguard site is working towards having a shared care record for all services across the vanguard area, including mental health services.

Similarly, West Cheshire Way MCP is using a shared care record in the integrated care teams but this is still read-only; the team do not have a shared care plan that they can all edit dynamically.

The acute care collaboration vanguard, MERIT, is introducing an integrated patient record system in 2017 across the four participating mental health trusts, to ensure that service users receive rapid support, wherever they are and regardless of which trust's area they come from.

In addition to shared care records, some vanguards are rethinking how care is delivered through digital technology. For instance, MERIT is also planning to introduce a co-ordinated bed management system across the four participating trusts. This will enable staff to identify where beds are available using visual electronic boards to provide 'at a glance' information. The aim is that patients are less likely to be placed in a bed outside the area.

Summary

The range of developments reviewed in this section illustrates the progress that has been made in some vanguard sites in integrating mental health into new models of care for people with highly complex needs, ongoing long-term and/or urgent care needs. These examples may be helpful to local system leaders when designing new models of care. The next section focuses on delivery, as we examine some of the practical lessons learnt across our three case study sites.

Some of the developments described are consistent with known best practice and guidance. For example, there is an established evidence base behind models such as 'core 24' liaison psychiatry. In other cases, there is a need for more evidence about what works. For example, as discussed in the next section, it remains to be established what best practice would look like in relation to incorporating mental health expertise into integrated care teams. These evidence gaps highlight the importance of adequately evaluating the mental health components of new care models – a theme we return to in section 6.

⑤ Emerging lessons for local system leaders

There is no simple rulebook to guide successful integration of mental health within new models of care. However, based on our research in several vanguard sites, we have identified some practical lessons that will be relevant for local leaders involved in the development of new models of care in other parts of the country. As MCPs, PACS and other models are rolled out in new areas (including through the implementation of STPs), these emerging lessons provide timely insights into some of the key factors that need to be considered.

As with the previous section, the analysis here is based primarily on research conducted in three case study sites (*see* Appendix B) but also draws on interviews with leaders in other vanguard sites. Appendix A gives a list of useful resources for commissioners and system leaders relating to the integration of mental health care.

Incorporating mental health into integrated care teams

The value of including mental health in integrated care teams was clear for those interviewed in our case study sites. GPs and multidisciplinary team members reported that they found the contribution of mental health colleagues extremely valuable, and adding extra in-house capacity and/or developing arrangements for closer working with other mental health teams was seen as a high priority for future service improvement. In several sites, there was an ambition to increase the level of mental health input over time, in recognition of the high levels of demand among the population groups served.

Mental health expertise was seen as adding value to the work of integrated care teams in a number of ways, including through:

- supporting a more holistic assessment of people's needs

- improving care for people with complex needs, including depression or other mental health problems alongside co-morbid and multimorbid physical conditions

- improving psychological aspects of care for anyone supported by the team (*see* 'Broadening the scope of mental health' below)

- improving dementia management

- providing consultation and training to community health teams and primary care professionals.

It remains to be seen whether the best approach is always to embed mental health professionals within multidisciplinary teams or whether it can also be effective to seek input as and when needed through consultation/liaison arrangements (or a combination of the two). Professionals working in a fully embedded model argued that it can be very helpful for mental health colleagues to be able to contribute to all case discussions, regardless of whether a person has an identified mental health problem. However, some mental health trusts expressed concern that their workforce would be spread too thinly if teams were fragmented across a number of local integrated care teams, each covering a relatively small population. They feared that this could create challenges in terms of supervision arrangements, professional development, and recruitment and retention, as well as loss of economies of scale.

The optimal number and professional mix of mental health staff within these teams is not yet clear. Where mental health professionals are fully integrated, at present this is generally limited to a relatively small number of nursing staff. In some cases, consultant psychiatrists have been linked to these teams to provide consultation and advice. Some integrated care team members remarked that it would also be helpful to have access to psychologists, either in-house or through close relationships with other teams.

Broadening the scope of mental health

Building on these experiences, when developing new models of care it is important to recognise that mental health expertise can add value to the care of a broad range of people, including but not limited to those with a diagnosable mental health problem. Many of the examples from the vanguard sites serve a wider population, and illustrate that knowledge and skills around psychology and mental health are important ingredients of integrated care, whatever the client group. Ensuring integrated care teams have access to these forms of knowledge and skills allows teams to:

- understand the psychological aspects of care – for example, the impact of psychological factors on engagement and capacity to self-manage

- provide care to people with 'sub-threshold' symptoms (such as distress, fear or loneliness) that do not meet psychiatric diagnostic criteria but which may nonetheless be highly debilitating and detrimental to physical health

- help people to adjust psychologically to the challenges of living with a long-term condition (or multiple conditions)

- improve the management of persistent physical symptoms where there is an interaction with psychological factors.

Focusing on prevention as well as care

Several of the vanguard sites involved in our research have attempted to use the development of new models of care as an opportunity to strengthen the provision of preventive interventions, such as improving the mental health and wellbeing of people receiving support from integrated care teams and preventing further deterioration in their condition. This has often involved working closely with the voluntary sector.

For example, the wellbeing co-ordinator role in integrated care teams in West Cheshire Way MCP is highly valued and is seen as having had a very positive impact on people supported by the team. As a result, there are plans to expand the wellbeing offer over time (*see* section 4). Similarly, in North East Hampshire and Farnham PACS, the Making Connections programme (run in partnership with Age UK) has been seen as a successful way of connecting people with non-medical

and community services to improve their health and wellbeing, and enabling GPs and integrated care teams to offer an additional type of support. In these examples, voluntary sector organisations are increasingly being seen as a core part of the delivery system rather than as an external partner.

The sites we studied had also partnered with their local authority, and had made links with the local health and wellbeing boards. However, we did not find examples where preventive work had made full use of local authority services such as debt advice, employment support, fire service and housing. This is an area where future care models could extend their scope in order to strengthen work on population health management.

Developing the workforce

Developing mental health competencies in the general health and care workforce should be a core objective for new models of care. Several vanguard sites have made attempts to strengthen the competence, confidence and skills of GPs, integrated care teams, care home staff and others in relation to mental health – although there remains much more to be done on this front to ensure that all professionals have the necessary skills. Building capacity in this way is important given the mismatch between the level of mental health needs in the population and the availability of mental health expertise. Developing the skills of non-specialists can also help to reduce the stigma attached to mental health by making it a normal part of care.

In some vanguard sites, mental health professionals involved in new models of care have had an explicit role in education and training. For example, in West Cheshire Way MCP, a new older people's consultant psychiatrist post has been created to provide educational input into the integrated care teams and primary care. In Tower Hamlets Together MCP, mental health nurses in the integrated community health team have protected time to provide training to primary care as well as to community health teams.

Inter-professional approaches can be a particularly effective way of improving skills across the workforce. For example, the North East Urgent Care Network vanguard has funded multi-agency simulation training involving mental health professionals, Northumbria Police and other partners, which has been regarded as very successful.

A further lesson in relation to workforce is that new models of care can be used to create new opportunities to promote staff wellbeing. For example, in North East Hampshire and Farnham PACS, the vanguard work has included an explicit focus on the mental health and wellbeing of the workforce, and outcome measures include indicators on this.

Building the right relationships

Developing a new model of care such as an MCP or PACS involves establishing or strengthening relationships that span system boundaries. We found that the work conducted in many vanguard sites was seen as having enabled conversations between providers that otherwise would not have happened. For example, one interviewee described the most innovative aspect of the work in North East Hampshire and Farnham PACS as being the coming together of organisations that have traditionally operated in relative isolation from one another, particularly NHS and voluntary sector organisations.

It is important to recognise that relationship-building takes time and may require cultural change within organisations. We heard that several factors can facilitate this, including direct communication, regular face-to-face meetings, co-location of integrated teams, and the alignment of strategic objectives.

Some interviewees stressed the importance of having mental health leaders 'around every table' in order to consistently keep mental health on the agenda. One reported that it was particularly helpful to have someone with recent experience of delivering mental health services within the central programme management office responsible for overseeing the implementation of a new model of care, to help identify and articulate the value that mental health expertise can add to different components of the model. There may also be value in creating strategic joint posts accountable to all partner organisations rather than working for one organisation. For example, in Tower Hamlets Together MCP, there is a public health post for the vanguard. This was reported to be particularly valuable as it creates capacity to do system-wide work across the local area.

