GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Mental Health and Wellbeing Strategy

23 February 2016

Contents

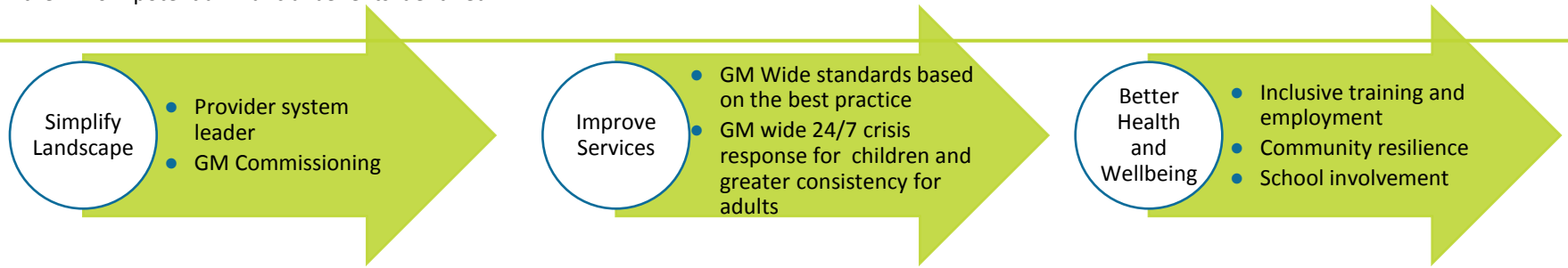
Compelling Vision

GM Mental Health and Wellbeing Strategy

Improving child and adult mental health, narrowing their gap in life expectancy, and ensuring parity of esteem with physical health is fundamental to unlocking the power and potential of GM communities. Shifting the focus of care to prevention, early intervention and resilience and delivering a sustainable mental health system in GM requires simplified and strengthened leadership and accountability across the whole system. Enabling resilient communities, engaging inclusive employers and working in partnership with the third sector will transform the mental health and well being of GM residents.

GM Vision: Aims

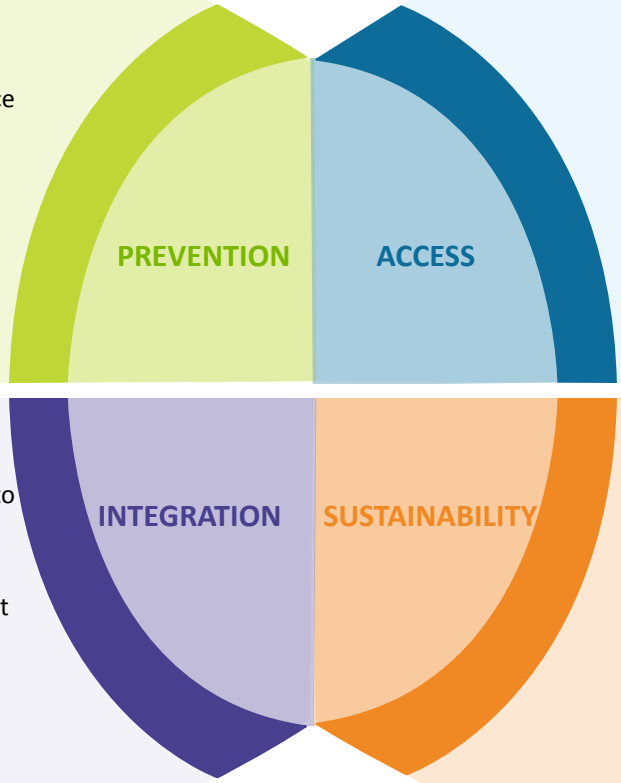
- We propose a whole system approach, that includes involvement from the independent and third sector, to improve the mental health and wellbeing of individuals and their families, supported by resilient communities, inclusive employers and services that maximise independence and choice.
- The GM strategy aims to build on existing best practice to lift patients' experience of care and support through the development & application of national and GM standards relating to access and care delivery.
- We will simplify the provider system and bring together commissioning across GM focused on the delivery of agreed GM level outcomes and standards to deliver, deeper integration, needs based pathway models, pooled budgets and more community-based recovery-focussed models of support.
- Children and Young People's mental health forms an integral part of our overall strategy. We will use the opportunities through devolution to collectively respond to the challenges outlined within Futures in Mind and in doing so transform the provision of services for the young people in GM
- We will support and develop our GM workforce to work in new ways to deliver our vision recognising their importance to delivering a sustainable whole system approach to mental health
- Greater integration across mental and physical health and social care services within each of the ten GM localities as well as across the wider GM conurbation. These will be patient, carer and family focused, accessed in a consistent, simple way. We will invest in community and crisis support to reduce the requirement for acute and long term care.
- Develop Prime Provider models to improve pathway design, capacity and efficiency for specialist services
- We will promote employment for people with mental health problems and provide timely and effective support to help people stay in employment through building on the current GM Mental Health and Employment Programme of activity.
- We will support those most vulnerable in society to help reduce the risk of developing poor mental health, and those with existing mental health conditions from deteriorating further. In doing this we will build on GMs existing approach to supporting people with complex needs with a particular focus on looked after children, child sexual exploitation, those with learning difficulties and disabilities.
- Ensure our focus on mental health is integrated with Local Care Organisations
- Through the implementation of the GM strategy, address the wider financial impact of poor mental health on the wider public sector system and deliver against the £146m potential financial benefits identified



Stakeholder engagement and feedback

Themes from stakeholder engagement

In developing the strategy we have undertaken a number of conversations and engagement sessions across GM. The key themes arising from these discussions are summarised below, set against each of the 4 strategic principles for improved mental health and wellbeing in GM.



- Increase low level intervention spend.
- Focus should be on prevention in order to reduce service demand in higher tiers.
- Target children through use of schools and communities.
- Appropriate mental health training for front line staff.
- Long wait for IAPTs therapies.

- Mental health support should be embedded in physical healthcare.
- Improve access for cohorts of population who currently find it difficult to access.
- Reduce waits and increase consistency of access for IAPT therapies.

- Eliminate inconsistency of service outcomes across GM.
- Improved integration and transition of children to adult services.
- Single point to access care and support.
- Commissioners (health and local authority) to act as one to give clarity of purpose for providers.
- Providers to be encouraged to build collaborative approach.
- Develop consistent minimum standards that allow for local delivery choices.

- Eliminate the vast majority of out of area placements.
- Group GM resources to commission more efficiently and effectively.
- Untangle the current governance to streamline decision making and actions.
- Agree common delivery outcomes across GM (the what).
- Allow local delivery methodology (the how).

Stakeholder engagement

What does great look like?

Through discussions, our stakeholders have articulated what great services would look like. Their suggestions on how we could do things differently are highlighted below under each of the four strategic principles

Prevention

- Mental health on education curriculum.
- Intervene earlier in children's and young people services as method of prevention.
- Support for families and carers.
- Support people with mental health problems to improve their general health for example to quit smoking
- Reduced crisis/demand management.
- Shift to self help.
- Public behaviour change.
- Training to employers and communities about mental health.
- Community support features in care plans.
- Service users offer back to the community.
- No stigma – rebadge mental health.
- Peer support.
- Commissioning research to find out what works.
- Mental health media campaign to demonstrate prevention.

Access

- Single point of entry.
- Service users access the appropriate level, setting, and location of services.
- Service users access services earlier.
- Directory of voluntary sector providers.
- First response at single point of access is consistent.
- Service users understand where to get the help they need.
- Access equitable to minority groups.
- Reduction in interfaces, more self-referral.
- Information is consistent and available in one location.
- High quality short-term interventions of high intensity when ill.
- Improve opportunities for self-care.
- Not just about Tier 3/4 services – need lower level Tier 2 services for children and young people.

Integration

- Every GP has mental health champion across the system.
- Multi-agency hubs, "mental health is my job".
- Stronger links to employment and skills and supporting people with complex needs
- Local commissioner that boroughs feed into – note some participants did not agree on this point.
- Integrated children and young people services across public sector boundaries e.g. CAMHS in schools.
- Care co-ordination.
- Services are co-designed and co-evaluated between commissioners, providers and the public.
- Less separation of mental and physical wellbeing.
- Fewer pathways, fragmentation and organisations. More joined up governance and leadership.
- Integration with 3rd sector.
- Whole person care.
- Role of family and circumstances acknowledged.
- Asset based community model.
- Shared information and communication.
- Joined up working to avoid duplication of assessment.
- Recruitment, promotion and performance framework based on shared principles.
- Economies of scale/one stop shop co-located services in community hubs so we are all working together.
- Mental health feels "less separate" from the rest of the "caring infrastructure".

