1. **Service Specifications**

*This is a non-mandatory model template for local population. Commissioners may retain the structure below or may determine their own in accordance with the Contract Technical Guidance. NHS England’s Contract Technical Guidance provides (at paragraph 36) further guidance on specifications generally and on what to consider for inclusion under the headings below.*

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| **Service Specification No.** | 1 |
| **Service** | Mental Health Support Services (Brighton and Hove and West Sussex) |
| **Commissioner Lead** | Anne Foster, Head of Mental Health Commissioning Brighton and Hove |
| **Provider Lead** | TBD |
| **Period** | 01 October 2025 – 30 September 2030 |
| **Date of Review** | TBD |

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| **1. Population Needs** |
| * 1. **National and local context and evidence base**   [‘No Health without Mental Health’](https://www.gov.uk/government/publications/no-health-without-mental-health-a-cross-government-outcomes-strategy) defines mental health as a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.  Nearly 2 in 3 of us will experience a mental health problem during our lives, and 1 in 6 of us is managing fluctuating levels of distress each week. This means that mental health problems commonly affect our lives, our families, workplaces, and communities, impacting everyone.2  Mental ill health currently represents 23% of the total burden of ill health in the UK and is the largest single cause of disability. According to the 2018 Global Burden of Disease UK Study, depression was the fourth leading cause of years lived with disability.  Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include but are not limited to:   * improved physical health and life expectancy * better educational achievement * increased skills * reduced health risk behaviours such as smoking and alcohol misuse * reduced risk of mental health problems and suicide * improved employment rates and productivity * reduced anti-social behaviour and criminality * higher levels of social interaction and participation.   National policy context is for a vision of integration, ensuring system partners such as Health, Social Care, and Voluntary Community and Social Enterprise (VCSE) work more closely to provide seamless services for the population. This necessitates making the very best use of resources to improve health and wellbeing outcomes for the whole population. To achieve this, Integrated Care Systems (ICS) have been set up in each region, the ICSs will bring health and care organisations together to develop shared plans and joined-up services. The ICS in Sussex is [Sussex Health and Care](https://www.sussex.ics.nhs.uk/our-work/our-strategy/).  Underpinning this integrated approach is to enable patients to have more control about their care and to be active participants empowering them to live independently, with the ability to make choices. There has also been an emphasis on collective leadership and joint working with a call for leaders from across Health, Social Care and the Voluntary, Community and Social Enterprise (VCSE) sectors to jointly deliver solutions appropriate to their own communities.  Improving population mental health and wellbeing and reducing health and care inequalities is a priority for the Sussex Integrated Care System (ICS) area. Brighton and Hove and West Sussex form part of the Sussex ICS along with East Sussex.  The proposed MHSS will help to deliver against the following strategic priorities:   * [The Community Mental Health Framework](https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf) describes the national vision for a place-based community mental health model to be realised, and how community services should modernise to offer whole-person health approaches, aligned with Primary Care Networks. * NHS Sussex Shared Delivery Plan (SDP), [Improving Lives Together](https://www.sussex.ics.nhs.uk/our-work/our-strategy/), sets out the ambition across health and care in Sussex over the next five years, with the aim to improve the lives of local people by supporting them to live healthier for longer and making sure they have access to the best possible services when they need them.   Within Brighton and Hove, mental health has been identified by the Health and Wellbeing Board and the Health and Care Partnership as one of the city’s five population health priorities for the city. MHSS will support delivery of outcomes in many of the city’s strategic plans including:   * [The Brighton and Hove City Council Plan 2023 to 2027](https://www.brighton-hove.gov.uk/brighton-hove-city-council-plan-2023-2027), All four of the main outcomes, A city to be proud of; a fair and inclusive city; A city where people can thrive.; A city of responsive and well-run Council services. * [The Brighton & Hove Joint Health and Wellbeing Strategy 2019 – 2030](https://www.brighton-hove.gov.uk/sites/default/files/health/brighton-hove-health-wellbeing-strategy-2019-2030-26-july-19.pdf), that includes an ambition that “mental health and wellbeing will be improved and easier access to responsive mental health services will be provided”. * [The Brighton & Hove suicide prevention action plan 2024 – 2027,](https://democracy.brighton-hove.gov.uk/documents/s194367/BH%20suicide%20prevention%20Action%20Plan%202024-2027%20-%20final.pdf)  action to reduce the risk of suicide and provide support to groups locally identified as an increased risk of poor mental health and suicide.   