Co-design and public involvement

The overarching purpose of developing integrated approaches to care is to effectively respond to the full range of a person's needs. Engaging with service users to identify and understand these needs and recognise the outcomes that matter to them is a prerequisite for getting the approach right.

There were several examples of public engagement in the vanguard sites included in our research, where the views of service users and carers were sought early in the design process and had a direct influence on the subsequent development of the care models. For example, co-design and service user involvement have been integral to the development of new models of care in North East Hampshire and Farnham PACS, particularly with regard to the Safe Havens and Recovery College.

Engagement can include co-design of specific service models, co-delivery of services and local representation at all levels of the vanguard work – for example, through citizen representation on working groups. Building links with the voluntary sector and local Healthwatch was seen as another way of facilitating meaningful public engagement.

Starting small and learning from experience

A common piece of advice for those involved in the development of new care models is to initiate new services on a relatively small scale, and subsequently expand them if they prove successful. This enables models to be tested and adapted if necessary. Continuous evaluation of outcomes and user feedback can help identify where changes may be required.

In Tower Hamlets Together MCP, a quality improvement methodology has been used to structure this process of testing and learning. The approach taken has involved encouraging frontline teams to identify problems when rolling out integrated care and to offer solutions.

When scaling up or spreading models, it is important to retain experience and learning. Some of the vanguard sites involved in our research told us they had benefited from maintaining consistent leadership and 'organisational memory' – for example, by ensuring that service managers that have been involved in the design and running of the pilot phase are also involved in scaling up the model.

6 What next?

The new models of care being developed in the vanguard sites have been described by NHS England as 'a blueprint for the future of the NHS' (**NHS England 2016d**). Given the strategic significance of these models, it is worth standing back from the details described in the previous sections and reflecting on the overall picture. In this section, we consider the extent to which the opportunities to develop integrated approaches to mental health within new models of care have been realised in practice. We also explore what needs to happen next as these models are rolled out across the rest of England through STPs and other mechanisms.

Progress so far

National policy has been clear that one of the objectives of the new care models programme is to dissolve the boundaries between mental health care and the wider system. For example, guidance published by NHS England describing the emerging care models in MCP and PACS sites indicates an expectation that mental health should be an integral part of these models (**NHS England 2016g**, **2016c**). However, while this general principle may have wide support, our research found that it has not consistently been put into practice.

The examples we provided in section 4 illustrate that in some vanguard sites there has been a focus on mental health, and some concrete developments have been made as a result. It is important to acknowledge and examine these developments – many of which are ongoing processes – and to learn from them. However, it is not always clear that the changes introduced go substantially further than innovations seen in other parts of the country, or indeed than the expectations laid out in national policy. For example, many of the changes being introduced in urgent and emergency care vanguards (such as strengthening liaison psychiatry services in acute hospitals) have been identified as requirements in the Forward View for Mental Health as well as in NHS England's *Urgent and emergency care route map* (**NHS England 2015**), while other components seen in these sites (eg, street triage) are being implemented widely across England through local Crisis Care Concordat

plans. Similarly, some of the mental health components of MCPs and PACS mirror work being conducted elsewhere – for example, the Recovery College model described in section 4 is becoming increasingly common throughout the country.

It is also clear that mental health has been a higher priority in some vanguard sites than others. While many of the urgent and emergency care vanguards have included substantial mental health programmes within their work, in the acute care collaboration vanguards there appears to be little consideration of mental health (with the exception of the MERIT vanguard). This is a missed opportunity, as some of the pathways being focused on in these vanguards could benefit from a mental health component. For example, integrating mental health treatment into cancer pathways has been found to improve mental health outcomes, reduce pain and fatigue, and improve general functioning and quality of life (Sharpe *et al* 2014), and there would be value in testing such approaches as part of new models of cancer care.

It should be noted that the three MCP and PACS vanguards we studied in greater depth were chosen because our scoping interviews indicated that they included a number of mental health components. As such, they do not necessarily reflect the overall level of priority placed on mental health across the vanguard programme. And even in these sites, it was notable that staff in integrated care teams suggested that extra mental health capacity would be highly valuable, indicating that the resources available may not yet fully meet the needs that exist.

Comparing the progress observed with the nine design principles developed by our expert group (section 3), a mixed picture emerges. A notable positive finding is that in many of the sites where we conducted research, we did find evidence that the development of new models of care had helped to foster relationships and networks between health care professionals working in mental health and physical health, at both the clinical and strategic levels (principle 6). New care models are also being used as a vehicle to provide appropriate mental health training to frontline staff – for example, in integrated care teams and primary care (principle 9). However, there is still some way to go before services are consistently providing a truly whole-person approach spanning an individual's physical, mental, emotional and social needs. As an illustration of this, integrated care teams were described in one MCP as 'predominantly a physical health service' despite the inclusion of some mental health staff.

Overall, we conclude that although important foundations have been built in several local areas, the full opportunities for integrating mental health within new models of care have not yet been realised. It should be acknowledged that the purpose of the vanguard programme was not to introduce a comprehensive package of reforms in all 50 sites, but rather to prototype and test different components of new care models across the sites involved. In relation to mental health, the critical measure of success is that taken together, the work done in the vanguard sites allows us to test hypotheses about the potential impact of integrating mental health within new models of care. Our concern is that the service changes implemented to date may not be sufficient to allow for these hypotheses to be adequately tested.

Barriers to be overcome

Attempts to develop any form of integrated care can run into barriers created by the 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, to name just a few. As might be expected, our research confirmed that these generic system barriers have been encountered in some vanguard sites.

Of greater interest here, we also found other barriers relating more specifically to the inclusion of mental health in new models of care. Mental health leaders involved in our research expressed the need to be physically present at all relevant meetings to keep mental health firmly on the new care model agenda, even where it had been identified as a strategic priority for the vanguard. In the words of one vanguard leader, 'people know it's important but operationalisation is challenging'. In this context, tokenism is an ever-present danger – the risk being that references to mental health are included in strategic documents, but without a clear plan for delivering these ambitions.

The expectation from policy-makers that vanguard sites will provide rapid answers to the current pressures in the health system, and the consequent focus of new care models on groups who use most resources in the here-and-now (often older people with frailty), appears to have sometimes steered strategic thinking away from addressing needs relating to mental health. Some of the leaders involved in our research felt that because of the pressure to demonstrate in-year savings, there had been insufficient space to develop innovative approaches to mental health care. This

illustrates the difficulty of trying to achieve transformation within available resources, even with the additional funding that vanguard status has delivered.

The situation was not helped by the financial settlement received by vanguard sites in 2016/17 and 2017/18. In some areas, some of the mental health components included in original vanguard plans had been scaled back or cancelled because national funding was less than expected (it should be noted that this experience was not limited to mental health components alone). Furthermore, we found that the non-recurrent nature of vanguard funding was seen as a significant barrier in some areas.

As with other parts of the health and care system, mental health services in England are currently operating under extreme pressure as a result of ongoing financial stringency, rising demand and workforce shortages (**Gilburt 2016b**, **2015**). Some mental health professionals expressed concern that in this context, an increasing focus on integrated working (for example, embedding mental health staff in integrated care teams or working more closely with primary care) could involve resources being diverted away from specialist services for people with severe mental illnesses. In the longer term, it is possible that by responding earlier and more effectively to emerging mental health needs, integrated working could reduce pressure on other mental health services (and indeed on wider health and care services). However, in the interim, it is important to ensure that investment in integrated working does not deplete much-needed resources for core mental health provision. Further research is needed to identify the specific components that are needed if integrated approaches to mental health are to help alleviate pressures elsewhere in the system, and to clarify the timescales over which this can happen.

Opportunities ahead

Previous publications have discussed the potential benefits of developing more integrated approaches to mental health at all levels of the health system, from prevention to acute hospital care (**Naylor** *et al* **2016**; **Royal College of Psychiatrists 2013**). If these opportunities have not yet been realised in full, what should the next steps be? One way to answer this question is to focus on the four levels of the MCP and PACS care models (*see* section 4), which provide a description of the main areas where it is intended they will bring about improvements. There are substantial opportunities to make further progress at each of these levels (as described below).

- **Complex needs:** Ensuring that local integrated care teams are able to make full use of mental health expertise in supporting people with complex and ongoing care needs, with mental health staff able to input proactively into all case discussions and offer advice and training to the wider team.

