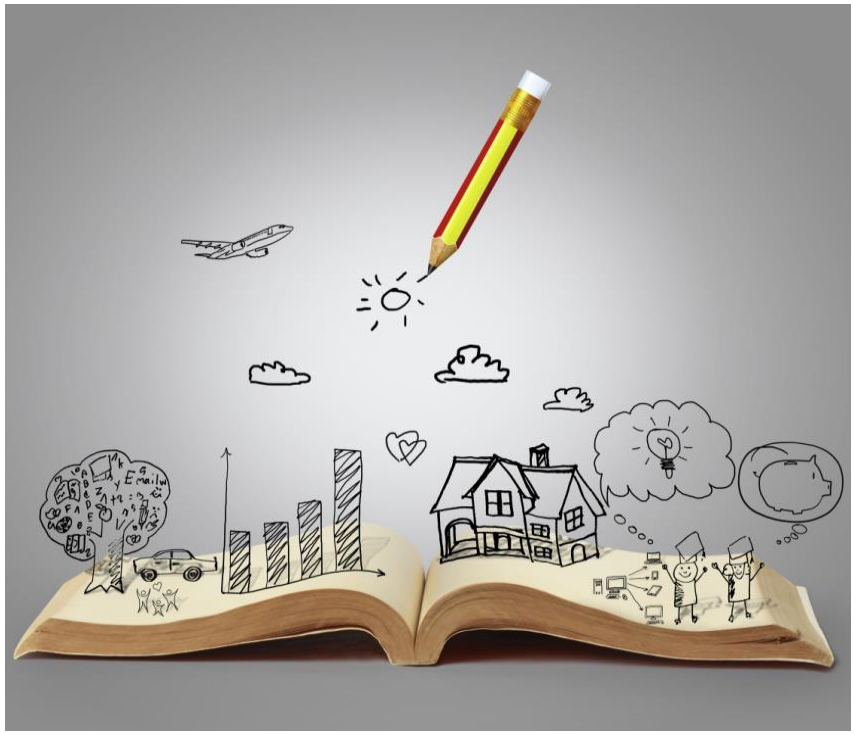
AGMA
ASSOCIATION OF GREATER MANCHESTER AUTHORITIES

NHS
Greater Manchester Association of Clinical Commissioning Groups

'Devo Manc' & Mental Health

(+ Improving Access to Psychological Therapies)

As Part of the Plan for Growth and Reform in GM



High Quality • Safe • Accessible • Sustainable

- **What is '*devo Manc*' and Why (including *Key Outcomes and Benefits*)?**
- **Relationship with *Public Sector Reform* Agenda**
- ***PSR Priorities*, *Lessons* and *Examples* for Health and Social Care Plans**
- **The *Mental Health* (& *IAPT*) Focus, and the Example *GM Extended Work Pilot* Programme Plans**
- ***Questions* – including *Risks / Concerns***

The Devolution of Health and Social Care has Made National Headlines; Both the Opportunity But also the Expectation

Greater Manchester £6bn NHS budget devolution begins in April
27 February 2015

Greater Manchester will control a combined NHS and social care budget of £6bn
Greater Manchester will begin taking control of its health budget from April after a devolution agreement was signed by the Chancellor George Osborne.".
Health devolution for Greater Manchester - 25 February 2015

***Greater Manchester is to become the first region in England to get full control of health spending*.**

FOR HEALTHCARE LEADERS HSJ

It's a historic day for Manchester, but not a 'town hall takeover'
27 February, 2015 | By Crispin Dowler

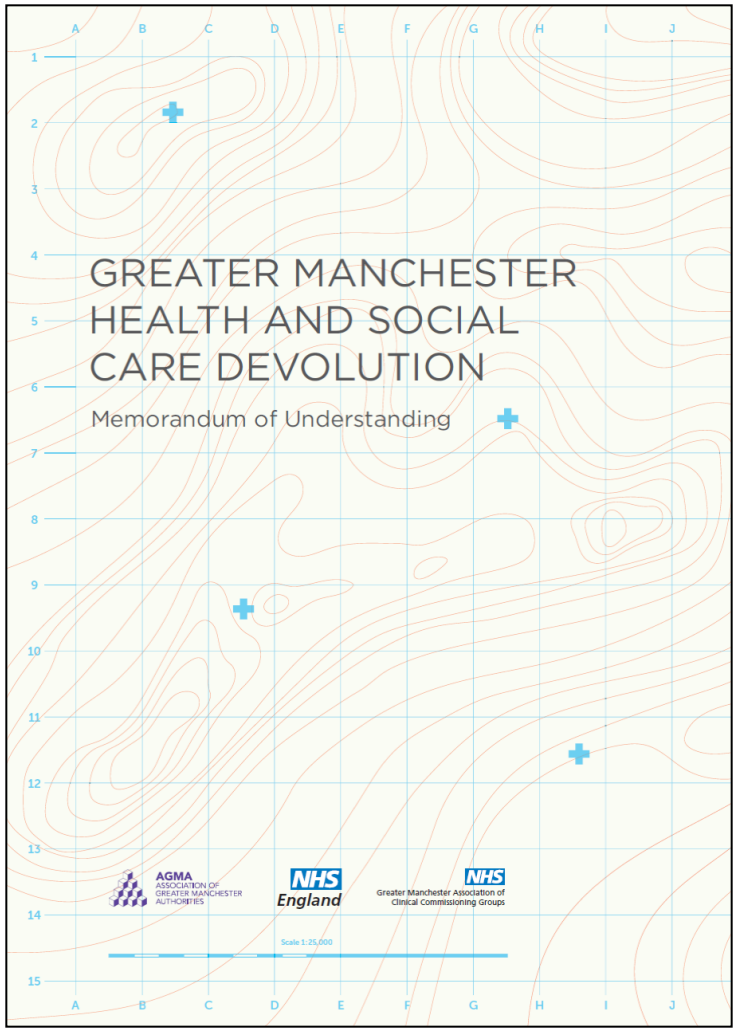
NHS insiders in Greater Manchester have been pleasantly amazed by the speed at which negotiations progressed leading up to **today's historic agreement to devolve and integrate £6bn of health and social care spending for the conurbation.**

Revealed: Details of £6bn Manchester health devolution plan
25 February, 2015 | By James Illman
Radical plans for Greater Manchester to take control of £6bn of health and social care spending will be overseen by a new statutory body from April 2016, according to draft plans obtained by HSJ.

"The belief that effective and appropriate public services can be planned through the happy accident of multiple national organisations driving uncoordinated policy, resource and regulation to the neighbourhood level is fanciful.

Worse still it can actually inadvertently foster dependency and prevent public services fully supporting the aspirations of residents, patients and communities to reach their potential"

What does Devolution offer?



