



Introduction and Contents



The Planning Guidance for 2017-2019 set out that NHS England would:

- 1. Use the Best Possible Value framework approach to assess all transformation investment decisions.
- 2. Run a single co-ordinated application process to minimise the administrative burden on local areas who would be applying for funding. This **single coordinated application process** will support NHS England to make best possible value investment decisions.

Sustainability and Transformation Plans (STPs) are central to this process and all bids should be explicitly linked to the relevant local STP plans. This process is open to any STP, although individual organisations or alliances may bid on behalf of an STP for this funding; submission of applications must be via STPs.

For each national programme there is a set of Call to Bid documents which follow the same approach and outline:

- 1. A clear set of interventions with supporting evidence base that the national programme is looking to fund.
- 2. The parameters to funding, governance and delivery requirements.
- 3. How the Best Possible Value framework approach has been applied to the national programme's interventions and how the framework will be used to appraise the bids received.
- 4. A standard application form for all interventions within a programme which is aligned to the appraisal criteria. The Call to Bid documentation and application forms are set up such that applicants only have to fill in the sections applicable for the interventions that they wish to bid for.

This document sets out the Mental Health interventions which have transformation funding from NHS England.

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Interventions to be funded Intervention 1 - Integrated IAPT



Condition	Recommended treatments
Depression in the context of one or more long-term conditions	For all severities cognitive-behaviour therapy (CBT) or interpersonal therapy (IPT). For severe depression these would normally be combined with medication.
	For mild to moderate depression, stepped care. If low intensity interventions (such as guided self-help) are insufficiently effective or declined, offer a choice of high intensity therapies including CBT, IPT, Couples therapy, Counselling or Brief Psychodynamic Therapy
	For people with a history of recurrent depression who are largely recovered but at risk of relapse, consider Mindfulness-based cognitive therapy (MBCT)
Anxiety Disorders (panic disorder,	The appropriate version of CBT delivered in a stepped care model (except for
agoraphobia, generalized anxiety disorder,	PTSD and social anxiety disorder where only high intensity interventions are
social anxiety disorder, post-traumatic	recommended). Eye movement desensitization reprocessing therapy (EMDR) is
stress disorder, phobias, and obsessive	also recommended for PTSD.
compulsive disorder) in the context of one	
or more long term conditions	
Health Anxiety	CBT (specialized version for health anxiety). High intensity only.
Irritable Bowel Syndrome (IBS)	CBT (specialized version for IBS). High intensity only.
Chronic Fatigue Syndrome (CFS)	Graded Exercise Therapy (GET) or CBT
Chronic pain that is markedly distressing	CBT as part of an integrated pain management plan
or disabling	
Persistent distress in association with medically unexplained symptoms that cannot be classified as panic disorder, health anxiety, IBS, CFS, or chronic pain	Comprehensive assessment and formulation followed by therapy broadly based on CBT principles

Interventions to be funded



Intervention 2 - Urgent & Emergency Mental Health Liaison Services for Adults and Older Adults

Following the publication of the *Five Year Forward View for Mental Health* (MH5YFV) in February 2016 and the 2015 Autumn Government Spending Review, NHS England is establishing a **transformation fund to improve urgent & emergency liaison mental health services for adults and older adults in acute hospitals**.

The fund supports the ambition in the MH5YFV that by 2020/21 at least 50% of acute hospitals with 24/7 A&E departments have liaison services that meet the core 24 standard for adults and older adults. The fund also supports the vision for the overall transformation of urgent & emergency mental health care so that by 2021, there is a 7 day NHS for mental health crisis response.

Bids for **Wave 1** of the funding – £15m in 2017/18 and £15m in 2018/19 – **are now invited from A&E Delivery Boards**.

Before proceeding with the application, please consider the checklist below for the minimum criteria to be considered to be deemed 'core 24'. If the answer to any of the questions below is 'No', then please do not apply.