- **Long-term care needs:** Making new forms of mental health support a central component of enhanced models of primary care, so that primary care teams are better equipped to address the wide range of mental health needs in general practice (including among people presenting primarily with physical symptoms), and also to address the physical health needs of people with long-term mental health problems. This will need to be done in a way that is aligned with wider efforts to transform primary care to ensure that it is sustainable for the future (*see* box, p 47).

- **Urgent care needs:** Strengthening mental health components of urgent and emergency care pathways. Again, this should include appropriate mental health support for people presenting with physical health symptoms as well as those experiencing mental health crises.

- **Whole-population health:** Incorporating a focus on public mental health and wellbeing 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 also on wider services such as drug and alcohol, homelessness or housing services and employment support.

Further evidence will be needed to guide action at each of these levels. As such, local and national evaluations of new models of care should include an assessment of their impact on people with mental health problems as well as on mental health and wellbeing-related outcomes across the wider population. It will also be important to assess how the mental health components of the new models of care have contributed to wider health and social outcomes. The 'learning and impact studies' to be conducted as part of the evaluation strategy provide one potential means of testing the mental health components of the models (Tallack 2017).

Learning from the vanguard sites should be combined with existing evidence about good practice. Many of the service models recommended in the Forward View for

Mental Health are supported by a considerable evidence base, and implementing these tried-and-tested models should proceed in parallel with attempts to integrate mental health into new models of care. There may also be relevant learning to draw on from other national programmes – for example, from areas that are currently piloting new approaches to child and adolescent mental health and secure care services (**NHS England 2014**).

As new models of care are developed in other areas beyond the vanguard sites, two things will need to be done to ensure that the opportunities relating to mental health are not missed. First, testing the mental health components of existing vanguard sites must be a central part of the evaluation strategy for new care models, as already argued. Second, looking beyond the vanguard sites, local areas rolling out an MCP or PACS model should aim to go further than the vanguards in the four areas listed above. To support this, we would again highlight the importance of including mental health from the initial design stages of new models of care, rather than as an adjunct.

Mental health and enhanced models of primary care

Transforming primary care is a major priority in many parts of the country. The extreme pressures being experienced in general practice make it clear that primary care services are not sustainable in their current form, and that substantial changes to models of general practice are now inevitable (**Baird** *et al* **2016**). The proposals in the GP Forward View build on the ongoing trend of GPs joining with other professionals in practice groups, federations and a variety of other models (**NHS England 2016a**). As local system leaders think about how to transform primary care, it is important that new approaches to mental health care are integral to their plans, given the high levels of unmet or poorly met mental health care needs among people using GP services, and the impact of this on patients and staff alike.

The 3,000 additional primary care mental health workers announced in the GP Forward View may play a part in this, but further detail is needed on where these workers will come from and what roles they will perform. The expansion of the physician associate workforce also potentially creates an opportunity to deliver more integrated mental health in primary care and elsewhere. The educational curriculum for physician associates currently includes limited coverage of mental health, so additional training may be required for these professionals to support integrated working.

The policy intention is that most of England's population will be covered by MCPs, PACS or similar care models within the next few years, with STPs being seen as the primary vehicle for rollout. Concerns have been raised that some STPs include only limited content on mental health and are not well aligned with the national ambitions laid out in the Forward View for Mental Health and elsewhere (**Gammie 2016**; **Naylor 2016**). It is vital that STP leaders are encouraged to make mental health a central part of their plans, and that they are able to take heed of the emerging lessons from vanguard sites. Data packs recently commissioned by NHS England may help STP leaders in selecting areas to focus on, but there will need to be additional support in terms of designing and implementing the care models that flow from this (**Gammie 2017**).

In the longer term, several parts of the country are seeing MCP and PACS models as a staging post on the way to building accountable care organisations or systems, with NHS England and NHS Improvement providing support to a number of areas exploring these approaches (**NHS England 2017**). This would involve: developing a single capitated budget for a broad range of services (potentially including mental and physical health care); building a single provider or partnership capable of holding that budget; and shifting the focus of commissioners towards measuring high-level, longer-term outcomes (**Collins 2016**). There are potential opportunities in these types of reform for integrated providers to choose to invest resources in mental health care in order to improve broad population health outcomes and to deliver better value across the wider system (the box below provides indicative evidence about the scope to deliver better value by doing so). It is important that mental health providers ensure they are active partners in the development of accountable care systems and organisations if these opportunities are to be realised.

Can integrated approaches to mental health deliver better value?

In primary care

- Integration of mental health into primary care teams in Intermountain Healthcare, an integrated health system in the United States, was associated with lower use of some forms of acute care and reduced costs in real terms across the system (Reiss-Brennan *et al* 2016).

- An evaluation of an integrated mental health service in GP practices for people with persistent physical symptoms and other complex needs in City and Hackney (London) found that over a follow-up period of 22 months, around a third of the costs of providing the service were offset by savings from reduced service use in primary and secondary care (**Parsonage *et al* 2014**).

In long-term conditions management

- In a research trial in the UK, integrating mental health support into cancer care pathways using the collaborative care model improved mental health outcomes, reduced pain and fatigue, and improved general functioning and quality of life (Sharpe *et al* 2014) and was found to be highly cost effective (Duarte *et al* 2015).

- Introduction of the 'three dimensions for diabetes' (3DfD) service in south London, which included integrated support for mental and social needs, was associated with improved control of blood glucose levels among the people served, reduced emergency attendances and reduced diabetes complications. In an economic evaluation, the financial value of reduced hospital activity was found to be 35 per cent higher than the costs of delivering the 3DfD service (**Ismail and Gayle 2016**).

- Including a psychological component in a breathlessness clinic for COPD in Hillingdon Hospital led to fewer A&E presentations and hospital bed days during the six months after the intervention (Howard *et al* 2010). This translated into savings of around four times the upfront costs of the intervention.

Can integrated approaches to mental health deliver better value?
continued

In acute hospitals

- In the Greater Nottingham urgent and emergency care vanguard, strengthening the mental health liaison team in A&E in line with the 'core 24' service standard is reported to have led to a 3 per cent improvement in the acute trust's overall performance against the four-hour wait target.

- An evaluation of the Rapid Assessment Interface and Discharge (RAID) service in Birmingham found that on conservative assumptions, benefits in terms of reduced inpatient bed use within the acute hospital exceeded the costs of the service by a factor of more than four to one (**Parsonage and Fossey 2011**).

7 Recommendations

Recommendations for local system leaders

- Ensure that mental health is a core component of all work on new models of care, including in MCPs, PACS, acute care collaborations, urgent and emergency care networks and primary care homes, using the nine design principles and emerging lessons in this report as a guide.

- Integrate mental health at all levels across the new care model and avoid seeing mental health as a separate work stream.

- Include mental health expertise in the central programme management team responsible for overseeing the implementation of a new model of care.

- Ensure that new models of care address outcomes that are important to patients, service users and carers, as well as outcomes that are desirable for the system. In order to achieve this, involve patients, service users and carers early in the design process.

- Strengthen mental health capabilities in the primary and community health workforce by improving the confidence, competence and skills of GPs, integrated care teams and others. Similarly, aim to strengthen the physical health competencies of mental health professionals.

- Ensure that professionals involved in new models of care have protected time to provide an educational function to other members of staff, in order to share learning between health professionals working in physical and mental health.

- Include mental health metrics in local evaluations of new models of care that reflect outcomes, activity and quality of provision.

Recommendations for NHS England

- Ensure that the national evaluation of the new care models programme captures the impact these models have had on people living with mental health problems, the impact on mental health and wellbeing-related outcomes across the wider population, and an assessment of how the mental health components of new models of care have contributed to wider health and social outcomes. The learning and impact studies conducted as part of the evaluation strategy should include a focus on mental health components of integrated care.

- Provide local systems with guidance and examples of good practice, demonstrating how mental health support can be successfully embedded in integrated care teams, enhanced models of general practice, and urgent and emergency care pathways.

- Ensure that local health systems receiving national funding for large-scale transformation programmes are required to go above and beyond national mental health policy expectations or to do so at an accelerated pace, to ensure that such work is consistent with the commitment to parity of esteem.

- Hold local system leaders to account for including the development of integrated approaches to mental health in STPs, and for implementing these effectively. We recommend that only STP footprints that have articulated a clear ambition for this should be supported to roll out a new contractual model, such as an MCP, PACS or care homes contract.

- Work with Health Education England to ensure that workforce development needs in relation to mental health identified in the vanguard sites inform wider strategic thinking on education, training and continuing professional development.