Sustainability

- Workforce is trained in a range of disciplines, knowledge of the relevant services for referral. Core skills defined and consistent across GM.
- Holistic approach -supporting people to self-manage, maintain work, looking at mental health in the context of areas such as justice, troubled families.
- Embracing technology.
- Community resilience – "community manages itself".
- Adequate funding for mental health.
- Sustainable recovery – follow up.
- Funding to release people to conduct peer challenge.
- Information sharing and data.
- Reduction in prescribing drugs.
- Mental health support for staff.

Compelling Vision

Strategic Plan on a Page

CHARACTERISTICS TO UNDERPIN VISION	
PREVENTION	Place based and person centred life course approach improving outcomes, population health and health inequalities through initiatives such as health and work.
ACCESS	Responsive and clear access arrangements connecting people to the support they need at the right time
INTEGRATION	Parity of mental health and physical illness through collaborative and mature cross-sector working across public sector bodies & voluntary organisations
SUSTAINABILITY	Ensure the best spend of the GM funding through improving financial and clinical sustainability by changing contracts, incentives, integrating and improving IT & investing in new workforce roles

MENTAL HEALTH AND WELLBEING STRATEGY

STRATEGIC GOLDEN THREADS

- Parity of Esteem
- Research Deployed to Inform Best Practice
- Technology providing new innovative forms of support
- Leverage Successful Programmes e.g. Troubled Families
- Prepare the Workforce for Integrated Joined Up System

PREVENTION	ACCESS	INTEGRATION	SUSTAINABILITY
Early Years: Children & Family	Single Point of Access and Care Co-ordination	Integrated place based commissioning & contracting aligned to place based reform	System leadership
Improve Mental Wellbeing	IAPT Services of Consistent High Quality for GM	Vertical & horizontal integration across community, primary & acute care	Working practices
Building Capacity for Self care	Improving Support for Carers and Parents at Risk	Whole person integrated vertical care pathway across a horizontal integration of care	Programme prioritsation
Suicide Prevention	Introduce 24/7 Mental Health and 7 Day Community Provision for CYP	A strong partnership with the community and voluntary sector	Pooling of mental health budgets
Early intervention	Ensure consistent 24/7 Mental Health and 7 Day Community Provision for adults including crisis concordat	Asset-based approach and devolution estate managed centrally	Provider Landscape Redesign
Targeted public health campaigns	Consistent Standards and Protocols for Step Up and Step Down	Integrated monitoring, standards and KPIs	Payment and incentives
Supporting vulnerable people	Self-sufficiency in GM Provision (out of area placements)	Integrated data sharing	Regulation reform
Workplace and employment support	Eating Disorders for Children and Young People		New investment streams
	Consistent ADHD services for all age groups		

Priorities Identified for Years 1 and 2

The Strategic Initiatives

CASE FOR CHANGE **PRIORITY POPULATION GROUPS** **STRATEGIC INITIATIVES**

Current Position

- By 2020/21 the GM health and social care system faces an estimated financial deficit of £2bn demonstrating the need for radical transformation.
- Costs to the wider health care system of our current approaches are significant:
  - Poor mental health makes physical illness worse and raises total health care costs by at least 45% for each person with a long-term condition.
  - This suggests between 12% and 18% 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 (GM, between £420m and £1.08bn).
  - Transforming mental health (along with physical health) services has the ability to contribute significantly to the £2bn projected financial deficit for Health and Social Care in GM by 2021
- There are 3,981 people in GM in contact with mental health services for every 100,000 of the population compared to 2,176 nationally.
- At the current estimated rate of prevalence, there will be 34,973 people living with dementia in Greater Manchester by 2021
- £615m is spent on mental health services across Greater Manchester, with a wide variance across localities. This is made up of:
  - LA spend (£97.05m).
  - CCG Learning Disability spend (£38.3m).
  - CCG MH Specialist Commissioning (£76.5m) (which includes specialist units.
  - CCG MH Spend (£403.4m) - Approximately £30.1m of this is spent on out-of-area inpatient treatment (7.27% total CCG spend) including acute admissions due to capacity shortfalls and longer terms placements with complex needs
- The wider economic cost to GM of mental health is approximately £3.5bn (see page 21 for breakdown)
- In addition to the above, further costs are incurred within the GM economy as a consequence of poor mental health. These include the wider costs of mental health associated with unemployment, children with conduct disorder, alcohol and substance misuse and suicides. The impact of these costs on the GM economy are presented in the economic case on pages 23 onwards.

System Challenges

- The provider landscape is complex with 5 Adult and Children's Mental Health NHS Providers, many independent and voluntary sector providers and a range of specialist mental health services provided outside of GM.
- The commissioning landscape is fragmented. 10 LA's, 12 CCG's and an estimated 82 Mental Health and Wellbeing Programmes, dedicated expertise and capacity is scarce and it is therefore difficult to achieve focus, shared solutions and shared priorities.
- There is variability in service provision and outcomes across GM and a lack of consistent and accurate data on activity and outcomes. KPIs are outdated, which makes it difficult to accurately evaluate performance across GM. Social care and Housing are underrepresented in service provision leading to higher health activity and costs. Reforming social care to improve information, prevention, personal budgets, choice and control will yield benefits across the whole service.
- A lack of mental health expertise in GP surgeries and wider primary care and A&E departments is consistently reported and delays getting access to the right care.
- Improving the mental health of GM residents, and providing reliable access to early help redressing the balance towards early intervention and prevention will improve family circumstances, help people find and keep good work, improve school attainment and strengthen communities.
- Lack of integration with wider pubic services
- There is a lack of out of hours, 24/7 crisis care services for children and young people, and inconsistent delivery for adults.
- Services for children and young people and their families and carers, are inconsistent, misaligned and disrupted by transition points. Young teenage people are often caught in between services and often don't meet thresholds
- Mental health problems in children and young people are associated with educational failure, family disruption, disability, offending and antisocial behaviour, demands on social services and the youth justice system. If left untreated this can create distress not only in the children and young people, but for their families and carers, continuing into adult life and affecting the next generation.
- Mental Health problems are often part of a wider set of complex issues for individuals and families. For example:
  - Mental health problems consistently arise with the families we are supporting trough our Troubled Families Programme,
  - 68% of the clients on our Working Well Programme (aimed at supporting long term unemployed into sustainable employment) highlight mental health as an issue
  - 18% of secondary care patients in Manchester are not in stable accommodation, mental health problems can be a cause and effect of housing issues
- Mental Health and wellbeing affects some of our serving personnel, regular and reservists, ex serving personnel and their families. Improvements in Identification, data collection and assessment of need are required to support effective outcomes based commissioning at a local level

Learning from local best practice examples and academic research

There are many examples of best practice across GM which could feasibly be scaled up.

The implementation plan will set out how this can be achieved and identify mechanisms through which we can scale up local exemplars.

At the GM level the SelfHelp sanctuary crisis model is being rolled out. This will divert people from A&E, reduce the number of section 136s and provide a suicide prevention service

Greater Manchester wide 6 month "Overcoming barriers" Pilot Scheme, commissioned by the NHS to understand the barriers to ex serving personnel accessing services action learning sets have been delivered in Oldham ,Trafford and Wigan.

Perfect Weeks - Wigan
This is an initiative to 'suspend the rules' for a week to test parts of the system. This has had success in Wigan where Adult Mental Health workers were linked in to schools and referred a mother for services, subsequently establishing a good outcome for both mother and child.

School Model in Chiltern High Manchester – 42nd Street

Resilience workshops and assemblies, mental health workers with case load and drop in, dedicated help line for staff and services offered over the school holidays.

GM West RAID – Bolton and Trafford
Successfully implemented RAID – Rapid Access Interface Discharge for its Bolton and Trafford facility, reducing bed days by supporting more timely discharge and hence drive efficiencies.

Key Workers - Trafford
Key workers have been used in the Stronger Families Phase 1 in Trafford to improve integration, coordination, prioritisation of support for people with mental health problems, focused on evidence based interventions and greater levels of flexibility going beyond the status quo.

Centre for Mental Health and Safety
Develop the links between research base to practice across GM.

Crisis Concordat - Oldham
GMP in Oldham and Pennine Care NHS FT jointly developed Oldham Phone Triage/RAID Pilot Project to provide a service available to local police officers who attend incidents where an individual appears to be experiencing mental health problems; police able to contact dedicated 24 hour telephone number for assistance from the Trust's psychiatric liaison service RAID (Rapid Assessment Interface and Discharge). This has now been rolled out across GM

Tameside, Oldham and Glossop MIND
Approached by the local authority to build a wellbeing centre. Transformation of the building took 12 months and c.£250k. The result is used by the community and well regarded nationally as a modern wellbeing centre.