The service will be commissioned to operate as an on-site, distinct 24/7 service in the acute hospital within one year of receiving the funding

The service will be in line with or close to the recommended staffing level for a core 24 service within one year of receiving the funding

The service will be commissioned to provide a 1 hour response to emergency referrals and a 24 hour response to urgent inpatient ward referrals within one year of receiving the funding

The mental health liaison service will be self-sustaining within one year of achieving the core 24 standard, and that funding will be reinvested recurrently

The application is for general acute hospital(s) with 24/7 A&E department(s)

Parameters to Funding, Governance & Delivery



- All bid participants must have agreed control totals before any transformation funds will be released.
- The bids must be explicitly linked to Sustainability and Transformation Plans (STPs). Governance of delivery will also need to be cross-system.
- This process is open to any STP, although individual organisations or alliances may bid on behalf of an STP for this funding.
- The funding available is for <u>revenue only.</u> There is <u>no capital funding available</u>. The new investment in both interventions is expected to fund workforce predominantly.
- Please note, that potential applicants in the <u>Greater Manchester devolution area are not eligible</u> for this
 application process, as they have received a proportion of the funding through the funding top slice for
 Greater Manchester.
- In return for funding:
 - applicants will be required to sign up the programme financial governance and monitoring arrangements (guidance on this will be issued with the funding decision).
 - we are expecting delivery of outcomes as outlined in the logic models on page 12 and 18.

Why use a Value Framework?



The Best Possible Value framework is a standardised framework which aims to place consideration of value to population, to patient and to taxpayer at the heart of decision-making, enabling NHS England to evaluate and compare different options using an evidence based methodology.

The value framework will:

- Identify the evidence base upon which the programme and interventions are built.
- Allow the consistent comparison and monitoring of value across the applicants.
- Support the appraisal panel and the NHS England Investment Committee to allocate investment to applicants in a robust, value-based manner.
- Enable the applicant to bid for funding in a clear, objective manner.

The key steps in the value framework approach are set out in the picture on page 7. The programme has been through steps one to three to create programme specific value equations, logic models and a set evidence base which supports the intervention they wish to fund. These tools have then been used to create value based appraisal criteria. Bidders are encouraged to use these tools and the appraisal criteria to develop their application. Once received the application will be scored against the criteria and an appraisal dashboard and prioritisation matrix will be generated to inform the investment decision.

The Best Possible Value framework was developed through the Future Focused Finance programme. More information about the wider Best Possible Value programme can be found on the Best Possible Value Website http://bpv.futurefocusedfinance.nhs.uk/

Value Framework Process - Key Steps



1 Value Equation

What are the elements of value that the invention may seek to generate?

2 Logic Model

Evidence Base 4 Appraisal Criteria 5 Application 6 Bid Appraisal

What is the programme and how does it deliver value?

What is the evidence base and how will we track success?

How will we appraise bids?

Bids Submitted

Output - scoring generates appraisal dashboard and prioritisation matrix













What are the key components driving value for the early adopter?

- Outcomes? (clinical, patient experience. safety/quality. financial sustainability)
- Resources to put model in place? (revenue / capital costs, staff)

What value generation assertions underpin each element?

> Elements of the plan delivering value?

For each element. what evidence of value generation exists?

> What further evidence is required to prove value ?

How will success be measured?

- Which metrics and targets are we going to use to track value?
- When will they be realised?

Appraisal Criteria has been developed based on the outputs from steps 1 to 3.

This appraisal Criteria assesses applications against strategic consideration, value, and risk in a robust objective manner.

Bidders should apply the outputs of step 1 to 3 of the value framework as set out in this pack to their applications.

Standard applications forms have been provided for each programme.

- The appraisal of the applications will result in:
 - **Appraisal** dashboard illustrates all applicants results against the appraisal criteria.
 - **Prioritisation** matrix maps all applicants graphically
- These outputs will be used to identify the best value investments

This Call to Bid document sets out how we have applied the value framework to this specific programme

Bid Requirements and Timeline



Please fill out the accompanying Application Form and attach the financial information as required.

- IAPT Bids should be submitted via STPs to <u>England.mentalhealth@nhs.net</u>. For queries about proposals and additional supporting materials please join the IAPT Yammer group, email <u>England.mentalhealth@nhs.net</u> for an invitation.
- UEC MH Liaison Bids should be submitted via STPs to NHS England regional Urgent and Emergency
 Care PMOs (see Application Form for email addresses) and copied to: england.adultMH@nhs.net

National programme specific webinars will be set up:

- 1. To help applicants to understand the Best Possible Value framework
- 2. How to best apply this to their applications
- 3. To provide additional information such as additional evidence and the scoring system for each intervention.

