MENTAL HEALTH RESILIENCE AND RECOVERY HUBS DRAFT MODEL AND PROPOSALS

This detailed description of the proposed model sets out our current thinking with regards to the commissioning of locality based Mental Health Resilience and Recovery Hubs. We would welcome feedback about all aspects of this document as part of the consultation.

1. VISION

Leicester, Leicestershire and Rutland (LLR) Clinical Commissioning Groups and Local Authorities are proposing to jointly commission a set of innovative locality based Resilience and Recovery Hubs, with the intention of developing supportive mental wellbeing communities and helping individuals with mental health needs to stay well and live full lives.

Locality Hubs would be key partners to implementing new models of care based on emerging evidence across the country which brings fundamental shift of power from providers to patients. This includes social prescribing, the integration of care around the patient, peer support and care networks, asset based community development and technology based care.

Locality Hubs would support a shift to resilient health rather than responding to ill health. That means giving people the information, power and control to stay healthy, manage their condition and choose their treatments. Hubs would help model and deliver a different approach to mental health wellbeing than that of traditional mental health services, whilst working positively with these services.

Locality Hubs would:

Take an innovative and problem solving approach.
Have co-production at the heart of service delivery.
Work in partnership with other services and mainstream resources.

In addition to direct funding under this contract, the provider would be expected to work with the local network to raise external funding (e.g. from private sector, community grant making organisations or from LLR health and social care commissioning outside this contract) in order to:

a) Provide added value and
b) Ensure a meaningful bridge is formed between traditional services and the mainstream community (e.g. local businesses, community organisations).

2. BACKGROUND AND CONTEXT

2.1 Local context

In LLR there are high rates of risk factors associated with poor mental health, reflected in increasing diagnosis of common mental health problems and high levels of presentation to crisis support services. So improving mental health outcomes is a priority for the local Better Care Together programme.

One priority of the Better Care Together Mental Health Programme is to build resilience and recovery within local communities through:

- Building community capacity – more than simply through statutory funded services
- Maximising the potential of networks - outside of mental health services
- Promoting self-management
- Building hope and optimism – we know people get better & lead rewarding lives - even when living with mental health problems
- Supporting more efficient and less costly approaches across the whole system

Locality Resource Hubs would support this priority, along with associated but separate initiatives including:

- Expansion of Recovery College satellite sites across LLR
- Development of Social prescribing
- Local Area Co-ordination in the County
- Development of Peer Support within statutory services
- Public Health resilience initiatives

2.2 National context

No health without mental health; A cross-government mental health outcomes strategy for people of all ages was launched in February 2011. It highlights the equal importance of mental and physical health, the need to focus on prevention, to intervene early and encourage partnership working to improve mental wellbeing across the population in order to achieve the following outcomes:

The Government's 'Mental Health Crisis Care Concordat', published in February 2014 describes the importance of early intervention in preventing mental health distress escalating into a crisis.

The Five Year Forward View published by NHS England in October 2014 encouraged the development of new models to suit local needs.

The Five Year Forward View for Mental Health February 2016 emphasises the importance of 'promoting good mental health and preventing poor mental health-helping people lead better lives as equal citizens'. Further it called for the need to create 'mentally healthy communities'

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The MIND Life Support briefing (2016) highlights that to stay well and live a full life, people with mental health problems often need practical help with day-to-day living and that this support comes from not just the health system but also from local community services including the public bodies, the voluntary sector and private firms. They often can be crucial in keeping people in the community and out of costly secondary care.

3. OUTCOMES

3.1 Individual outcomes

- I feel more able to manage my emotional health and wellbeing and access additional support if needed.
- I feel more able to manage my physical health and access additional support if needed.
- I feel more able to manage my home and daily living needs and access additional support if needed.
- I feel more in control of my finances and know where to access additional support if needed.
- I feel safer and more secure in my home and wider community.
- I feel more confident in being able to manage personal risks.
- I feel more able to manage relationships with the people who are part of my life.
- I feel more able to engage community activities, education or volunteering.
- I am more able to consider employment opportunities or sustain employment (if applicable).

3.2 Strategic outcomes

The service would support delivery of the following strategic outcomes:

Adult Social Care Outcomes Framework:

- Enhanced quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Clinical Commissioning Groups Strategic Aims:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting from avoidable harm

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4. AIMS, VALUES AND OBJECTIVES

4.1 Aims

To build mental health resilience and recovery within local communities through the provision of information, advice/ navigation and community recovery services, working in partnership with other services and mainstream resources.

