SCHEDULE 1: SPECIFICATION

Integrated Mental Health Network

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1. Introduction and Summary

1.1 The Authorised Officer for this Service is Andrew Trathen

Overview

1.2 This service will predominantly provide mental health support and recovery services to City and Hackney adult residents with complex mental health needs. Additionally, the service infrastructure should be used to support some prevention focused and more widely accessible interventions. The service will be delivered by a number of specialist providers managed by a main contractor. The specialist providers will be able to meet the varied needs of City and Hackney's diverse population, including helping to overcome barriers to access for marginalised communities.

1.3 The service will provide innovative and evidence based mental health interventions that will support people to improve their wellbeing, develop their skills, build resilience, reduce social isolation, work towards fulfilling personal goals and ultimately to be able to live healthily independently from the service. It will help to prevent secondary care admissions and reduce dependence on other local support services, as well as supporting residents to contribute socially and economically to their local communities. Importantly, the service will also help to address the inequalities in access to mental health services and mental health outcomes for the local population.

2. Service Principles

2.1 The service will be:

a. Recovery focussed
b. Outcome based
c. Inclusive
d. Designed to address health inequalities
e. Shaped by the needs, views and voices of service users, carers, families and communities of Hackney and the City of London
f. Person centred support that addresses the needs of the whole person
g. Flexible to the changing needs of the local population
h. Trauma informed
i. Closely integrated with other local partner services
j. Evidence based

3. Service Aims and Objectives

Aims

3.1 The proposed service aims to:

- Improve the overall psychological health and wellbeing for City and Hackney residents who experience complex mental health needs, so that they can live healthily, independently from the service.
- Reduce inequalities related to mental health in the City and Hackney by targeting population groups who experience greater barriers to access.
- Strengthen prevention by reducing the overall population burden of mental ill health, the severity of disease and the escalation of existing conditions.

Objectives

3.2 The service will:

- Provide a single coordinated service, delivered by a number of specialist providers, for residents with complex mental health needs
- Design and deliver a holistic approach to mental health support through a range of interventions, including 1:1 coordination support, 1:1 therapies, group activities, group therapies and skills development, designed to support service users to recover and thrive independently from the service.
- Deliver face to face interventions, supported by remote digital interventions.
- Balance the design and delivery of the different intervention types so as to maximise the benefit to service users, taking into account the number of service users supported, the amount of improvement and the starting levels of need and complexity.
- Design interventions and the service overall to increase accessibility for communities with historically high levels of need and increased barriers to accessing mental health services.
- Use the infrastructure of the service to support the development and running of peer and volunteer led interventions, which can support a wider range of mental health needs.
- Deliver services at times and locations that facilitate access to the service, especially for priority residents.
- Ensure that it is open and accessible, including for people from different ethnicities, LGBTQI+ people, disabled people, people with long-term health conditions, people who are neurodiverse and people with learning disabilities.
- Work in partnership with other local support services to deliver coordinated and complementary support.
- Use ongoing monitoring, development and innovation to ensure the service is continually learning and improving.
- Prioritise service users based on their need, as well as accessibility of alternative local mental health support.
- Ensure all referrals receive a personal response, including waiting times, an onward referral or tailored signposting to self-help resources as appropriate, copying this to the referring agency where applicable.
- Implement a single coordinated and consistent assessment process across all providers, as well as with agreed external partner agencies.
- Manage any waiting list to account for and manage risk.
- Collaborate with service users to develop service user support plans.
- Enable peer support and volunteer opportunities for service users.

- Support community and peer led activities to develop and become largely self-sustaining.
- Use the infrastructure of the service to support the wider development of community projects and organisations
- Coordinate a safe step down/move-on pathway from the service.
- Develop and maintain close working partnerships with other key local services.
- Provide a timely, responsive service to both service users and partners.
- Provide drop in safe spaces for residents to go to.
- Create a positive working environment that supports staff health and wellbeing.
- Contribute to local mental health systems, including the Psychological Therapies and Wellbeing Alliance and work with service partners to identify and resolve gaps in service provision.
- Improve levels of inclusion and acceptance of people experiencing mental ill health in the wider community

Outcomes

3.3 Overall the service aims to support service users to:

- Experience a lasting improvement in their personal mental health and wellbeing outcomes.
- Learn and develop skills, tools, strategies and confidence to empower them to maintain their own positive mental health and live active healthy lives, independently from the service.
- Improve their physical health and wellbeing.
- Improve their confidence and ability to access positive employment, training opportunities and meaningful activities, increasing their contribution to the local economy.
- Develop and maintain social connections and be involved in their local community, reducing social isolation where applicable.
- Participate in peer support and other volunteering opportunities .
- Have greater emotional resilience to withstand the impact of social and other factors that exacerbate mental ill-health.
- Collaborate with staff to determine their own achievable goals and a recovery care plan.
- Reduce their need for health and other support services (e.g. GPs) but have the knowledge and confidence to seek appropriate additional support services if and when they need to.
- Reduce their risk of harm or crisis relating to their own mental health and the likelihood that they will require emergency services and/or secondary mental health services.
- Enjoy improved independence, quality of life and fulfilment of self-determined goals.

4. Service Description Summary

4.1 The core service will be a mental health service for people with high needs and complex mental health problems living in the City of London and Hackney. It will support them to recover and/or manage their condition sufficiently that they are able to live healthily and happily, independent from external support.

4.2 The core service will include a range of time-limited interventions including activities, support groups, education sessions, practical support, talking therapies and 1:1 coordination, from which service users will be supported to select the interventions that best suit their needs. The support offered will be holistic and person centred, including a strong emphasis on service user choice and control and, where appropriate, will be delivered in partnership with other relevant local support services. The main contractor will determine the precise offer, mix and length of interventions.

4.3 In addition to the core service, the service will also use its infrastructure, expertise and connections to facilitate the development, coordination and promotion of 'open access' activities that will be primarily peer and community led. These will be lower level wellbeing activities that support general wellbeing and provide opportunities for social inclusion. They may be ongoing activities that focus on helping residents to maintain good mental health and prevent mental illness. They may be accessed by core service users, people on the waiting list, those who have left the service, residents from partner services and, where appropriate, all interested local residents.

4.4 The service should be focused on outcomes, seeking to achieve improvements in service user mental health, physical health and social factors contributing to mental ill health, such as social connectedness, employment related goals and financial security. These outcomes and improvements should be aligned to services users' personal goals and ultimately lead to move on from mental health services to independence.

4.6 Reducing inequalities is a key priority for this service. Access to the service should be determined by current need and future risk. The service must be tailored to the local population and especially to service users from communities that are historically underrepresented and/or have higher mental health related needs.

4.7 Good partnership working is also a priority for this service and it will be required to proactively work with other local services, to ensure the best experience and outcomes for service users. The service should ensure that it does not duplicate the offer of other existing local services but instead deliver care using a joined up, partnership approach.

4.8 In all of its work, the service should take a continuous learning and development approach. Regular monitoring and engagement should be undertaken to understand any changes that might make the service even better on an ongoing basis.

5 Service Structure

5.1 One organisation will be the main contractor responsible for the service as a whole. They will:

- Hold the entire contract.

- Be responsible for the overall running, coordination and performance of all aspects of this service
- Be responsible for the management and subcontracting of other service delivery organisations

5.2 The majority of the service's resources will be used to directly deliver support interventions to service users and these should be delivered by a range of specialist subcontracted providers. The main contractor may also undertake some direct delivery if they have the relevant expertise.

5.3 The requirements of both the main contractor and the direct delivery providers are described in more detail below.

5.4 The service should be presented and run as a single integrated service. It should not be simply a network of individual providers; service users must be managed and coordinated centrally. Staff from subcontractor organisations may still be involved in delivery of this coordination, as well as support activities but the service users will not be separately held in these organisations.

5.5 This structure must be flexible enough to ensure individual service user needs are met. For example, allocating a key coordination support worker who comes from a specific, culturally appropriate organisation. The main contractor will be responsible for designing and implementing a structure that supports this way of working.

Main Contractor Management Responsibilities

5.6 The main contractor will deliver the following functions of the service:

- Responsibility for the coordination of referrals, waiting list and assessment processes
- Promoting the service to partners and residents
- Coordinating and managing the service, including the delivery timetable and allocation of resources, in collaboration with delivery partners
- Ensuring that there is equity, consistency and quality of access across the service
- Monitoring and analysis of performance of the service and its different components, including assessing how well it is meeting the needs of its target population and monitoring the performance of different subcontractors and interventions.
- Assessing funding allocations in line with the flexible funding model (more information in section 15)
- Ensuring all performance targets and related performance standards are consistently achieved and accurately reported to commissioners.
- Providing management and delivery support for the subcontractor organisations, including highlighting good practice/successes and performance management where necessary
- Ensuring that there are suitable management and supervision mechanisms in place, so that all individual service staff are well supported
- Responsibility for staff wellbeing and ensuring a positive and collaborative working environment between all provider organisations

- Overall responsibility for managing and maintaining partnership relationships, including developing collaborative working arrangements with key external partners (subcontractors may also support this work on day to day level)
- Ensuring innovation and continuous learning and development of the service
- Carrying out administrative duties including financial management and the payment of subcontractor providers.
- Facilitating the involvement of all subcontractors in the decision making and ongoing development of the service.
- Coordinating and delivering a comprehensive training and development offer for all staff
- Managing any incidents, complaints or safeguarding issues
- Coordinating and supporting peer support and volunteering opportunities
- Ensuring that the service supports and promotes wider community and voluntary sector services.
- Work with the commissioner to identify and bid for additional external funds that would support the service to expand its offer and to test new and innovative ideas.
- Any other responsibilities reasonably required for the administration and management of the service

5.7 The main contractor may deliver no more than 35% (by value) of the service. This must include all management functions detailed above and any direct delivery. If the main contractor is not undertaking any direct delivery it is expected that this value will be considerably less. Any variation to the proportion of the overall budget allocated to any provider must be agreed in line with the flexible funding conditions.

5.8 There must be transparent mechanisms to ensure that all staff and organisations carrying out direct delivery are treated fairly, no matter which organisation they come from. This must include, as a minimum:

- Ensuring a fair and transparent process for allocating service users to interventions and delivery providers
- Managing delivery providers
- Assessing performance of delivery providers, staff and interventions
- Ensuring that all direct delivery providers have a voice and can influence the design of the service and its interventions

Delivery Providers

5.9 A range of specialist providers will be subcontracted to deliver elements of the service, supporting service users with complex needs who have been accepted to the service. The identification and appointment of subcontractor delivery providers is the responsibility of the Main Contractor.

5.10 All direct delivery providers will have experience in delivering evidence based, high quality interventions that support mental health and wellbeing and will contribute to service users' recovery. These may include psychotherapeutic interventions, as well as non-clinical interventions.

5.11 The number and mix of providers should be informed by their ability to meet the aims of this service in supporting the City and Hackney population with complex mental health needs and reducing health inequalities. The number of subcontractors should be no less than five, though more may allow greater representation of the target population. Consideration should be given to:

- The types of interventions that each subcontractor can offer. Overall the mix of providers should allow the service to offer a good range of interventions in order to meet service users needs through both specific mental health support, wellbeing interventions, as well as wider holistic support.
- How well providers can support and facilitate access for residents from underrepresented, target groups, so as to ensure the service is inclusive and to reduce inequalities. For example, this could include a provider that is already embedded in a specific community, staff with lived experience and/or provision of interventions that appeal to the target population groups.
- Any specialist knowledge, skills and experience that the provider may be able to offer.
- Ensuring that the offer does not duplicate services already available locally.

5.12 The funding awarded and scope of the services to be delivered by subcontractors may vary. For example, subcontractors may have responsibility for delivering a range of interventions, support and coordination, but could also be engaged to deliver a specific intervention type or small project. The latter may be appropriate if there is a specific intervention that the main delivery providers are not as suited to providing, as a means to support high quality smaller projects/organisations or to test new innovative ideas.