5 Ways to Well-being in Stockport
Aimed at improving mental health and well-being across the population and enabling people to reach their full potential

Learning from social models across the UK and beyond

There are many examples of services that enable people to manage their own care, to work together with peers, and to be supported at home with complex needs. Learning from these have fed into the development of the GM Strategy and initiatives.

Acute hospital A&E liaison (Birmingham)
Comprehensive RAID support available 24/7 to all people aged 16 in hospital

Clubhouse International (worldwide)
Where service users come together to work join in activities, cook and participate in their community

Mind and Body (Sheffield)
85% of participants sustained a change in life style and better health

Mental Health First Aid (Australia)
Training citizens and volunteers to recognise, respond to and support people in mental distress

THISWAYUP (Aus, NZ, USA and Canada)
Computer aided recovery course with 50% complete recovery

Whole System Redesign (Northumberland, Tyne and Weir)
Large scale acute care pathway redesign integrated triage and telehelath and rapid access to housing services, social care, third sector and specialist services

Big White Wall (UK)
Internet based anonymous community where 95% report improved health – better than many IAPT programmes

Street Triage
26 street triage schemes across England showing a reduction in use of police custody as a place of safety

Single Point Access Service (NHS 111 and MIND)
Developing training courses designed by people with lived experiences to support call handlers in times of crisis

Crisis Home Treatment (Leeds)
Survivor led crisis services ,commissioned for 24/7 response and care

Priority Initiatives for Early Implementation

Where are we now and where do we want to be?

Current state	Future state
1 Complex and fragmented commissioning for GM's 2.9 million residents across 10 LAs, 12 CCGs and 82 Mental Health and wellbeing programmes.	1 Place-based cohesive and collaborative commissioning care pathways, pan-Greater Manchester for specialised services, to deliver stronger outcomes, deeper integration, needs-based pathway models, pooled budgets and more community based models of support linked to wider GM reform activity.
2 Medical-focussed model of care, which does not always pick up on the holistic and complex needs of the individual and their environment.	2 Mental health is 'everyone's business', enabling local areas to make decisions for system wide outcomes supported by shared information. This includes mental health and social care, but more broadly the opportunities to consider the best approach across public services and the 3rd sector with a focus on community, early intervention and resilience building on 5 Ways to Well Being
3 Discrepancies in outcomes and quality standards across 4 Adult MH NHS providers, 4 CAMHS providers, specialist provision and numerous voluntary sector providers results in care that can be inconsistent, misaligned and disrupted by transition points.	3 Standardised outcomes framework with minimum standards, outcomes and access across all providers of health and social care and shared approaches to strengthening communities and voluntary sector effectiveness.
4 Mental health and well being not prioritised in the workplace and workforce development.	4 All employers promote good employment practice for MH, building capacity for conversations to support suicide prevention. Employees will be supported to feel happy at work and helped to achieve life satisfaction. Build on GMs existing Working Well programme to deliver better outcomes.

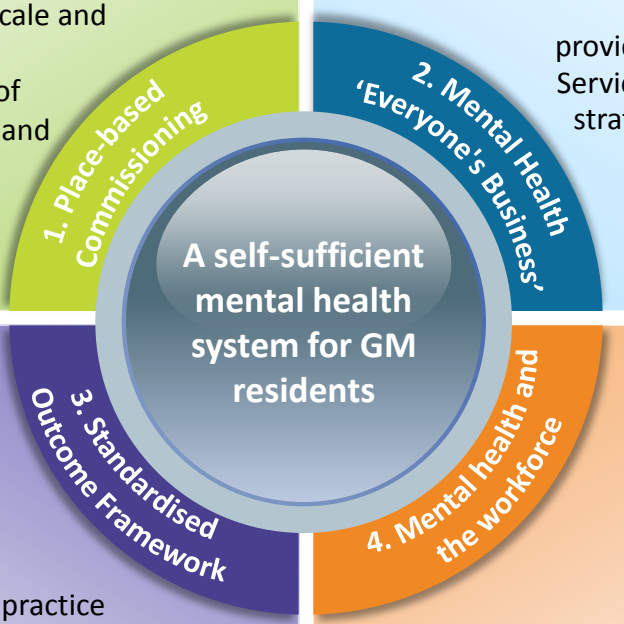
Priority Initiatives for Early Implementation

How do we get to the future state?

Place-based commissioning and place-based delivery, pan-Greater Manchester for specialised services. Simplify, consolidate and streamline the current commissioning landscape to create a robust and accountable commissioning function which removes duplication, creates economies of scale and provides consistency.

Determine a clear vision and understanding of what services should be provided at the GM and locality levels.

Consolidate commissioning expertise and develop new payment and incentive mechanisms.



Through our GM Reform Programme we will take a preventative and early intervention approach supporting people with a range of complex needs, working collaboratively across local services to deliver the right support at the right time to help people address the factors which prevent them from realising their potential. Mental Health provides a unique connection across all our Public Service Reform objectives and is driving the wider strategic partnerships required beyond core NHS and social care to wider local government services, GMP, GMFRS, NWAS and others to ensure **mental health is everyone's business as part of wider Public Service Reform**.

Develop minimum standards, with a set of KPIs, which also cut across non-care settings, for all providers of health and social care which can be expanded as necessary at the local level to reduce variations between different communities.

Minimum standards will be built around best practice interventions incorporating a focus on prevention and reducing future demand, taking into account a need for local variations dependent on different demographics. GM is committed to ensuring the new national waiting time standards are achieved and where possible exceeded.

We will sign up organisations across GM to a **Best Workplace Charter** in relation to managing stress, mental health issues, and drive wellbeing in the workplace. We will also ensure there is consistent support available across GM for those currently unemployed and seeking employment building on the GM Working Well programme.

Wider Strategic Considerations – GM H&SC Devolution

GM has an ambition to become a self sustaining city region supporting growth and connecting GM residents to the benefits growth brings.

In Nov 2014 GM settled a historic devolution agreement which give local representatives control over decisions previously taken at a national level.

Taking Charge of our Health and Social Care

On 25 February 2015 Greater Manchester entered into a ground-breaking agreement with government for the devolution of health and social care . The Memorandum of Understanding formally gave GM control of £6billion of pubic sector funding from 1 April 2016. "Taking Charge of our Health and Social Care" describes how clinical and financial sustainability will be achieved in GM, aligned to the Five Year Forward View.

GM is committed to achieving parity of esteem for people with mental health issues, tackling access and waiting time standards and breaking down barriers to how care is provided.

Reimagining services across our whole care system

The GM Strategic Plan, "Taking Charge of our Health and Social Care", identified five key areas for transformation change:

- **Radical upgrade in population health prevention** – a shift on focus to population health that supports GM residents to self-manage, innovates the model for prescribers and pharmacies and tackles the future burden on cardiovascular disease and diabetes
- **Transforming community based care and support** – a new model of care closer to home that includes scalable evidence based models for integrated primary, acute, community, mental health and social care.
- **Standardised acute and specialist care** – the creation of single shared services for acute hospital and specialist services to deliver improvements in patient outcomes and productivity through establishment of consistent best practice and reduced variation
- **Standardised clinical support and back office support** – The transformational delivery of clinical support and back office services at scale, including the establishment of coordination centres to help navigate GM residents through our complex system
- **Enabling better care** – Creating innovative organisation forms, new ways of commissioning, contracting and payment design, standardised information management and technology to incentivise new ways of working

Wider Strategic Considerations - National

Five Year Forward View (2014)

The Five Year Forward view set out a clear ambition for the future of mental health services in England:

- To create genuine parity of esteem between physical and mental health.
- Improved waiting times so that 95% of people referred for psychological therapies start treatment in 6 weeks or a fortnight for those experiencing their first episode.
- Provision close to home for those with intensive needs, particularly for young people
- New commissioning approaches to transform service delivery

Five Year Forward View for Mental Health Taskforce (2016)

The taskforce's report sets out a number of priorities for change over the next five years, including:

- **Supporting people experiencing a mental health crisis** – by 2020/21 expand crisis resolution and home treatment teams to ensure 24/7 community-based mental health crisis response is available
- **Improving responses to mental and physical health needs –** by 2020/21 more people living with severe mental illness have their physical needs met
- **Transforming perinatal care for children and young people –** fundamental change in the way children and young people's services are commissioned and delivered, more children and young people having access to high-quality mental health care when they need it and more women accessing evidence-based specialist mental health care during the perinatal period
- **Access standards and care pathways –** by 2020/21 clear and comprehensive set of care pathways with accompanying quality standards and guidance for the full range of mental health conditions
- **Models of payment –** developing payment models that incentivise swift access, high-quality care and good outcomes
- **Acute and secure care** – partnership led co-produced standards to ensure acute mental health care is provided in the least restrictive manner and as close to home as possible
- **Tackling inequalities in access and outcomes –** addressing inequalities in access to early intervention and crisis care and rates of detentions
- **Supporting employment –** recognising employment as a crucial health outcome and supporting people with mental health problems to find and stay in work.
- **Transparency in data –** to support improvements in commissioning, inform effective decision-making and promoting choice, efficiency, access and quality
- **Workforce** – good management of mental health in the workplace and the provision of occupational mental health expertise and effective workplace interventions

Wider Strategic Considerations - National (cont.)