Within West Sussex, MHSS will support delivery of outcomes in the following strategic plans:   * [West Sussex County Council Plan 2021 – 2025](https://www.westsussex.gov.uk/about-the-council/policies-and-reports/corporate-policy-and-reports/our-council-plan/), contains a priority to Helping people and communities to fulfil their potential focusing on improving wellbeing and integrated care * [[West Sussex Joint Health and Wellbeing Strategy 2019 – 2024](https://jsna.westsussex.gov.uk/updates/public-mental-health-needs-assessment-2024/)](https://jsna.westsussex.gov.uk/updates/public-mental-health-needs-assessment-2024/), the Living and Working Well goals of action outline areas around wellbeing and mental health. * [West Sussex Suicide Prevention Framework and Action Plan 2023-2027](https://www.westsussex.gov.uk/media/20480/ws_suicide_prevention_framework_2023_27.pdf), the action plan focuses on nine key areas, the areas focusing on mental health are to reduce the risk of suicide and improve the mental health of key high-risk groups, and tailor approaches to mental health in risk groups.   The Sussex response to delivering the national Community Mental Health Framework is to develop [Neighbourhood Mental Health Teams](https://nhs.sharepoint.com/sites/msteams_a50cae-MHSupportServicesContracting/Shared%20Documents/MH%20Support%20Services%20Contracting/Task%20%26%20Finish%20Groups/Design%20Task%20and%20Finish%20Group/Scope%20Docs/Archive/NMHT%20Sussex%20Framework.docx) (NMHT). It is expected that NMHTs will form part of the emerging ICT (integrated community teams) that are described in Delivery Area 1 of the Sussex Shared Delivery Plan. The Neighbourhood Mental Health Teams will:   * Offer high quality support to people with a range of mental health needs, at different stages of their journey, with a choice of interventions. This will ensure that anyone experiencing emerging or established mentally ill health, can access timely, holistic support close to home. * Work together with key services to provide more joined up and coordinated care. * Be personalised, accessible, seamless and fully integrated, leading to a better experience and better outcomes for those accessing mental health support. * Have a core partnership between Sussex Partnership NHS Foundation Trust (SPFT), Voluntary, Community and Social Enterprise (VCSE) organisations, Primary Care and Social Care. * Engage and work in partnership with communities to ensure a strong community voice. * Aim to improve access to:   + Clear information on how and where to access support   + Wider social support and determinants of health, including employment, education, housing and money advice   + Criminal Justice support   + Coordinated support from adult social care   + Physical health care   + Effective support, care and treatment for co-occurring drug and alcohol-use disorders   + Community assets to support and enable people to become more embedded within their community (e.g. volunteering, arts & culture, spirituality, education, sports & health, etc.)   MHSS will be an integral component of Neighbourhood Mental Health Teams (NMHT), and it is anticipated that these services will enable people experiencing mental ill health to be supported to live well in their communities, to maximise their individual skills, and to be aware and make use of the resources and assets available to them. The conceptual framework for the NMHT model is detailed in Figure 1, and it is expected the MHSS will deliver both the, ‘Getting advice, information and guidance’ and ‘Getting Support’ functions. Whilst different types of support may be delivered by a range of providers, it will be delivered as an integrated system.  Figure 1: Neighbourhood Mental Health Team Model  A diagram of a group of people  Description automatically generated   * 1. **Local context - Mental health and wellbeing needs**   **Brighton and Hove**  The Brighton and Hove all ages Mental Health and Wellbeing Needs Assessment (2003) describes high levels of mental health need in the city, identified groups at higher risk and highlighted a range of preventative factors in terms of community assets. Key points for Brighton and Hove are:   * Population is almost 280,000 * Higher prevalence of adults with common mental health conditions such as depression or anxiety (1 in 5 people) compared to England (1 in 6 people). * Greater proportion of people on GP registers for severe mental illness (such as schizophrenia or bipolar disorder) - 1.3% of adult population compared with 0.95% for England. * The suicide rate is statistically significantly higher than the national average, with a proportionately higher rate of deaths by suicide in women. * The rate of hospital admissions for self-harm for 10–24-year-olds is 1.5 times higher than England.   