6. Interventions

6.1 Service users accepted into the core service will be able to access interventions directly delivered by the service providers, in addition to 1:1 coordination and care planning. Key workers will discuss and agree with service users which interventions they will access and this should be detailed in their care plan. Interventions delivered as part of the core service should not duplicate interventions available from other external local services and instead, service users should be supported to access these external services as part of their care plans.

6.2 The exact mix of core service interventions may vary over the duration of the contract based on continuous learning and improvement within the service. However, the range of interventions should always balance effectiveness, demand and value for money, including how effective they are at addressing health inequalities. All changes must be confirmed with the Authorised Officer.

6.3 The providers must manage demand for the core service by:

- Prioritising service users based on need
- Ensuring referral pathways are effective and efficient
- Ensuring the offer and criteria of the service are made clear in promotion.

6.4 All interventions delivered as part of the core service should be designed to support service users with recovery and move on from the service. The number of sessions

within a course of interventions will therefore need to be limited, with the specific number being based on the intervention type, as well as need.

6.5 Interventions in the core service should not duplicate other activities or interventions that are already available locally. Key workers should support service users to access these and they should be included as part of their support plan. Where appropriate, the service should work with the organisations delivering these external interventions to ensure they are, or help them to become, suitable for and supportive of people with complex mental health needs.

6.6 As described in more detail in 6.38, in addition to the core service, the service should also support a number of 'open access' interventions outside. Unlike core service interventions, these may be more general wellbeing activities, with less emphasis on recovery and more on prevention and maintaining good mental health. As a result, unlike with core service interventions, it may be appropriate for service users to attend these indefinitely.

6.7 In general, interventions should be open to all core service users who would benefit from them and inclusivity should be encouraged. It is understood that targeting certain interventions at specific communities may be important to reduce barriers to access for some residents, an important aim of the service. However, unnecessarily restricting access to interventions to be for specific service user groups only should be avoided where possible, provided this will not act as a significant deterrent to the target community,

6.8 For 1:1 support (both key worker and therapeutic), any declared service user preference should be met wherever possible and appropriate (e.g. for a certain cultural background, gender, or LGBTQI+ status), especially if this is likely to facilitate or improve access to the service, retention or recovery. However, all staff should have a good awareness of some of the main cultural issues that may impact mental health relating to the communities of the residents that they are working with and the service's management should provide appropriate information and training on this as required.

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Core Service Interventions

6.9 While there is flexibility in what may be delivered, the service should ensure that all of the following categories of intervention are covered in the service offer.

Key worker coordination and support

6.10 All core service users will be assigned a key worker, who they will meet with regularly. Key workers will work with service users to identify the most appropriate care and interventions for their circumstances and together will create a care plan. This should include appropriate interventions delivered outside of this service.

6.11 Key workers should use the relationship they develop with the clients to support discussions concerning what recovery means for each individual, identifying personal goals and measures of progress. A key worker's role is also one that models for the client how to manage new challenges and celebrates clients successes.

6.12 Responsibilities of the key workers will include:

- Working with service users to develop and agree care plans and goals and monitor their progress against these.
- Ensuring that service users are aware of the full range interventions within the service and supporting them to select those that are most appropriate for them.
- Ensuring that they are aware of external interventions available that may also be included in care plans
- Supporting service users to identify volunteering opportunities within or outside of the service.
- Supporting the service user with advice and guidance around mental health, daily living and other relevant factors.
- Checking in regularly with service users to ensure that they are successfully adhering to their support plan and identify/help to resolve any issues they may encounter or facilitating changes where needed.
- Working and communicating with key workers counterparts in other relevant services to ensure service users' care plans are joined up and that the service user experiences the best overall support.
- Being a point of contact should the service user have any urgent queries or concerns
- Ensuring that service users know how to access crisis support if they need to, both during and after their time with the service.

6.13 Exactly how often service users meet with their key workers may to some extent be based on individual need and circumstances but as a minimum this should be:

- At the start and end of their time in the service
- Before and after any course of interventions
- Shortly after a service user begins an intervention to ensure it is appropriate, that they are able to fully benefit from it and to identify/prevent issues occurring that may lead to drop out.
- At least monthly

Where a service user is being supported in partnership with another service where they also have a key worker (for example domestic violence or substance misuse services), it may be appropriate for the partner service to carry out some of the key worker sessions on behalf of both services (and vice versa). provided that all aspects of their care, relating to both services are covered and the total amount of support they receive is as stated above.

6.14 For all service users who are unemployed or are in insecure or unsatisfactory employment, key workers should also encourage and support them to find work or resolve employment related issues. This should include supporting them to identify and access resources or interventions to help them develop their skills, knowledge or experience in relation to their desired employment field and to address any barriers they may be experiencing. This should be done in partnership with employment support services where possible.

6.15 Similarly, all service users should be supported with, or supported to access external practical support around managing finance and debt.

1:1 Talking therapies and IAPT interventions

6.16 Where it is deemed important for recovery, offering 1:1 therapies may be considered as part of support plans for service users.

6.17 In the first instance, when considering talking therapies, the service should assess whether the interventions offered by IAPT could be suitable. Service users who *only* require IAPT should have been referred on at assessment. However, some service users who require the more holistic approach of the service, might also benefit from IAPT talking therapies as part of their wider support package, in which case the service should support service users to access this as part of their care plan.

6.18 When first entering the service, some service users who might potentially benefit from IAPT, might not be at a point in their recovery where it is appropriate for them to access it. In these cases, accessing talking therapies through IAPT should be included later in support plans and the service should support these service users to access IAPT when they are ready to do so. Where appropriate, the service should help to prepare service users for IAPT. Reasons for not being 'ready' for IAPT therapies include:

- Complexities in the service user's life, such as those relating to employment, housing difficulties, financial problems, relationship distress, or substance misuse for example, which need to be addressed first before IAPT talking therapies will be beneficial.
- Service users may be reluctant initially to access 'therapy', perhaps due to concerns around stigma or viewing it as not being for them, but would actually benefit from it.

6.19 The service should liaise closely with IAPT services around the appropriateness and timing for service users attending talking therapies. Wherever possible and appropriate, the need for 1:1 therapy should be met by IAPT.

6.20 All core service users accessing 1:1 therapy provided by IAPT as part of their care plan, would still be able to access other holistic support offered by the service. However, service users should not attend more than one type of psychotherapy concurrently and therefore should not receive any such intervention, including group psychotherapy, from the service at the same time as they are attending IAPT.

6.21 If a service user requires 1:1 therapies but those offered by IAPT are not suitable (or will not be following stabilisation), then the service may consider offering an alternative type of psychotherapy intervention internally. The specific interventions offered should be based on individual assessments of service user needs by a specialist practitioner. However, the volume at which alternative 1:1 therapies can be offered within the service and the needs of individual service users should be balanced against the impact of providing these resource intensive interventions on the rest of the service and other service users. The offer of these interventions will need to be closely monitored and adjusted accordingly by the service to ensure that the objective of the service to maximise benefit is being met.

6.22 Therapeutic 1:1 interventions should be time limited and usually between four and twelve sessions, based on individually assessed need. Any decision to extend the

period of treatment should be for no longer than a further six sessions, authorised by a clinical supervisor and reported to the Authorised Officer.

Therapeutic groups

6.23 The service should also offer therapeutic and psychoeducational groups that are specifically focused on addressing mental health and wellbeing of service users. They should support service users to better understand their own behaviours, including identifying inaccurate or distorted thinking patterns, emotional responses and behaviours, as well as to acquire knowledge, tools and techniques to address any issues identified and to look after their own mental health.

Participation in therapeutic groups should be limited to a set number of sessions in a defined module or course. It is expected that these would always be carried out by suitably qualified staff.

Activities

6.24 The service should offer a range of non-clinical activities that support service users' wellbeing and recovery. These activities should be consistent with the principles of Five Ways To Wellbeing (or 5 to Thrive) and actively support the service user to improve their long-term wellbeing.

1. Connect with other people
2. Be physically active
3. Learn new skills
4. Give to others
5. Pay attention to the present moment (mindfulness)

6.25 The selection of activities will be determined by the providers. The focus of these may be on the activity and they do not necessarily need to be explicitly about mental health from the participants' perspective. However, all activities should still contribute towards supporting service users to achieve recovery and independence from the service.

6.26 Similarly, staff delivering these courses do not need to be mental health specialists but should be suitably qualified, both for the course they are delivering, and for working with potentially vulnerable people with significant mental health needs.

6.27 Participation in all core offer activities should be time limited.

Training

6.28 Training, either as part of a step towards employment, or for personal development and wellbeing, should also be encouraged for all service users. Key workers should help to identify appropriate opportunities within the service or outside of it (for example, courses with the Recovery College or with Hackney Learning), as well as any additional steps, support or guidance that may help them to access these.

6.29 A new course can be a significant undertaking and key workers should communicate regularly with service users starting a new course and support them to address any issues they face to increase the chances that they successfully complete it.

Volunteering

6.30 All service users should be strongly encouraged to participate in volunteering, either with the service, for example supporting the open access activities, or with other voluntary and community organisations. The service should support them to identify opportunities that are of interest and help them to access these, including identifying or providing any training requirements.

6.31 The service should ensure that all volunteers receive suitable supervision and any relevant training to allow them to fulfil their roles safely. The service may also wish to consider offering additional benefits to volunteers after they leave the service. As a minimum this should include being able to attend open access opportunities and potentially also other activities in the service if they are not fully subscribed.

Educational sessions

6.32 The service offer may include some learning/training sessions on specific topics. These could be one off events or a series of lessons, practical or informative. They may be about a mental health related topic or something else that is relevant or of interest to service users. However, these sessions should not duplicate the offer of the other services, such as Recovery College or Hackney Learning. Where courses are offered externally, services users should be supported to attend these as part of their care plans and the service should help to facilitate this access where possible.

Digitally delivered interventions

6.33 The service should use digital technology to enhance the variety, reach and quality of its offer. This should include:

- Offering some remote options for most categories of interventions (e.g. 1:1s, groups, activities etc.). In doing this the service should consider the advantages and drawbacks of both options, for example the benefits of in-person interactions compared to the convenience of digital, and may wish to vary the offer to service users on a case by case basis, depending on their needs. It is expected that the service will be delivered primarily in person, utilising digital options where this is beneficial to service users' recovery and taking into account service user preferences.
- Offering some specific interventions that are suited to digital delivery. This could include webinars, interactive online or app based programmes or virtual group chat options. These may be more suited to the open access interventions rather than those of the core service.

IAPT Preparation Only

6.34 Some residents may be unsuitable for IAPT for reasons such as those described in paragraph 6.18 but will not meet the prioritisation threshold (see section 10 for more information) for the core service either. While these service users would not be eligible for the full service offer, where possible they should be offered tailored support to help with stabilisation, including practical support and engagement in activity programmes for example, with the aim of supporting them to a point where they would then be suitable for IAPT support.

6.35 This is a new and untested intervention and at the time of writing, data is not available to indicate how many potential service users this would apply to or how much resource would be required. This should therefore begin as a relatively small pilot intervention.

6.36 The service must work closely with the IAPT service on the delivery of this intervention.

6.37 Service users accessing the service for IAPT preparation only should also be able to attend the open access opportunities described below.

Open Access Opportunities

6.38 As previously noted, the majority of the service budget should be allocated to directly delivered, time-limited, recovery focused interventions for the core service, such as those described above. These will be for residents with high and complex needs and should be focused on recovery and supporting service users used to be able to live healthily, independently from the service. However, these interventions should be complemented by a range of lower level prevention and wellbeing focused 'open access' activities, which can be accessed by a wider cohort of residents and need not be time limited and a relatively small amount of service resources should be used to support these, a post for example.

6.39 As a minimum, most open access interventions should be available to all core service users (including those on the waiting list), service users from partner services (see section 18), previous service users and residents who applied but were not prioritised for/accepted into the core service. Some may be available to all residents. Open access activities may also be targeted at, or restricted to, specific population groups if and where this is appropriate.