Appendix A: Further resources

National mental health policy resources

- Mental health access and waiting time standards www.england.nhs.uk/mental-health/resources/access-waiting-time/

- *Delivering the five year forward view for mental health: developing quality and outcomes measures* www.england.nhs.uk/mental-health/resources/

- New payment approaches for mental health services https://improvement.nhs.uk/resources/new-payment-approaches/

Resources for vanguard and STP leaders

- NHS England's STP aide-mémoire: mental health and dementia www.england.nhs.uk/stps/support/

- 'Where to look' packs for STP footprint areas www.england.nhs.uk/rightcare/intel/cfv/stp-footprints/

- Identifying and addressing the physical health needs of mental health service users: data packs for STPs, forthcoming, NHS England

- *The Forward View into action: new care models: support for the vanguards* www.england.nhs.uk/ourwork/new-care-models/vanguards/support/

- *Evaluation strategy for new care model vanguards* www.england.nhs.uk/2016/05/ncm-evaluation-strategy/

- *The multispecialty community provider (MCP) emerging care model and contract framework* www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/community-sites/

- *Integrated primary and acute care systems (PACS) – describing the care model and the business model* www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/primary-acute-sites/

- *The framework for enhanced health in care homes* www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/care-homes-sites/

- *Bringing together physical and mental health: a new frontier for integrated care* www.kingsfund.org.uk/publications/physical-and-mental-health

Resources for CCGs

- CCG Commissioning for Value 'Where to look' packs www.england.nhs.uk/rightcare/intel/cfv/stp-footprints/

- Commissioning for Value tools http://ccgtools.england.nhs.uk/cfv2016/mh/atlas.html

- *Guidance for commissioning public mental health services* www.jcpmh.info/resource/guidance-for-commissioning-public-mental-health-services/

- *Guidance for commissioners of primary mental health care services* www.jcpmh.info/good-services/primary-mental-health-services/

- *Modelling the interface between primary care and specialist mental health services: a tool for commissioning* www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/research/interfacestudy.aspx

- *Guidance for commissioners of services for people with medically unexplained symptoms* www.jcpmh.info/good-services/medically-unexplained-symptoms/

- *Access and waiting time standard for children and young people with an eating disorder: commissioning guide* www.england.nhs.uk/2015/08/cyp-mh-prog-launch/

- *Guidance for commissioners of liaison mental health services to acute hospitals* www.jcpmh.info/good-services/liaison-mental-health-services/

- *Guidance for commissioners of drug and alcohol services* www.jcpmh.info/good-services/drug-and-alcohol-services/

- *Guidance for commissioners of rehabilitation services for people with complex mental health needs* www.jcpmh.info/resource/guidance-for-commissioners-of-rehabilitation-services-for-people-with-complex-mental-health-needs/

- *Guidance for commissioners of mental health services for people with learning disabilities* **www.jcpmh.info/good-services/learning-disabilities-services/**

- *Improving the physical health of adults with severe mental illness: essential actions* **www.rcpsych.ac.uk/mediacentre/adultswithsmi.aspx**

- *Improving the physical health of patients with serious mental illness: a practical toolkit* **www.england.nhs.uk/mental-health/resources/smi-toolkit/**

- *Guidance for commissioners of financially, environmentally, and socially sustainable mental health services (future proofing services)* **www.jcpmh.info/good-services/sustainable-services/**
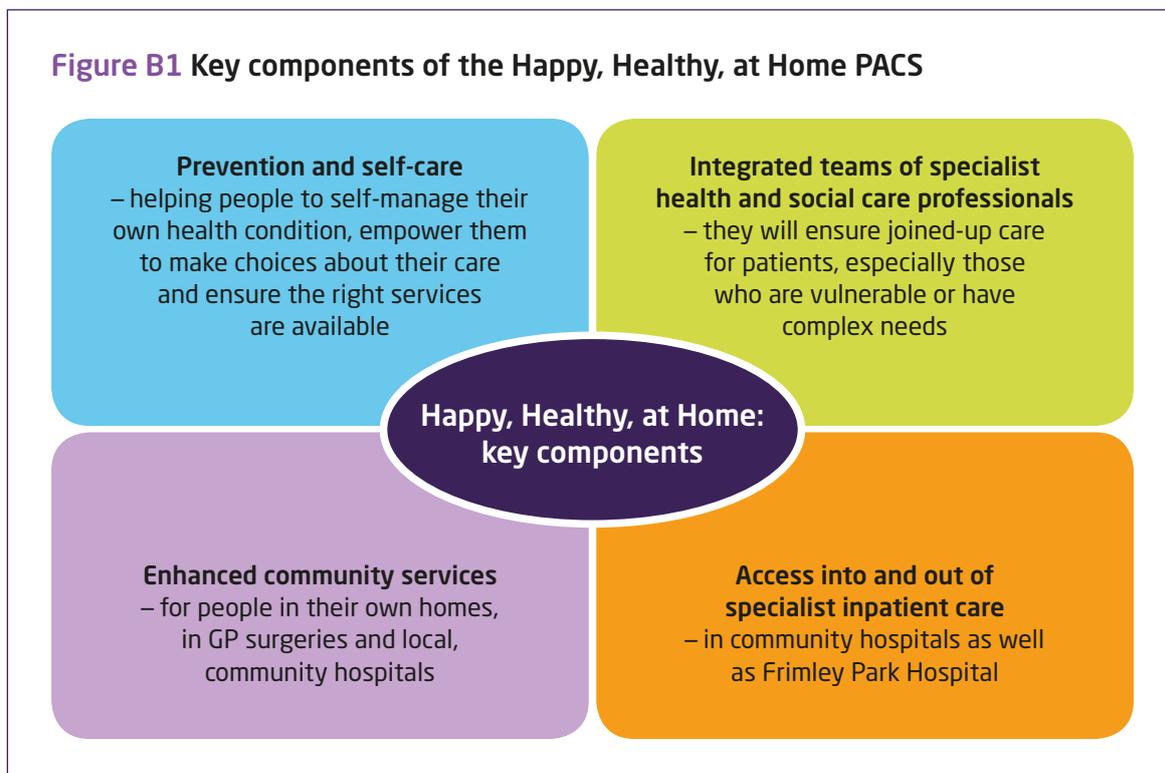
Appendix B: Case study site profiles

Case study 1: Happy, Healthy, at Home PACS North East Hampshire and Farnham

Overview

The Happy, Healthy, at Home vanguard is an integrated PACS, serving a population of 220,000 across North East Hampshire and Farnham (*see* Figure B1 for key components). A number of organisations and partners are involved, including:

- NHS North East Hampshire and Farnham CCG

- Frimley Health NHS Foundation Trust (an acute trust)

- Southern Health NHS Foundation Trust (a community and mental health trust)

- Surrey and Borders Partnership NHS Foundation Trust (a mental health and learning disabilities trust)

- South East Coast Ambulance Service NHS Foundation Trust

- North Hampshire Urgent Care

- Hampshire County Council

- Surrey County Council

- local third sector organisations

- the local population, including patients, service users and carers.

Figure B1 Key components of the Happy, Healthy, at Home PACS

Prevention and self-care
– helping people to self-manage their own health condition, empower them to make choices about their care and ensure the right services are available

Integrated teams of specialist health and social care professionals
– they will ensure joined-up care for patients, especially those who are vulnerable or have complex needs

Happy, Healthy, at Home: key components

Enhanced community services
– for people in their own homes, in GP surgeries and local, community hospitals

Access into and out of specialist inpatient care
– in community hospitals as well as Frimley Park Hospital

The vanguard is described as 'an integrated health, social care and wellbeing system', which aims to 'put prevention at the centre of everything [they] do'. It involves three broad work streams, outlined below.

1. Acute work stream

This includes work to improve access in and out of specialist inpatient care. Elements include: GPs working on wards at Frimley Park Hospital to support and facilitate discharge; GPs based in Frimley Park A&E; the introduction of 'EMIS viewer', allowing staff in A&E and out-of-hours services to view GP records; and work to enhance out-of-hours services and improve triage.

2. Community work stream

This includes: the development of integrated teams of health and social care professionals (including mental health professionals) working to deliver and co-ordinate care in the community; and the development of a new recovery,

rehabilitation and re-ablement service, which aims to prevent hospital admissions and enable earlier discharge by bringing together services provided by the community trust, the acute trust and the local authority.

3. Prevention work stream

This includes: a Recovery College offering support for people living with, or recovering from, chronic mental or physical health conditions; mental health crisis support through the introduction of Safe Havens; social prescribing, including the Making Connections programme, which connects people with local resources and voluntary sector services; and carers' support networks. These elements of the vanguard work are described in detail below.