There is strong national evidence that some communities and groups are more exposed and vulnerable to unfavourable social, economic, and environmental circumstances. For many of these groups, Brighton and Hove has high or very high need:   * People with alcohol and/or drug dependence: Compared to England, drinking and substance misuse are significantly higher amongst both children and young people and adults. * People experiencing homelessness: Brighton & Hove has the second highest rate of statutory homelessness (households in temporary accommodation) of all local authorities in England outside of London (18th highest in England including London). * People with complex needs and multiple disadvantage: Brighton & Hove, has a higher estimated rate of people with multiple disadvantages than England. The majority have mental health needs.   Other population groups with increased risk include:   * Ethnic minority groups * Lesbian, gay, bi, trans, queer, questioning, asexual (LGBTQ+) people * People with long-term physical health conditions * People living with physical disabilities * People living with learning disabilities * People with sensory impairment * Carers * Neurodivergent/ce * Migrants, refugees, asylum seekers and stateless persons * Gypsy, Roma and Travellers * Children in care and care leavers * Mothers of children taken into care * Students * Armed forces personnel and veterans * Prison population, offenders and victims of crime   **West Sussex**  The West Sussex Mental Health Joint Strategic Needs Assessment Key points identify:   * The population is 892,350. * Approximately 119,890 adults are estimated to have common mental health disorder. * There are 120,000 (one in six) adults identified as having symptoms of a common mental disorder, with approximately one in twelve having severe symptoms * Currently 24% of the population self-report high anxiety. * There are over 102,000 people with depression on GP registers, * In 2022/23 there were 9,050 people on the severe mental illness (SMI) GP registers, this represented 0.97% of registered patients. * The mortality rate for suicide and injury undetermined has tended to be similar to England overall. In the 3 years of 2020-2022 there were 270 deaths. The male suicide rate locally * and nationally is higher than that of women. * One in five adults stated that they had had suicidal thoughts at some time in their life. * In 2022/23 there were 102,430 people recorded with depression on GP registers, this represented 13.6% of registered patients aged 18+ years. * An estimated 6,150 young people aged 17 to 19 years, and 10,880 young people aged 20 to 25 years have a probable mental health condition. * In Q4 2023/24 there were 9,106 people on the SMI register * The highest rates of secondary mental health hospital admission in West Sussex are ages 20-34. * 20,000 people aged 65 years or over are estimated to have a common mental health condition. * Depression is one of the most common mental health conditions experienced by older adults. * Population age profile for West Sussex in 2022 = Aged 0 to 15years 17.7%. Aged 16 to 64 years 59.3%. Aged 65+years 23.1%. Based on data projections from 2018 West Sussex * population is project to increase by a further 47,000 people within the next 10 years with the 65+ age group projected to increase by 23%. |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**  This contract is to be viewed within the overall context of the NHS’ desired commissioning outcomes and indicators.   |  |  |  | | --- | --- | --- | | **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **x** | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **x** | | **Domain 4** | **Ensuring people have a positive experience of care** | **x** | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **x** |   **2.2 Local defined outcomes**  The approach to delivering MHSS is designed to be less prescriptive and more flexible to enable responsiveness to a dynamic and changing environment. Whilst the service description provides an overview of delivery expectations (the What) there is flexibility as to how MHSS deliver to meet the needs of the communities (the How).  Due to this the Commissioners (NHS Sussex and Brighton and Hove City Council) along with partners in West Sussex County Council will work collaboratively with the Provider once awarded to develop locally defined outcomes and Key Performance Indicators (KPIs) to ensure outcomes and KPIs are achievable and in line with the proposed service model.  