National Suicide Prevention Strategy

GM is committed to preventing mental ill health, reducing suicides and promoting mental well-being. Suicide prevention is a key strategic initiatives of our overall strategy. In taking this forward we will build on the national strategy "Preventing Suicide in England". This strategy highlights key risk groups: young and middle aged men; people in the care of mental health services including inpatients; people with a history of self-harm; people in contact with the criminal justice system and those form specific occupational groups.

In response to the national evidence GM will work towards the development of a suicide prevention strategy aimed at becoming a 'suicide safer city region'

No Health Without Mental Health

The national strategy focuses on delivering improved mental health outcomes for people of all ages and identifies participation in meaningful activity, secure accommodation and schools relationships as supporting recovery from mental ill-health and promoting mental well being. The strategy highlights five key outcomes:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Wider Strategic Considerations – Greater Manchester

Greater Manchester Principles of Reform

Our GM Mental Health Strategy will work to address identified difficulties and create stronger links between mental health services and locality based integrated working. Ensuring flexibility in mainstream services and developing evidence based packages of support aligned to our GM principles of reform:

- A new relationship between public services and citizens, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services. Do with, not to.
- An asset based approach that recognises and builds on the strengths of individuals, families and our communities rather than focussing on the deficits.
- Behaviour change in our communities that builds independence and supports residents to be in control
- Integrated services that place individuals, families, communities at the heart
- A stronger prioritisation of well being, prevention and early intervention
- An evidence based understanding of risk and impact to ensure the right intervention at the right time.

Greater Manchester Public Service Reform Programme

The existing GM Public Service Reform programme, focused on supporting people with complex needs, will enable people and families to develop resilience and promote independence. Transforming community based care and supporting integrated place based working provides the opportunity to integrate mental health into wider reform activity focused on the delivery of key outcomes including:

- Supporting 50,000 people facing complex challenges move towards employment
- Engaging and supporting over 27,000 families through the expanded Troubled Families programme
- Reductions in reoffending through the implementation of Intensive Community Orders
- Reductions in reoffending as a result of transforming the work of Women's Centres
- Implementation of our GM Early Years new delivery model
- Reductions in duplication through better integrated local service provision

Wider Strategic Considerations – Greater Manchester (cont.)

Greater Manchester Programme for Dementia Care – Dementia United

2013 data indicated that the number of people with dementia in Greater Manchester was 29,560, affecting 7.1% over 65s. This is expected to rise rapidly over the next 12 years. Greater Manchester currently spends £221m per year on dementia across health and social care. If we diagnosed everyone in GM who we think currently has the disease this would raise to £320m per year.

As part of our wider work on mental health Greater Manchester has been developing a programme of activity with an agreed vision to:

Make Greater Manchester the best place in the world to live with Dementia

Greater Manchester has made 5 pledges that will support the delivery of this vision:

1	To improve the lived experience of people with dementia and their carers	**Goal: Develop a measure for Greater Manchester of the lived experience which can be tracked over the 5 year period and used to inform the effectiveness of changes.**
2	To reduce variation	**Goal: Develop a single evidence-based commissioning framework for Dementia services across Greater Manchester and monitor performance using agreed measures.**
3	To co-produce and re-design	**Goal: Provider services to re-design health and care systems with patients and their carers to ensure services meet their needs.**
4	To introduce a key worker for people with dementia	**Goal: Every person living with Dementia will have access to a key worker 24 hours per day, 7 days per week who will support them to live well with Dementia.**
5	Technology adoption	**Goal: Every person living with Dementia will have access to technology that will help them to monitor their health, enrich their social lives and navigate local services in a way that is helpful to them.**

Priority Initiatives for Early Implementation

What we will have in place by January 2017

By January 2017

How will the system look different

- GM will be working towards the standards set out in the Crisis Concordat.
- There will be a reduction in need for Section 136 powers which when needed will be used consistently across all 10 LAs in GM through a better understanding of 'places of safety' and introduction of street triage support.
- We will have agreed an approach for Place based commissioning and provision at locality level with increased collaboration between providers for specialist services. Integrated commissioning approach based on outcomes aligned with GM commissioning standards framework. Social Care and Housing will be fully engaged in commissioning and delivery.
- We will develop links with the Centre for Mental Health and Safety to inform systematic reduction in suicide across GM.
- We will have established formal provider collaboration to achieve self-sufficiency in GM.
- Enhanced GM wide suicide prevention strategy
- The PHE Workplace Charter will be signed by all public sector agencies in GM.
- Increased integration of RAID into acute services and A&E facilities across GM.
- Create fit for purpose governance arrangements responsible for delivering the GM wide all-age mental health strategy.
- GM Children and Young People outcomes and standards developed and agreed.
- We will have identified leaders and champions to deliver this strategy and they will have produced delivery plans for each of the initiatives.
- Developed a GM wide approach to commissioning services for armed forces families aligned to the GM Commissioning Strategy and informed by a GM Joint Strategic Needs Assessment

How we will measure success:

1. Number of employers signed up to the PHE Workplace Charter.
2. Increased number of patients referred to Raid services.
3. Reduction in the requirement for S136 powers used and evidence of consistent application across GM.
4. Increased focus on prevention through wider implementation of Connect 5 and 5 Ways to well Being

Anticipated Financial Benefits

High level financial savings will be achieved through better commissioning, simplified provider landscape, earlier intervention through RAID and a focus on resilience in the workplace and community.

Priority Initiatives for Early Implementation

What we will have in place by January 2018

By January 2018

How will the system look different

- A single system, with clear leadership and partnership working across all public sector organisations.
- We will simplify the provider landscape across GM including the integration with social care and housing by rolling out integrated place-based commissioning using a prime-provider model, with routine outcome measures.
- Consistent GM wide implementation of 24/7 crisis care and community support for adults including full implementation of GM Crisis Care concordat.
- Development and implementation of 24/7 crisis care support for children and young people providing easy access to services that are responsive and provide appropriate help across all GM.
- Established and published the “citizens deal” with a set of all age standards or citizens rights for commissioners to use as a floor that no GM services can fall below.
- Strategic partnership arrangements with positive and mature engagement between the private, public, community, voluntary sector and social enterprises.
- Implementation and application of standards for Children and Young People’s services, focused on young people’s perspectives and expectations building on the national work, Young Minds, and work already taking place in GM.
- All acute provision (acute beds, PICU, active rehabilitation, LA alcohol and drugs services and residential care) will be within GM, and patients will only be sent out of area for inpatient or outpatient services in exceptional specialist circumstances.
- Wider implementation of the PHE Workplace Charter on mental health across private sector in GM delivered in collaboration with the LEP and local Universities and organisations commissioned by GM public sector organisations.

How we will measure success:

1. Improved quality across the Sector (patient satisfaction, reduced serious untoward incidents, and reduced never events, e.g. a reduced suicide rate).
2. Improved access and reduced waiting times.
3. Consistent standards across Greater Manchester

Anticipated Financial Benefits

High level financial savings will be achieved through removal of Out of Area placements and reduced spend in high-end acute settings and reduced unemployment because of mental health.