The provider would ensure it can support the greatest number of people possible by promoting self-management. This would enable prioritisation of available resources for those in greater need.

4.2 Values

The Provider would have the following person centred values:

- Listening and working with people to empower them to find solutions.
- Recognising people are experts about their own needs, responds to the whole person and tries to be flexible and meet their needs in a way that is best for them
- Believing everyone has the scope to lead fuller lives by building on the principles of hope, control and opportunity.
- Recognising accessing support from the Provider is a step on the individual's recovery journey and not the end destination.
- Recognising that good quality mental health services include a strong element of emotional support, so need to be delivered by staff who understand mental health and are well trained in communication

4.3 Objectives

- Increase understanding of common mental health disorders across local communities and raising awareness of sources of support, with the purpose of challenging the stigma and discrimination associated with mental illness.
- Provide support to people experiencing mental health distress and/or requiring advice and information on mental health and wellbeing services in the locality.
- Enable individuals to maintain and improve their mental health wellbeing and/or recover from mental illness through greater access to community resources.
- Promoting independence through building individuals emotional, social and economic resilience, development of self–help and peer support and facilitation of engagement with mainstream services
- Becoming an integral part of the wider local mental health and social care system, creating effective relationships and developing successful networks and pathways with existing services.

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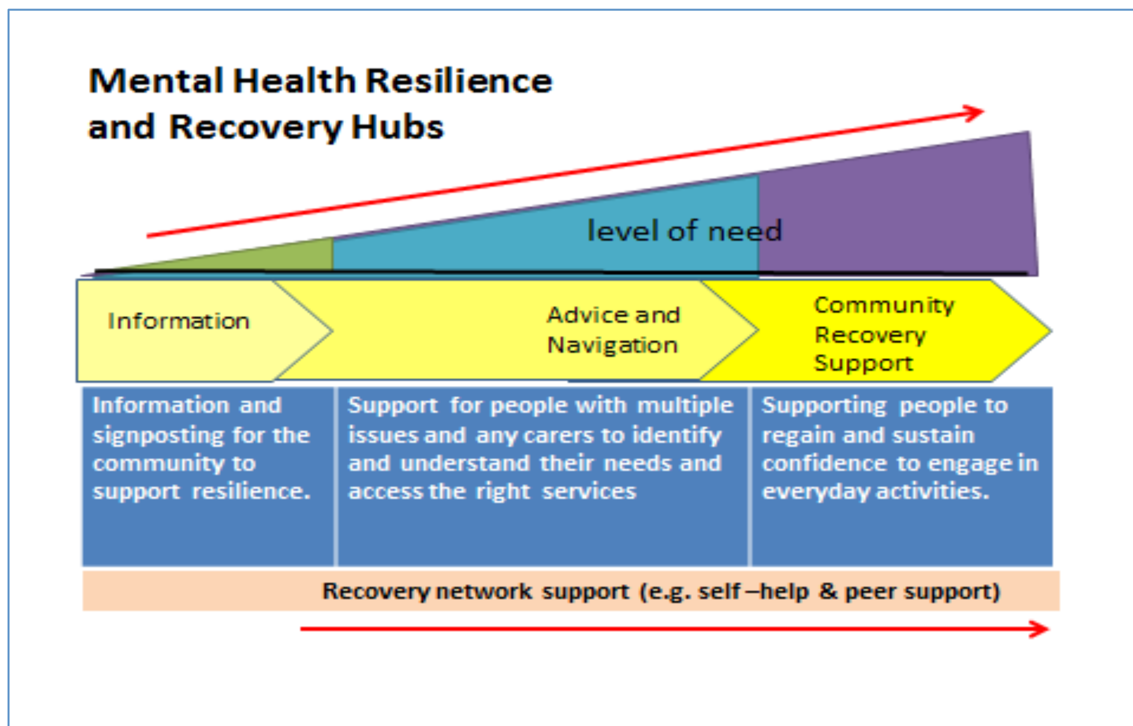
5. SERVICE DESCRIPTION/ CARE PATHWAY

5.1 Overview



5.2 Mental Health Information:

The Provider would provide an information and signposting service for the locality population. Information should be easily accessible via numerous routes e.g. a drop-in service, user-friendly website, telephone and other creative technology solutions where possible.