6.40 The service's role regarding open access activities will be a supporting and coordinating one. The service should select and collate a menu of open access activities that will be shared with the minimum list described above. This should include a range of activities covering all of the categories listed below.

- A few carefully selected London or national resources, such as the Good Thinking apps.
- Interventions or activities provided by external services that support good mental health and wellbeing and are openly available, for example the Recovery College, the council's adult and family learning service, the Service User Network (SUN) and free local running and walking groups or events such as Park Run.
- Interventions or activities provided directly by the service. These should be low cost and/or interventions that would be provided as part of the core service anyway but can easily be opened up to more people, for example educational webinars.
- Interventions that are primarily led and delivered by volunteers and/or are self-sustaining but may be supported by the service. The requirements for the service, in relation to this type of open access intervention, are described in more detail below.

6.41 The service will facilitate service users (including former service users) to develop and run wellbeing related activities. These activities should be mostly self-sustaining with no or minimal ongoing financial resource requirements. The service providers will not directly run these interventions but will use its experience and contacts to provide advice and support around the design, development, monitoring, coordination, risk assessment and promotion of activities. The service should offer appropriate training and have a small budget to cover limited one off and/or minor costs, e.g., equipment, insurance etc.

6.42 Service users may wish to partner with existing voluntary or community organisations for the delivery of these activities. Opportunities to partner with services and local businesses unrelated to mental health could also be considered.

6.43 The Five Steps to Wellbeing (or Five to Thrive) should be the basis for open access activities, with each activity providing opportunities for at least one of: connecting to others, being physically active, learning, giving and being mindful, with a particular emphasis on connecting and addressing social isolation.

6.44 For illustrative purposes, some examples of possible volunteer-led open access activities are listed below.

- Walking (or running/cycling etc.) groups

  Regular attendees or those with relevant experience could be encouraged to become walk leaders, volunteers could support with any administrative duties and required training could be funded by the network)
- Gardening club

  This could link with organisations such as the council that have access to suitable plots that could be used. Some basic tools etc. could initially be funded by service.
- Peer support or social networks e.g. whatsapp groups

  These could be moderated by trained volunteers within the groups
- Craft/sewing groups

  Some initial equipment and materials could be funded by the service and the group could potentially sell some of what it makes to ensure it is self-sustaining
- Coffee/lunch groups

  Could potentially be combined with walking groups or drop in spaces. Participants could bring their own lunch or coffee and bring it to an arranged meeting point. .

6.45 The overall care for those residents who only attend the open access opportunities will not be coordinated or managed by the service and residents would not be required to be part of the core service to access them. If residents have been referred in by another service to open access interventions coordinated by the service, that service would retain overall responsibility for managing their care.

6.46 Given the lasting or self-sustaining nature of these activities, it is expected that the number and variety of supported open access activities will increase over the duration of the contract.

6.47 All organisations should be made aware of/agree to their inclusion on the menu. No organisation will be paid in return for being included.

6.48 The service is responsible for coordinating the menu of open access activities, keeping it up to date and designing how this will be presented and communicated to residents and professionals in a clear and helpful format. It is also important that service ensures and maintains a high level of quality and relevance for interventions, listed so that its value is not lost; the list should not include all possible activities but those that are most relevant.

6.49 The service should coordinate with Better Conversations to ensure that there is coordination and not duplication between the two, as well as any other relevant partners where there is any crossover.

Drop In/Safe Spaces

6.50 The service should offer some safe or drop in spaces for residents. This could also be considered as an open access opportunity. These places would be for residents to physically go when they have the need for them, for example:

- To have somewhere to go
- To avoid isolation
- To get out of cramped or unsuitable accommodation for a time
- To go to when they are worried about their own risk to themselves
- To support others

6.51 Drop-in spaces would not be expected to always be available but each space should be available on a regular basis (e.g. the same afternoon or an evening each week) so that they can be promoted and residents know when they are available. The service should ideally utilise existing spaces, for example in buildings of local providers, or potentially appropriate public or partner spaces.

6.52 Any entry restrictions for spaces would need to be considered on a case by case basis. Being openly accessible and inclusive are both encouraged but it is accepted that some spaces may not be suitable for certain residents e.g. those at risk of crisis.

6.53 Trained volunteers should be present at each space. They would not be expected to deliver any specific interventions but should be able to offer basic advice and signposting if required. Specialist staff should be onsite should they be urgently required.

6.54 Drop-in spaces should also provide a mechanism for identifying and referring in residents who are suitable for the core service and they may facilitate access for those who are reluctant to access formal services.

7. Delivery Volume

7.1 The core service will support a minimum of 1,800 adults living in Hackney and the City of London. This will include service users who primarily are supported through the core service, as well as those who are jointly supported with partner services, for

example with domestic violence or employment services. Service users only accessing open access activities, IAPT preparation only and service users primarily supported by partner services but accessing specific interventions from the core service should all be counted and reported separately.

7.2 The service must work to prevent dropouts, as a minimum by:

- Supporting participants to overcome any barriers to attendance
- Ensuring participants are registered to attend suitable interventions
- Use historic information on dropout rates to account for this in intervention starting numbers
- If appropriate, run two courses/activities concurrently and merge them later if dropouts occur
- Monitor if high dropout rates are associated with any particular interventions or factors, investigate this and make changes accordingly, in line with the continuous learning and improvement approach of the service.

8. Accessibility - Location, Digital Delivery And Opening Times

8.1 The service will minimise practical barriers to access for service users by ensuring that it is delivered in convenient locations and suitable times, utilising digital technology where this is safe and appropriate.

Location

8.2 The service should be delivered from a variety of accessible community based venues in Hackney and the City of London. There should be a wide geographical spread that includes venues in or close to the City of London. Colocation with other established services outside of the network (e.g. food banks, libraries, Job Centre Plus etc.) is also strongly encouraged.

8.3 Delivery locations should include consideration of the neighbourhoods model in the City and Hackney, with services provided in or near all neighbourhoods. However, the service is not expected to provide the same offer in each neighbourhood, as this would negatively impact its ability to provide tailored and specialist services.

8.4 Staff at all locations must be appropriately managed and supported and the service must ensure a consistent service identity is maintained across all locations.

8.5 The following should be considered when selecting locations:

- Ease of getting to the venue (e.g. transport links, walking distance etc.)
- Physical design and decor and the impact of this, (including for physically disabled people, neurodivergent people, people with anxiety etc.)
- How they can facilitate engagement with target communities
- Suitability for delivering 1:1 and/or group activities as required
- Staff and service user safety and security

- An appropriate, welcoming, reception and waiting area space
- Toilet facilities for staff and visitors
- Office space and staff lunch facilities
- Health and safety for the premises
- Any possible impact on local residents and businesses
- Whether any refurbishment is required
- Whether there is a suitable space to allow the venue to be used as a safe space (see 6.50)

Home Visits

8.6 The service is not expected to routinely carry out home visits but may adopt a pragmatic approach if it is deemed by the service to be important for the service user's recovery and where doing so is feasible and in accordance with organisational risk management procedures.

Digital Delivery

8.7 It is expected that a large proportion of the core service will be delivered in person, due to the wellbeing related benefits this offers. However, this should be complemented by a digital offer which could include:

- Some groups, activities and 1:1 sessions offered online instead of in person.
- Specific digital interventions offered as part of the range of interventions provided by the service.
- Digital resources that service users can access in their own time independently.

8.8 The service should determine the balance of in person and digital interventions based on:

- What leads to the best outcomes for service users, including considering the benefits to service users of in person services
- Service user requirements (this may relate to their specific mental health needs or practical issues, such as fitting appointments in around other commitments/not having digital access)
- Value for money and whether digital provision can allow the service to increase capacity and therefore improve its overall outcomes
- The types of intervention

8.9 The service will also have a business continuity plan for how it will move entirely to digital delivery should this be necessary (for example due to a new serious coronavirus wave).

8.10 The service should also consider using technology to enhance the running of the service, for example to support appointment scheduling and reminders, recording

information and sharing it with partners and helping service users to stay on track with their care plans. More innovative uses are also encouraged.

8.11 The service must ensure that there is no significant disadvantage to people who are digitally excluded and will ensure the service is designed to also accommodate their needs.

Opening Times

8.12 The service should set its opening times based on service users' need but also take into account staff availability and wellbeing. As a minimum the provider must ensure the service:

- Operates 52 weeks per year, excluding bank/public holidays
- Delivers 1:1 and group interventions on at least three evenings, early mornings or weekends per week

8.13 The days and times above apply to in person and digital options, as well as for a range of venues, with a good geographical spread and types of intervention offered. Having only a few small/specific components of the service available offered on the weekend or evening would not be adequate.

9. Ensuring The Service Is Accessible For All Population Groups

9.1 Through consultation and analysis of local data, a range of population groups have been identified as having higher needs in relation to mental health and/or existing support services are not as well suited to their needs. These groups may be identified by demographic characteristics, by their circumstances or their experiences. Where service users intersect a number of these groups, their mental health risk multiplies. Nevertheless, somebody may be a member of multiple groups but have good mental health and wellbeing, so it is also important that the service does not act or promote itself in a way that could stigmatise any specific groups.

9.2 The service must be designed to:

- Be inclusive to all population groups in the City and Hackney, especially those listed below, ensuring the service is designed so as not to create any access barriers to these groups, including practical, social and psychological barriers
- Ensure the interventions offered are attractive to and tailored for these groups.
- Consider the increased risk/need that may be associated with any of these factors and build this into the prioritisation process for access to the service.

9.3 Below is a list of groups the service must consider in its design, identified through consultation. The list of groups listed is very unlikely to be exhaustive and the service should work to reduce barriers for all service users.

- Refugees
- Migrant communities

- People for whom English is not their first language
- Residents who are living in the 10% most deprived neighbourhoods nationally
- Homeless people
- Families, especially those experiencing poverty and lacking the necessary resources to obtain them
- People providing at least one hour's unpaid care and support each week to a friend, neighbour or relative because of illness or old age
- People with a learning disability
- Neurodivergent residents
- Physically disabled people or those with a long-term limiting illness
- Older adults, especially those who are socially isolated
- Residents who are digitally excluded
- LGBTQI+
- Young People
- Ethnic minority communities. African and Caribbean communities, Turkish and Kurdish, Irish, South Asian, other Middle Eastern, Eastern European and Latin American communities have been highlighted as gaps, although there are likely also others. It is also acknowledged that often there will be many different communities within these and their needs and the barriers they face will vary with this.
- The Charedi Jewish population
- People experiencing domestic violence
- People with experience of trauma

9.4 Measures that the service must consider to increase access for these groups include:

- Flexibility in the times and locations the service is delivered
- How the service is promoted, including what channels are used, how people from target populations are reached and the languages of any materials used
- Employing staff who speak languages other than English and/or who are representative of the local diverse population
- Ensuring that services are accessible for those with and without access to digital technology.
- How any unintended costs of the accessing service can be avoided (e.g. travel/having to attend in working hours).
- Designing interventions to specifically appeal to or better support certain needs, e.g. a group for victims of domestic violence or an activity that appeals to a certain community. Including family based interventions in the service offer should also be considered.
- Adjusting interventions to accommodate service users needs or preferences, for example, where possible, appropriate and not detrimental to the performance of interventions, allowing parents to attend with babies or young children should be considered, especially where alternative childcare is not available.

10. Eligibility Criteria

Eligibility and Prioritisation

10.1 The core service will be provided to service users who meet the following eligibility criteria.

- They must be 18 or over. (Young people aged 17 could be added to a waiting list in advance of their 18th birthday if appropriate, in order to reduce problems or delays when transitioning from young people's services.)
- They must be a resident in the City or Hackney, registered with a City or Hackney GP or be a City or Hackney care leaver up to the age of 25.
- They must have complex mental health needs. This does not need to be a clinically diagnosable mental health condition.*

10.2 Within these criteria the service will prioritise residents to receive the service based on their mental health needs. The service will be required to propose a method for this prioritisation, to be agreed by the commissioner. Mental health needs should be assessed first and foremost based on the following.