Bidders should contact the programme at England.mentalhealth@nhs.net for further information.

Date	Action
12 th December 2016	Process launched and Call to Bid documents published
December 2016 and January 2017	Support provided to bidders through Webinars sessions for each programme.
18 th January 2017	Submissions deadline for bidders
February 2017	Investment Decision taken by NHS England Investment Committee
March 2017	Notification of investment decisions



Intervention 1

Integrated IAPT

Intervention Specific Parameters to Funding, Governance & Delivery: Intervention 1 - Integrated IAPT



- Funding is for delivery of integrated IAPT services to develop integrated services at scale
 (for instance teams of 10 therapists or more).
- A significant aspect of the funding will be for expanding the IAPT workforce through new IAPT trainees or recruiting suitably qualified experienced therapists not already in IAPT. Training places will be subject to capacity at Universities, which we will work with Health Education England to secure.
- Because the academic year spans financial year the salary of trainees (and potentially their course costs) will also span the financial year. <u>Areas will need to plan to locally fund trainees in 2018/19</u>.
- We expect new Integrated IAPT services to start during the course of 2017/18 the right time will depend on the current local position and alignment with training courses.
- High quality integrated IAPT will lead to reduced demand / savings in physical healthcare services. A commitment to identify and reinvest savings into IAPT services, making the funding sustainable, will be a key part of successful proposals.
- Health Education England are commissioning top up training for experienced therapists in working with people with Long Term Conditions – successful sites will be able to access this, with remaining capacity being freely available to areas.
- Applications are welcome from STP or CCG footprints but must be submitted via STPs.
- Proposals will need sign off from commissioners and both physical health and IAPT providers.

Value Equation for Integrated IAPT



Clinical outcomes

Psychological therapies tailored to long term conditions and integrated into long term conditions pathways will improve **clinical outcomes**.

Outcomes

Patient experience

Improved by joining up mental and physical health care

Safety/Quality

Improved through better integrated care, while maintaining the quality of the core IAPT service

Sustainability

IAPT services will become sustainable in the medium / long term

Value

Resources

Revenue costs

Resources required are reasonable and focused on building capacity locally: majority of costs expected to be clinical staff and trainees.

Logic Model for Integrated IAPT



Inputs Activities Outputs Outcomes

Resources

- IAPT funding:
- National transformation funding
- Existing local funding
- Tariffs
- Local IAPT staff and trainees, additional staff working in psychology not yet in IAPT

Local

- Local population mental and physical health needs
- Local experience of integrating care
- Local mental health and physical health leadership
- Local long term conditions, medically unexplained symptoms and mental health pathways

National

- · NICE guidelines
- Interim implementation guidance for integrated IAPT (available from england.mentalhealth@ nhs.net)

Enablers

- Engagement and relationship building between IAPT services and health psychology, general practice, acute care teams and community care teams
- Development and design of the integrated service and pathway(s) focusing on areas of local need where good evidence for mental and physical health improvements.
- Involvement of people who will use services in their design

Evidence-based psychological therapies for people with co-morbid depression / anxiety disorders and physical health long term conditions, or persistent and distressing medically unexplained symptoms

- Evidence-based high quality care
- Care genuinely integrated into physical health pathways, with therapists working as part of multidisciplinary teams
- Strong clinical leadership focuses on outcomes and improving quality

Expanding capacity and capability in the workforce

- Expansion through trainees and recruitment of therapists currently working outside IAPT
- Nationally-commissioned CPD training for experienced therapists

Sustainability: Disruption to 'core' IAPT service managed

Individual level

- More people receive and complete evidence-based psychological therapies
- Both physical and mental health care professionals involved in a person's care understand more about their whole experience
- People better able to manage their physical health problem

Service level

- Psychological therapies integrated into physical long term conditions / medically unexplained symptoms pathways
- Efficient services, meaning the cost per person accessing treatment is reasonable.
- Good staff experience: meaning high retention rates

Information and evidence

- Mental and physical health improvements are measured and continually improved
- Financial savings identified, tracked and realised locally: providing investment case for continued operation of integrated services.