The overriding purpose of the initiative represented in this Memorandum of Understanding is to ***ensure the greatest and fastest possible improvement to the health and wellbeing of the 2.8 million citizens of Greater Manchester*** *(GM).*

This requires a ***more integrated approach to the use of the existing health and care resources*** *- around £6bn in 2015/16 -* ***as well as transformational changes in the way in which services are delivered*** *across Greater Manchester.*

…… A Focus on People and Place

Greater Manchester: *30 Years of Working Together*

Fro m1986

AGMA, GMITA & Airport

AGMA ASSOCIATION OF GREATER MANCHESTER AUTHORITIES

Greater Manchester Integrated Transport Authority

MANCHESTER AIRPORT p.l.c. BRITAIN'S CENTRAL GATEWAY

2008

Business Leadership Council Established

Association of GM PCTs

2009

Prosperity For All Greater Mancheste Strategy

Publication of the MIER

2010

Thematic Commissions Established

GMCA & LEP established

GMCA GREATER MANCHESTER COMBINED AUTHORITY

Greater Manchester Local Enterprise Partnership

2011

Transport for GM

Transport for Greater Manchester

2012

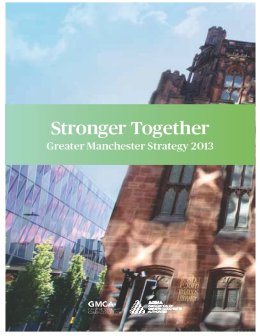
Manchester City Deal

Community Budget Pilot

2013

Association Of GM CCGs

New GM Strategy



2014

Growth & Reform Plan

Growth Deal

Devolution Agreement

Healthier Together + GM Alcohol Strategy

Greater Manchester

- ***Forefront*** of the National Debate on ***Devolution***

- We are Progressing the ***Most Ambitious Large-Scale Programme of Public Service Reform*** in the UK

- Aim to Provide ***Largest Implementation Site for the Five Year Forward View Removing Artificial Barriers*** between Primary Care, Secondary Care, Social Care, Self-care and Social Support

- Devolution Opens up ***New Opportunities for Accelerating Health & Care Reform*** (**inc MH**) ***and Improving the Quality of Life of Greater Manchester residents and patients*** by Securing Greater Local Control Over Certain Budgets and Powers to ***Effect Change***

Devolution is a Mechanism, Not the Master…

What is the problem we are trying to solve…?

Consequences

- Unplanned, Haphazard change
- Poorer Care and Treatment
- Difficulty in Meeting Future Health Needs
- Failing the Health & Care Workforce

Increasing Pressure on Health & Social Care

…. Devolution can be the Trigger for Greater and Necessary Positive Reform

Greater Manchester local health profile is significantly worse than England Average

Deprivation
Higher than average | Lower than average

General health
Generally worse | Better | Mixed

Comparison to England average

Local Authority	General health	Deprivation	Children living in poverty	Life expectancy	Life expectancy gap. most and least deprived areas	Year 6 children classed as obese
Rochdale			11,900	Lower for men and women	• 9.7 years lower for men. • 7.9 years lower for women	20.7%
Trafford			6,500	Higher for women	• 10.1 years lower for men. • 6.3 years lower for women	18.4%
Wigan			12,000	Lower for men and women	• 9.4 years lower for men. • 8.5 years lower for women	18.9 %
Tameside			10,300	Lower for men and women	• 10.9 years lower for men. • 8.2 years lower for women	18.6%
Stockport			8,500	Similar for men and women	• 10.8 years lower for men. • 8.4 years lower for women	17.1 %
Salford			12,700	Lower for men and women	• 11.5 years lower for men. • 8.2 years lower for women	21.5 %
Oldharn			13,300	Lower for men and women	• 11.2 years lower for men • 9.2 years lower for women	19.3%
Manchester			34,630	Lower for men and women	• 9.6 years lower for men. • 8.2 years lower for women	24.7%
Bury			6,670	Lower for men and women	• 11.5 years lower for men. • 7.6 years lower for women	19.3 %
Bolton			13,040	Lower for men and women	• 12.1 years lower for men. • 9.2 years lower for women	20.0 %

SOURCE: 2014 Local Health Profiles, AHPO

Greater Manchester Needs to Improve Health Outcomes as well as the Quality and Experience of Care

Outcomes

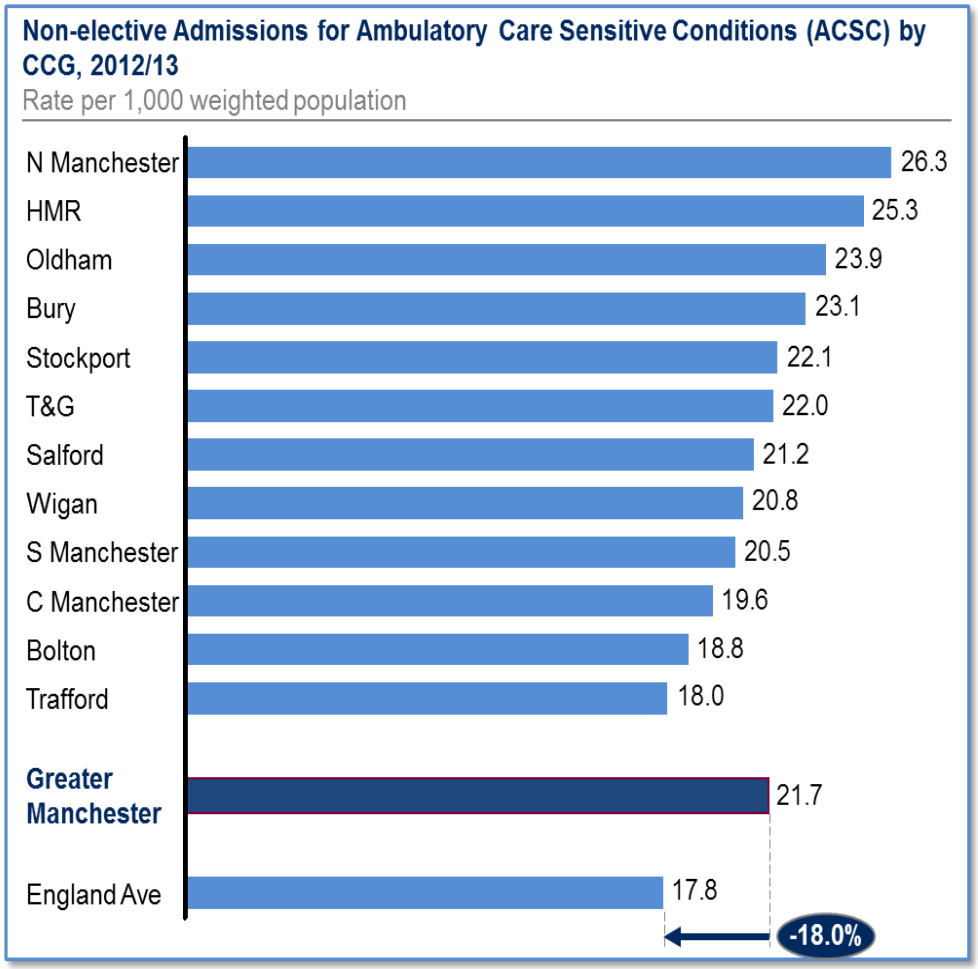
- **Health outcomes are poor** and lag behind other parts of the country.
- **Manchester women have the worst life expectancy in England** and men the second worst
- **High prevalence of long term conditions** such as cardiovascular and respiratory disease mean that Manchester residents not only have a shorter life expectancy but can expect to experience **poor health at a younger age** than in other parts of the country
- 7 of the 10 Greater Manchester Local Authorities have **significantly higher levels of internal inequalities in life expectancy than the England average**, while no Greater Manchester Authority has lower than average levels of internal inequalities

Patient Experience

- Patient and representative groups, report that **access to many services is fragmented and/or confusing**, highlighting the current complexity of the system and lack of true integration
- **Many patients receive non-sequenced care** from a number of organisations under the umbrella of the NHS, so will too often **experience parts of the pathway that are not connected or duplicated**

SOURCE: Healthier Together: Case for change; Better Care Fund plan submission

Rate of Avoidable Admissions in *All* Greater Manchester CCGs is *Higher than National Average*



SOURCE: Hospital Episode Statistics, 2012/13

Whilst our disease registers show a high level of disease prevalence we've still only found about half of the preventable disease that exists

In those patients with disease we have only around 40% are treated to evidence based levels leading to our high level of ambulatory care admissions

We can improve treatment processes resulting in real impacts on the rates of disease progression and reductions in preventable admission costs