Work related to mental health

Integrated care teams
Integrated care teams are a key aspect of the vanguard work in North East Hampshire and Farnham. They are locality-based, multidisciplinary teams that work with individuals with complex care needs, including older people living with frailty, people living with long-term conditions or multiple co-morbidities, and people approaching the end of life. They are able to address complex needs by drawing on a variety of expertise, and co-ordinate care from different professionals and services. Team members include: community nurses, occupational therapists, physiotherapists, social workers, pharmacists, mental health practitioners, geriatricians, GPs, voluntary sector workers and team co-ordinators. There are five teams, each covering one locality area. The teams are based in the community, and deliver care to people in their own homes.

Referrals commonly come from GPs, community nurses and hospital staff. Information from the ambulance service and A&E enables the team to identify individuals at risk of hospital admission or at other crisis points who may benefit from their involvement. All individuals referred are required to give their consent to be discussed.

During regular team meetings, all cases under the team and any new referrals are discussed. Depending on their needs, referrals are then directed to the most appropriate professional(s) within the team for assessment and management, but will continue to be discussed regularly by the full team.

Three mental health practitioners (two band 7 nurses and one occupational therapist) work across the five teams. Their main role is to work with adults with co-morbid physical and mental health conditions, particularly when an underlying mental health problem is affecting an individual's engagement or their ability to self-manage. The mental health practitioners have monthly clinical supervision with a consultant psychiatrist, who they can contact for advice or guidance if required. Current plans are to increase the number of mental health practitioners to one band 7 practitioner per team, all also receiving supervision from a clinical psychologist.

The teams work closely with GPs, and mental health practitioners have an important role in supporting primary care professionals to manage mental health issues and understand the interaction between physical and mental health.

Recovery College
The Recovery College offers educational courses and workshops to help people improve their own health and wellbeing, and is run in partnership with the mental health trust, voluntary sector and local authority.

The college was originally developed for individuals living with personality disorder, and was largely focused on mental health and wellbeing. Following a successful pilot phase, the college was included within the vanguard, and was significantly expanded as a result. Courses are now open to a wide range of participants, including service users, carers and professionals. There is no separation in terms of which courses people can attend, and it is increasingly common for a class to include service users, carers and professionals. Individuals can be referred or may self-refer. Courses are delivered in community locations such as libraries and community centres.

The vanguard has expanded the remit of the college to focus on both mental and physical health, and there is a dedicated course exploring the links between the two. It now offers more than 30 courses covering a wide range of topics, including: health and wellbeing; understanding; skills and creativity (a full list can be found in the prospectus on the Recovery College website). Work is ongoing to further develop the offer, particularly to enhance the focus on physical health, wellbeing and prevention.

The Recovery College was co-designed with service users, carers and staff, and this ethos of service user involvement has continued throughout its development. All courses are co-produced by individuals with relevant lived experience, and most are also co-delivered. Individuals involved in delivering courses receive training, supervision and support. Service users and carers are able to volunteer to support the work of the college – for example, through assisting with transport, administration and course design and delivery. A number of individuals with lived experience are employed by the trust as recovery coaches or senior recovery coaches.

Safe Haven

Introduced as a short-term pilot in 2014, the Safe Haven was set up to offer out-of-hours mental health crisis support and an alternative to A&E. Although the project predates the vanguard, it has been significantly expanded as a result. There are now six Safe Havens based in town centre locations across Surrey and North East Hampshire. The service is provided by a partnership between the mental health trust and third sector.

Each Safe Haven is staffed by a qualified mental health practitioner from the mental health trust, and two trained staff from third sector providers. Peer support from people with lived experience is also encouraged and increasingly available.

The Safe Haven model is open access, and does not require referral or a prior appointment. In addition to offering direct support to individuals experiencing a mental health crisis, the Safe Haven team are able to access home treatment or inpatient services if necessary. The Safe Havens also work closely with police and ambulance services to prevent unnecessary A&E attendances, and with A&E liaison to identify people attending A&E who could benefit from the Safe Haven, linking them into the service.

As in the case of the Recovery College, there was a strong emphasis on service user engagement and co-design during development of the model.

Social prescribing

The vanguard has developed a programme called Making Connections, with dedicated Making Connections workers (a new role delivered through the voluntary sector) in GP surgeries. These individuals act as navigators, connecting people to local resources and helping them to identify and access community services that

may improve their health and wellbeing. This enhances the non-clinical support available to patients and service users, and provides GPs and professionals in the integrated care teams with an additional type of support to offer.

Carers' support network

In addition to focusing on patients and service users, much of the vanguard work also includes a focus on the needs and wellbeing of informal carers. Programmes such as the Recovery College and Safe Haven can be accessed by carers, and work is also under way to develop a carers' support network. This has included the development of carers' hubs offering advice, signposting and support, and carers' engagement events run in partnership with the local Healthwatch and The Princess Royal Trust for Carers.

IAPT expansion

North East Hampshire and Farnham is one of 22 areas being supported by NHS England to expand IAPT. These 'early implementer' projects are intended to lead the way in integrating psychological therapies with physical health care.

Care pathways in North East Hampshire and Farnham include a pathway for persistent physical symptoms in which therapists work with GPs and patients who frequently attend primary and urgent care services; there is also a pathway for COPD, which offers integrated working with pulmonary rehabilitation teams, house-bound working and psycho-educational courses. Pathways are also under development for cardiovascular disease and perinatal care.

While this does not directly fall under the vanguard work streams, it is viewed locally as being part of the same drive to bring together mental and physical health pathways. Progress achieved through the vanguard has facilitated the integration and co-location of mental health services with primary care, which will be further developed through IAPT expansion.

Outcomes

There is limited outcomes data available so far for some elements of the work – for example, there is no comprehensive data on outcomes of the integrated care teams (a core element of the model). However, early data is available for some elements, particularly for the Recovery College and Safe Havens, as follows.

- A provisional evaluation of the Safe Havens found excellent service user feedback, a 33 per cent reduction in admissions to acute inpatient psychiatric beds and a plateau in A&E attendances for mental health issues (in contrast to continuing growth in attendances from surrounding CCGs).

- Early data from the Recovery College (from pre- and post-course questionnaires) shows improvements in process of recovery (QPR) scores and reductions in GP visits, A&E attendances and police contacts. This questionnaire data also shows reductions in contacts with home treatment teams, psychiatric liaison teams, crisis lines and the Safe Havens.

More extensive evaluation of all aspects of the work is ongoing.

The additional mental health support these schemes provide has been welcomed by professionals. The mental health expertise embedded in the integrated care teams has been particularly well received by GPs, district nurses and others, who can not only refer patients on but are also able to obtain advice and guidance directly from the mental health practitioners. There has also been positive feedback from other services – for example, from police and ambulance services regarding Safe Havens.

Much of this work is continuing to develop, and early indications from the Frimley STP suggest that aspects of the vanguard are likely to be scaled up across the footprint.

Key enablers

- The vanguard work has built on longstanding existing relationships (for example, between the mental health trust and the CCG, and between the mental health and acute trusts). Other relationships that were previously less well developed – for example, with the local authority and third sector organisations – have been strengthened through the work.

- The strong emphasis on mental health and wellbeing in much of the vanguard work has been facilitated through involvement of mental health representatives at all levels, including in key senior positions. Strong mental health leadership has been a key driver of the progress made.

- Many aspects of the vanguard work, particularly the Safe Haven and Recovery College models, have benefited from a strong emphasis on service user involvement and co-design.

- For some aspects of the work, a focus on measuring early outcomes has helped to gain support and traction; early evaluations of the Safe Havens and Recovery College have been important in building the case for expanding and spreading the models.

Further information

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Case study 2: Tower Hamlets Together MCP

Overview

Tower Hamlets Together is an MCP vanguard serving a population of 287,000. It aims to deliver innovative, integrated and seamless care to patients, carers and families across the borough. Partners include: Tower Hamlets GP Care Group, Tower Hamlets Clinical Commissioning Group, Barts Health NHS Trust, East London NHS Foundation Trust, the London Borough of Tower Hamlets, and the Tower Hamlets Council for Voluntary Service.