- The severity and complexity of potential service users' mental health needs.
- Their being ineligible for, unsuitable for, or unable to access any other local mental health support services. If service users would prefer to access the service but also have the option of other services, such as IAPT, they should not be prioritised over somebody with equivalent need who cannot. Details of IAPT eligibility are available here.

10.3 Complex mental health needs refers to challenging life circumstances that are closely interrelated with and exacerbate mental health problems. These can be environmental, social, biological and psychological factors. When these complexities are significant they can make addressing mental health problems more challenging to address in isolation. These could include a wide range of factors including having housing difficulties, debt, isolation, experience of domestic violence, learning disabilities or neurodivergence, physical health conditions or disabilties, experience of discrimination (e.g. due to being from an LGBTQI+, migrant or ethnic minority community) or being digitally excluded.

10.4 The prioritisation process should be monitored by the main contractor and a review of any proposed changes included in the annual report, for discussion with the commissioner.

10.5 *If for any reason all referrals meeting the eligibility criteria have been accepted and the service has capacity remaining (assuming adequate promotion of the service), referrals for more moderate mental health needs may be considered and should be prioritised according to need based on the criteria outlined above. If this occurs, the main contractor should make the commissioner aware.

Exclusion Criteria

10.6 Overall this service should focus on inclusivity and therefore strict exclusion criteria are not desirable. However, the service will not be able to adequately meet the

needs of all individuals and some will be better supported elsewhere. Where the service can partially meet a person's needs, partnership support arrangements should be implemented wherever possible. Some examples where exclusion from the core service may be considered are described below.

- Residents whose needs are already or can be fully met by another service would not be eligible or prioritised for this service respectively, as this would indicate that their need would be comparatively low. Where residents' needs can only be partially met by another service, they may be considered for the service, provided that there is no duplication in provision. In these instances support should be coordinated by both services in partnership. Where the majority of a service users' needs are met by another service, but they require a certain intervention(s) within the Integrated Mental Health Network service, access to these specific interventions may be agreed under a partnership agreement (see section 18)

- Individuals who require immediate specialist intervention should be treated in secondary care, for example due to acute psychotic and related disorders (including schizophrenia and bipolar disorder) and those who are at high risk of harming themselves or others, to the point that they cannot be safely managed within the service. The service will support these individuals to access the appropriate specialist care for their needs and can support these individuals before and after these specialist interventions where this is deemed suitable and helpful for their recovery. The service should work in partnership with secondary care providers to agree coordinated support.

- Individuals should not be excluded from the service due to drug and alcohol misuse but where this is the primary problem specialist intervention from Hackney Recovery Service should be sought. In all these cases, the service should work in partnership with Hackney Recovery Service to agree the best approach to supporting these individuals. This may involve a direct referral to Hackney recovery service or it may be preferable to provide support in partnership. (Further information on supporting dual diagnosis service users is available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf)

- Individuals with a primary diagnosis of dementia should be supported to access services through the dementia pathway. If staff from either service believe that an individual would benefit from additional mental health support through the service, then this should be discussed and agreed on a case by case basis by both services. However, it is not anticipated that this would apply to many, if any service users.

- For individuals with learning disabilities and/or neurodivergence, those who have higher needs or are more severely/profoundly disabled, are likely to require specialist services and the service should support them to access these. However, the majority of people with learning disabilities and/or neurodivergence have lower level needs and are not known to specialist services or don't need them, so should not be excluded. They will often benefit from having some adjustments made to mainstream services in order to help them access these. The service should proactively consider what

adjustments may help improve accessibility for these individuals. Further information on what this may involve can be found in the following guides.

- Reasonably adjusted mental health services for people with learning disabilities and people with autism: A guide for provider services: https://www.ndti.org.uk/assets/files/Summary_for_provider_trusts.pdf
- NHS England: Reasonable adjustments: https://www.england.nhs.uk/learning-disabilities/improving-health/reasonable-adjustments/ (includes a nice film)

10.7 Should a service user refuse a referral to, or partnership support with, another service, the service may use its expertise and discretion to determine whether support by the service alone will still be helpful to the individual's recovery, and if not they may be excluded. However, efforts should be made to find a better solution to exclusion wherever possible.

10.8 These exclusion criteria should be monitored by the main contractor and any feedback or proposed changes included in the annual report, for discussion with the commissioner.

11. Referrals

Referral Process

11.1 The service should have a principal point of contact, which it is expected that the majority of referrals from residents and partners into the core service will come to. However, individuals should also be able to be referred into the service via the service's subcontractor providers.

11.2 The service's main contractor will be responsible for coordinating the referral, signposting, and waiting list processes. As part of this they are responsible for ensuring that all referrals are assessed equitably and consistently. Processes for referrals should be as smooth and simple as possible, including utilising the local single referral form that is being developed, to ensure a positive experience for service users and efficiency savings for the service.

11.3 The service will accept self-referrals, as well as referrals from other local services including:

- Talk Changes (IAPT)
- GPs
- East London NHS Foundation Trust and other mental health trusts
- Other local NHS services
- Mental health accommodation services
- Local community and voluntary sector organisations
- Job Centre Plus
- Local authority run and commissioned services

11.4 All referring organisations should ensure that referrals meet the eligibility criteria and have a good chance of being accepted based on the prioritisation process. The

service should work with partners to support them to make appropriate referrals, including providing feedback if inappropriate referrals are made.

11.5 Trusted referral processes should be set up and the standardised local referral form (currently being developed) used where possible, to improve resident experience and improve efficiency. The service should encourage partners to make direct referrals wherever possible to reduce risk of drop, and facilitate partnership working.

11.6 The service will provide a tailored response to all referrals as outlined below.

- **Accepted referrals**: Notification of their acceptance to the service, including estimated waiting time, information on what they can expect from the service and details of resources they can access while waiting. If the service recommends a joint support plan with another partner, (e.g. substance misuse), the service should also consider informing them of this at this point too.
- **Another service is more appropriate:** Notification that either they have been referred on for support from another service if consent for this was provided, or if not, with details of a more suitable service that they can refer themselves to. Information on the alternative service and why the onward referral has been made should be included where possible. They should be informed of approximate waiting times and details of resources they can access while waiting. If they did not initially consent to their details being shared with other services, it may be appropriate to offer a direct referral to the specific recommended service, especially if self-referral is not possible.
- **They do not qualify other local services**: Notification that they have not been accepted to the service, with details of information, resources, activities and support available to them, ideally highlighting options that are likely to be most relevant for them. This could include online and app based resources (e.g. Good Thinking), helplines, relevant community and voluntary groups, local activities and other local services, such as libraries for example, as well as open access activities

11.7 Template responses may be used but care must be taken to ensure that responses are relevant and helpful to individuals and their personal needs and circumstances. Should the number of rejected referrals make this difficult, this should be addressed by working with referrals, as well as reviewing publicly available information to reduce the number of inappropriate referrals.

11.8 Where referrals have been made by other local services, the referrer should be copied into responses. Where consent is provided, GPs should also be notified that service users are receiving support from the service,

11.9 Referrals will be addressed as quickly as possible but within the following timescales as a minimum.

Activity	Timescale
Referral screened and acknowledged.	Within 2 working days of receipt of the referral

Eligibility assessment carried out if required	Within 5 working days of receipt of the referral
Notification of acceptance or not into the service.	Within 3 working days of the eligibility assessment if applicable, otherwise from the time of referral

11.10 It is expected that an eligibility assessment will be required in the vast majority of cases. Exceptions to this may be where the resident meets the exclusion criteria or if it is very clear from the referral information they will not meet the prioritisation criteria. The eligibility assessment may differ from the full assessment of needs.

11.11 If possible, any supporting documentation such as Care Act eligibility, occupational therapy assessments, relevant Care Programme Approach (CPA) records (Mental Health Act status, risk assessment, statement of need) should be provided by the referrer or provided by the service user (if a self-referral) if available, and included as part of the referral process.

Waiting Lists

11.12 Where a service user has been assessed and accepted into the core service but there is insufficient capacity within the service, they should be placed on a waiting list. This should be confirmed in writing to the service user and referring organisations where applicable), including an estimated wait time.

11.13 The main contractor will ensure that the waiting list is carefully managed and that people on the waiting list are prioritised by need, are supported with any urgent issues and are contacted regularly by the service to ensure that the person feels supported and that their risk or priority has not substantially increased. Waiting times and capacity should be closely monitored so that estimated waiting times provided are reasonably accurate. However, if on occasion this is not possible and the wait time significantly changes while a person is on the list, they should be provided with an updated timetable.

11.14 The provider should work to avoid a long waiting list if possible but if this becomes unavoidable based on the eligibility and prioritisation criteria, the provider should discuss this with the commissioner.

11.15 Residents on the waiting list should be provided with information about what resources they can access in the meantime and what to do if they need urgent support (e.g. in a crisis).

12. Assessment And Support Planning

12.16 The service must develop a process for assessment, support planning and review for all service users accessing the core service. This should include signing off support plans, monitoring reviews and discharge plans.

12.17 The service will carry out a comprehensive assessment for all service users on entry to the service, subject to the informed, written consent of the service user. It may be

appropriate to do this in two stages, beginning with the eligibility assessment and completed following acceptance to the service. The latter should build on and not duplicate any information gathered at the eligibility assessment to avoid the service user needing to repeat themselves and also does not need to all take place in a single session.

12.18 There should be a standardised, service user centred and consistent approach to assessment for all service users. This must capture the minimum level of information required to inform support planning and must be reflective of service users' ambitions and preferences for their personalised recovery journey. The assessment should include or refer to the following information:

- Service user details
- Service user goals and aspirations, whether directly related to their recovery or not
- Service user expectations and views (e.g. agreement with the referral, the time limited nature of the support and future aspirations)
- Service user's economic and financial circumstances (e.g. employment status, welfare benefits, accommodation needs)
- Service user's social circumstances (e.g. caring responsibliities, quality of interpersonal relationships, living conditions, relationship problems, domestic or sexual abuse, social isolation, any hobbies or protective factors)
- Personal support needs (such as personal care, hygiene, healthy eating, exercise, recreation, childcare)
- Relevant service user experiences (e.g. of trauma of discrimination)
- Any possible mental health conditions or issues - frequency, duration and severity (including self-harm, frequency of inpatient admissions, details of relapse symptoms)
- Drug and alcohol misuse
- Physical health issues (such as mobility, long-term health conditions, sensory impairment, obesity and smoking status)
- Any learning disabilities or acquired cognitive impairments (if necessary consult with a relevant specialist when developing treatment plans and strategies)
- Specific cultural, language or communications needs
- Offending history (i.e. violence, arson, MAPPA) if applicable
- Safeguarding adults (i.e. vulnerability to exploitation by others, risk posed to other adults) if applicable.
- Safeguarding children (i.e. risk posed to children)
- Identify any other services which the individual is receiving or would benefit from
- Identify whether an individual is eligible for or is receiving a personal budget or a direct payment.
- A risk assessment and any resulting actions identified (including always asking directly about suicidal ideation and intent for anyone with a common mental health disorder as a minimum)

12.19 This process shall be inclusive and sensitive to the stigmatising nature of mental health problems and diagnosis. Assessments will explore service user goals and should be both aspirational and outcome focussed.

12.20 Assessment must lead to the development of a structured and personalised support plan. The service will support service users to create their own support plan and select appropriate interventions, in collaboration with a named key worker and other professionals involved in the service user's care where this is relevant and appropriate. Key workers must evidence the service user's support needs and how they are to be met through the plan, and this will be subject to scrutiny by service managers. The support plans should be outcomes focused and written so that progress against these plans can be monitored.