Health and Social Care Services in Greater Manchester Face a £1.1bn+ Financial Challenge

	Financial pressures	Challenge[1]
NHS commissioners	• Allocations growing at 0.7-2.5% p.a. • **Underlying demand growth**: 4.4% in 2014/15, then 5.1% p.a. due to demographic pressures (aging and population growth) and other non-demographic pressures • Need to invest in new services and improve existing services	£237m Excluded from total to avoid double counting[2]
NHS Trusts	• **Reductions in price** while costs increase (4.0-4.5% p.a. gap between tariff and cost inflation) • **Reduction in hospital activity** from integrated care and other commissioner demand management programmes • **Rising costs** to meet new clinical service standards (e.g., 24x7 consultant cover)	£851m[3]
Adult Social Care	• **Shrinking budgets** • **Rising demand** from population growth and aging	£333m
		£1,184m

1 Commissioner and Trusts challenge as projected for FY 2018/19. Social care challenge as projected to FY 2018/19
2 Plans to resolve the commissioner challenge contribute to provider challenge, thus excluded from total to avoid double counting
3 £237m of the £851 Challenge is directly due to NHS commissioner changes

SOURCE: January 2015 ASC, CCG and Trust information returns

Greater Manchester Priorities

- ***Sustainable Economic Growth*** *And* ***Connecting People to that Growth,*** *So* ***All Benefit*** *from* ***Sustained Prosperity*** – This is the aim of the ***GM Strategy*** and our ***Growth & Reform Plan*** *with* ***Individuals and Communities More Resilient***

- ***Generating Growth and Jobs Insufficient*** To Meet Our Ambitions of Becoming a ***Net Contributor and Asset to the National Economy***
  - GM Spends around £4.5bn More than Our Total Tax Contribution
  - Total Spend Not Changed in Real Terms, But Proportions have – Now much more on **Welfare Benefits: Costs of Failure** (2008/09–2012/13)
- We know GM's population will be Larger and Wealthier, But ***It Must Also Be Mentally and Physically Healthier*** if **Public Services Are to be Sustainable!**

Greater Manchester Priorities

- ***We Need Direct Action with Our Communities*** to ***Change the Relationship with the Public***

- Need to ***Significantly Increase Pace and Scale of Reform*** - So ***People Are Healthier, Independent and Self-reliant*** – And ***Reduce Demand*** for Expensive, Reactive Services

- Priority is to ***Generate Stronger Evidence*** to Inform Discussions with Government and Our Own **Future Budgets**

- Looking for a ***Reform Roadmap to Radical, Differential Devolution on Reform, with Shared Risk/Reward, 5-Year Budgets*** and ***Place-based Accountability for Reducing Demand and Complex Dependency***

Reducing Demand and Complex Dependency

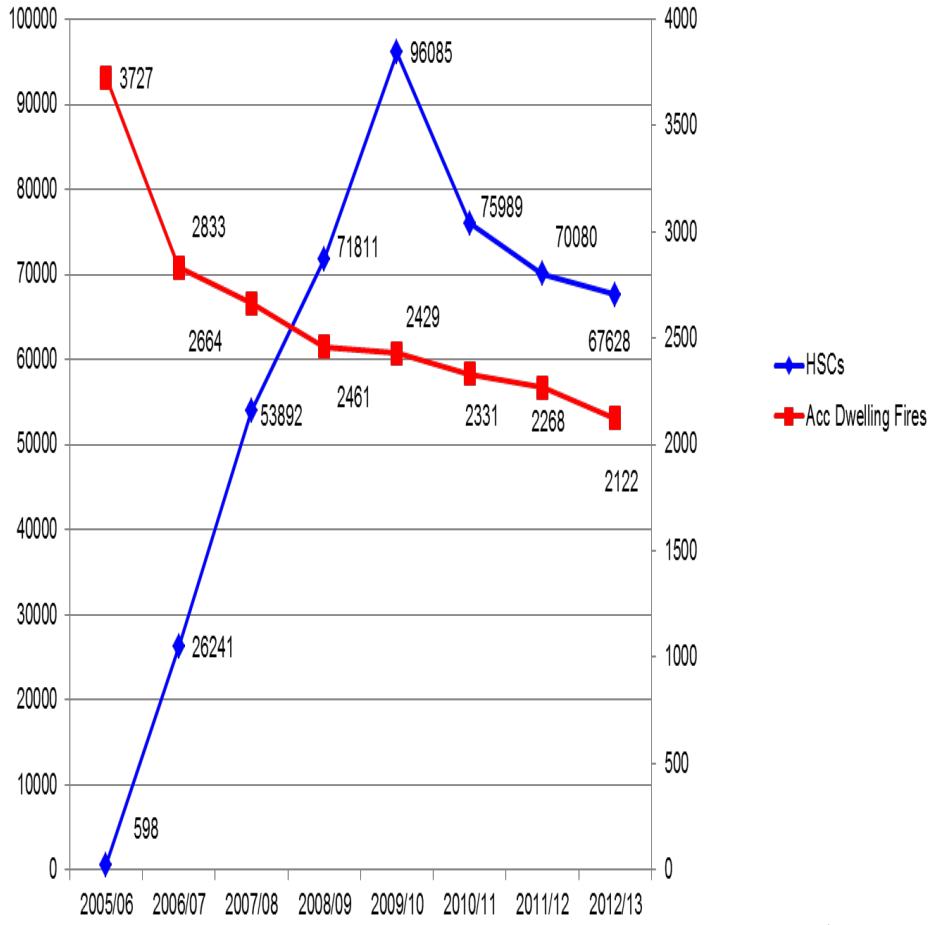
Overlapping GM Priority Cohorts Across The Lifespan

Partners have Identified a Range of Characteristics which Might Indicate Dependency, Especially when there are Multiple Characteristics within One Individual or Family

Worklessness & Low Skills	Children & Young People	Crime & Offending	Health & Social Care
Long-term JSA claimants **ESA claimants (WRAG)** **'Low pay no pay' cycles** • Working Tax Credit claimants • Low skill levels (vocational or academic) • Insecure employment **NEET (Young People)** Compounding factors: • Lone parents with children 0-4 • Poor literacy and numeracy • Poor social skills • Low aspirations • Living alone	**Child in Need Status (CIN) / known to Children's Social Care** **Child not school ready** **Low school attendance & exclusions** **Young parents** **Missing from home** Compounding factors: • Repeat involvement with social care • LAC with risk of offending • Poor parenting skills • SEN • Frequent school moves • Single parents	**Repeat offenders** **Family member in prison** **Anti-social behaviour** **Youth Offending** **Domestic Abuse** **Organised Crime** Compounding factors: • Lost accommodation • Dependent on service • Vulnerability to sexual exploitation • Missing from home • Violent crime	**Mental Health (including mild to moderate)** **Alcohol Misuse** **Drug Misuse** **Chronic Ill-health (including long-term illness / disability)** Compounding factors: • Unhealthy lifestyle • Social isolation • Relationship breakdown / loss or bereavement • Obesity • Repeat self-harm • Living alone • Adult learning difficulties