The service will contribute to national outcomes and KPIs for the following:   * Increasing access to community mental health services * Improving physical health care for people with severe mental illness (SMI) * Individual Placement and Support (IPS)   It is expected that local outcomes and KPIs will reflect the need to provide additional focus on communities of interest that include but are not limited to:   * Ethnic minorities, * Neurodivergent/ce * 18 to 25 year olds, * LGBTQ+, * Carers * Gypsy, Roma, and Traveler, * Those with experience of the care system, * Globally displaced communities, – those seeking asylum, refugees, vulnerable   Migrants   * People who misuse drugs and alcohol * People who are experiencing homeless * Armed forces – Veterans and their families   Commissioners will work with the provider to develop Patient Reported Outcome and Experience Measures (PROM/PREM). The Provider will be expected to use the Recovering Quality of Life (ReQoL) tool for certain elements of the MHSS delivery as well as other locally agreed outcome measures that will be identified during mobilisation. |
| **3. Scope** |
| **3.1** **Aims and principles of service**  The aim of the Mental Health Support Services (MHSS) is to improve the mental health and wellbeing of the adult population in Brighton and Hove and West Sussex.  The MHSS will adopt the following principles.   1. **Addressing health inequalities**. MHSS will have an emphasis on increasing access and improving outcomes for those with protected characteristics (Protected characteristics | EHRC (equalityhumanrights.com) and for populations at higher risk of developing mental ill health.    1. MHSS will be based on inclusivity, particularly for people with coexisting needs, learning disabilities and those with the highest levels of complexity and who experience marginalisation.    2. MHSS will work within the local health and care systems to address health inequalities and social determinants of mental ill health.    3. MHSS will promote population mental health and wellbeing, prevent ill health, and reduce stigma and discrimination towards people experiencing mental ill health. 2. **Co-production**. MHSS will be co-produced in partnership with people who use services and their friends and family carers. They will be co-produced with people who are representative of the communities they serve. 3. **Accessible and person-centred**. MHSS will take account of the whole person recognising their health and social needs and their roles as a parent, carer, worker, student, friend, and family member.    1. MHSS will be easily accessible for individuals, friends, families and carers.    2. MHSS will improve the lives of people living with, experiencing and recovering from mental ill health. 4. **Partnership and neighbourhoods**. MHSS will be integrated and joined up with other support services, working as part of the NHMT model and aligned with neighbourhood Integrated Community Teams (ICT).    1. MHSS will be seamlessly delivered and maximise continuity of care. 5. **Evidence based**. MHSS interventions will be based on best practice, population need, what works, what is cost effective and what data and people tell us. 6. **Trauma-informed**. MHSS will be delivered in a psychologically and trauma informed way. 7. **Innovation**. MHSS will be delivered flexibly with innovation in service delivery to provide value for money and to meet local need. 8. **Promotion & Prevention**. MHSS will aim to prevent escalation of distress, reduce risk of suicide and self-harm with a focus on engaging with and ensuring support for populations that may be at higher risk of harm.   Delivery of the MHSS will be monitored and measured with Key Performance Indicators (KPIs) linked to the overall aim and principles.  **3.2 Service description**  The service description provides an overview of expected delivery requirements (the What) but not a prescription on how the service is designed or delivered (the How). Providers will use this as a framework to design delivery that meets the needs of the local communities being served.  MHSS will provide support to promote well-being, prevent mental ill health by intervening early and offer opportunities to pursue meaningful activities and avoid social isolation. They will also complement other services, provided by the NHS and local authorities, General Practice (GP) and VCSE to deliver holistic care as part of a pathway approach. MHSS have a key role in supporting delivery of national targets for mental health including reducing reliance on acute and crisis pathways and expanding access to community-based support.  MHSS will include four key areas:   * Provider responsibilities (governance, data collection and reporting, system leadership, lived experience advisory group) * Community Development, prevention and promotion * Advice Information and Guidance * Getting Support   It is expected that the MHSS will support people and will offer:  Community Development, Prevention and Promotion:   * Take an asset-based approach to community development in disadvantaged and higher risk communities to build community wellbeing and strengthen community voice * Workforce training to include suicide prevention and MH awareness * Campaigns and awareness raising including anti-stigma work * Data and insight into the output, outcomes and demographics of service users.   