The Provider would have up to date information on a range of local and national services, tools and other resources that could support a person's wellbeing (e.g. information on relevant wellbeing apps).

The Provider would work with local mental health networks to undertake activities to promote mental wellbeing within the locality, targeted at people who are most likely to be experiencing mental health problems or who are at risk of requiring additional support to manage their mental health needs.

With the purpose of tackling stigma and discrimination the Provider would raise awareness of mental ill health and support available across the locality and would use opportunities such as Mental Health Awareness Weeks to promote these key messages.

5.3 Advice and Navigation:

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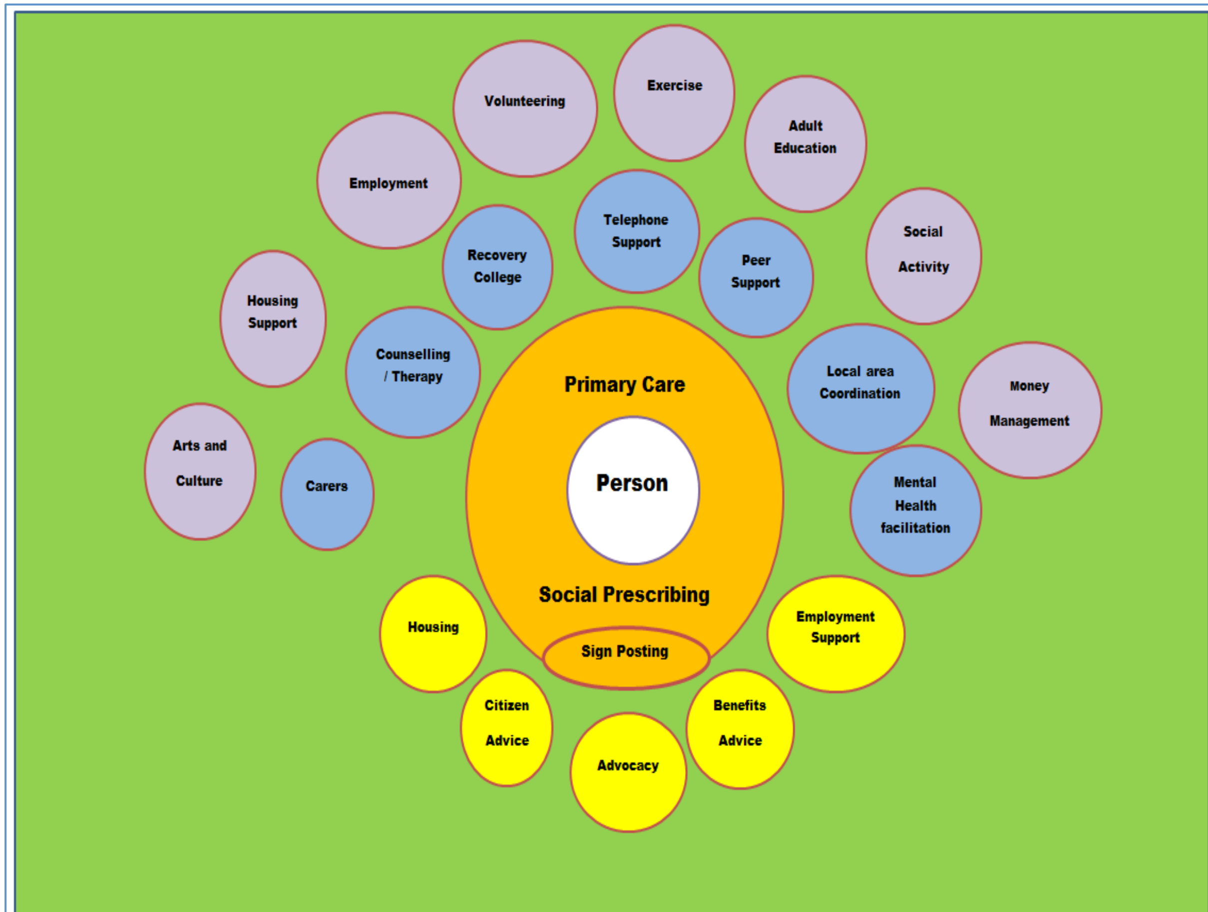
The Provider would support access to services that promote an individual's mental health and wellbeing by accessing appropriate support from the range outlined below:



Proactive navigation should be provided for people and their carers where it appears they may not engage otherwise. This could include making referrals and liaising with services to help unblock barriers to entry.