12.21 Support plans should:

- Be created in collaboration with the service user.
- Identify what interventions the service user will access. These may include any of the interventions offered by the core service, open access activities, and interventions offered by partner services, in order to provide holistic support. Find Support Services may be a useful tool to help identify alternative support available.
- Identify objectives adhering to SMART (specific, measurable, achievable, realistic and time-bound) principles.
- Focus on recovery, with move on from the service promoted with service users from the early stages of engagement.
- Support service users to improve their mental health, including addressing related factors, such as substance misuse, employment, housing and isolation.
- Consider the cultural and ethnic background of the service user as well as their gender and sexuality and any impact this may have on their support needs.
- Identify information sharing requirements.
- Be clear what the responsibilities are of the service user and of the service
- Be agreed and signed by both the service user and key worker, with a copy of the support plan offered to the service user on every occasion it is updated or on request.
- Include details of all other partner services that are identified and involved in the support plan.
- Identify move on and support options following service exit.
- Include information on what to do in the event of service user crisis

12.22 Support plans shall be reviewed and updated as a minimum after no more than six contacts, on completion of a course of interventions and following a change in service user circumstances. Reviews should focus on the service user's progress and whether the support plan is meeting their needs, if changes are required and how whether move on from the service is, or will soon be relevant.

12.23 All service users must have their clinical outcomes assessed using appropriate and standardised. Key outcomes should be measured at appropriate points so that an

end point is available even if service users finish treatment early. The service will aim for pre to post treatment outcome data in over 90% of their service users.

12.24 As much as possible assessments should be carried out so as not to feel like an assessment but a support intervention and staff carrying out assessments should be provided with training to support them to do this well. In designing and carrying out assessments, the service will need to ensure that the importance of information gathering is considered alongside the impact of the assessment on service users, including the need to prevent risk of them being retraumatised or from accessing the service. To some extent this will need to be judged on a case by case basis and in some instances it may be appropriate to gather less urgent information and follow up appointments.

12.25 All assessments and support planning should be carried out by appropriately trained staff, working under the supervision of appropriately trained and experienced clinicians. The service should monitor the quality and effectiveness of these processes and ensure that they are continuously adapted and improved as appropriate. The service must record all contacts with service users throughout the duration of their engagement including structured and unstructured contact.

13. Exit Strategy And Move On From The Service

13.1 The commissioner recognises that support is not necessarily a case of moving along the pathway from first point to last. Different people will be at different points and may move forwards or backwards as their circumstances change. Each service user's time in the service should be based on their individual need and circumstances. However, access to the core service should not continue longer than required, so as not to prevent new service users from accessing the service.

13.2 Move on could be when the service user no longer requires the service's support due to improved mental wellbeing, acquisition of tools and techniques to support their own mental health or a change in circumstances, for example secure employment or improved social networks and activities. It may also include moving on to a different service in certain circumstances.

13.3 The maximum target period for time spent in the service is two years. However, the full two years should only be utilised if necessary and it is expected that many service users will require substantially less time than this. The reduction and withdrawal of support should be clearly communicated from the beginning and discussed as part of the support planning process and reviewed on an ongoing basis in conjunction with the service user and, where relevant, with professionals working in other services who are also involved with supporting the service user. Should the service believe there is a compelling case for a service user to remain in the core service longer than two years, this shall be agreed by the leadership team and notification of this included in the quarterly monitoring submission.

13.4 Where appropriate service users should also be supported to access opportunities in their community, such as volunteering and peer support, which could include supporting some of the open access activities. This may be a good option for service users who are ready to but do not want to leave the service, and may help to smooth the exit process. The open access opportunities should remain available to the

service users after they have left the main service indefinitely. The service should help service users to access other services, such as the Service User Network (SUN) and provide them with details of what to do in the event of relapse or crisis.

14. Promotion Of The Service

14.1 The provider will publicise and promote its activities, both to potentially eligible residents, and with other relevant local support services, across both the City and Hackney with approval from the contract manager and in line with Hackney Council's and the City of London Corporation's communication guidelines.

14.2 The service will devise a communications plan, covering as a minimum the mobilisation and first year of delivery, including:

- How it will target residents with high and complex mental health needs and reach population groups underrepresented in mental health services.
- How it will work with other local partners to ensure good knowledge of the service and what it does, to support them to make appropriate referrals and to help manage service user expectations
- How it will communicate and target the offer (to partners and residents) in a way that generates appropriate referrals, including limiting referrals from those who would not be accepted following the prioritisation process, but does not create accessibility barriers to those who are.
- How it will manage potential service user expectations around what the service provides and what it can and cannot offer.
- What communication channels will be used, with consideration given to residents who are digitally excluded.

14.3 This plan should be closely monitored and revised as required and should take account of different partners, processes and needs in the City of London.

14.4 The service should produce appropriate publicity materials and text in order to promote the service through a range of means, including:

- Existing partner communication channels
- Directly to partners services - e.g. through conversations with their staff.
- The provider's organisational website
- The Hackney Council and City of London websites and the CCG directory of services/newsletter.

14.5 Promotional materials should outline the service and include contact and referral details, with consideration given to the needs of diverse communities and particular groups who are under-represented in mental health services. All materials must be current, relevant and easy to understand by all and be tested with current, past or potential service users.

14.6 The provider should also consider what the most appropriate name of the service should be. Feedback indicates that the current 'Wellbeing Network' name may be misleading given the increased focus on complexity of the service, with the current name suggesting a service that addresses low level wellbeing needs. Any change in

name should be agreed in partnership with service users, approved by the contract manager and communicated to all relevant partners, service users and residents.

15. Funding Allocations

Provider Allocations

15.1 As part of its management role, the main contractor will be responsible for agreeing and managing the funding allocations for all of the different providers that are delivering the different interventions within the service. These values should be initially agreed with subcontractors prior to submitting a bid. Changes to these allocated values within the overall funding pot may be varied annually by up to 10% each year, for the duration of the contract, in line with the flexible funding model described below. The variation should not exceed 10% unless:

a) A subcontractor provider voluntarily chooses to accept a greater reduction in their own funding allocation (e.g. due to reduced capacity to deliver)

b) There is insufficient demand for some or all the interventions delivered by a subcontractor provider, so that has become an ineffective use of resources to deliver at the specified volume, and the provider is not able to offer any suitable alternative options.

c) There is an ongoing performance issue that means the provider organisation is unable to meet its objectives or contribute sufficiently to the overall aims and objectives of the service, despite support from the main contractor and a sufficient opportunity to improve performance.

d) For single destination interventions or pilot projects, where this is agreed in advance with the subcontractor provider and the commissioner

e) A subcontractor provider leaves the service

f) In other exceptional circumstances, agreed by the commissioner

15.2 In the event of an organisation leaving the network, the main contractor should assess any gap in need that this creates and, in the first instance, should seek to use the newly released funding to meet this if relevant. If there are other, more pressing needs that have been identified, these could also be considered, especially if the departure was related to insufficient need or demand for that provider's particular offer. This gap created may relate to an intervention type and/or the population group it served. Any impact on the local sector should also be considered; for example if a small local voluntary sector organisation were to leave, ideally the funding would be reallocated to a similar type of organisation.

15.3 All proposed changes to funding allocations for subcontractor providers within the service, including those relating to flexible funding allocations, should be presented by the main contractor to, and approved by, the commissioner. Any proposal should be accompanied by evidence to support the changes and all of the service providers should be given the opportunity to be involved in the discussion and assessment of need.

15.4 Funding for each delivery provider should be determined based on what resources or interventions they provide.

Flexible Funding Allocations

15.5 In order for the service to be responsive to the changing needs of the local population and the successes of and demands for different interventions, the service should review needs, demands and performance in relation to all aspects of the service, on an annual basis as a minimum. The service should put in place measures and utilise technology to reduce the resource implications of doing this. The service should engage with the commissioner and other local stakeholders when considering any emerging or unmet local needs.

15.6 Each year up to 10% of the budget for all direct delivery provision of the service will be subject to review and possible reallocation. Reallocated funding may be used to introduce new interventions targeting an identified need that is not already sufficiently met by the service. Alternatively, it may be used to add funding to an existing intervention type within the service that is in very high demand and/or performing particularly well. Additional interventions may be provided by existing providers, or by new ones, depending on what is required and appropriate to meet the need.

15.7 Overall, this will mean that some interventions, and their respective providers, will retain the same funding each year, some will have an increase and some a decrease. It is theoretically possible that comparatively lower uptake and/or poorer performance could lead an intervention/provider to have a budget reduction every single year of the contract. However, the opposite may be true of high need/top performing interventions/ providers.

15.8 Any pilot projects funded may be an exception to the flexible funding model, as it is unlikely to be appropriate in these circumstances. The continuation of the funding should be dependent primarily on the success of the pilot. Similarly, if a specific single destination intervention was funded from an organisation that was not one of the main subcontractor providers, reducing the budget may not be appropriate, as it may be the case the intervention either runs or it doesn't. Where flexible funding will not be applied, this should be agreed with and made clear to the provider of these interventions. Continuation or not of these interventions should still be primarily based on performance, need and demand.

15.9 This flexible funding model is not primarily intended as a performance management initiative, although it is acknowledged this may become an untended product of it. It is primarily intended as a way of ensuring a flexible, responsive and continuously improving service. It is the responsibility of the main contractor to ensure that this process is managed effectively and openly, minimising any negative impacts within the service. All providers are encouraged to recognise the benefits this model has overall for service users and for best meeting the needs of the local population in a changeable environment.

15.10 While it is important that flexible funding allocations are applied to all areas of direct delivery, including any provided by the main contractor, should this lead to a reduction in budget such that the main contractor's position is no longer financially viable, this may also be taken into account when proposing and agreeing any changes.

Subcontractor Payments

15.11 The main contractor will be responsible for paying all other subcontractor providers for their contribution to the service. They should agree with subcontractor providers the methods of payment, a timetable for these and how complaints regarding late or non-payment will be dealt with. This should also be approved by the commissioner. The timetable should not cause avoidable financial pressures for smaller providers.

16. Risk Management

16.1 The service shall assess the support needs of each service user based on written and verbal information which shall include both the static and dynamic risk factors. This process shall inform the frequency and intensity of planned interventions and shall contribute to the content of the service user's support plan.

16.2 Risk (including of suicide risk of harm to self or others) should be assessed at initial contact and each contact thereafter. High risk service users (i.e. high suicidal risk, serious self injurious behaviour, psychotic symptoms) identified through clinical judgement and/or objective risk outcome tools should be urgently referred to the appropriate specialist services. The referring agent should be informed without delay. The service should keep open the service user's case, so that should they need step down care, they can return to the service as straightforwardly as possible and without additional delay.

16.3 The provider shall undertake a risk assessment based on information from the referrer (if not self-referral), as well as contact with and observation of the service user. This shall consider the risk of harm and take into consideration other contributory factors. Risk assessment forms should be aligned as appropriate with those used by Hackney and the City's Adult Social Care Teams.

17. Service User Involvement And Consultation

17.1 Service users should be well informed about the service and their care so that they can communicate their needs and views and make informed choices. They should be fully involved in the development and ongoing review of their support plans.

17.2 Service users should be consulted about the service and interventions provided and offered opportunities to be involved in their running and design. The service should regularly gather feedback from and consult with service users about the quality and effectiveness of the services. This should include standard questions developed in collaboration with service users.

17.3 All service users should be supported and encouraged to participate in peer support and voluntary roles within the service, alongside or following their core interventions. Services users should also be supported to cocreate or develop their own peer led activities, for example as part of the open access offer.

18. Partnership Working

18.1 In order to ensure that all service users receive the best holistic support, the service will often need to collaborate with other relevant local services to provide coordinated care and support. Where other specialist services are better able to meet certain aspects of a service user's care, the service should avoid creating duplication and should engage the other service and, with the consent of service users, work with them to agree and deliver a joined up support plan.