Advice, Information and Guidance:   * Provide advice, information and guidance via physical or virtual Mental Health Support Services. * Develop a network of communities to facilitate the promotion of the service and messaging and campaigns * Provide central communications phone/email/webchat * Online self-help digital offer * Debt and welfare/benefit advice * Links to wider community offers such as substance misuse, housing with co-working where needed. * Peer support * Provide early intervention – i.e. reaching out to people demonstrating an emerging mental illness or reduced sense of wellbeing to offer early intervention and prevent the need for more specialist services. This includes psychosocial support and social prescribing options such as arts & culture, spirituality, education, physical activity, engagement with nature, support with financial difficulties, employment support, and more. * Aim to prevent people relapsing into mental ill health and needing hospital or other specialist services. * Connect to appropriate interventions within and outside of MHSS. * Data and insight into the output, outcomes and demographics of service users.   Getting Support:   * Ensuring individuals with complex or higher risk needs are considered as part of the multi-agency NMHT coordinated triage to reach agreement on the most appropriate interventions. * Assessment, development of care support and crisis plans. * Care co-ordination and navigation to appropriate services. * Support for behaviours change through motivational interviewing and other support interventions. * Delivery of one to one and group psychosocial support and education (eg: self care and management, problems solving) * Assess and provide targeted and personalised support for people waiting to access services. * Awareness and ability to respond flexibly to emerging and changing local needs. * Provide support for healthy behaviours and encourage uptake of wider health intervention services such as healthy weight, physical activity, smoking cessation, cancer screening to include interventions following physical health checks for those with serious mental illness. * Direct individuals to the most appropriate service offer, including wider services such as Staying Well, NHS Talking Therapies, housing and drug and alcohol services. * Facilitate conversations when signposting or referring to other services, to ensure no individual falls through gaps, is declined a service offer without a suitable alternative offer being made and to prevent multiple assessments. * Develop and assure knowledge and skill of workforces who support adults experiencing mental ill health including self-harm and suicidal ideation through training * Provide targeted interventions for the most vulnerable groups, including people affected by homelessness and substance misuse, to connect them with appropriate mental health support services * Employment support through links with Individual Placement Support (IPS) model. * Data and insight into the output, outcomes and demographics of service users.   MHSS will act as a central hub for all community mental health support referrals, working to the defined aims and principles. Focus will be made to ensure there is ‘no wrong front door’ and to contribute to removing gaps in service provision.  Collaboration to deliver MHSS as an integral component of NMHTs is essential and key partners are Sussex Partnership Foundation Trust (SPFT) and Primary Care Networks (PCNs) Collaboration is also required with wider system partners to meet people’s needs. This includes but is not limited to; adult social care, children’s social care (where service user is a parent or carer), drug and alcohol services, housing support and advice, criminal justice, social prescribing and others.  As the NMHT’s are still being developed there are some operational details that have not been finalised. There are 3 component parts of the NMHT (see figure 2) – Core Team, Aligned Services, and Wider Networks, all working as part of an integrated model. It is expected that all MHSS will be part of the NMHT model – but at this stage it has not been confirmed precisely which services will be included in each of the 3 component parts of the NMHT. Although we are unable to specify which elements of the MHSS will be in each component part of the NMHTs at this time, the NMHTs will be designed at “place” the Provider will need to collaborate with the existing NMHT Operational Delivery Group to develop the specific details of the place-based offer.  **Figure 2: Neighbourhood Mental Health Teams Alignment**  A diagram of a network  Description automatically generated  **3.3 Community Development, Prevention and Promotion.**  This function of the mental health support service focuses on preventing mental ill health and deaths by suicide through community development, engagement, campaigns and communications and training for MHSS staff and the wider partner workforce.  