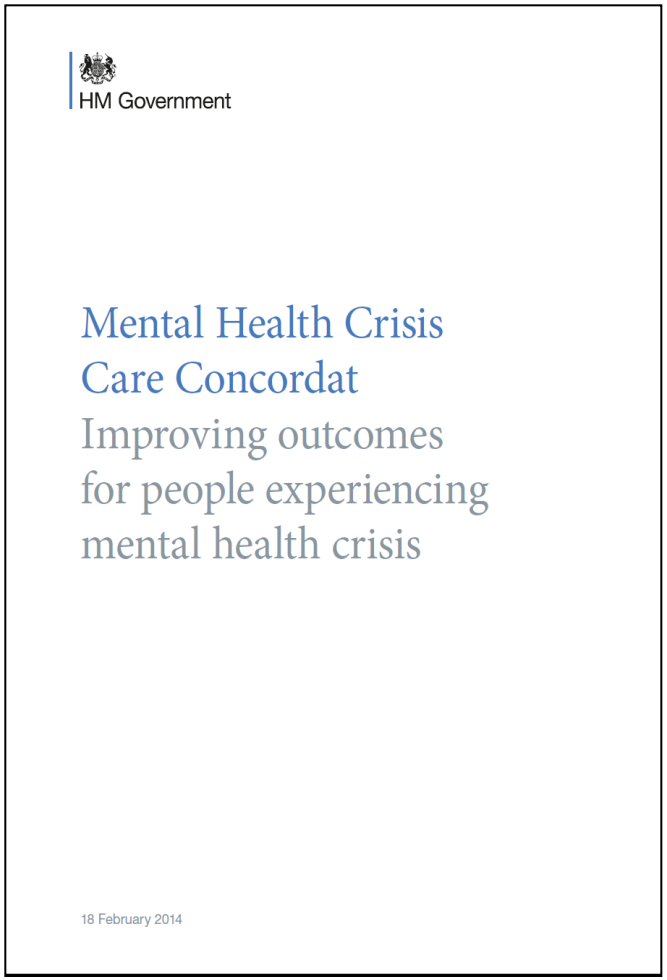
Radical Public Sector Reform?

- ***Shifting the Balance of Investment*** **Towards** ***Proactive, Early Help*** **and Away from a Crisis Response**
- **Health & Care Defined by an** ***Prevention*** **Approaches**
- ***Intelligence-led, Highly-targeted Preventative Action*** **Based on Deep Knowledge of Our Communities and Their Strengths** ***(ABCD)***
- ***More Integrated Public Services*** **Responding to All Forms of Vulnerability in Localities/Groups**
- **Increased** ***Healthy Life*** **Expectancy**



Developments with GMP/PCC

- GM Strategic Mental Health Partnership Board
- All Mental Health Trusts offering 24/7 telephone triage and advice to police officers
- A Number of Pilots Supporting Co-located Health Workers in Neighbourhood Teams
- Local Pilots Supporting Missing Patient Projects
- Local Pilots Focussing on Early Intervention and Prevention
- Developing Liaison and Diversion Plans



Home Office Innovation Fund Mental Health Professional Located with GMP Trafford Pilot

- Targeting a cohort of **high demand service users for GMP** subject to intensive case management by the MH professional/s based with GMP teams

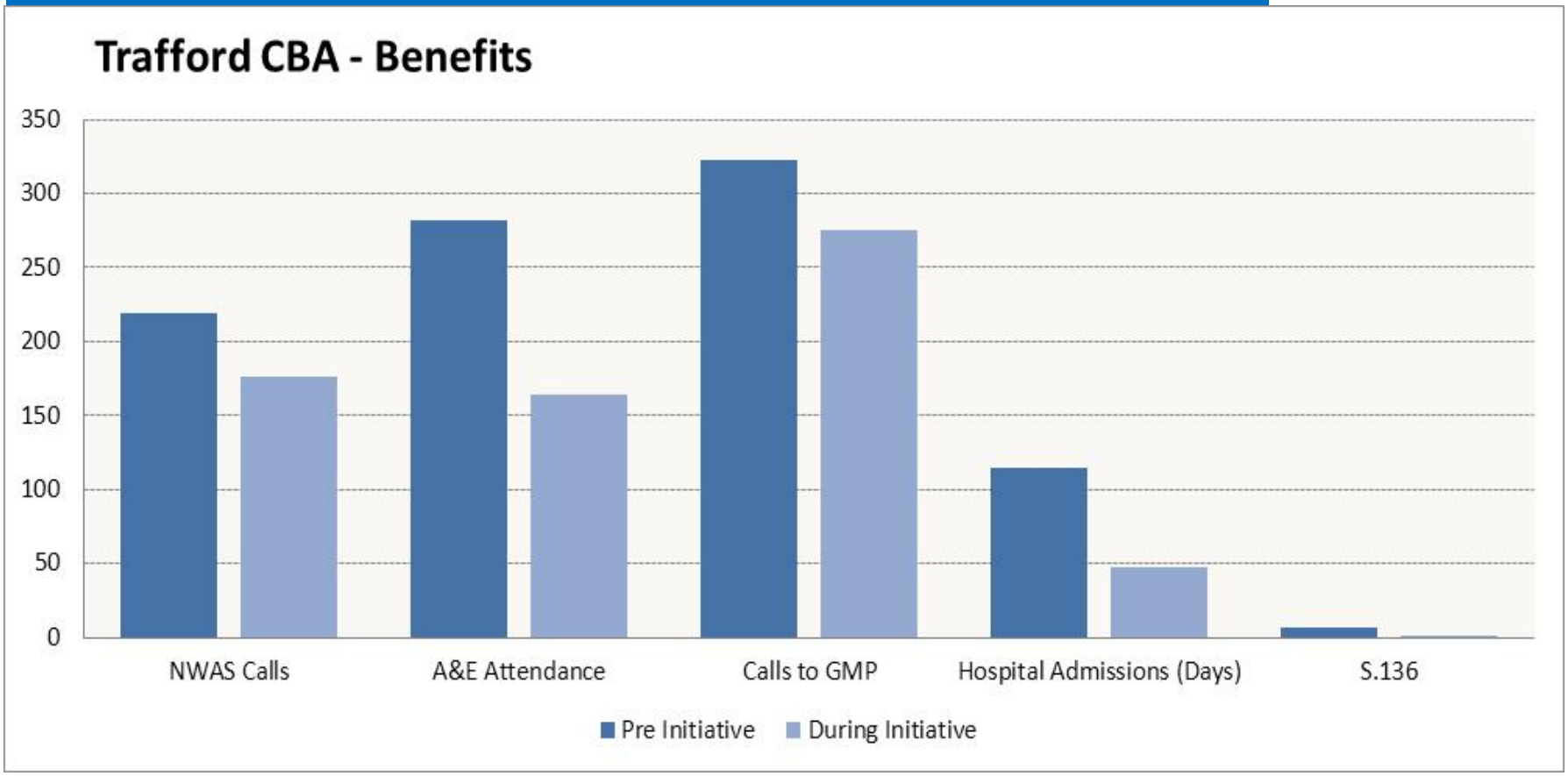
- Actual or probable diagnosis /undiagnosed mental illness, personality disorder or learning disability But seen as **sub-threshold** for specialist service access criteria

- **Often concurrent problems with alcohol/substance misuse or psychological issues** which require assertive support/intervention

Greater Manchester West
Mental Health NHS Foundation Trust

Trafford Pilot Results

Benefits



GMF&RS Developments

- Historic joint work on ***Falls Prevention*** as part of home fire risk assessments
- ***Partnership Agreements*** in place with all Mental Health Providers to share information and identify risk
- Joint work with NWAS/GMP on ***Community Risk Intervention Teams*** to support a timely response to ***Green rated ambulance calls*** and ***Low level MH support***

- Prevention Strategy
- Home Safety Strategy
- Road Safety Strategy
- Youth Engagement and Education Strategy
- Volunteering Strategy