People living in Tower Hamlets face significant health inequalities, with the highest rate of child poverty in England and the second highest premature death rate (of all the London boroughs) among adults from circulatory disease, cancer and respiratory disease. People in Tower Hamlets also have the lowest healthy life expectancy in England and develop co-morbid long-term conditions earlier in life. To address some of these issues, Tower Hamlets Together has embarked on an ambitious transformation programme that focuses on three priority areas:

- improving care for adults with long-term conditions or complex needs

- developing a population-wide health programme that focuses on prevention

- developing a new model of integrated care for children and young people.

Across the Tower Hamlets borough, 36 primary care practices are organised into eight networks, which are then aggregated into four localities.

The vanguard programme is overseen by the Tower Hamlets Together board, which is responsible for co-ordinating the development of new governance arrangements with the CCG. The board will have two operational committees that oversee system management and quality, and four transformation programme boards.

Work related to mental health

The programme includes various pieces of work relating to mental health, which are at different stages of development. Arguably, the most advanced work around mental health is focused on the Integrated Care Programme. It is aimed at: people with the highest care needs through co-ordinated community-based and inpatient care; those with ongoing care needs through enhanced primary and community care; and those with urgent care needs through integrated access and rapid response functions.

In the description that follows, we have included a number of components that were initially established before the vanguard but which local leaders argue are an indispensable part of an effective MCP.

Priority 1: Integrated care for adults with complex needs
In response to this vanguard priority, Tower Hamlets Together has developed integrated community health teams, a primary care mental health service, and expanded its liaison psychiatry service in the local acute hospital.

Integrated community health teams
Tower Hamlets Together has developed four integrated community health teams with the purpose of delivering enhanced care for people with complex and ongoing needs in the community. This service is open to adults who are on the primary care registers for dementia, palliative care or care homes, along with people who would benefit from a multidisciplinary approach.

The four integrated community health teams serve a total of eight networks across the borough and include: community mental health nurses; district nurses; allied health professionals; pharmacists; social support workers; and community matrons. In terms of the mental health expertise within these teams, there are four

whole-time equivalent (WTE) senior mental health nurses (band 7) in each locality, with experience of working in mental health services for adults, older adults and supporting people with drug and/or alcohol issues. These mental health nurses are supported by a 0.5 WTE consultant psychiatrist, who also works with two WTE mental health occupational therapists to support care homes in the borough to deliver person-centred care for people with dementia.

Mental health nurses within the integrated community health teams attend practice-based multidisciplinary team meetings to help identify patients who potentially have a mental health problem that may be complicating their presenting illness. They also provide brief treatment where patients require additional support but do not warrant a referral to secondary care.

In addition to the above, mental health nurses provide consultation and training to community health teams and primary care professionals to improve their knowledge on mental health. The curriculum for this is under development. Separate but related to this, these teams also aim to support clinically appropriate discharge of patients who have serious mental illnesses from secondary mental health services into primary mental health services.

Primary care mental health service
Tower Hamlets Together MCP, working with partners from City and Hackney and Newham, has developed a primary care mental health service to support the discharge of people with stable serious mental illness into recovery-oriented primary care services, and provide step-up support to people from primary care (*see* Figure B2). Since the scheme's inception in 2013, more than 5,000 people have received support from the primary care mental health service in east London, helping to create a smaller but more responsive secondary care service and improve patient and practice experience.
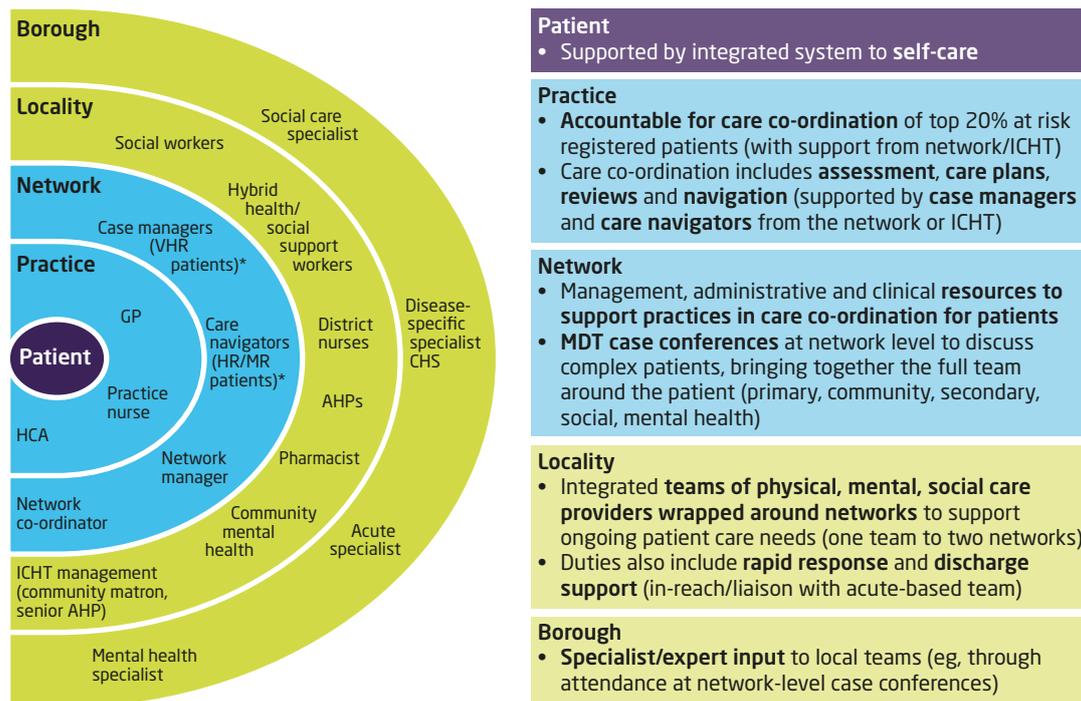
The service includes a contract with practices to provide additional practice-based support for service users with a focus on healthy lifestyles, along with a team of primary care-based mental health professionals providing recovery-oriented support. An integral part of the model is the significant improvement in communication between secondary and primary care that the service has brought about, with regular practice-based multidisciplinary teams attended by secondary care consultant psychiatrists. Figure B2 illustrates this in more depth.

Figure B2 Care co-ordination model in Tower Hamlets

Tower Hamlets has developed a localised vision for an integrated care system wrapped around patients and primary care

● Primarily care co-ordination
● Primarily care provision

Borough

Locality
Social care specialist
Social workers

Network
Hybrid health/social support workers
Case managers (VHR patients)*

Practice
GP
Care navigators (HR/MR patients)*
District nurses
Disease-specific specialist CHS
Patient
Practice nurse
AHPs
HCA
Network manager
Pharmacist
Network co-ordinator
Community mental health
Acute specialist
ICHT management (community matron, senior AHP)
Mental health specialist

Patient
• Supported by integrated system to **self-care**

Practice
• **Accountable for care co-ordination** of top 20% at risk registered patients (with support from network/ICHT)
• Care co-ordination includes **assessment**, **care plans**, **reviews** and **navigation** (supported by **case managers** and **care navigators** from the network or ICHT)

Network
• Management, administrative and clinical **resources to support practices in care co-ordination for patients**
• **MDT case conferences** at network level to discuss complex patients, bringing together the full team around the patient (primary, community, secondary, social, mental health)

Locality
• Integrated **teams of physical, mental, social care providers wrapped around networks** to support ongoing patient care needs (one team to two networks)
• Duties also include **rapid response** and **discharge support** (in-reach/liaison with acute-based team)

Borough
• **Specialist/expert input** to local teams (eg, through attendance at network-level case conferences)

Intensity of patient care co-ordination depends on risk of readmission

* Case managers (clinical/social)/care navigators (administrative) could be employed at network or locality level. These functions could be provided by aligning existing staff in primary/CHS/social care, with additional recruitment if required.

Source: adapted from Towers Hamlets Together 2016

Psychological medicine in acute hospitals

The Department of Psychological Medicine provides a mental health liaison service to people of all ages (16+) in Tower Hamlets, based on the RAID model. The service provides mental health assessment to patients who attend the A&E department and to inpatients at The Royal London Hospital, Mile End Hospital or the London Chest Hospital. The service is available 24/7, with a target of assessing referred patients who present to A&E within one hour and assessing referred patients on inpatient wards within 24 hours.

The multidisciplinary team combines expertise in adult and older people's mental health to provide assessment, treatment and management of mental health problems, including anxiety, depression, dementia, schizophrenia, and any other mental health or psychological problem in a ward setting or in the A&E department (including specialist alcohol and drug support). The team also provide clinical support and supervision in mental health interventions, alongside formal and informal training for general acute hospital staff.