It has 3 elements:   1. Community engagement and development 2. Campaigns and communications 3. Training on mental health awareness and suicide prevention   The first 2 elements are to be delivered in an integrated way. Effective promotion of key messages through campaigns and other approaches requires strong community engagement.  Each element aims to benefit the whole population in Brighton & Hove and West Sussex, with a particular focus on communities at increased risk of mental ill health and suicide. These groups are identified in the Brighton & Hove and West Sussex Mental Health JSNAs (see Appendix 6)  The MHSS and these elements will focus on additional support to communities of interest as listed in section 2.2.  Key Performance Indicators will be agreed with Providers during contract mobilisation and may evolve over the lifetime of the contract.  **3.4 Community engagement and community development**  The aim is to work in partnership with higher risk or disadvantaged communities to:   * Use an asset-based approach to strengthen community voice and community engagement * Identify and build on assets; * Identify and address challenges related to mental wellbeing and suicide prevention. * Provide activities to improve community mental health and wellbeing to be informed by evidence of what works and what is cost effective.   This element is to be aligned and linked to the campaigns and communications element.  Definition of community development and engagement: Asset-based community development is where people and communities are facilitated to come together to achieve positive changes, harnessing their own knowledge, skills and lived experience of the issues they encounter in their own lives.  Community engagement involves taking a strategic approach to an organisation's community-based stakeholders. This includes building relationships, developing communications, and managing interactions in order to achieve specific outcomes for the organisation and the community itself.  Expected Outcomes evidenced in data collected and submitted by provider:   * Communities are able to identify their mental health and wellbeing concerns and identify, develop and shape initiatives to mitigate identified concerns * People with lived experience will have their voices heard and valued, driving meaningful change and shaping inclusive, effective services. * Personal and community resilience * Local community assets * Awareness of mental health support services in the community * Access to local mental health services and information in particular by more disadvantaged communities * Trust in mental health support services in particular by more disadvantaged communities * Empowerment of communities to speak directly to the system and inform system change and give context to data   Requirements:  The provider is expected to:   * Work in partnership with communities to identify issues related to mental health, wellbeing and suicide prevention and mapping local assets to inform strengths-based solutions * Build on existing community development approaches and work in collaboration with community development organisations who have trusted and established relationships with communities and residents * Feedback to MHSS, NMHTs and the wider system on the insights from communities, including identified local issues, challenges, assets and proposed local approaches * Alongside communities, provide or co-ordinate a mixed balance of activities, programs and services that focus on enhancing wellbeing based on identified local needs and gaps in support * Regularly review existing approaches and how well they meet outcomes, and develop and amend based on learning * Support residents to Identify need and any barriers to access and work to support by removing barriers or helping people overcome them to provide fairer and more equitable access.   **3.5 Local and national campaigns and communications**  ***Note:*** *In West Sussex, WSCC Public Health currently commission suicide prevention and awareness training for various workforces. It is expected the provider will support the current framework and collaborate on future efforts to align delivery across the county. WSCC also undertake, in partnership with organisations across the county, comms campaigns throughout the year. The provider is expected to collaborate and contribute to this work.*  Aim: To increase awareness of how to maintain good mental health and wellbeing of self and others, to recognise the signs of poor mental health, and to increase awareness of how, where and when to seek help. To work with communities to address stigma and to increase knowledge of services, promote relevant national campaigns and develop local campaigns.  This element will be aligned and linked to the community engagement and development element.  