Economic Case

Markers of Activity/Demand, Opportunities to Address (1)

The table below summarises the key drivers of activity and demand this strategy aims to influence and successfully address

Outcomes	
Reduced inpatient admissions and bed days	• Strategic initiatives have been developed to better manage the drivers of activity and demand based around the 4 strategic pillars for transformation (prevention, access, integration, sustainability). There are also cross-cutting themes or "golden threads" running through all four pillars. Communication is needed to change behaviour and create social movement changes to ensure these strategic initiatives deliver the expected transformation. • The economic benefits of this strategy are generated by the areas for intervention outlined below: – A shift towards early intervention and prevention where those with mental health issues currently in the health system are supported to access evidence-based less cost-intensive models of care. This will result in reduced spend in acute in-patient settings. – A more general increase in the support for those with mental health conditions to move back into work. The benefits here are in a reduction in public sector spend more generally. – Early identification and intervention as soon as mental health problems emerge. – The promotion of mental wellbeing and prevention of mental health problems in childhood and adolescence. – The promotion of mental wellbeing and prevention of mental health problems in adults. – Addressing the social determinants and consequences of mental health problems. – Improving the quality and efficiency of current services. • An important long-term goal is to repatriate GM NHS and LA patients being treated long-term in out of area placements. This will be dependent on freeing up capacity in local in-patient settings, which is in turn dependent in enabling community or home-based models. Numerous initiatives for this are already underway in GM, including: – The out-of-hospital schemes introduced by Pennine care. – RAID (rapid assessment, interface and discharge), which installs psychiatric liaison teams in acute hospitals, reducing admissions and length of stay for patients with mental illnesses. – Intermediate care for patents with delirium, providing a further deflection in acute admissions. It is also logical to assume a further 10% reduction in acute in-patient mental health stays through a combination of these initiatives. • Further savings are likely to be achieved in the reduction of the number of mental health trusts and the number of commissioners involved in commissioning mental health.
Improved life chances for children with mental health conditions	
Reduced number of life years lost to mental health	
Reduced out of area placements	
Reduced running costs for integrated commissioning	

Economic Case

Markers of Activity/Demand, Opportunities to Address (2)

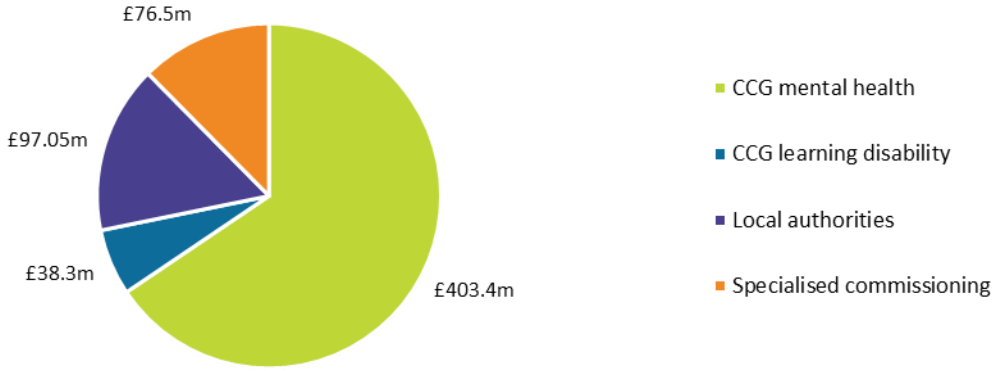
The table below summarises the key drivers of activity and demand this strategy aims to influence and successfully address

Outcomes	
Reduced cost and demand (particularly repeat demand) to GMP	Specific economic evidence to support this approach aligned to the strategic initiatives developed includes the Department of Health Report, 'No Health Without Mental Health' 2011, which identified the following costs of mental disorders across the life course: • **Mental illness during childhood and adolescence** results in UK costs of £11,030 to £59,130 annually per child. • **Conduct disorder:** Lifetime costs of a one year cohort of children with conduct disorder (6% of the child population) has been estimated at £5.2 billion. Cost of crime attributable to adults who had conduct problems in childhood is estimated at £60 billion a year in England and Wales, of which £22.5 billion a year is attributable to conduct disorder and £37.5 billion a year to sub-threshold conduct disorder. • **Depression:** Total annual costs of depression in England in 2007 were £7.5 billion, of which health service costs comprised £1.7 billion and lost earnings £5.8 billion. This does not include informal care or other public service costs. Lower productivity accounts for a further £1.7–£2.8 billion and human costs for another £9.9–£12.4 billion, bringing the total annual cost of depression to £20.2–23.8 billion a year. • **Anxiety:** Health service costs of anxiety disorders in 2007 were £1.2 bn. The addition of lost employment brings the total costs to £8.9 billion. • **Schizophrenia:** Total costs of schizophrenia were approximately £6.7 billion per year in England in 2004–05. Cost of treatment and care was £2 billion, annual costs of welfare benefits were £570 million and the cost to families of informal care and private expenditure amounted to £615 million. Costs of lost productivity due to unemployment, absence from work and premature mortality were £3.4 billion. The opportunity therefore to make efficiency savings is significant. • **Dementia:** Total annual UK costs of dementia are £17 billion. Accommodation accounted for 41% of the total, health services eight per cent, social care services 15% and estimated costs for informal care support and lost employment 36%. Numbers with dementia in England are predicted to rise from 680,000 in 2007 to 1.01 million people by 2051. Long-term care for older people with cognitive impairment in England could rise from £5.4 billion to £16.7 billion between 2002 and 2031. • **Suicide:** Average cost per suicide is £1.7 million in England, £1.3 million in Scotland and £1.5 million in Ireland. Better identification of risk in primary care and in drug and alcohol services. In 70% of suicides the person has seen a GP in the last month, so better access to primary care is critical. • **Alcohol misuse** is estimated to cost the health service £2.7 billion every year and results in output losses of £6.0-7.3 billion due to sickness absence, reduced employment and premature death while annual cost of alcohol related crime and disorder is £9-15 billion. Total cost of alcohol misuse is estimated at £17.7–£25.1 billion a year, which includes costs of treating alcohol-related disorders and disease, crime and anti-social behaviour, loss of productivity in the workplace and social support for people who misuse alcohol and their families. • **Smoking:** Annual direct cost of smoking to the NHS is £5.2 billion with smoking responsible for 462,900 hospital admissions in 2008/9.97 Almost half of total tobacco consumption is by those with mental disorder. • **Inequality:** At the national level substantial costs are generated by inequalities in mental health. Estimated to be £56 -68 billion nationally (No Health without Mental Health**)**
Increased productivity and employment across GM	
Increased life expectancy for mental health patients	
Reduced suicide rates	
Reduced alcohol-and substance misuse related MH A&E admissions	

Economic Case

GM Wide Direct Costs of Mental Health

Between CCGs, locals authorities and specialised commissioning, GM spends c.£615m across on Mental health services across health and social care.



- Greater Manchester spends significantly more on mental health than the majority of UK cities and £30.1m of that is inpatient treatment spent out-of-area (7.27% total CCG spend).
- Excluding specialised commissioning and non-identifiable data, GM spends £35m per year on children's mental health, £248m on adult mental health and £130m on older adult mental health.
- The Local Authority's social care expenditure on mental adult comprises of mental health support services and excludes learning disability spend (£216m on adults 18-64 and £34.5m on adults over 65). It also excludes physical, sensory or social support costs.
- Based on inflation anticipated figures (using FYFV assumptions), this projected health and social care spend on mental health services if we don't change is set to increase to £644m by 2021.

	2014/15	2020/21
	£m	£m
Local Authority Spend	97.05	110.8
CCG Learning Disability Spend	38.3	39.4
CCG MH Specialist Commissioning	76.5	78.8
CCG MH Spend	403.4	415.2
	615.3	**644.3**

- However, in addition to the above, costs are incurred within the GM economy as a consequence of poor mental health as illustrated on page 21.

Source: Local authority budgets, CCG programme budgeting returns and CCG reported data.
NB - The specialist commissioning figure does not include learning disabilities and is based on the Secure & Specialised Mental Health Database.

Economic Case

Cost of Mental Health services in GM

Across GM approximately £403m is directly spent on Mental Health services by CCGs.

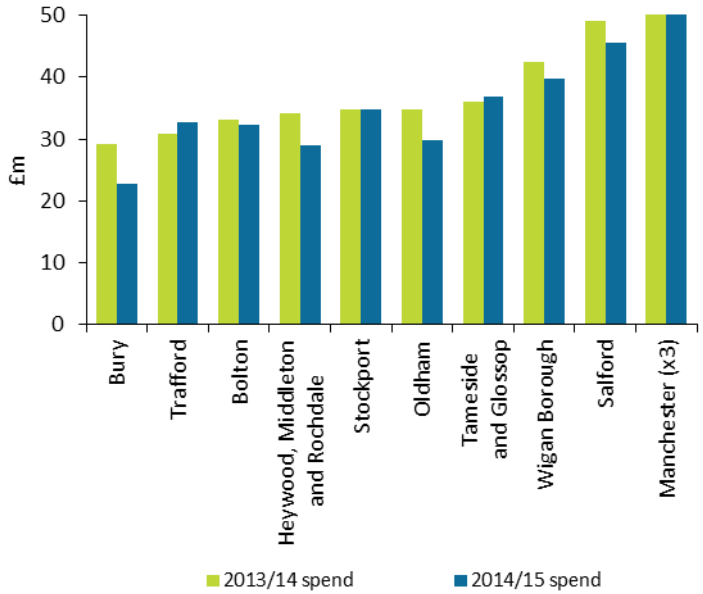
When adjusted for population variances Salford and Manchester CCGs spend the most.

Wigan, Oldham, Bury, Stockport and Bolton spend below the average in the North per CCG.