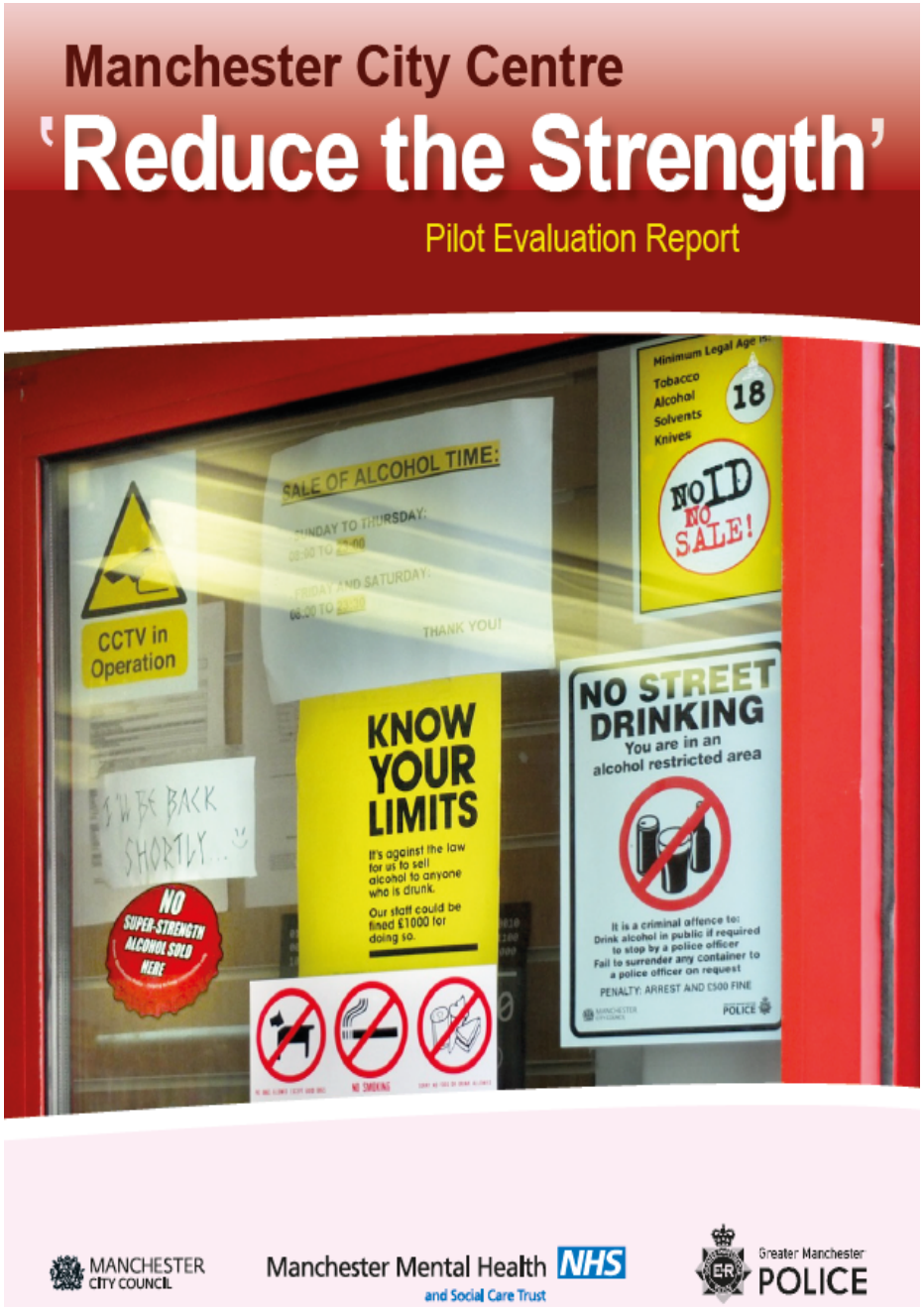
Tacking Health System Alcohol Burden

Rapid Assessment, Identification and Diversion/Transfer (RADAR) of Patients presenting to Acute Hospital who want to stop drinking and require a detoxification who otherwise would have been admitted to acute bed

Rapid Access to Medically-Managed Detoxification to a Specialist Facility 24 hour per day from Acute Hospitals across GM

- Close working with Alcohol Nurse Specialists within Acute Hospitals (gate-keeping, referral pathway)
- 5-7 day admission multi-disciplinary team, 24 hour hospital at night and medical support specialist individual and group Psycho-Social Intervention therapies, with an emphasis on supporting engagement in aftercare and recovery communities

Significant Savings to Health Economy (? £2million in 12-month period) + ***Adding to*** **Wider RAID / Liaison Programmes Across GM**



Started June 2014 in defined Action Zone **covering 22 off-licensed premises** operating in the Northern Quarter and Piccadilly Gardens area of Manchester City Centre

Alcohol-related crime in the Action Zone Reduced by a Greater Amount than in the remainder of Manchester

Alcohol-related ASB did not Increase

Wider increase in all forms of ASB Less Pronounced in the Action Zone than in the remainder of Manchester

'A Manifesto for Better Mental Health – The Road to 2020'

- **MH is Everybody's Business** – affecting all families and communities
- **Good MH is the key to better Quality of Life** – so we need to prioritise positive mental health, prevention of mental ill-health and intervention early when people become unwell
- **Parity of Esteem needed in Standards, Expectations, £**

- **People have the Right to Timely and Effective Help, to Live Well**, and have **A Fair Chance to Fulfil Potential**
- **New relationships** between MH services and users

- *'A level of care, support and service that any of us would be happy for ourselves, our families and our friends'*

Addressing National + GM MH Priorities

- **Better Access and Choice Across Ages**
  - **IAPT** – Psychosocial Prevention Support, Low Intensity, High Intensity, Specialist LT Psychotherapy and PD Support
  - Better Support for **Dementia**
  - **Early Intervention for Psychosis** inc family interventions
  - **PbR**
- **High Impact Effective Service Delivery**
  - **More Responsive Core MH Services** - CMHTs, In-Patient Care and Crisis Support (Acute Care Pathway Redesign)
  - The **Crisis Concordat**
  - **RAID and Liaison/Diversion**
    - Acute including A&E Presentations
    - Police and Criminal Justice System Diversion
    - Primary Care

Addressing National + GM MH Priorities

- **Improved Quality of Life Outcomes for All and Targeted Groups**
  - Military Veterans, LGBT, LT Conditions/MUS, BME, LDD, Autism, Dual Diagnoses, CAMHS and Transitions, Out-of-Area Placements, Offenders
- **Integration of Physical and Mental Health**
  - **Reducing Health Inequalities and Better Physical Health** (eg smoking, alcohol, exercise, healthy workplaces)
  - Support for **Co-Morbid Conditions**
  - Good **End of Life** experiences
- **Public Sector Reform**
  - **Starting Early Upstream** - Enhancing mental health well being / prevention with MH Friendly Lifestyles/Communities and *normalising* distress where appropriate
  - **Reducing Risk** (eg Suicide and Self-Harm) and Learning Lessons
  - **Work and Jobs**
  - **Support for Families, Carers and Communities as a whole**

Key GM Mental Health Commissioning Principles

- ***Increasing Pace and Scale of Public Sector Service Reform*** – High Impact Changes Across Life Course & Partnerships
- ***Maximise Local Solutions within a GM Vision and Framework*** (clear principles, action and enablers)
- ***Working Upstream*** But:
  - Balanced without Reducing Core MH Service Offer – Both Prevention and Treatment Essential
  - Not one at Expense of Other
  - Establish Virtuous Cycles
- ***MH Services Equipped*** to:
  - Strengthen individual and community resilience
  - Respond to increasing demands
  - Respond to changing demands
  - Tackle unmet needs
  - Right care, right time, right place, and Value For £
- ***Collaborative and Aligned Commissioning***
- ***Avoiding Re-stating A Case for Change Without Practical Ideas to Do It***