This service was set up in 2014 so predates the vanguard but is considered by local system leaders to be an essential component of an effective MCP model as it contributes to achieving system-wide outcomes for the borough. For instance, during the first three quarters of 2016/17, The Royal London Hospital reported a 12.7 per cent reduction in occupied bed days for people with dementia, serious mental illness and depression.

Priority 2: Population-wide health programme, including prevention
Tower Hamlets Together has a range of preventive and public health interventions as part of its vanguard work, although some projects predate the vanguard.

Wellbeing Hubs
Tower Hamlets Together seeks to embed wider determinants of health into the new model of care. The majority of people (80 per cent) living in the borough are considered to be at a low risk or very low risk of admission to hospital (224,000 people). For this group, plans have focused on population health management models and targeting people with risky lifestyle factors.

Tower Hamlets has established four Wellbeing Hubs where people can access information on a range of resources available in the local community. Through a '360-degree' social care assessment, people may be referred to: lifestyle services, including health trainers; an Integrated Employment Hub; recovery and wellbeing services; or to the single point of access. Similarly, through patient activation, people can self-manage their own condition better, drawing on support from health outreach workers for information and signposting, volunteers for additional support to help access services, and a social prescribing service.

It is expected that the hubs will hold detailed information on mental health provision within the borough and, where appropriate, people will be signposted to such services and support mechanisms. Likewise, mental health services, where appropriate, will be able to signpost their clients to hubs for support in addressing their wider needs within the community.

Community Recovery and Wellbeing service
A Community Recovery and Wellbeing service was commissioned by the CCG in June 2016, through a combination of CCG and council funding, to a consortium of organisations called INSPIRE. This service aims to support people with low-level mental health issues that would not warrant a referral to specialist services. The team provide one-to-one interventions and support in the community, including peer support and signposting to relevant services or groups.

Furthermore, people living with severe and enduring mental health problems can access courses offered by the Recovery College, which aims to support people to work towards achieving meaningful, self-defined recovery. Again, this service predates the vanguard but forms an important component of support available for those with ongoing health needs.

Making Every Contact Count
The Making Every Contact Count (MECC) initiative aims to encourage those who work with the public to make the most of every opportunity to have a conversation about a healthy lifestyle and offer signposting information to facilitate behaviour change.

In Tower Hamlets, frontline staff receive training on how to pick up on conversational cues about staying healthy that someone may be willing to discuss further, and how to encourage them to act. Through MECC, one of the conversations that staff are encouraged to discuss is 'five ways to wellbeing', to support people to consider their mental health and wellbeing. The other lifestyle factors that are included in the MECC approach (such as physical activity and healthy eating) will also have some positive impact on mental wellbeing.

Priority 3: A new model of integrated care for children and young people
Universal preventive services for children and parents
Across Tower Hamlets, the ambition is to reduce the number of children who need social care services and to improve their education outcomes. Through the vanguard work, Tower Hamlets Together is integrating universal health services so that health visiting, midwifery and school health is joined up with local authority services, children's centres and education services. This includes a focus on emotional wellbeing and targeted support where necessary. Examples include:

- the existing Five to Thrive programme increasing its focus on emotional wellbeing among people who use the service

- the existing portage service (a home-visiting educational service for pre-school children with additional support needs and their families) being expanded to children's centres.

Integrated health services for children and young people
Similar to the model adopted for adults, Tower Hamlets Together is now reorganising services for children and young people so that care is provided in a more integrated way. Children's health services have previously been managed by individual specialist areas, and the model will see integrated multidisciplinary working across children's health services. The plan is for services to integrate with child and adolescent mental health services.

Outcomes

- Since 2014/15, Tower Hamlets MCP has seen a 2.2 per cent fall in emergency admissions, compared to 2.7 per cent growth for all other MCP vanguards and 3.3 per cent growth for non-vanguard CCGs. Furthermore, there has been 3.7 per cent reduction in occupied bed days, compared to 1.9 per cent for non-vanguards.

- Since its inception in 2013, more than 5,000 people have accessed the primary care mental health service. This has helped to create a smaller, leaner but more responsive secondary care service and improve patient and practice experience at the same time.

- In 2016/17 there was a statistically significant 12.7 per cent reduction in occupied bed days for people with depression, serious mental illness and dementia, while rates of emergency admissions have remained static.

- As described on p 33, Tower Hamlets partners are currently developing a system-wide outcomes framework that defines the partners' collective ambition to improve outcomes for people who live in the borough. It is anticipated that they will monitor performance against this framework during 2017/18.

Key enablers

- In Tower Hamlets, the vanguard work around mental health has been built on several existing initiatives. In 2012, the Integrated Pioneer programme across Tower Hamlets, Waltham Forest and Newham CCGs allowed them to introduce nine high-impact interventions across the three boroughs. Two of these interventions focused on mental health initiatives: the development of a fully compliant 'core 24' RAID service and a primary care mental health service. The vanguard programme has enabled the partners to expand their transformation programme within an accelerated timeframe.

- Creating a shared ambition through the vanguard has helped partners align their own organisational plans for health and social care services and to focus on objectives for the whole system.

- East London NHS Foundation Trust is a full partner in the vanguard, which was considered to be an enabling factor for driving improvements in mental health integration.

- The foundation trust recruited a public health lead to support the development of more integrated mental/physical health and preventive pathways in the context of the vanguard, working with the Tower Hamlets vanguard public health consultant.

- Tower Hamlets has aligned incentives and reimbursement models to encourage integrated care across the system. Provider partners have been working together to deliver against a shared local incentive scheme since 2016/17. This scheme places provider income at risk and makes available a potential £1 million benefit to providers, dependent on the delivery of 10 outcome goals over the course of the year. Two of these are related to mental health:

emergency readmissions for people with depression, serious mental illness or dementia; and total bed days for the same groups.

- The use of a capitation-linked dataset to understand patterns of primary care, acute and social care utilisation by people with mental health problems has enabled system leaders to understand the financial and quality opportunities of new pathways across mental and physical health.

- Tower Hamlets is working with Newham and Waltham Forest CCGs and UCL Partners to develop a multidisciplinary team concordat that aims to support the team to work more effectively together, with a focus on having the right discussions, with the right people, targeting the right patients.

Further information

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http://towerhamletstogether.weebly.com/

Case study 3: West Cheshire Way MCP

Overview

West Cheshire Way is an MCP serving a population of 260,000. Partners include:

- Primary Care Cheshire (a federation of all 35 local practices)

- NHS West Cheshire Clinical Commissioning Group

- Cheshire and Wirral Partnership NHS Foundation Trust

- Countess of Chester Hospital NHS Foundation Trust

- Cheshire West and Chester Council

- voluntary sector and community groups.

Cheshire and Wirral Partnership NHS Foundation Trust is the main provider of mental health services in the area covered by the vanguard, and also provides community services for physical health. The vanguard programme is structured around three life-course stages:

- starting well

- working well

- ageing well.

At the core of the model being developed is nine integrated care teams, each working with a cluster of GP practices and serving a population of around 30,000. These teams bring together professionals from health, social care and the voluntary sector, including:

- community nurses

- district nurses

- a community matron

- speech and language therapists

- occupational therapists

- physiotherapists

- social workers

- wellbeing co-ordinators.

The integrated care teams support patients with highly complex needs who are generally housebound and often frail. People over the age of 65 account for around 75 per cent of the caseload, the remainder being younger adults with multiple conditions or people in need of intensive post-operative care at home. The teams accept referrals from GPs and hospital wards, and hold monthly multidisciplinary team meetings with each GP practice served.

A distinctive aspect of the approach taken in West Cheshire is the emphasis placed on helping people to stay well in a broad sense – physically and mentally. This includes a focus on connecting integrated care teams with resources in the voluntary and community sector, using wellbeing co-ordinators employed by Age UK.

Figure B3 illustrates three ways in which the integrated care teams secure expertise and support for people with mental health needs. These are elaborated on in the remainder of this section.