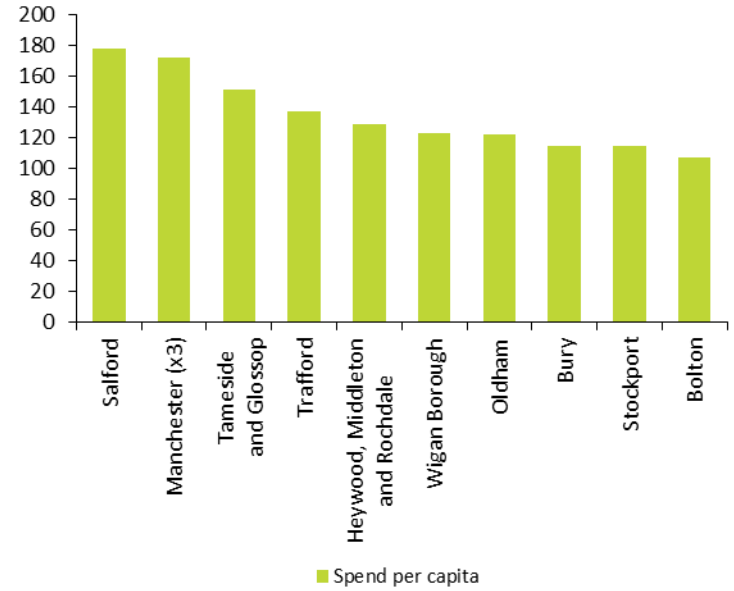
CCG commissioned spend

The 12 CCGs in GM spent approximately £403m on mental health services in 2014/15 compared to £441m in 2013/14.

Spend per CCG



Spend per capita



The CCG spend analysis above demonstrates the constrained budgets available for CCGs as only Trafford and Tameside and Glossop were able to spend more in 2014/15 than in the previous year.

When plotted against the registered population, Salford and the Manchester CCGs were found to be spending the most per capita at over £170 per head of population.

The average spend in the North was £124 and Wigan, Oldham, Bury Stockport and Bolton spent under this in 2014/15.

Learning from localities has fed into this GM wide strategy.

Source: 2013/14 and 2014/15 CCG programme budgeting returns.

Economic Case

Wider Cost of Mental Health across Greater Manchester

Cohort	Volume/Impact on GM economy	Cost (£)
GM Population Unemployed with Mental health conditions	• **144,000** Individuals on Employment Support Analysis/Incapacity benefit across GM. Up to **80%** of benefits claimants have a mental health condition.[1]	**£1.05 bn** Based on £9,091 fiscal cost per claimant per year.
Children with conduct disorder	• **5.8%** of children (~2200 in each GM year group cohort) estimated to have conduct disorders. [2]	**£330m public sector costs** Based on £150,000 over the lifetime of each child (including NHS, social services, education and criminal justice). [2]
Alcohol misuse	• **504,263** Alcohol-related hospital admissions and attendances across GM (2013) (1,155 deaths directly attributable to alcohol).	**£167m** [3] (hospital admissions, A & E attendances). **£1.2bn** in wider costs due to lost productivity, crime, health and social care costs
Substance misuse	• **2,994** Estimated OCU (Opiate or Crack) Users not in treatment in GM in 2014/15. [4] • **86%** of Troubled Families with mental health issues also have issues with substance misuse	**£78m cost of crime** (this is a conservative estimate and does not include other drugs such as Amphetamines, Cannabis, prescription drugs and legal highs) [4] Based on cost of crime for those not in treatment of £2924 per person.
Mental Health bed based-inpatients	• **44%** of total CCG MH spend on bed-based inpatients. [5] • On average, **10,495** occupied bed days for MH inpatients in GM per 100, 000 population (higher than the 7,199 national average).	**£176m** CCG spend on bed based-inpatients. [5] (£21m uncategorised by CCGs).
Suicides	• **277** suicides registered in Greater Manchester (2014). [6]	**£2.9m** in direct costs to the NHS and policing **£442.7m** wider costs due to lost waged and non-waged output, as well as intangible human costs . Based on total cost per suicide of £1.6m [6]
Homelessness	• **25-35%** of all those accessing homelessness services present with mental health as their main need.	**£2.8m** cost to Local Authorities Based on total GM spend on homelessness of £9.45m per year[7]

Source:
(1) GMCA Mat Ainsworth Working Well: Supporting long term ESA claimants into sustained employment. http://stats.cesi.org.uk/events_presentations/SeminarSeries2014/Tacklingemployment/MatAinsworth.pdf
(2) a) http://www.hscic.gov.uk/catalogue/PUB06116; b) http://www.nice.org.uk/guidance/qs59/documents/qs59-antisocial-behaviour-and-conduct-disorders-in-children-and-young-people-support-for-commissioning2
(3) http://www.alcoholconcern.org.uk/training/alcohol-harm-map/
(4) a) 'ITEM 6 - Substance Misuse in Greater Manchester', GMCA; b) http://www.nta.nhs.uk/uploads/whyinvest2final.pdf
(5) a) CCG programme budget returns; b) Mental Health Benchmarking 2012to13 vs 2013to14 v4.
(6) a) ONS, Suicides in England and Wales by local authority, 2016; b) Scottish Executive, Evaluation of Choose Life, 2006
(7) Local authority outturn returns 2014/15

Summary: Investment Case and the Potential Benefits

The following sets out a summary of the impact of some of the strategic initiatives within the strategy across GM. These figures relate to opportunities and based on publically available information and published studies. All figures are given on an annual basis. Further detail including assumptions and referencing are provided on the next four pages. Detailed financials relating the actual activity to be delivered will be developed as part of the implementation planning for the strategy.

Scheme	Cost	Fiscal Benefits[1]	Additional Public Value Benefits[2]
Early years	£15.1m	£15.8m	£28.1m
Education: School based social and emotional learning	£5.8m	£44.4m	Unknown
Troubled families	£22.8m	£33.4m	£75.2m
Alcohol Misuse: Screening and brief early intervention	£1.3m	£5.9m	Unknown
Suicide Prevention: Suicide awareness training and intervention	£0.4m	£0.3m	£48.0m
Working well	£3.0m	£5.1m	£13.0m
Workplace screening for depression and anxiety	£1.2m	£0.7m	£2.2m
Promoting wellbeing in the workplace	£0.04m	£0.0m	£0.5m
Housing step down support facility	£0.5m	£5.2m	Unknown
RAID - Psychiatric Liaison	£1.5m	£2.4m	£0.2m
Intermediate Care for patients with delirium	£9.6m	£12.7m	Unknown
Crisis prevention through IAPT	£6.9m	£11.6m	Unknown
Assertive Outreach for individuals with complex dependency	£1.0m	£1.5m	£1.4m
Total of above schemes	**£69.3m**	**£139.0m**	**£168.4m**

[1] the financial or 'fiscal' impacts to government agencies
[2] the overall public value created by a project including economic benefits to individuals and society; and wider social welfare/wellbeing benefits

Assumptions

The Investment Case and the Potential Benefits (1)

	GM MH Strategy & Underlying Assumptions
Early Years: Children & family	**Early Years Programme[1]** • Though investment in parenting support, maternal/postnatal health, and early childhood education yields major, long-term social and economic growth, and also help prevent children develop anti-social personality disorders as adults. Based on a cohort of 38,000 children across GM. • Costs and benefits of the Early Years programme were modelled over 25 years, with returns increasing annually. Some benefits, e.g. reduced A&E attendances/improved school readiness, to be accrued in the short term. Others e.g. increased employment when children leave school to be accrued long-term. • Division of fiscal benefits between agencies: DWP 53%; Schools 17%; Local Authority 14%; NHS 10%; Police 3%; Other CJS 3%; Housing Providers < 1%.
Education	**School-based social and emotional learning[2]** • Programmes to help children and young people recognise and manage emotions, and to set and achieve positive goals. Based on a cohort of 38,000 children, as per Early Years. • Costs of intervention include teacher training, programme coordinator and materials. • Cumulative benefits taken as an annual average from across ten years of operation. Recognition is given to the build-up in benefit over time. • Division of fiscal benefits between agencies: Criminal Justice System 58%; NHS 36%; Education 6%; Social Services 1%; Voluntary Sector <1%.
Troubled Families	**Troubled Families Programme[3]** • Interventions to support such families characterised by there being no adult in the family working, children not being in school and family members being involved in crime and anti-social behaviour. These problems are associated with mental health issues and wider determinants of mental health such as domestic violence, relationship breakdown, mental and physical health problems. Assumptions based on cohort of 13,561 troubled families (out of total of 27,200 troubled families across GM). • All figures are an annual average based on a ten-year intervention. The average reflects the fact that costs are only incurred in the first six years, whereas benefits are accrued for all ten. Significant lead-in time for benefits, with increases from £4.4m in the first year to £41m in the fifth. • Division of fiscal benefits between agencies : Local Authority 44%; NHS 17%; Housing Providers 11%; CJS (exc. police) 10%; DWP 9%; Police 9%; HMRC/Schools/Department for Education < 1%.
Alcohol Misuse Intervention	**Alcohol screening and advice[2]** • An inexpensive intervention in primary care which combines screening by GPs, followed by a 5 minute advice session for those who screen positive. • Brief interventions in primary care settings achieve an average 12.3% reduction in alcohol consumption per individual. • Based on approximately 30% of 66,000 patients screened registering as positive. • Division of fiscal benefits between agencies: Criminal Justice System (including police) 73%; NHS 27%.
Suicide Prevention	**Population-level suicide awareness training and intervention[2]** • Suicide prevention education for GPs can have an impact as a population level intervention to prevent suicide through greater identification of those at risk. Individuals can receive cognitive behavioural therapy (CBT), followed by ongoing pharmaceutical and psychological support to help manage underlying depressive disorders. The cost of this type of intervention includes ten sessions of CBT in the first year with further ongoing pharmaceutical and psychological therapy together with suicide prevention training for GPs. By applying the England-wide economic model to the GM context, this amounts to approximately 30 potential suicides. • Division of fiscal benefits between agencies: NHS 63%; police 37%. • Public value benefits include the prevention of lost wages and non-waged output as well as associated intangible human costs.