Outcomes

- Improved mental health for people with long term physical health problems or persistent and distressing medically unexplained symptoms
- Improved self management of physical health problems for people receiving integrated psychological therapies
- Reduction in healthcare use for people with comorbid anxiety/depression and long term physical health problems: including acute admissions, length of stay, and primary and community care use.
- Better experience for patients: with integrated services meaning less inconvenience and closer working between health professionals

Evidence Base for Integrated IAPT



- 30% of people with a long term physical health condition have a mental health problem.
- Co-morbid mental health problems interact with and exacerbate physical health problems raising healthcare costs by at least 45% for each person with an physical long term condition and a mental health problem.
- Psychological interventions can save 20% of physical healthcare costs.*

The evidence for physical healthcare savings is most comprehensive in the following areas:**

- Diabetes. An IAPT pathfinder site found a healthcare net cost reduction of £372 for people with comorbid diabetes and common mental health problems.
- Cardiovascular disease. An intervention in people with angina reduced both admissions by 33% and length of stay in patients the following year, with savings of £1,337 per person in 2007.
- Respiratory disease, particularly COPD. In Hillingdon gross savings of £837 per person over 6 months in secondary care costs (fewer A&E presentations and bed days when admitted), and £1,300 in overall healthcare costs over 6 months.
- There may also be areas of current good practice for mental and physical health areas want to build services around, for instance medically unexplained symptoms, musculoskeletal disease or cancer with a good prognosis.

LTC/MUS	General LTC / medically unexplained symptoms	Cardiovascular disease	Diabetes	Respiratory disease / COPD
Gross cost saving per person per year	20% of local physical healthcare costs	£1,300	£1000	£1200

^{*}Chiles, J.A., Lambert, M.J. and Hatch, A.L. (1999), "The impact of psychological interventions on medical cost offset: A meta-analytic review", Clinical Psychology: Science and Practice, 6(2): 204-220.

Naylor et al, The King's Fund (2012) 'Long-term conditions and mental health – The cost of co-morbidities'

^{**}Layard, R. and Clark, DM (2015) *Thrive: The Power of Psychological Therapy* (Chapter 11), Penguin, London, which sets out the evidence in detail.

Appraisal Criteria for Integrated IAPT



Programme Name:	IAPT Program	me		
			Strategic Priority	Importance (%)
OUTCOMES	Clinical	1	Expand access to psycholgical therapies	5%
		2	Focus on LTC /MUS where good evidence for MH and physical health improvements	10%
		3	Clinical leadership in service focused on improving quality.	6%
		4	Evidence-based high quality care.	14%
	Patient Experience	5	People using services involved in design, leading to good experience.	7%
	Safety / Quality	6	Care genuinely integrated into physical health pathways.	12%
		7	Proposal for maintaining and improving 'core IAPT' services (ensuring quality doesn't suffer).	8%
	Sustainability	8	Financial CCG commitment: to fund after 2017/18	10%
		9	Financial: plan to find and track physical health savings.	5%
		10	Non-financial: plans for retaining staff and so service sustainable.	8%
RESOURCES -		11	Resources reasonable - revenue cost per person treated.	5%
		12	Proportion of spend going towards expanding the capacity of the workforce	10%
RISK		13	Achievability of value	25%
		14	Ability to collect and report outcomes data	25%
		15	Ability to implement including workforce	25%
		16	Ability to build relationships between services locally	25%
STRATEGIC CONSIDERAT	TION	17	Does the STP align with ambitions for integrated physical and mental health care?	100%



Intervention 2

Urgent & Emergency Mental Health Liaison Services for Adults and Older Adults

Intervention Specific Parameters to funding, Governance & Delivery: Intervention 2 - Urgent & Emergency Mental Health Liaison Services for Adults and Older Adults