Putting What Is Known Into Practice

1. Right ***information***
2. Right ***physical health care***
3. Right ***medication***
4. Right ***psychological therapies***
5. Right ***rehabilitation, training for and support for employment***
6. Right ***care plans*** addressing ***housing, work, education, healthcare and self management***
7. Right ***crisis care***

- ✓ Mental health has over 100 NICE Health Technology appraisals, NICE guidelines, Public health related guidelines and Quality standards…..
- ✓ The problem is not lack of guidance
- ✓ The problem is that we have not focused on how we learn and disseminate from those that can and have implemented
- ✓ The standard of Care has unacceptable major variation across England

Draft GM MH Priority Population Domains	Case for Change	Areas of Progress	Aspirations & Opportunities
A. People with impaired mental wellbeing	• Higher level of known factors related to impaired mental wellbeing • High impact on Productivity • Significant impact on health inequalities	• Fit for Work Scheme • GM Working Well • GM MH & Employment Pilot • Alcohol strategy action plan • Veterans programmes • Criminal Justice Systems Support e.g. Intensive Community Orders • GM Public Service Reform	• Closing the health inequalities gap within GM and between GM and the rest of the UK • Better mental health wellbeing for all • Strong personal, family and community resilience
B. People with mental health needs as well as physical and social care needs, but often only one identified or addressed	• Higher rate of co-morbid MH issues • Underestimation of the MH issues of people with physical health problems • Exacerbation of health • inequality	• Locality based multidisciplinary teams • Mental Health Performance Improvement Programmes (IAPT, Dementia programmes, RAID, RADAR, CAMHS, GMP Crisis Concordat) • Learning Disabilities Improvement Programmes	• Achieving parity of esteem • A more holistic, coordinated • Approach which treats a person as a whole • Proactive identification of people with higher risk of Co-morbid MH / LD / Carer issues
C. Population with severe mental health and complex LD needs	• High severe MH illness prevalence • Higher MH admissions • Higher rate of everyday admissions related to MH Problems • Higher spend on specialist MH services	• Specialist Admission / Treatment Beds, • Specialist LD/Psychiatric Rehab Capacity Reviews/ Provider Frameworks • Acute Care Pathway Redesign • Shared Care/Step down care and support pathways	• Network of excellence delivering better and more accessible specialist mental health services • Primary care/Community standards/Flagging systems

Next Steps (Being Developed by Joint CCG/LA/Provider Execs Board)

Short Term Actions

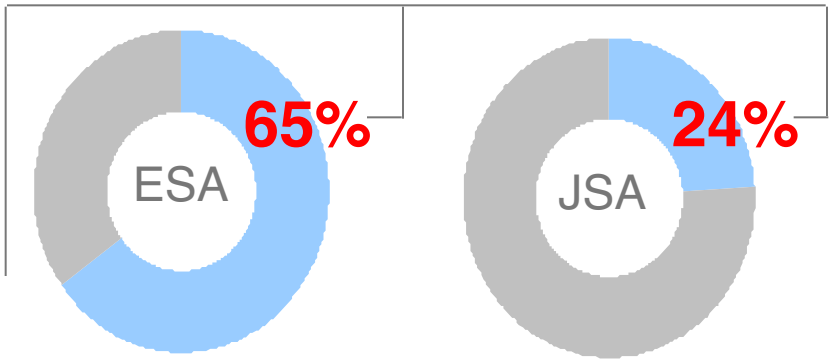
- Best practice collation & Impact evidence
- Opportunities to spread
- Mental Health & Employment

Medium Term Actions

- Networked Model
- Integrated community models – including primary care, community and MH standards
- PSR evidence base/health economics drive investment decisions

Action Needed to Tackle the Clear Links Recognised Between Mental Ill-Health and Employment

Across GM, mental health issues are a barrier to employment for a significant proportion of benefit claimants



1 in 7 men develop clinical depression within 6 months of losing a job

1 in 4 adults are affected by mental ill-health in their lifetime – And increases to nearly 20% among long-term unemployed

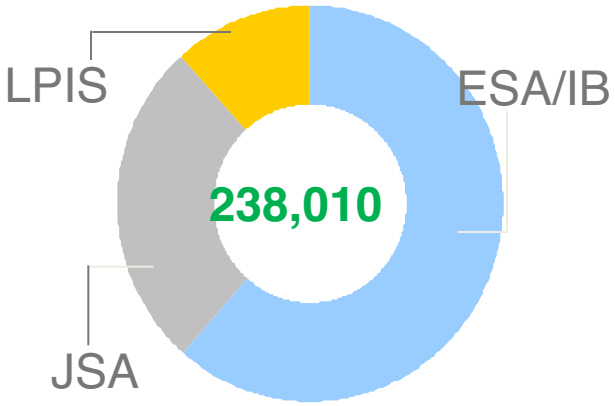
Given the Level of Long-Term Worklessness Across GM, the Impact of Mental Ill-health on Our Region is Significant

£105 billion

Annual cost of mental ill-health to the UK economy

141,360

GM BENEFIT CLAIMANTS



The number of people receiving ill-health related benefits has remained relatively static across GM over the past 13 years, through periods of growth and recession

Those receiving ESA and IB (ill-health related benefits) account for over half of GM's total benefit claimants and 8.1% of the GM working age population

Despite Evidence, Limited Co-ordination Common Between Health and Work Services

1. Work as health outcome not given sufficient priority in patient care - Employment status not routinely identified within the healthcare system

2. Understanding the range of factors impacting on people and their families is not routine in approaches to assessment and support offered by health and employment services

3. Lack of guidance & training for healthcare providers on the need to act on risks of worklessness or the value of making active referrals to appropriate services

4. Structural barriers hold back integration (eg differences in Referral and Payment mechanisms between health and employment systems)

5. Limited access/range of therapies offered. Self-help groups and self-management of mental health conditions are encouraged, but the main psychotherapy in use for mild to moderate mental health conditions is CBT

*So across GM, we have already been working collaboratively in new ways to support people with health barriers to employment – **CQUIN +***