Note: (1) New Economy – Early Years Cost/Benefit Analysis (2015)
(2) Mental health promotion and mental illness prevention: The economic case. LSE/PSSRU, Institute of Psychiatry, Kings college London (April 2011).
(3) New Economy – Troubled Families Cost/Benefit Analysis (2014)

Assumptions

The Investment Case and the Potential Benefits (2)

	GM MH Strategy & Underlying Assumptions
Employment Support	**Working Well Programme[1]** • This includes expansion of the Working Well programme across GM to help people with MH conditions who are on Employment and Support Allowance (ESA) to overcome their barriers to work. The benefits provide a prudent estimate related to a cohort of people (1,500) directly identified as having a MH condition. However, the number of people within the overall programme is greater and may also include those be impacted by mental health issues. • Each person taking part in the scheme will receive individually-tailored packages of support ensuring, through careful co-ordination, that the issues which are holding them back from work are tackled at the right time and in the right order. • Division of benefits between agencies: DWP 64%; NHS 30%; Police 2%; Prisons 1%; Courts/Legal Aid 1%; Other CJS 1%.
Employment Support	**Workplace screening for depression and anxiety[2]** • Work place based enhanced depression care consists of completion by employees of a screening questionnaire, followed by care management for those found to be suffering from, or at risk of developing, depression and/or anxiety disorders. Those identified as being at risk of depression or anxiety disorders are offered a course of cognitive behavioural therapy (CBT) delivered in six sessions over 12 weeks. The assumption is made that 25,000 employees will be screened. The cost of intervention covers the cost of facilitating the completion of the screening questionnaire, follow up assessment to confirm depression, and care management costs. This also includes six sessions of CBT for those identified as being at risk. • Figures are based on a benefit which includes a one-year lead in. Benefits to the HSC system only accrued in the second year. Therefore numbers are annual averages from a five year programme. • 100% of fiscal benefits are attributable to the health sector, and accrued in the year following the intervention. Further potential fiscal benefits to the exchequer through reductions in unemployment, but these have not been quantified. Public value benefits relate to increased productivity through reduced absenteeism and presenteeism.
Employment Support	**Promoting wellbeing in the workplace[2]** • A multi component health promotion intervention consisting of personalised health and wellbeing information and advice; a health risk appraisal questionnaire; access to a tailored health improvement web portal; wellness literature; and seminars and workshops focused on identified wellness issues. • Evaluation of this type of programme has reported significantly reduced stress levels among workers, as well as reduced absenteeism. All benefits derived are therefore attributable to employers, not health or necessarily even other public services. As such, benefits are expressed of public value rather than fiscal in nature.
Housing Support	**Supported housing step down facility[3]** • A step-down facility to enable prompt discharges from psychiatric hospitals into the community. The provision of four weeks of floating support to clients immediately after they move on provides vital continuity of support during transition. This helps to reduce the revolving door scenario where people relapse during stressful changes in circumstances and need more intensive support again. • Based on a cohort of 200 clients per annum. brings net saving of approximately £25,900 per client, per year. • All figures are annual. Costs within reference material are not divided between agencies more deeply than a broad attribution to the 'wider health and social care system'.

Note: (1) New Economy – Working Well Cost/Benefit Analysis (2015)
(2) Mental health promotion and mental illness prevention: The economic case. LSE/PSSRU, Institute of Psychiatry, Kings college London (April 2011).
(3) Health and housing: worlds apart?:Housing care and support solutions to health challenges. National Housing Federation 2009.

Assumptions

The Investment Case and the Potential Benefits (3)

	GM MH Strategy & Underlying Assumptions
Acute Admission Avoidance (RAID)	**RAID: Psychiatric Liaison[1]** • RAID teams working in wards and A&E depending on the focus of their team (including A &E, Older people, Alcohol Addiction). Includes reduced hospital admissions/readmissions, reduced bed days, and reduced residential care admissions, • Division of benefits between agencies: CCGs 61%; Acute Trusts 25%; Local Authorities 14%; DWP < 1%.
Acute Admission Avoidance (MH Intermediate Care)	**Intermediate Care for patients with delirium[2]** • Based on a scaling of Saffron Ward , an intermediate care ward, across ten GM boroughs. Delirium appropriately identified and treated by a trained multidisciplinary team able to identify and design targeted appropriate packages of care for the patient. Additional benefit from new appropriate onward referrals. Intermediate care is cheaper than standard ward care, and more likely to prevent escalation into residential care. 90% of total occupied bed days in standard ward care are reduced from Saffron ward for patients with delirium. Costs are mainly derived from workforce figures. • 100% of fiscal benefits are accrued by the NHS, although there are potential further unquantified savings to the social care system as the result of prevented entry into residential care.
Crisis prevention through IAPT	**Using IAPT to reduce patients in crisis in A&E[3]** • Analysis disperses the prevalence of incidents proportionately across the national population, equating to 9,321 A&E attendance due to self-harm in GM per year. • Early intervention, including the use of IAPT services earlier on, results in a lower acuity of treatment. Assumes that GM meets the target of a 50% success rate, which it regularly exceeds. This reduces the cost of more intense treatment and the number of A & E attendances, generating net savings. • Division of benefits across agencies: HMRC (tax gains) 40%; Health and Social Care 39%; DWP 21%.
Reduction in police call outs for MH (S.136)	**Assertive Outreach and problem solving for individuals with complex dependency[4]** • Section 136 is used by the police to remove a person (who appears to be suffering from a mental health disorder) from a public place to a place of safety. In Trafford, a system has been piloted which involves embedding a specialist nurse practitioner within response teams to provide assertive outreach support for individuals who present with need on a repeated basis. Through intensive problem solving, the long-term demand which these individuals present on services has been curtailed. • Division of benefits across agencies: CCGs 79%; GMP 11%; NWAS 10%; Other CJS/Housing Providers/Local Authorities <1%.

Note:
(1) New Economy – Hospital-based Liaison Care Cost/Benefit analysis (2012).
(2) Frontier Economics – Evidencing Pennine Care's Impact (2015)
GM NHS Provider Trusts Federation – A standardised offer for community Care (2015).
(3) Department of Health – Impact Assessment of the expansion of talking therapies services as set out in the Mental Health Strategy (2011)
(4) New Economy – Home Office Innovation Fund Specialist Mental Health Practitioner Pilot (2015)