18.2 Partnerships should be much more than other organisations that the service refers to or receives referrals from and the service should work with each partner to agree how they will effectively work together, for example:

- The service should seek to set up trusted referral processes with all appropriate partners, in order to avoid service users needing to unnecessarily repeat themselves, to simplify and speed up the referral process and to reduce dropout.
- Where referrals are received from another service the service should acknowledge these, including the outcome (e.g. if offered a place in the service/any onward referral etc.). If referrals are made into another service and a receipt of this is not received, the service should follow up wherever possible to check the outcome and ensure that the service user did not drop out of the system.
- Staff training and awareness sessions delivered by other services about what they do should be encouraged and similarly training and awareness sessions should be delivered to other services as appropriate. It is important that all services understand what each other provides, in order to ensure referrals are appropriate, to manage expectations and so staff know when joined up care may be appropriate.
- Wherever possible and appropriate, and with consent, the service should support service users in partnership with other services and agree joint care plans, to ensure their care is well coordinated and any risks are monitored. The service should work with partners to agree how this will be managed effectively. It may be that less frequent appointments with each individual service because each is helping to support the plan of the other (overall the total number of appointments should be at least the same, if not higher). In certain circumstances, where the vast majority of the service user's care (including key worker or holistic support) is provided by another partner, it may be appropriate for service users to only access specific interventions within the service - e.g. therapeutic interventions. This should only occur when the service can be assured that other aspects of the service user's care are adequately being provided and their care should still be jointly coordinated. The service user must also still meet the threshold for the service through the prioritisation process.
- Service users from partner service should be able to access the open access interventions. Partners may also wish to include interventions they offer on the list of open access interventions.
- The service should use technology to facilitate information sharing with partners, such as Health Information Exchange and the Patient Knows Best system.

- Where applicable, services should consider whether they have any physical spaces or other resources that they can share to increase overall efficiency, patient experience and to support smaller organisations. For example, the service may deliver interventions from partner locations, and the service's providers could allow relevant partners to use spaces in their buildings, e.g. a VCS project that requires a venue for a few hours a week.

18.3 The service should actively seek to identify and create any suitable partnership opportunities (in addition to those described below).

18.4 In order to facilitate partnership working, staff contacts for partners should be identified within the service. Furthermore one member of staff should have overall responsibility for partnership working and this role will include:
- Being a single point of contact for partners where a more specific contact is unknown or if any communication issues arise
- Ensuring that a specific contact for each partner is identified
- Ensuring that existing partnership relationships are maintained, including regularly sharing staff contact details and information, such as how and when to refer to the service, to ensure this is not lost over time.
- Exploring ways to further improve and integrate existing partnerships
- Proactively seeking out new partnerships
- Coordinating training for partners on the service as required and arranging for partners to provide training on their respective offers to the team

18.5 Each external partner should be allocated a specific staff partnership contact within the service (this could also be the lead partnership manager). Each staff partnership contact could be the contact for multiple partners or just one. These partnership contacts should:
- Be the main point of contact for their allocated partner(s)
- Ensure that individual support/key workers from the service are connected with the corresponding worker from the partner's service, in order to be able to provide joined up care
- Ensure all contact details are kept up to date
- Meet regularly with the partner(s) to discuss the partnership, how it is working and identify and opportunities for improvement
- Support the overall partnerships manager with the duties described above

18.6 Some of the key partnership relationships that the service will be required to maintain are listed below, along with ways of working that have been agreed with these services prior to the writing of this specification and are in addition to those listed above. However the relationships, details and practicalities will need to be made and agreed with each partner during mobilisation. The service is also encouraged to go beyond the ways of working listed and should also seek to engage additional partners.

IAPT
- Work with IAPT to ensure that the IMHN service does not accept clients that would be eligible and more suitable for IAPT services but that they are supported to access IAPT instead. .

- Support service users to access 1:1 talking therapies with IAPT as part of their wider care plan where this is appropriate and when they are suitable and ready to do so. A trusted referral process should allow them to do this in a similar way to if they were accessing any of the core interventions within the service.
- Where residents are eligible for IAPT but not at a point where they are ready or suitable for talking therapies, and also not eligible for the core service, the service will help to 'ready' them for IAPT services. (See 6.34 for more information).

East London Foundation Trust (ELFT) - including neighbourhood Primary Care Networks (PCNs)

- Work with the PCPCS service, who have some overlap in clients, to define when clients would be best suited to which service and how this will be managed between the two, as well as clearly promoted to partners
- Refer clients with complex needs to the Neighbourhood MDT meetings and attend these as appropriate
- Work with the PCNs to understand what the need in terms of interventions and support for residents with complex needs
- Explore further opportunities for integration with the ELFT and the PCNs as they develop, especially around opportunities for joined up care delivery.
- Agree a process for step down support from crisis and secondary care services where this is appropriate, including a process with ELFT for supporting relapse.
- Support service users to access the SUN Network, during their time in the service and/or as part of step down care
- Support service users to access the Recovery College. This could be as an intervention as part of wider support plans, a volunteering opportunity or as part of move on from the service.
- Explore whether joint recruitment for psychology posts could be used across the two services

GPs

- Service staff should liaise with service users' GPs to ensure that care provided is coordinated with their physical health care, as well as any medication provided, agreeing shared care plans where appropriate.
- Where possible and where consent is given Patient Knows Best should be used as a tool to facilitate this, although should not replace direct communication where this is required.
- Proactively and regularly engage GPs around how and when to refer and what service's offer is.

Hackney Recovery Service (HRS)

- If individuals refuse joint support (or a referral) from HRS then the service should consider other options, including in reach and advice and support from HRS staff for key workers in the service, to help them to provide the best support.
- Secondment opportunities for staff should be encouraged.

Community navigation system

- The service will work with community navigation partners to integrate the service and the community navigation system in City & Hackney,
- Work together with community navigation partners to define which service is most appropriate for residents in which situation. The trusted referral process will also help to create a no wrong door experience where this does not occur.
- Key community navigation services the provider will be expected to develop links with include Social Prescribing, Health & Wellbeing Coaches, Wellbeing Practitioners, Engage Hackney, WellFamily+ and the ELFT Community Connectors.
- A service representative should participate in community navigation forums including the Community Navigation Network and the Community Navigation System Design Group.
- Some residents not eligible for the service may be eligible for community navigation services and they should be supported to access them. Similarly there should be a smooth process for ensuring residents supported by community navigation services that are suitable can access the network .
- Explore how best to manage the list of open access activities and ensure community navigation services can support clients to access opportunities suitable for them.

Local authority physical activity offer

- At the time of writing this was being developed. However, there will likely be opportunities for some physical activity activities to be listed in the open access activities and service users (as well as those from other partner services) should be encouraged to access these as part of their plan.
- Similarly the physical activity services may be a valuable route of identifying residents who may benefit from the Integrated Mental Health Network and supporting them to access it.

Hackney Opportunities

- Staff from both services to discuss and jointly support any relevant aspects of service users' needs
- The courses could be included in the list of open access wellbeing activities offered using the platform/structure of the network and could be accessed by service users as part of their support plan (as well as by partners' service users).

- The two services could use their joint expertise to identify potential unmet needs and development opportunities to inform the design of new courses.

Children's services
(including health visiting, maternity services, children's centres, special educational needs, super youth hubs)

- Services should work together to agree how best to support service users who are eligible for more than one service, to avoid duplication and ensure the best experience for residents. Where parents would be eligible and prioritised for the service but are already receiving key worker or holistic support elsewhere, it may be appropriate for them to only access specific interventions within the IMHN service, which they cannot get from their primary service - e.g. therapeutic groups and not necessarily the full range of interventions/key worker support.
- The service should work with perinatal services to understand how the service fits in the perinatal pathway and agree pathways between the services.
- The service should work with children and young people's services to ensure a smooth transition between services where this is applicable.

Voluntary and community sector
The service should also work with VCS (Voluntary and community sector) partners who are not members of the network. What this will involve will vary for each partner but could include:

- Making training available to VCS partner services where capacity allows, e.g. where there are spare spaces on planned training
- Make the open access aspects available to VCS partners' clients, depending on capacity and suitability
- Work with Hackney VCS to ensure any opportunities, such as those around funding, development and partnership working are shared with organisations who may be interested.
- Support services users to access volunteering opportunities within the VCS organisations
- Promoting VCS organisations' activities where this is requested, e.g. though open access opportunities.
- Support small organisations/projects to identify spaces that they can use (e.g. for a few hours a week)
- Consider offering small amounts of seed funding and support to projects that could become self-sustaining.

Libraries

- Explore using libraries as a place to base open access activities from and/or run in partnership with.
- Work with libraries to develop an approach to jointly supporting service users

Community Champions

- The service should work with the Community Champions programme to ensure that both services complement each other. Member organisations should be encouraged to host community champions

Stop Smoking Services

- All service staff should receive smoking cessation and the service should support smoking cessation services with mental health training
- If IT systems allow, service staff should make direct referrals into stop smoking services, or if not a simple referral system should be put in place.

Young Hackney

- The service should explore opportunities to support young adults in partnership with Young Hackney Substance Misuse.

Domestic violence services

- For residents experiencing domestic violence, who are supported by local domestic violence services, it may be appropriate for them to get all/the majority or their support and coordination from these partners and only access the service for specific interventions, such as psychotherapy.

18.7 The Provider may be invited to participate in relevant partner forums and meetings and involvement is strongly encouraged.

19. Provider Workforce

Staffing Requirements

19.1 The provider must ensure that all staff (both employees and volunteers) are competent in their roles and are actively engaged in continuous professional learning and development procedures.

19.2 In relation to the service, the provider must:

a. Ensure that all employees and volunteers (if appropriate) working for the service agree to be bound by the Terms and Conditions of the main contractor, which will outline specific competency and training requirements.
b. Ensure all staff have the appropriate experience, knowledge, skills and training and are suitably qualified for their roles. Any specialist clinical staff must be competent, appropriately qualified and hold current registration (where applicable) to deliver the clinical interventions.
c. Ensure that for all roles that require it, staff and volunteers are cleared by the Disclosure and Barring Service (DBS) at the appropriate level prior to employment. The provider must review the status of all employees at least every three years.
d. Ensure that all staff are provided with any additional training required to effectively carry out their role, including thorough induction training.
e. Ensure a sufficient level of staff at all times to provide a safe, effective and accessible service, with a mechanism to evidence this as part of quarterly

monitoring arrangements, including accounting for staff turnover, annual leave and sickness absence cover.

f. Ensure all staff are well supported to carry out their roles, in their personal development and their wellbeing, including supervision and annual appraisals. Live observation and feedback should be provided for all front line staff at least twice a year.

g. Ensure staff have pay scales that promote movement and recognition , access to staff benefits and clear career development pathways and opportunities

19.3 The staffing model of the service must include, at the very least, the following roles:

- Adequate number of practitioners to deliver interventions and support the service caseload size
- Specialist practitioner roles, as required, to fulfil the requirement for clinical 1:1 psychotherapy
- Service Manager(s) / Senior/Team Manager (s)
- Senior therapist or counsellor to support staff delivering psychotherapeutic interventions
- Administration staff, including for the management of data collection and analysis

Staff Training

19.4 In addition to the requirements set out in the terms and conditions of this contract, the provider shall ensure the following as a minimum. This should be delivered through a comprehensive induction programme during the first 6 weeks of employment, with additional and/or refresher training provided on a regular basis.

19.5 The service shall ensure that all of its staff receive training on mental health at a level appropriate for the types of activities that they are delivering. This will include as a minimum, but will not be limited to the following. Where staff have prior mental health qualifications and/or experience, this may be considered equivalent at the services' discretion, provided that they can demonstrate their up to date competencies in the areas listed:

- Recognition of various mental health conditions, behaviours and risk factors
- Prevention and managing relapse
- Motivating service users
- Working with challenging behaviour and attitudes
- Life skills development
- Behaviour change models and techniques
- Outcome focussed support planning and
- Risk assessment
- Cultural awareness
- Understanding trauma and trauma informed practices
- Suicide prevention

19.6 All staff should also be trained and be able to demonstrate good knowledge of:

- Substance misuse and its relation to mental health
- Domestic abuse
- Learning disabilities and neurodivergence
- Smoking cessation advice - VBA level 1 or level 2 training depending on staff roles (the stop smoking service may also be able to deliver a hybrid, tailored version on request)
- Tailored training
- Making Every Contact Count

19.7 Staff directly delivering psychotherapy, whether through 1:1 or group sessions should be appropriately qualified: BACP, BABCP, or UKCP, or the British Psychoanalytic Council, OR be a Chartered psychologist (clinical or counselling, and a member of the BPS).