- The funding is to pump prime and accelerate existing plans to expand acute hospital liaison mental health services so that they operate at the core 24 standard within one year of receiving the funding.
- The closer the service is to core 24 (and therefore the smaller the amount of funding requested) and the more robust the delivery plans that are in place, the greater the likelihood of the bid being successful.
- Applications should not be submitted for acute hospitals that are unable to reach the core 24 service level in 2017/18 or 2018/19.
- Successful applicants will receive funding in either 2017/18 or 2018/19, and not both years.
- Applications will need to confirm that the service will be commissioned sustainably and funded locally recurrently.
 In addition the bid will need to demonstrate how savings will be reinvested to sustain the core 24 liaison mental health service at a minimum, and how any of the expected further savings will be reinvested.
- Proposals are expected from A&E Delivery Boards and must be submitted via STPs. These should:
 - confirm involvement of senior membership from acute and mental health trusts in A&E Delivery Boards;
 - confirm senior engagement and sponsorship from the relevant STP partnership; and
 - clearly lay out collaborative arrangements between neighbouring CCGs as appropriate.
- The strongest bids will demonstrate local collaboration and joint ownership between acute and mental health providers, and support from other local structures e.g. UEC Networks, mental health Clinical Networks, Crisis Care Concordat groups, and UEC PMO involvement in developing bids.
- The strongest bids will demonstrate partnership with other non-NHS partners e.g. social care, public health, housing.

Value Equation for urgent & emergency liaison mental health for adults & older adults



Access & safety

- Core 24 staffing
- On-site, distinct 24/7 service
- Recommended response times
- Older age expertise

Patient experience

 Improve & routinely collect patient experience data

Outcomes

Clinical effectiveness

- NICE-recommended interventions provided and outcomes data collected
- Improve MH diagnostic coding in acute hospital

Efficiency & sustainability

- Deliver financial benefits articulated in implementation guidance
- implementation guidance
 Commitment to self-sustain at least at same service standard with local recurrent funding

Value

Resources

Revenue costs

 Service delivery costs of new liaison services as well as any setup/implementation costs, relative to size of service coverage

Logic Model for urgent & emergency liaison mental health for adults & older adults



Inputs Activities Outputs Outcomes

Financial Resources

- · Liaison funding:
- National transformation funding
- Local funding already committed for mental health liaison

Local

- Data on local hospital adherence to Core 24 (LPSE-3)
- Existing local liaison service development and improvement plans
- Acute providers, MH providers, CCGs, A&E Delivery Boards, UEC Networks/PMOs
- · Liaison workforce
- Other multi-disciplinary workforce

National

- UEMH liaison implementation guidance, helpful resources & examples (forthcoming from NHSE, NICE, NCCMH)
- NHS England Urgent & Emergency Care Review: Safer Faster Better
- RCPsych College Centre for Quality Improvement Psychiatric Liaison Accreditation Network: quality standards
- Existing economic evaluations e.g. from the Centre for Mental Health
- Mental Health Partnerships:
 Model Service Specifications for
 Liaison Psychiatry Services –
 Guidance

Enablers

- · Conduct gap analysis to Core 24
- Create robust project plan with milestones, risk analysis and mitigating actions to achieve Core 24 within 12 months

Clinically-focussed activities

- Develop system to measure response times
- Establishing rota and operational policy for 24/7 cover
- Ensure all MH patients receive a biopsychosocial assessment by expert staff
- Ensure patients seen by liaison team have a UEC MH Care plan in place for immediate needs
- Involve liaison teams in planning discharge of patients with MH needs from wards
- Establish robust referral mechanisms with primary/community MH services and IAPT
- Arrange follow-up outpatient appointments
- Systems in place to routinely collect and monitor clinical outcomes and patient experience
- Improve identification of people with MH needs in A&E to acquire clear picture of demand – through clinical audits of diagnostic coding, case note audits
- Establish robust protocols for referrals by acute hospital staff to liaison teams

Expanding capacity and capability in the workforce

- Recruitment of new liaison staff to help achieve Core 24 within 12 months
- Training/upskilling of MH staff to work in liaison teams to help achieve Core 24 within 12 months
- Providing training to non-specialist MH ED & acute hospital staff

Governance & sustainability

- Establishing strong local joint governance and leadership between CCGs, MH trusts, acute trusts, A&E Delivery Boards
- Ensure STP oversight and alignment with Plans
- Identify lead CCG and establish proportionate investment between all local CCGs based on the populations the hospital(s) serve(s)
- MH trust, acute trust, A&E Delivery Board, CCG conduct modelling of efficiency and productivity benefits to be realised from expanded liaison service