WORKING WELL

5,000 — ESA claimants leaving the Work Programme

JCP — Referral to Working Well providers

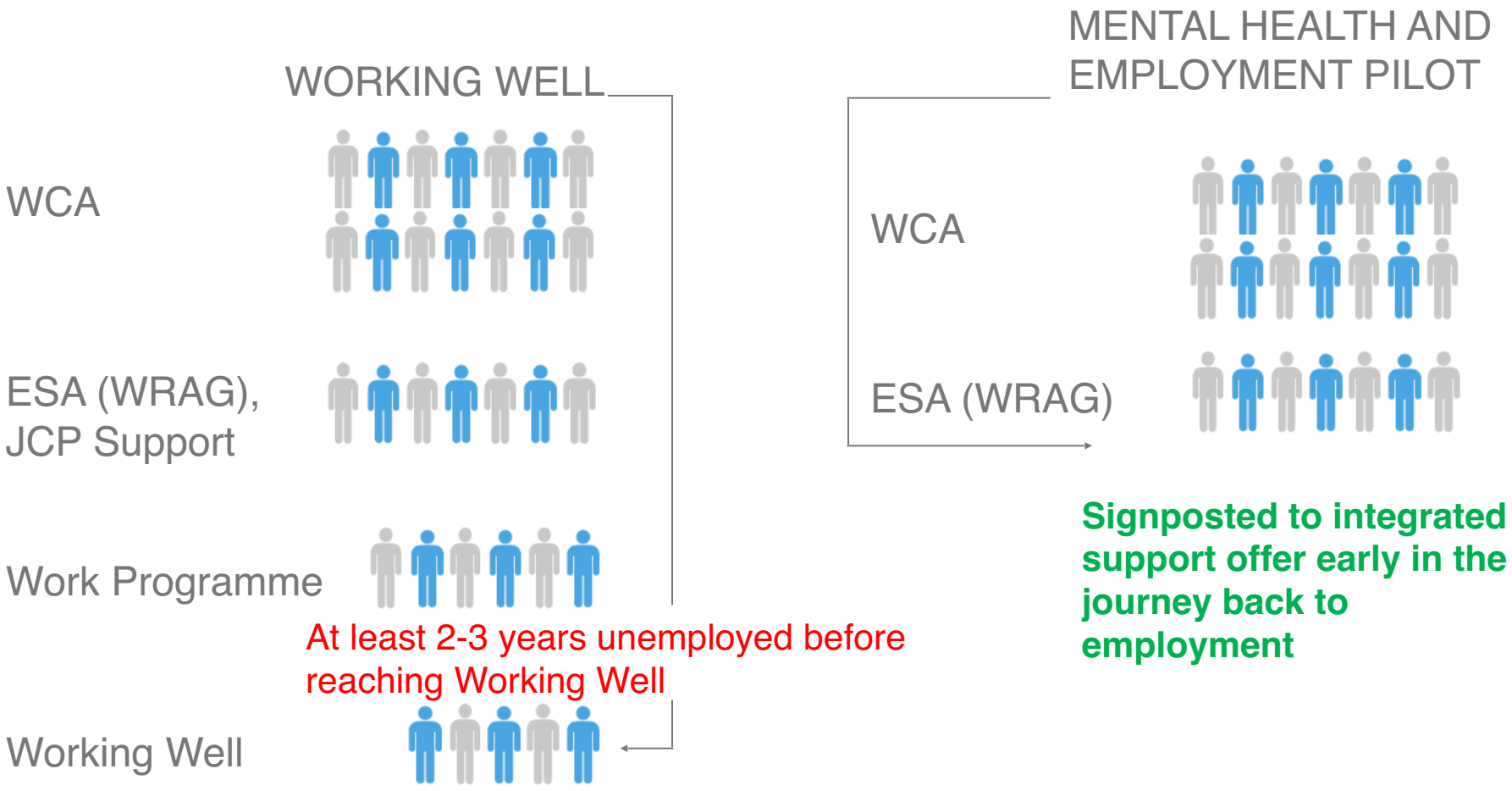
- **Assessment of barriers to employment**
- **Intensive support**
- **Sequenced support**
- **Drawing on expertise of wide range of local services**

Keyworker

Integrated local services

Coordinated support focused on the specific needs of each participant rather than multiple competing interventions

Extending this approach, we are now Developing Support focused on Helping People Earlier in their Journey Back to Work



New National MH & Work Support Pilot

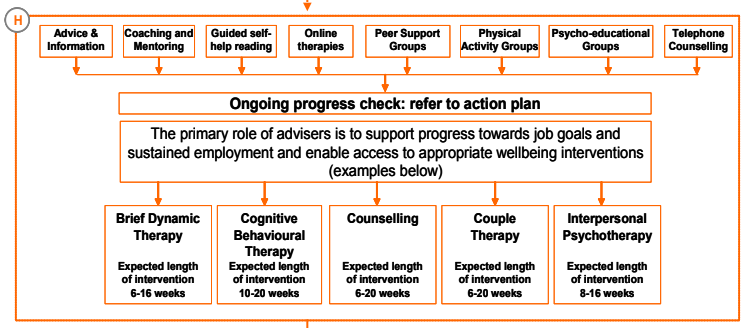
- ***Clear signposting and referral routes*:** A clear referral pathway from JCP ensuring the right patients are identified and referred through a patient selection mechanism co-designed with GPs
- ***A bio-psychosocial assessment*:** A single holistic assessment of an individual, their life and their family, developing a bespoke programme of support using motivational interviewing
- ***A new key worker role*:** This enhanced role linking MH services and employment services directly, with co-ordinated support and casework around the individual, a joint health and work plan involving a mix of telephone-based and face-to-face support
- ***A mixed health and work approach*:** Integrated support designed to move the client towards employment but also dealing with the social determinants and barriers to progression
- ***Improving access to appropriate services*:** Using the single assessment and link worker to identify and coordinate integrated pathways of support appropriate to the individual
- ***Access to a range of therapies*:** Focusing beyond CBT, trialling a wider range of brief therapies, recognising that different people will respond to different approaches **(NEW £/TENDER),** But retaining the focus on **WORK!**

Referral (1) | Assessment (2) | Action Plan (3) | Engagement with Support (4) | In-work support (5) | Exit programme (6)

Keyworker facilitates engagement and integration of support, ensuring interventions occur in the right order, at the right time

Drawing on range of Therapies that will be made available across GM…

See next slide for detail of planned extended therapeutic support options



…and a range of integrated wraparound support services coordinated across local areas, including…

- Debt advice
- Family support
- Volunteering
- Housing Support
- Work Experience
- Alcohol and Drug services
- Skills development
- Physical health services
- Domestic Violence services

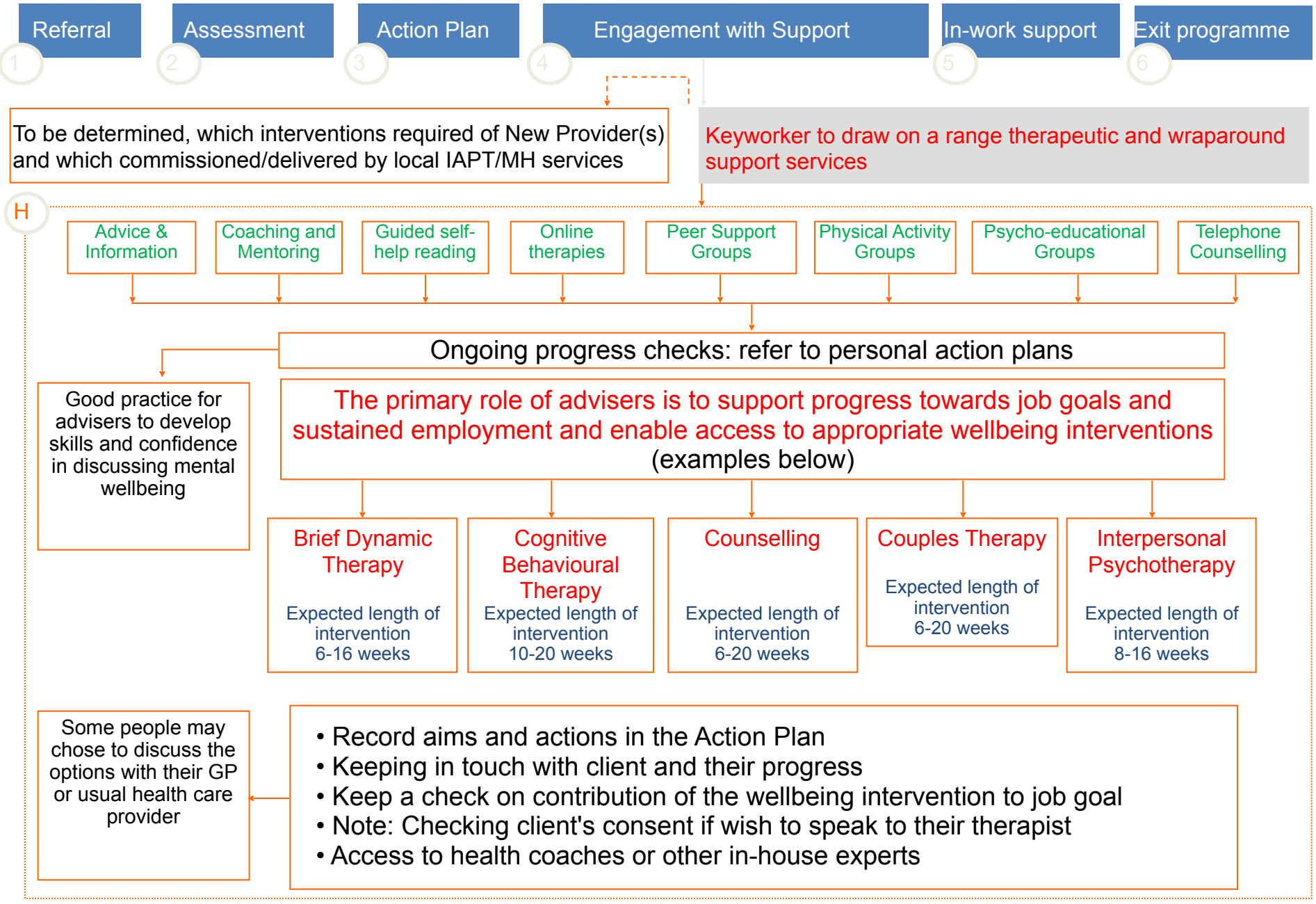
Drawing on the therapeutic and wraparound support services available, keyworkers will develop bespoke packages of support tackling the range of barriers participants face to work (often multiple health conditions, alongside low skills, family issues, social isolation, debt and housing problems). So Keyworkers will determine the right order in which to tackle issues, meaning any therapeutic support may come later in the support process.