The following services are examples of organisations with which Hubs would be expected to form successful partnership arrangements (and link people to):

Primary and community based mental health services including IAPT, primary care Mental Health Facilitators and Community Mental Health Teams, Homeless centres, drug and alcohol services.

Services that support a person's health and wellbeing and programmes to reduce unhealthy eating, smoking and low levels of physical activity and help people to manage long-term conditions.

Services that support people who need assistance with social and criminal justice problems that may be impacting on their wellbeing, for example, problems with housing, crime and anti-social behaviour.

Local welfare rights or advice services for people identified as having financial difficulties.

Housing providers and services that support housing sustainability.

Employment services which support individuals and carers who are struggling to remain in employment or need help to access employment opportunities due to health problem;

Community volunteering initiatives.

Social Inclusion services which aim to connect local people create opportunities for engaging and help reduce loneliness and isolations, e.g. peer support groups and faith communities/organisations.

5.4 Community Recovery Support:

The key aims of this element of the service is to increase the possibility of individuals building '*a life beyond illness*' through increasing:

Hope
Control
Opportunity

This could be achieved by supporting an individual to rebuild their life through:

finding meaning in what has happened
finding a new sense of self and purpose
discovering and using their own resources and resourcefulness
growing beyond what has happened – taking back control
rebuilding a satisfying, hopeful and contributing life

The outcome tool (to be used by all Hubs) would be used to identify key areas the individual needs support to improve recovery.

The Provider would work with local statutory, voluntary and community services to put in place support to promote improvements identified in the outcome tool.

Support may be delivered on an individual basis or in small groups/ peer support settings where people share potentially similar goals.

The Provider would need to be flexible and responsive to individual needs, including operating at weekends and evenings if required.

Agreed outcomes would be reviewed with individuals on a 6 weekly basis to monitor progress and identify any additional needs.

The need for ongoing support from the Provider should be reviewed at least every 6 months. The need for ongoing support must be clearly recorded.

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It is recognised individuals have fluctuating needs and following discharge some individuals may need at a future point to re-access the Community Recovery Support service. At each referral point the outcome tool should be completed and monitored.

5.5 Peer Support and mentorship

Peer support can play an important part in supporting and sustaining recovery in individuals. The provider would therefore take proactive role in :

> Supporting the development and sustainment of local peer support networks, working alongside other local statutory, voluntary and community services.
>
> Supporting individuals to become peer mentors, either on a voluntary or paid capacity.

6. ABILITY TO RESPOND TO DIVERSE NEEDS

The Provider would be expected to be aware of the diversity of local communities and responsive to the profile of need as outlined in the relevant JSNA. Adjustments should be made which would support increased access and minimise barriers.

In line with the Equality Act 2010, provision should be delivered with Due Regard to the nine protected characteristics and other disadvantaged groups who often face barriers to accessing services e.g. carers, people experiencing economic and social deprivation, vulnerable migrants, homeless, people who misuse drugs and alcohol, people from LGBT communities, socially isolated people etc.

The Provider would be required to meet the Accessible Information Standard which aims to ensure that people who have a disability or sensory loss receive information that they can access and understand, for example in large print, braille or via email, and professional communication support if they need it, for example from a British Sign Language interpreter. (e.g. BSL or if first language is not English).

Working age men aged between 18- 49 are recognised as most vulnerable to suicide risk and the service would be expected to target resilience initiatives at this group to support suicide prevention.

The Provider would be expected collect demographic information on individuals supported by the advice/ navigation and community recovery supports elements of the service.

7. ACCEPTANCE AND EXCLUSION CRITERIA AND THRESHOLDS

The Information, Advice and navigation elements of provision are open access to the general public, or people can be referred by health and social care professionals or community and faith organisations. People may request face to face appointments where they feel they would benefit from more in-depth support.

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Referrals for the Community Recovery Support would come from health or social professionals or by self-referral. The Provider is expected to use their professional judgement to determine which individuals are deemed suitable for Community Recovery Support. The Provider would request permission from the service user to obtain supporting information from the General Practitioner or a Health and Social Care Practitioner about their diagnosed mental health problem, and to gather information about any risks in order to refer into the service. The service may refuse provision of support if this permission is denied.

These services are free to eligible individuals and people would not be expected to contribute towards support from any Personal Budgets they may be receiving.