Individual level

- More people with urgent and emergency MH needs in acute hospitals receive timely access to care
- More people with urgent and emergency MH needs in acute hospitals receive evidence-based care
- More people with urgent and emergency MH needs in acute hospitals receive an appropriate and compassionate response
- Both ED/acute staff and mental health staff involved in a person's care understand more about their whole experience and each other's roles and skills

Service level

- More acute hospitals able to provide 24 hour 7DS for MH
- Improved quality and completeness of MH diagnostic coding
- Discharge plans take account of patients' MH needs
- · Better identification of MH needs in EDs
- Better identification of MH needs on wards
- Liaison teams have ready access to other specialist expertise e.g. older adult and substance misuse

Partnership level

- Benefits realisation plan agreed to achieve Core 24 within 12 months
- Financial savings realised locally and reinvested
- · Commitment to reinvest recurrently
- Strong local partnerships between CCGs, acute trusts, MH trusts, other partners

Outcomes

- Improved quality of care for patients with mental health needs in acute hospitals:
 - · 24/7 timely access
 - Prevention of future crises
 - Better patient experience
 - improved health outcomes as care delivered in line with NICE standards and evidence base
- More effective joint working between acute, MH staff, other expertise e.g. for older adults, substance misuse, to provide seamless patient care
- Improved efficiency and patient flow in acute hospitals:
 - Reduced A&E 4hr breaches & improved 4hr target performance
 - Reduced ward LoS and non-elective bed days used
 - Reduce avoidable nonelective inpatient admissions
 - Reduce avoidable A&E re-attendance rates
- Better staff experience: improved competency & confidence of ED & acute staff to identify and respond to MH needs
- Improved understanding of overall MH needs in EDs & acute hospitals
- Increase in sustainable liaison services with clarity around local governance responsibilities

Evidence base for urgent & emergency liaison mental health for adults & older adults



Please see the following sources for the evidence underlying the interventions:

https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf

https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-helpful-resources.pdf

All documents can be found at:

https://www.england.nhs.uk/mentalhealth/resources/

Appraisal Criteria for urgent & emergency liaison mental health for adults & older adults



Value equation	Value equation	Ref	Outcomes/criteria		
	Access and Safety	1	The service will be staffed at or close to recommended levels for Core 24 within a year of receiving the transformation funding	24%	
		2	The service will operate as an on-site, distinct 24/7 service within a year of receiving the transformation funding	8%	
		3	The service will provide response times at recommended levels within a year of receiving the transformation funding	8%	
		4	The bid confirms that the service is for older age as well as working age adults and will have access to older adult psychiatry expertise	3%	
OUTCOMES	Patient Experience	5	The bid confirms that the service will improve and routinely collect data on patient experience	3%	
	Clinical Effectiveness	6	The bid confirms that the service will offer interventions in line with NICE-recommended care, and will routinely collect outcomes data on clinical effectiveness	3%	
		7	The bid confirms that the service will seek to improve diagnostic coding of mental health in acute hospitals to improve understanding of clinical need in the acute hospital	3%	
	Efficiency and Sustainability	8	Evidence is provided that the service will bring financial benefits, and sets this out by point of delivery	5%	
		9	There is commitment to sustain the service recurrently at the minimum core 24 service level or above	30%	
RESOURCES 10 Total fo		10	Total funding being requested	13%	
RISK		11	The bid sets out how it will seek to recruit, retain and train the specialist workforce required to establish and maintain a core 24 service	55%	
		12	The bid sets out how the mental health liaison service is part of a wider system of care, with suitable local alternatives to A&E to prevent unnecessary attendances at A&E for urgent and emergency mental health needs	45%	
STRATEGIC CONSIDERATION		13	The bid aligns with STP plans for transforming urgent & emergency mental and physical health care	40%	
		14	The bid sets out convincing joint governance, ownership and commitment to mental health liaison between local commissioners and providers	30%	
		15	The delivery timetable and milestones are credible and robust	30%	