Figure B3 Mental health inputs into integrated care teams in West Cheshire Way MCP vanguard
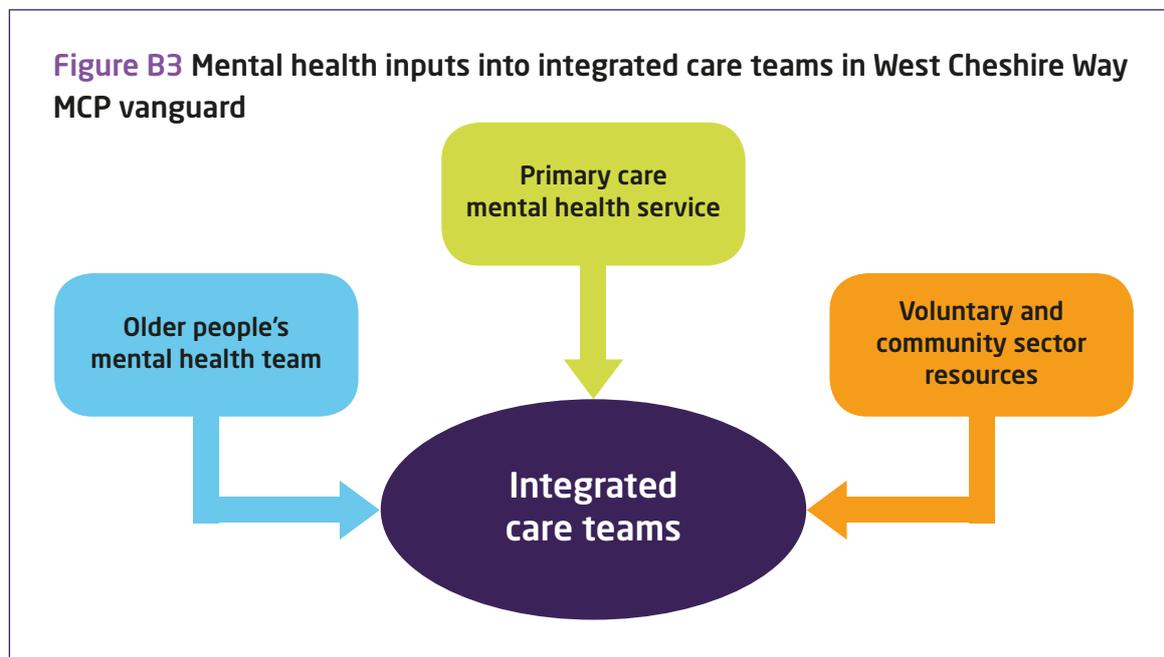
Work related to mental health

Linking integrated care teams with specialist mental health services
Rather than being fully embedded in the integrated care teams, mental health professionals work in close liaison with the teams. Two main sources of support are available – the older people's mental health team, and the primary care mental health service.

For adults over the age of 65, there is a close connection with the older people's mental health team. The nine integrated care teams are arranged into three localities and each locality is supported by a designated band 7 community psychiatric nurse in the older people's mental health team. Members of the integrated care team can contact their named clinical lead by phone for advice, and they may be invited to attend a case discussion in a multidisciplinary team meeting. The support offered includes help with dementia diagnosis, managing challenging behaviours, assessment of capacity, and helping to navigate pathways into specialist mental health services.

A new older people's consultant psychiatrist post has also been created to provide additional educational input into the integrated care teams and primary care (the post involves doing this half-time and working half-time in the older people's mental health team). Each integrated care team takes part in three educational

sessions per year, covering topics such as challenging behaviours, cognitive assessment, the role of memory clinics, dementia, mood, capacity, case discussions, and any specific areas requested by the team.

For adults below the age of 65, each of the integrated care teams has a link worker in the primary care mental health service (*see* below). Through this arrangement, staff in the primary care service are able to provide psychological management and support for people with long-term conditions being seen by the integrated care team. This means that the integrated care teams have access to mental health support for people of working age as well as older adults. This has resulted in more psychological input into a number of care pathways (for example, mental health nurses and psychologists provide input into diabetes clinics and the cardiac rehabilitation programme).

At present, mental health professionals are only invited to attend an integrated care team's multidisciplinary team meeting to discuss specific cases. However, the plan for the future is to let the relevant mental health teams know which patients are to be discussed at each multidisciplinary team meeting so they can decide if there is anything they would like to offer input on, and also to give them the opportunity to bring any cases they would like to discuss to the meeting.

Developing closer joint working with mental health teams has been identified as one of the main priorities for service development by staff in the integrated care teams.

Wellbeing co-ordinators
Wellbeing co-ordinators in each integrated care team play a critical role in promoting positive mental health and wellbeing among the people supported by the team. Their main role is to help connect people with local voluntary and community sector services – particularly people at risk of social isolation and in need of some extra support, or who are known to be struggling emotionally. By tackling issues such as social isolation, the intention is both to prevent people developing mental health problems such as depression and to support the recovery of those with existing mental health problems.

The aspiration is to widen the wellbeing offer in the integrated care teams over time, with the addition of peer coaches, self-management courses and (potentially) other resources such as dementia care navigators.

Primary care mental health service

This is another service that predates the vanguard programme, originally consisting mainly of community psychiatric nurses, nurse therapists and psychologists embedded in primary care. It includes the local IAPT services but is also able to offer services to a much wider range of patients, including people with long-term conditions and/or persistent physical symptoms. It can also act as a discharge pathway out of secondary mental health services. As part of the MCP programme, additional funding has been made available for extra nursing staff and a half-time consultant liaison psychiatrist, and a link worker arrangement has been established with the integrated care teams as described above. The addition of a liaison psychiatrist has enhanced the team's ability to work at the interface of physical and mental health, with the intention of allowing more to be done in primary care.

Mental health in care homes

As part of the West Cheshire Way MCP vanguard, mental health input into care homes has been redesigned. A consultant older people's psychiatrist works alongside community psychiatric nurses, GPs, advanced nurse practitioners and community matrons to provide support into nursing homes, with plans to expand this model to all care homes over time. A pharmacist will also be added to the team in future to conduct medication reviews. The service is now much more proactive, and includes education of care home practitioners rather than a referral and treatment model. Care home staff are supported to provide better care, using a quality improvement methodology.

Outcomes

- Local leaders involved in the West Cheshire Way vanguard report that having rapid access to mental health nurses has meant there are now fewer referrals from integrated care teams to specialist mental health services, as well as better quality care (eg, through joint case working).

- Stronger relationships between mental and physical health professionals allow staff to ask for informal advice without making a referral to mental health services, with this being reported to lead to a more seamless experience for patients.

- Wellbeing co-ordinators have supported discharge from integrated care teams by putting appropriate voluntary and community sector resources in place.

- Quantitative assessment of the impact of integrated working is ongoing.

Key enablers

- The presence of wellbeing co-ordinators in integrated care teams is highly valued and was reported to have made a huge difference both to the people receiving the service and also to members of the team, who are now in a better position to enable people to recover in a more holistic way rather than being reliant on medical intervention.

- There is a history of strong primary care-based approaches to mental health in West Cheshire, which provided the MCP with good foundations to build on. In addition to the primary care mental health service already described, every GP practice in the area has a mental health lead, and these leads come together on a monthly basis to update their skills and discuss service improvements. A local enhanced services (LES) payment is used to support mental health skills development in primary care.

- Giving mental health professionals protected time to conduct educational work with integrated care teams was seen as an important way of equipping these teams with the knowledge and skills they need in relation to mental health.

- Some interviewees commented that it was very helpful for mental health services and community services for physical health to be provided by the same organisation. In particular, it means that there is a shared management structure, with service managers across the two sectors working to the same set of priorities and with a similar ethos.

- Co-location of staff was also identified as an important enabler, making it easier to build cohesive integrated care teams.

Further information

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The new models of care being developed and tested in the vanguard sites aim to dissolve traditional boundaries in the health system, and are being seen as a 'blueprint for the future of the NHS'. But how far is mental health being integrated into these new approaches?

Mental health and new models of care: lessons from the vanguards looks at the opportunities to improve care by embedding mental health expertise within multispecialty community providers, primary and acute care systems and other care models. It describes some of the progress made so far in the vanguard sites, and draws on their experience to offer lessons and insights for local leaders in other parts of the country.

The report finds that:

- despite some positive steps in vanguard sites, the full opportunities to improve care through integrated approaches to mental health have not yet been realised

- many sites are finding that improved access to mental health support can be a highly valuable component of integrated care for people with complex and ongoing care needs

- in some areas, developing new models of care has created an opportunity to improve relationships and support learning between professionals working in physical health and mental health care

- success is more likely where patients, service users and carers are involved early in the design process and in implementation.

Other local areas rolling out new care models should aim to go further than the vanguards in integrating mental health into care pathways in four key areas: complex needs, long-term care, urgent care, and population health. Those leading sustainability and transformation plans (STPs) should draw on early lessons from the vanguards to put mental health care at the centre of their plans.