8. POPULATION COVERED

The service would be provided to people aged 18 years and over who live in the designated locality. The service would be expected to proactively support the needs of all communities within the locality.

9. INTERDEPENDENCE WITH OTHER SERVICES/ PROVIDERS

The Provider must develop/maintain links with, and work in partnership with, a wide variety of agencies and organisations. For example:

GPs and other healthcare professionals.
Other mental health services within the locality (including primary care psychological therapy services, bereavement support, other third sector mental health services).
Secondary care mental health services (i.e. LPT).
Child and Adolescent Mental Health Services (CAMHS) and Locality City Pathway for Children and Young People with Behavioural, Emotional and Mental Health Needs.
Adult Social care assessment teams and social care providers
District and Borough Councils
Advice services including Citizens Advice Bureau, law centres and welfare rights services.
Local drug and alcohol services.
Interpreting support services
Local colleges and education/ training agencies.
Employment services and the full range of mainstream employment and benefits services including Job Centres, Benefits Agency.
Housing agencies including residential care providers, supported housing providers,
Floating support providers.
Services which support homeless, vulnerable or isolated people
Advice services including Citizens Advice Bureau and law centres.
Faith and spiritual organisations.

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Local community groups.
Lifestyle Services e.g. Healthy Exercise, Healthy Eating, Smoking Cessation etc.
Volunteering networks.
Community development networks.
Domestic and sexual violence services
Services for Older people
Advocacy services
Asylum seekers and refugees support services
Services promoting equality (e.g. The Race Equality Council, LGBT centre)

This above list is illustrative, rather than exhaustive, and demonstrates the wide level of networking and awareness-raising required by the service.

10. QUALITY REQUIREMENTS

Quality assurance is a key aspect of the providers' performance and would be measured against outcomes centred on an individual's needs assessment and the outcomes identified.

As part of these processes, the Provider would:

Work with individuals, family, carers, commissioners and advocates to develop, implement and evaluate improved outcomes (and indicators) for individuals;

Acknowledge that commissioners may make arrangements to independently monitor the quality of the service, through direct contact with individuals;

Supply Commissioners with any information reasonably required for monitoring the performance of the service, preparation of local authority or CCG reports, government statistics or information required to respond to enquiries/ complaints.

The Provider would demonstrate internal quality monitoring mechanisms that assist in the ongoing delivery of value for money and continuous improvement.

In addition evidence would be required to demonstrate that:

Support is available right across the locality, including in isolated areas.
Hard to reach groups are able to access the service.
The service has promoted mental health awareness across the locality.
Waiting lists have been managed effectively.
Stakeholder feedback is actively sought and acted upon.

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11. SERVICE DEVELOPMENT AND INNOVATION

The contract with the Provider would be for 2017-2020 with up to 2 year extension possible. A review of the service would take place in 2018.

The locality provider would work closely with commissioners towards:

Continuous improvement and ongoing service development.
Developing innovative and new collaborative ways of working and developing new partnerships.

To support both these areas the provider would be required to attend LLR wide quarterly commissioner/ provider meetings.

12. EXPECTED ACTIVITY LEVELS/OUTCOMES MEASURES

Service Area	*Indicative activity*	*Specific outcome measure*
Information and service promotion	Individual contacts	
	Mental Health awareness development activity undertaken	
Advice and navigation	Numbers supported with housing issues	
	Numbers supported to consider volunteering, education and employment opportunities	
	Numbers supported to take up increased physical health activities.	
	Numbers directed to IAPT and other counselling services	
	Numbers directed to STOP smoking and other healthy lifestyle services	
	Numbers directed to services providing support with financial management	
	Numbers directed to housing support services	
	Numbers directed to crisis support or "secondary care" mental health services	
	Demographic information on supported individuals	
Community Recovery Service	All people referred have a baseline wellness assessment to identify recovery needs	Average outcome tool score at assessment for clients currently in the service or who have left within the last quarter Percentage of clients who have
	Number of 6 week reviews completed	

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	Number of 6 month reviews completed	made positive progress Average amount of change on the outcomes tool for all those making progress
	Number of people accessing the service in each monitoring period	
	Number of people receiving support ongoing more than 6 months	
	90% of client files with up to date outcome indicators completed jointly by the worker and the service user	
	Demographic information on supported individuals	
	Number of Peer Support Networks being supported	
	Number of new Peer Networks developed	

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