Outcomes

20% into work

15% into sustained work and

Improvements in range of health measures


Referral
Assessment
Action Plan
Engagement with Support
In-work support
Exit programme
1
2
3
4
5
6
To be determined, which interventions required of New Provider(s) and which commissioned/delivered by local IAPT/MH services
Keyworker to draw on a range therapeutic and wraparound support services
H
Advice & Information
Coaching and Mentoring
Guided self-help reading
Online therapies
Peer Support Groups
Physical Activity Groups
Psycho-educational Groups
Telephone Counselling
Ongoing progress checks: refer to personal action plans
Good practice for advisers to develop skills and confidence in discussing mental wellbeing
The primary role of advisers is to support progress towards job goals and sustained employment and enable access to appropriate wellbeing interventions (examples below)
Brief Dynamic Therapy
Expected length of intervention 6-16 weeks
Cognitive Behavioural Therapy
Expected length of intervention 10-20 weeks
Counselling
Expected length of intervention 6-20 weeks
Couples Therapy
Expected length of intervention 6-20 weeks
Interpersonal Psychotherapy
Expected length of intervention 8-16 weeks
Some people may chose to discuss the options with their GP or usual health care provider
• Record aims and actions in the Action Plan
• Keeping in touch with client and their progress
• Keep a check on contribution of the wellbeing intervention to job goal
• Note: Checking client's consent if wish to speak to their therapist
• Access to health coaches or other in-house experts

Guiding Principles for Access to Psychological Services

- ***Target treatment to people who need it and Achieve Access Targets***
  - Prevalence, Recovery, Timeliness
- ***Offer patients a choice* when several equally effective treatment or forms of delivery exist**
  - Credibility, Preference, Range
- ***Maximise the chances that patients will take up, and persist* with, an evidence-based treatment**
  - Flexibility, Contact style, Case-management

Guiding Principles for Access to Psychological Services

- Patients *achieve maximum degree of recovery possible* but do not in the process use more resources than are necessary to that end
- Patients *move quickly and conveniently from less intensive to more intensive treatments if these are required* - but the always start with lowest intensity first
- Integrated support in line with wider Public Sector Reform and Reducing Complex Dependency programmes
  - Early Intervention, Stronger Families, Worklessness, Transforming Justice, Vulnerable Groups
- *Monitored clinical, social and employment outcomes* with routine standardised measures

7 Priorities for Organising & Delivering Psychological Therapies

- ***Clear Leadership***
  - Clinical / Professional / Management
  - Capable / Competent / Confident /Credible
- ***Comprehensive offer*** - full range and types of major psychotherapies (ABC)
- ***Safe*** - formally registered practitioners with supervision
- ***Clinically effective*** - efficacy vs impact, matching complexity/need
- ***Co-ordinated Targeted Model*** - LI vs HI vs Specialist
- ***User-friendly*** - accessible, informed choices, critical role of therapeutic alliance
- ***Cost effectiveness*** - stepped care, minimising false starts and avoiding multiple assessments, avoiding over-treatment

'devo Manc' Principles

- '***All Decisions About GM Will Be Taken With GM***'
- ***Upholding All Standards in National Guidance and Statutory Duties*** in NHS Constitution and Mandate - And for Delivery of Social Care and Public Health services
- ***Decisions Focused on the Interests and Outcomes of Patients and People in Greater Manchester*** – And All Local Organisations Collaborating to Prioritise This Agenda
- ***Working Collaboratively*** with All GM Providers and Local Non-GM Bodies and Taking Into Account Impact of Any Decisions on Them and Their Communities
- ***Decision-making Underpinned by Transparency*** and Open Sharing of Information – Valuing front-line ideas

‘devo Manc’ - *Making Change Happen*

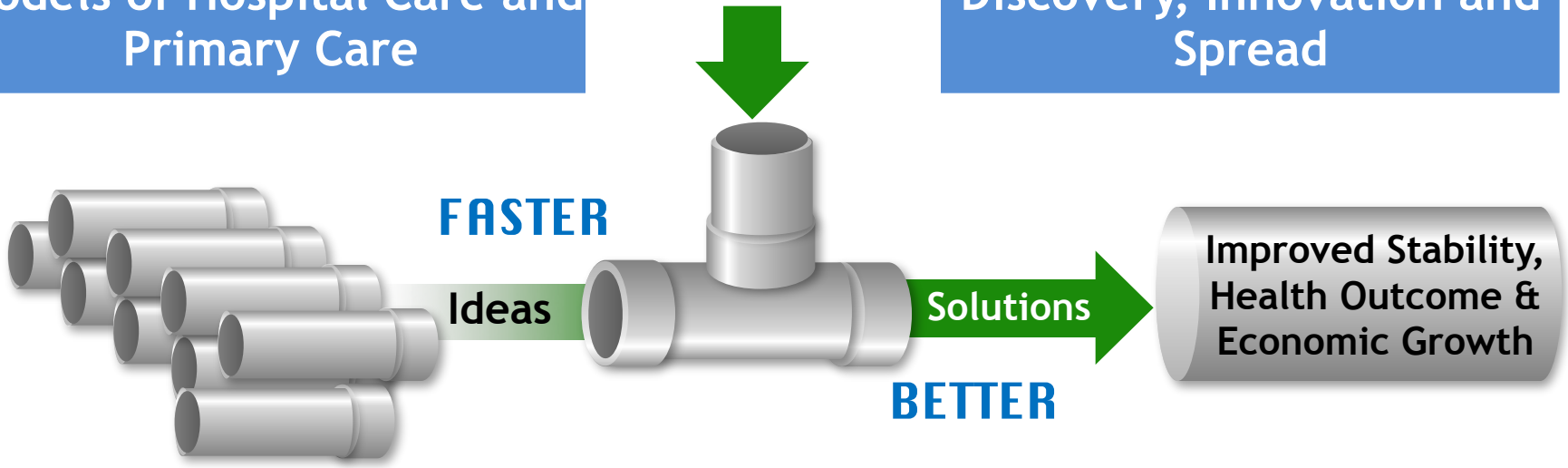
Radical Upgrade in Prevention and Public Health

Building Capacity in Community Assets

Transforming Integrated Community-based Care and Support

Safe Transition to New Models of Hospital Care and Primary Care

Radical Acceleration of Discovery, Innovation and Spread



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Thank you

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