20. Information And Systems

ICT Systems

20.1 The service will have or procure ICT systems and hardware that fully support the running of the service including, but not limited to, sufficient broadband width to cope with the service demands, telephone systems to cope with the service demands and secure email services. The service should also consider mobile devices to support staff members working away from the main office location, such as tablets, that will support efficient case management recording and analysis of information.

20.2 The ICT system will be able to support the service with:

- Managing the referral and assessment processes
- Tracking service users within the service (e.g. what interventions individuals are receiving, their attendance etc.)
- Managing waiting lists
- Tracking move on from the service
- Analysing and presenting information required by the Council for monitoring purposes
- Managing risk

20.3 In order to support partnership care, communication with service users and other professionals involved in their care, the service should also ensure they utilise the appropriate information systems that facilitate this. Therefore, where possible, the service should utilise the tools and systems that are used by, or compatible with, other local providers in order to provide a common language across systems (e.g. Patient Knows Best and the Health Information System).

Case Management

20.4 The service will adopt a single case management system that allows the service to collect the data and information required to assure safe and efficient support and fulfil contract monitoring arrangements. This should also take service user needs into

account, including length of paperwork, the impact of paperwork on therapeutic relationships with key workers and the impact of having to repeat your story. All service users will receive individual case management.

20.5 The service will adopt an electronic case management system with standardised documentation to cover the following as a minimum:
- Referral Source and any referrals made to other services by the service
- Confidentiality and consent
- Assessment
- Support plan, including agreed interventions
- Case review
- Chosen recognised outcomes monitoring tool
- Treatment Exit

20.6 All costs associated with the ICT and case management systems will be borne by the provider, via the contract price.

21. Information Governance

21.1 The provider must have a robust information governance framework in place on commencement of the service in respect of, but not limited to, the following points:
- Information Governance Policy
- Compliance with the General Data Protection Regulation (GDPR)
- Confidentiality and Consent
- Code of Conduct
- Business continuity arrangements in relation to events beyond the control of the provider, for example, IT failure
- Regular case file auditing
- Data Protection Act Registration

21.2 The provider must undertake a Privacy Impact Assessment in collaboration with the Contract Manager as part of the mobilisation of the contract and on an annual basis thereafter.

21.3 The provider must:

a. Have organisational and technical security measures in place to protect personal data and ensure appropriate access is controlled.
b. Evidence a formal information governance protocol developed in conjunction with partners services if the services uses any external information recording systems.
c. Act as the Information Governance Lead and Data Processor of all special category data / personal service user information that the service is privy to support the delivery of effective treatment. Hackney Council is the data controller for information collected by this service regarding service users.

d. Evidence accountability and responsibility for the appropriate assurance of information confidentiality issues in the processing and sharing of personal information related to service users.
e. Ensure that all information shared with the contract manager and other services external to the service is shared via a method of secure transmission.
f. Evidence that all information processing systems are informed and underpinned by formal Information Governance requirements.
g. Evidence compliance with Hackney Councils' service level data schedule

22 Consent And Confidentiality

22.1 The service may only be delivered where the service user has provided written informed consent which is held on file and reviewed at quarterly intervals as a minimum. The service must ensure that there is a confidentiality and consent policy in place

23. Clinical And Quality Governance

23.1 In order to ensure the safety, quality and effectiveness of the service the service providers must have access to the appropriate clinical experience and expertise, including the development of robust clinical governance and quality assurance arrangements.

23.2 Appropriate accreditation, supervision, Continuous Professional Development (CPD), quality assurance and clinical governance arrangements must be in place, with agreed pathways and protocols with primary and secondary psychological treatment service, around the management of risk, access to expert advice, clinical supervision and consultation.

23.3 The Contract Manager may undertake quality assurance, audit processes on any part of the service provision at any time including via case files, support plans and live observation of service delivery.

24. Complaints/Compliments And Incidents

24.1 The provider will have a written complaints procedure that ensures responsive action towards client complaints and uses these as a positive feedback tool.

24.2 All providers will record and monitor all incidents, compliments and complaints. A summary of these should be included in the quarterly monitoring return, including any actions taken or learning where applicable.

24.3 The service will report any serious incidents and investigations to the contract manager within 48 hours of occurrence, and any service user death within 24 hours of notification. Other regulatory bodies, such as the CQC, must also be updated as

per the NHS Serious Incident Framework. Lessons learnt from each incident/investigation should be shared with the contract managers when possible.

25. Performance Management

25.1 The Council requires that the service is provided to the highest standards at all times. Throughout the duration of the contract, the service will be monitored against a variety of performance measures by the authorised officer. The main contractor will meet with the contract manager on a quarterly basis as a minimum to review the service's activity, data and outcomes.

25.2 The main contractor will forward a report on the performance of the contract to City and Hackney Public Health at least two weeks prior to the arranged contract review meeting, containing the following information as a minimum:

- **Summary statement:** A brief summary highlighting the key matters of interest from the relevant quarter, including achievements and progress, significant events, challenges and risks to service delivery and partnership working
- **Performance data:** Details of performance against the key performance indicators, including values and a few lines to provide any relevant context
- **Additional monitoring data:** Data and narrative outlining the service's activity for the measures
- **Governance**: details of any quality assurance issues, safeguarding information, compliments and complaints.
- **Partnership working:** Details of working arrangements with partners and plans to further develop this
- **Workforce, training and development:** including vacancies.
- **Horizon scanning:** Overview of priorities for the following quarter.

25.3 Quarterly monitoring submissions should be provided six weeks following each quarter. The meeting for the final quarter of each year will be an annual review.

25.4 The main contractor will be responsible for monitoring and performance across the whole of the service, ensuring that there is satisfactory performance and a drive for continuous improvement with all subcontractor providers.

25.5 Occasional planned or unplanned visits by the authorised officer may be made to the service base or point(s) of service delivery.

25.6 The main contractor should engage all subcontractor providers in the monitoring process and share information as appropriate to facilitate an open and constructive approach. All providers should have the opportunity to voice ideas and put forward suggestions regarding the service, or comment on decisions that will impact it. If subcontractor providers wish to be involved in some way in the quarterly monitoring meetings, including having the opportunity to meet with the commissioner directly, how best to do this should be discussed and agreed with the commissioner.

25.7 Where appropriate, service users should also be encouraged to engage in monitoring roles, such as carrying out service user surveys, satisfaction questionnaires or facilitating focus groups.

25.8 The contract monitoring arrangements will support an illustration of inputs, activities, outputs, outcomes and impact of the service as follows:

26. Service Outcomes

26.1 The Provider shall demonstrate that the Service is being delivered to the highest quality standards through measurement of performance against the requirements of the Contract and the Key Performance Indicators (KPIs) as set out on the following pages. The Key Performance Indicators (KPIs) will be reviewed on an annual basis collaboratively between the Provider(s) and the Contract Managers, in line with performance, target and local need.

26.2 Additionally the Provider will supply performance data through statistical monitoring of data/workbooks as supplied by the Provider. Detail of data required is set out at Schedule 1: Data Collection. This list must not be considered as exhaustive and Hackney Council reserves the right to make revisions at any time throughout the duration of the contractual term.

Schedule 1: Data Collection

1A: Service Key Performance Indicators

KPI No	Objective	Reason for Status / Rationale	KPI	Target	Reporting Frequency
1	A good number of residents supported through the service	To ensure support is available to residents who need it.	A. New core service user per year B. Total core service users per year	1,150 1,800	Quarterly
2	Service users experience a clinically relevant improvement in wellbeing	This is the purpose of the service	Percentage of service users demonstrating clinically relevant improvement using validated measurement tools over the course of their time in the service	60%	
3	Access to the service represents the local population, weighted towards groups identified as having the highest levels of need and/or who are underrepresented in mental health services locally	To support a reduction in health inequalities and ensure the service targets populations identified as having higher risk	Service users accepted into the service are representative of the percentage listed in the key service population groups targets table below	90% of population group target met	Quarterly
4	Achievement of partnership working and integration, demonstrated through service users' care being coordinated	It is vital that the service is very well integrated and working in partnership with other relevant local services that contribute towards service user recovery	A. At least one external partner is involved in service users' support/care plan B. The number of different external partner services that the service works with that	25% of service users 6	Quarterly

	with additional external partner services		are involved in the shared support/care plans		
5	Service users supported to access employment and development opportunities	Employment, learning and development are very important components of mental health that the service can directly influence	A. Reduction in the percentage of service users who are unemployed B. Percentage of service users in training or volunteering roles while accessing or after leaving the service for at least 6 months or for the duration of the course	50% 12%	Quarterly
6	Service users experience an improvement in physical health	Physical health is a very important component of mental health that the service can directly influence	A. Percentage of service users who report being smokers who are offered a referral to stop smoking services B. Percentage of service users who demonstrate alcohol dependence or who report using illegal drugs that are offered support coordinated with Hackney Recovery Service as part of their care plan C. Percentage of clients self-reporting an improvement in physical health between entry to the service and exit	90% 90% 90%	Quarterly
7	Service users experience a reduction in social isolation / increased social inclusion	social connectedness is a very important component of mental health that the service can directly influence	A. Improvement in self-reported social connectedness for service users B. For service users for whom social isolation was identified as a concern at	80% 75%	Quarterly

			entry, engagement in community or regular social activities/classes		

Key service population groups targets:	
A. LGBTQI+	9%
B. Refugees	0.5%
C. People born outside of the UK	35%
D. English is not the first language	25%
E. Residents who are living in the 10% most deprived neighbourhoods nationally	15%
F. People providing at least one hour's unpaid care and support each week to a friend, neighbour or relative because of illness or old age	7%
G. Number of young Black men entering services per year: a. 18-24: 10 b. 25-30: 15	 10 15
H. People with learning disabilities	2.4%
I. Autistic people	1%
J. Physically disabled people or those with a long-term limiting illness:	30%
K. Black African: 10%	10%
L. Black Caribbean: 6%	6%
M. Other Middle Eastern	2%
N. Eastern European	2%
O. South Asian	8%
P. Turkish or Kurdish	7%
Q. Orthodox Jewish	8%

1B: Additional Monitoring Data

This data should also be collected, monitored and submitted in advance of quarterly monitoring meetings. This is to support the ambition of continuous learning and improvement within the service. Using this data (as well as any other information the service may collect), the service should seek to adjust and develop its offering throughout the term of the contract.

Hours of delivery

- By intervention (potentially grouped)
- By intervention type (e.g. groups, 1:1, activities, open access, IPAT readying webinars etc)
- For 1:1 therapies, the number of sessions provided

Service user numbers

- Number of service users entering and exiting the core service by month
- Attendance numbers for the open access interventions
- Number of unique service users accessing the IAPT preparation only offer
- Number of unique service users accessing specific core service interventions only (but are primarily supported by a partner service)
- Number of unique service users who the core service is jointly supporting with a partner service
- Number of unique service users solely supported by the service (not partnership arrangements in place)
- Average time active in the core service (up to 6 months / 6-12 months / 12-18 months / 18 months - 2 years / 2 years +
- Attendance rates - by intervention type, including dropout rates.
- Number of different interventions that were accessed by service users throughout the course of their time in the service (to be measured on exit)

Additional wellbeing measures

- Number of service users making no or a negative improvement for wellbeing
- Measures of wellbeing collected by the service in addition to those listed in the KPIs or in this list.
- Changes in wellbeing by intervention type

Support plans

- Percentage of support plans identifying service user goals and outcomes
- Percentage of service users who feel that they are involved in deciding on their own support plan

Referrals

- Number of referrals received
- The proportion of referrals accepted
- Breakdown of referral source and where this is from partner organisations, whether this was via the trusted referral processes
- Time take to respond to referrals, both for those accepted and those that were not
- For referrals received from partner organisations, percentage that were acknowledged/informed whether this were accepted.
- For referrals not accepted, how many were:
    - Referred on to another service (directly)
    - Given details of other local services they can self-refer to
    - Provided with self-help info /national support available

Waiting list

- Number of people accepted for the service but on waiting list
- Average time on waiting list
- Longest time on waiting list

Internal management

- Staff turnover
- Number of vacant posts against the staff structure
- Staff satisfaction
- Satisfaction of subcontractor organisations with the main contractor
- Staff training delivered

Service user feedback

- Satisfaction with the service
- Constructive suggestions for improvements to the service

Demographic and vulnerabilities information

- Breakdown of information regarding: ethnicity / LGBTQI+ / disability / gender / age / religion / belief / main language / armed forces / deprivation (via postcode) / employment / homelessness / born outside of the UK / refugees / carer status / traveller status / CIty vs Hackney
- Experience of trauma, abuse, or PTSD / domestic abuse / common MH conditions / SMI / suicidal thoughts / prior suicide attempts / problems with housing and finance / relationship breakdown / stress / loneliness or feeling isolated / managing anger issues / grief/loss / disordered eating / discrimination [annual reporting]

Physical health

- Change in smoking status from service entry to exit
- Change in alcohol consumption from service entry to exit
- Change in status regarding use of illegal drugs from service entry to exit
- Change in self-reported activity levels from service entry to exit

Partnership working

- With reference to the specification, a brief summary of partnership work undertaken
- Number of partners training sessions delivered / received.
- A list of partners where arrangements have been formally agreed and a named contact in the service identified.