Strategic Initiatives by Pillar

1. Prevention
2. Access
3. Integration
4. Sustainability
5. Golden Threads

Strategic Initiatives

Prevention

1.1	Early Years: Children and Family	Improving perinatal, child and parental mental health and wellbeing is key to the overall future health and wellbeing of our communities. We will look to direct activities towards the whole family and school life experiences including maternal mental health, family support (at all points during the whole life course), tackling domestic abuse; together with Community, Schools and Education programmes.
1.2	Improve Mental Wellbeing	A GM wide system approach to helping people improve their wellbeing by using the principles of the 'Five ways to wellbeing' framework - *Connect*; *Be Active, Take Notice, Give, Keep Learning (New Economics Foundation).* This aims to improve physical and mental health, and protect people from loneliness and depression such as engaging in activities, building support networks within communities, and social prescribing.
1.3	Building Capacity for Self Care	Aims to build the individual's capacity to better manage their own care and increase their resilience through providing self management resources, creating on-line communities and peer support. Also, raising awareness of the benefits of self care and the individual's role in taking responsibility for their own health and wellbeing with support from the people involved in their care.
1.4	Suicide Prevention	Working with the GM Suicide Prevention Executive to reduce suicide risk by reflecting the main elements of the national strategy ie men's mental health, mental health services, self-harm, young people, suicide hotspots, working with the media. Highlighting the features of MH services we have shown to be linked to lower suicide rates eg outreach, early follow-up on hospital discharge, adopting NICE guidance on depression and self harm. Supporting the development of real time data and information and workforce development to support suicide prevention.
1.5	Early Intervention	Increase GM wide interventions to build good wellbeing and resilience including universal approaches for the general population and targeted wellbeing interventions for those facing particular risk factors, including mental illness to improving health and social outcomes, reducing prevalence of mental illness and supporting recovery. GM will also provide support on the wider determinants of mental health; addressing lower levels of mental distress earlier on helping to reduce the likelihood of a more chronic and debilitating illness.
1.6	Targeted Mental Health Campaign	A targeted public mental health and wellbeing campaign to raise awareness of mental health issues, reducing stigma and discrimination and helping the public in understanding their role in own wellbeing and how they can support others to deal with such issues. Campaigns will also enable improved access to appropriate support.
1.7	Supporting Vulnerable People	Supporting those most vulnerable in society to help reduce the risk of developing poor mental health, or from any existing mental health conditions in deteriorating further. Aims to address inequalities in access, experience and outcomes for vulnerable people including looked after children, child sexual exploitation and learning disabilities. Interventions include 'wrap around' services for those with complex needs such as housing support, drug/alcohol counselling, education programmes. Better targeted case management and outreach support for frequent attenders.
1.8	Workplace and Employment Support	By focusing on wellbeing in the workplace, we will support working individuals in feeling happy at work and help achieve life satisfaction. We will sign up organisations across GM to a *Best Employment Practice charter* in relation to managing stress, mental health issues and drive wellbeing in the workplace. We will also ensure there is consistent support available across GM for those currently unemployed and seeking employment, including access to CV clinics, coaching and mentoring.. We will build on the Working Well Programme.

Strategic Initiatives

Access

2.1	Identify single points of access across primary and secondary care and develop a care co-ordination role	Strengthen the role of the GP as an initial point of contact, and ensuring there is a consistent care co-ordinator role with the right skills and competencies across GM. This will bring together primary mental health care and social care support. Train practice nurses and other primary care workers in early intervention and ensure access to EIP, perinatal MH and IPT.
2.2	IAPT services of consistent high quality across GM	We will look at national best practice and aim to build our minimum standards around these interventions, taking into the account a need for local variations dependent on different demographics. We will work across the 10 Local Authorities to develop consistent approaches to social care for mental health. Introduce combined mental and physical enablement and group based practice.
2.3	Improving support for carers and parents at risk	Support services for parents at risk through home visits by professionals, GMs troubled families' programmes and/or befriending initiatives by voluntary organisations. This will encompass the full range of community support in the NHS, Local councils and the Voluntary Sector. Improve police training and support services.
2.4	24/7 mental health services and 7 day community provision for children	We will create 24/7 crisis care for children and provide 7 day access to Community mental health teams that are able to provide support across GM.
2.5	Ensure consistency of 24/7 mental health services and 7 day community provision for adults including crisis care concordat	We will ensure consistency is achieved in the delivery of 24/7 crisis care for adult service users and ensure consistent 7 day access to Community mental health teams that are able to provide support across GM including full implementation of the GM crisis care concordat
2.6	Standards and protocols for step up and step down (Inc. prisons)	We will work with clinicians, care managers, including the third sector to review the thresholds for access to all mental health services and ensure these are explicit within operational policies.
2.7	Self Sufficiency in provision for GM (out of area placements)	Increase collaboration across providers to tackle current out of area provision, using GM capacity on GM residents, improving care and driving efficiency
2.8	Eating disorders in CYP	Flexible specialist Children and Adolescent Eating Disorder (CAEDS) service model through Multidisciplinary community based teams
2.9	ADHD in CYP and service expansion for adults	Co-commissioned multi-agency care pathway for children and young people with ADHD across the lifespan into early adulthood and service expansion into adulthood.

Strategic Initiatives

Integration

3.1	Integrated place-based commissioning and contracting	Simplify, consolidate and streamline the current commissioning landscape to create a robust and accountable commissioning function which removes duplication, creates economies of scale and provides consistency. Commissioning will be both place-based (as part of new care organisations) and across GM providers. Commissioners will have specialist competency training.
3.2	Locality Care Organisations to integrate care both vertically and horizontally across community, primary and acute settings	Design and implement appropriate MH services at suitable spatial levels -GM level and place-based settings. MH will be an assumed part of place-based commissioning and local care organisations will be a major contribution to parity of esteem with integrated leadership and collective accountability across the public sector.
3.3	A whole person integrated vertical care pathway across a horizontal integration of care providers	This involves 4 elements: all-age, integration between physical and mental health, integration across care settings and integration with the individual's wider environment. This will engage the whole range of local services including housing, leisure and learning.
3.4	A strong partnership with the community and voluntary sector	Building a stronger partnership with the voluntary sector will ensure the third sector is an integral part of each patient's pathway and that the third sector can work in an integrated way to ensure appropriate care is provided in the right place. The service will operate on an outreach as well as responsive model to reduce inequalities.
3.5	Asset-based approach and devolution estate managed centrally for the benefit of GM	Provide a GM environment that is appropriate for 21st Century mental health care by reviewing, assessing and managing all MH physical assets and facilities management across GM and ensure alignment with place-based working across the public sector. Make services available by telephone and over the internet.
3.6	Integrated monitoring, standards and KPIs	Develop a consistent set of shared minimum standards and outcomes for GM with a set of standard KPIs that cover the whole range of mental health services that are involved in changing and promoting positive mental well being.
3.7	Integrated data sharing	Improve information sharing between agencies to facilitate collaboration and drive integrated care, through integrated patient records and/or patient ownership of information.

Strategic Initiatives

Sustainability

4.1	System leadership	Systems leadership is necessary in driving new integrated care models, and it requires a real commitment across senior leadership to align their organisation's goals with the goals of the wider system. ONE LEADER.
4.2	Improve SOCIAL CARE, community and primary care capacity	Our vision for mental health is that it is led by wider primary care (including community pharmacies, schools and adult education), fully integrated with social care and supported by specialist interventions provided where necessary, based on an integrated, neighbourhood management model.
4.3	Working practices	Changes to working practices and training to facilitate a culture of shared leadership accountability linking with the Academic Health Science Network and others to develop new curricula and qualifications.
4.4	Programme prioritisation	Establishing a consistent standard benchmark for programmes which must be implemented in all areas, and a more robust methodology for evaluating the success of a programme and the next steps.
4.5	Pooling of Mental Health budgets	Pooling of budgets to enable joint decision making for the system as an integrated whole.
4.6	Provider Landscape Redesign	A: Strengthen collaboration between providers, more substantially than integration of back office functions, to enable full needs based pathways. B: Short-term solution for MMHSC unsustainability.
4.7	Payment and incentives	Recognising the value in alternative sources of investment, for example social impact bonds.
4.8	Regulation reform	Freedom to relax or reform regulation in areas where radical change to the system is proposed.
4.9	New investment streams	Recognising the value in alternative sources of investment, for example social impact bonds.

Strategic Initiatives

Cross-cutting Golden Threads

5.1	Ensure parity of esteem between mental and physical health	Initiatives to address this parity must address the multiple sources of this inequality – financial, attitudes and beliefs, both within and beyond health and social care and as MH accounts for 23% disease burden, need greater equality re resource through reducing unnecessary acute trust admissions, OPCs, investigations.
5.2	Improve deployment of research to inform best practice care across GM	We will work in partnership with HInM and the Centre for Mental Health and Safety to ensure mental health research is sufficiently prioritised, drive better co-ordination, and that interventions which have been proven to be effective are swiftly rolled out.
5.3	Prepare a workforce to work as part of an integrated, joined-up system	Staff must be enabled to become more adaptable in order to respond to systems-wide changes, and more multidisciplinary, in order to drive integrated care. This will require leadership, training and culture change.
5.4	Utilise technology to provide new forms of support	Technology offers the opportunity to transform mental health and support self-care, but we need to ensure that all interventions are carefully assessed and evidence-based.
5.5	Leverage the success of existing programmes (e.g. Troubled Families, Working Well) which prioritise the top 10% which account for 40% resources through repeat admissions, detention and crises	These programmes must have access to the right mental health treatment, and they should be effectively integrated with other health and social care services. Target the 10% of people that generate 40% of activity and cost.