Open access

- A list of open access activities currently running, initiated by the service

- Numbers of core service users and other residents accessing these activities
- A list of partner delivered open access activities

Peer support and volunteering

- Percentage of service users participating in volunteering and/or peer support within the service / in external services
- Summary of activity undertaken to support volunteering / peer support

Spend

- Information on service spend against the budget [annual]

The main contractor is also encouraged to suggest and discuss with the commissioner any other data that might be relevant or useful for monitoring, if there might be more effective ways of measuring the same outcomes or highlight if any data collection is particularly onerous or challenging.

The main contractor should put in place an effective system to balance minimising the burden of data collection/processing for all providers and any negative impact on service users with ensuring sufficient, high quality and useful data is collected. It should be clear how data collected will be used. Use of technology to support this should be considered. How to usefully capture and use qualitative data should be considered. Should the monitoring requirements pose a challenge to the effective delivery of the service, the provider should raise this with the commissioner, including proposing an alternative.

Schedule 2: Payments

1. PRICE

1.1 The Service Price per year shall be a maximum of **£1,350,000.** This is inclusive of all service delivery related costs.

1.2 The service price is inclusive of any inflationary, London Living Wage or other increases for the duration of the contract. No additional uplifts will be applied.

2. INVOICING ARRANGEMENTS

2.1 Invoices shall be submitted to the London Borough of Hackney, quarterly in arrears in 4 equal instalments of **337,500**.

2.2 Invoices shall be sent on the first operational day of the quarter following the quarter due for payment, ie – on or the first working day after:

1st July
1st October
1st January

With the exception of the final quarter's payment (January to March) which should be sent no later than 15th March 2014.

2.3 Two copies of the invoice shall be sent – referencing the purchase order number - one by email to the Authorised Officer and one to the Payments Team as follows:

London Borough of Hackney Payments Team
PO Box 494
Northwich, CW9 9AZ
(for paper invoices).

Or hackneyinvoice@bscs.basware.com (for PDF invoices)

Failure to follow this procedure may delay payment to the Provider

Schedule 3: Safeguarding

The Alliance leadership Team will be responsible for ensuring that appropriate arrangements are in place across Network service providers and are monitored to ensure the safeguarding of vulnerable adults and children.

Safeguarding Adults

The Provider shall have a Protection of Vulnerable Adults/Safeguarding Policy in place that reflects the principles and procedures of City and Hackney and LB Hackney's *Protocol for Implementation of London Safeguarding Adults Policy and Procedure* and is consistent with *Protecting Adults at Risk: London Multi Agency Policy and Procedures to Safeguard Adults from Abuse* .

The Council's Safeguarding Vulnerable Adults procedures can be found at the following:
http://www.hackney.gov.uk/safeguarding-vulnerable-adults.htm

All organisations providing services within the MH network will be expected to sign up to this policy.

Safeguarding Children

The Provider will have a policy for safeguarding children and young people consistent with the *London Child Protection Procedures and Working Together to Safeguard Children: A Shared Responsibility*.

Information about the protection of young people and children can be found at:-
http://www.hackney.gov.uk/childprotection.htm

All organisations providing services within the MH network will be expected to sign up to this policy.

General

The Service Provider will identify a person(s) with lead responsibility for safeguarding.

The Provider will ensure that all staff and volunteers are able to attend training on Safeguarding and on the Mental Capacity Act 2005 attend relevant professional forums convened by the Council or other partners.

Safeguarding will be identified in the Service Provider's training needs analysis and training plan and the staff will receive refresher training every 3 years.

The Service Provider will have an up to date "whistleblowing" procedure, which is referenced to the London multi agency policy and procedure and covers arrangements for staff to express concerns, both within the organisation or to external agencies.

The Service Provider will ensure that there is a safeguarding supervision policy in place and that staff have access to appropriate supervision.

Schedule 4: Policies And Procedures

The main contractor must demonstrate that it has an adequate range of policies, protocols and strategies and that these have designated leads. These must be submitted to the council by the provider within the first three months of contract award. Where they are absent, the service provider must demonstrate that steps are being taken towards their development.

The service provider must ensure that all staff and service users are aware of all relevant policies and the impact of any policies on their working practices.

As a minimum the service provider must evidence the following policies. These may be combined in a single document or policy where appropriate.

a. Safeguarding children
b. Safeguarding adults
c. Complaints
d. Serious untoward incidents
e. Service user engagement and involvement
f. Information sharing
g. Consent and confidentiality
h. IT governance, including information collection and data storage
i. Quality assurance
j. Lone working
k. Maximising access to underserved / socially excluded groups
l. Dual diagnosis (substance misuse and mental health
m. Use of volunteers
n. Service User Involvement
o. Health and safety
p. Equal opportunities and diversity
q. Staff management, including recruitment, induction, alcohol and drug use in the workplace, management of absence, supervision policy (including access to external supervision), continuous professional development, disciplinary, grievance, capability and training
r. Staff leave, including holiday, compassionate, sickness, maternity and paternity leave
s. Whistle blowing
t. Business continuity planning
u. Referrals, priorisation, assessments, appeals and exclusions, including how waiting lists will be managed
v. Integrated service protocols setting out how the service will ensure that all activities are integrated, coordinated and delivered effectively as a single service.

Appendix 1i: Evidence Base

Hackney and City of London Local Context

The design of this service has been informed by local and national data, as well as an extensive consultation with local stakeholders

City And Hackney Population

While detailed information on the most recent census is not yet available, it has been confirmed that In Hackney, the population size in 2021 was 259,200, while the City of London had a population of 8,600. Hackney was the third most densely populated of London's 33 local authority areas and the City of London was the fourth.

Rates of poor mental health are high in Hackney, with the estimated prevalence of common mental disorders of residents aged 16 & over being 24.4% of the population, the highest rate in London and significantly higher than the national average. In the City of London the rate is lower at 13.4%, although there are communities with high mental health needs within the population.

Hackney is the 18th most deprived area in England, out of 151 local authorities Around 25% of children aged under 16 and 41% of adults aged 60+ live in low-income households in Hackney. This is likely to be one factor in the high mental health needs in the borough, as is well established that deprivation (a lack of money, resources and access to life opportunities) or being in a position of relative disadvantage (having significantly less resource than others) is associated with poorer health, including mental health. In contrast the City ranks 126th out of 151, with around 7% of children and 8% of over 60s living in low income households.

Hackney also has a relatively high proportion of social housing compared to London and national averages, as well as a higher percentage of residents claiming benefits (Universal Credit and Job Seekers Allowance). However, while the proportion of claimants has decreased in Hackney, London and England in the last year, it continues to increase in the City of London.

Hackney and the City are very diverse borough areas, with 30% of City residents and 42% of Hackney residents coming from non-White ethnic backgrounds. The largest group is Black African at 10% of the population and 5.7% are Black Caribbean. 37% of the population are White British and 19% are “other White.” There are also well established Irish, Asian, Turkish and Kurdish and Orthodox Jewish communities, as well as newer communities of people from African countries and Eastern Europe. At least 89 different languages are spoken in the borough.

City and Hackney have a relatively large population of young adults, with almost a third of the population being aged 18-35. People aged over 55 make up 18% of the population.

Further information on the City and Hackney population is available at:
https://hackneyjsna.org.uk/virtual-profiles/#

Local Consultation:

Extensive stakeholder consultation has been undertaken regarding the re-commissioning of this service. This included:

- Two stakeholder workshops
- Stakeholder meetings, including
  - the City and Hackney Mental Health Coordinating Committee
  - City and Hackney Psychological Therapies and Wellbeing Alliance Meeting
  - City and Hackney Joint Mental Health Meeting
  - Hackney VCS Mental Health SIG meeting
  - City of London DLT
- 1:1 discussions with stakeholders including but not limited to ELFT, the CCG, local voluntary sector organisations, current providers, related services
- Stakeholder survey
- Potential provider survey
- Interviews with potential providers
- LGBT and YBM focus groups
- VCS Assembly findings
- Mental health pathways mapping
- Nous service evaluation
- Routine monitoring information
- Routine service user feedback
- Service user survey
- Service user focus group
- Relevant external reports and data (national and local)

All information sources were collated and used to inform the design of the service specification and some of the main findings are listed below.

The findings included the confirmation of a number of key strengths by local stakeholders and the importance of maintaining these in the new service. Some of those most frequently raised were:

- the increased reach into the community that the service provides improving access for a number of local population groups,
- the provision of alternative mental health services and settings to those provided by the NHS
- and the provision of a service for people who do not meet the criteria or thresholds for other mental health services but have significant and complex mental health needs
- the importance of the service offering a variety of types of interventions and for the support to be holistic in nature, taking a whole person approach.

A range of challenges that the new service will face were also identified including:

- The notable increase over the last few years in the number and proportion of residents whose mental health needs are considered to be complex.

- The very high demand for mental health services locally and levels of mental ill health in the local population, which exceeds the resource available for support service provision
- The need for increased clarity and communication on what the offer of the service is and who it is for, both for potential service users and partners.
- The number of different communities and overlapping groups within the local area and how to ensure provision is fair and inclusive, without being spread too thinly.
- The need for more integration both between different organisations within the network and with other local mental health services and those delivering related interventions.

Other comments on the new service design included:

- The need for the service to be better able to flex to the changing needs of the population and gaps identified in service provision.
- An acknowledgement of the value of having a network of smaller providers, with different expertise in terms of both interventions and also different population groups but the desire for them to have more of a voice in the overall service.
- Both the value of the security of long term funding and the challenges associated with longer term commitments for smaller organisations were raised.

Impact Of Coronavirus

Evidence[1] also indicates that people already vulnerable to poor mental health are at increased risk of worsening mental health as a direct result of the Pandemic.

The impact of COVID-19 on mental health has not been the same for everyone. Public Health England's Beyond the Data report provides clear evidence that Londoners who were already experiencing poorer social, economic and health outcomes, have been disproportionately affected by the pandemic.

- Demand for specialist services and more complex cases, such as young people with eating disorders, and self-harm, has increased.
- COVID-19 itself has a direct impact on mental health both for survivors of the illness, and those bereaved by it.
- The economic impact of the pandemic has affected Londoners' mental health and wellbeing, and will continue to do so.
- More Londoners are vulnerable to suicide. Although the official statistics on suicide rates during the pandemic have yet to be released, there is a recognition that due to the extreme challenges posed by the pandemic more Londoners will be considered vulnerable to suicide, leading to an increased risk of suicides across the city.
- The mental health impacts from covid fall unequally across society. Some groups have been experiencing more critical mental health concerns, with the effects more likely to persist.

[1] Thrive LDN: Towards Happier, Healthier Lives: Ideas and actions for how London can recover and thrive