Expected Outcomes evidenced in data collected and submitted by provider:   * Increased awareness of how to proactively develop and maintain positive mental wellbeing * Increased recognition in self and others of the signs of common mental health conditions such as stress, anxiety and depression; and the symptoms of suicidal ideation * Increased knowledge of when and where to seek help for self and others for mental ill health, self-harm or suicidal thoughts * Reduced stigma and increased ability for communities to have open conversations about mental health, self-harm and suicide * Increased awareness of the complex relationships between social media and mental health, including risks around addictive use, exploitation and negative impact on self esteem * Offer opportunities for social connection and peer support.   Requirements  The provider is expected to:   * Reach and engage with groups at increased risk of poor mental health to understand how best to promote key messages to enable more equitable and fair access to MHS services * Review and align with local communications approaches to engaging with groups at greater risk of mental ill health, suicide and self-harm, and promoting relevant prevention campaigns and signposting to local support. * Develop local campaigns, communications and tailored resources related to reduction of stigma, mental health awareness, self-harm awareness and suicide prevention e.g. Five Ways to Wellbeing * Co-design messaging and resources with people with lived experience, working closely with the community engagement and community development element to tailor messaging for local communities * Adhere to the Samaritans media guidelines for reporting suicide * Ensure accessibility of all public-facing communications, including but not limited to:   + Easy Read materials for adults with learning disabilities   + Translated materials and videos for adults who do not speak English as a first language   + Physical resources for people who face digital exclusion   + Videos for people with low literacy levels   + Screen-reader compatibility for digital resources   **3.6 Training for professionals on mental health awareness and suicide prevention**  ***Note:*** *In West Sussex, WSCC Public Health currently commission suicide prevention and awareness training for various workforces. It is expected the provider will support the current framework and collaborate on future efforts to align delivery across the county. WSCC also undertake, in partnership with organisations across the county, comms campaigns throughout the year. The provider is expected to collaborate and contribute to this work.*  Aim: To provide workforces who is knowledgeable, skilled and confident to support adults experiencing mental ill health including self-harm and suicidal ideation. Training to be tailored where possible to different workforces and roles.  Expected Outcomes evidenced through service user feedback submitted by providers:   * Increased confidence, skills and knowledge in workforces in the city who support adults with mental health needs, including self-harm and suicidal ideation * Workforces are confident to have conversations about mental health, suicide and self harm * Increased knowledge in workforces about how to signpost and where to go for more help * Increased confidence, skills and knowledge of professionals in the city in identifying early signs of suicidal ideation, keeping people safe, and where to go for mental health crisis support   Requirements  The provider is expected to:   * Work in collaboration with existing mental health awareness and suicide prevention training programmes * Co-design training content with people with lived experience of mental health, self-harm and/or suicidal ideation and their carers * Create an annual plan that covers both open access training opportunities and a targeted programme * Regularly review existing approaches and how well they meet outcomes, develop and amend, based on learning * Deliver flexible training sessions in terms of length and type of delivery to enable all frontline staff including those with limited capacity to be able to attend. * Provide attendees with signposting resources about the services supporting people with mental health and wellbeing needs and/or suicidal thoughts   **3.7 Indicative funding breakdown for MH Promotion, Suicide and Self Harm Prevention, and Community Development**  Brighton & Hove  Public health has allocated £270,000 toward these activities, we would expect to see a minimum of two thirds of public health funding to be allocated to community engagement and development programmes, 15% should be allocated toward the overall operations and delivery of MHSS (e.g. contract management, on costs, etc.). Indicative funding is given below however contract monitoring will focus on the provider delivering specified outputs and outcomes  West Sussex  Local and national campaigns, and training for professionals is currently commissioned by West Sussex County Council through other delivery partners. The Provider is expected to support and align existing work with public health but is not expected to deliver these activities. The community engagement element needs to be delivered as part of the MHSS service. Indicative funding is not provided but we will expect to see how this element is delivered and what budget is allocated. Contract monitoring will focus on the provider delivering specified outputs and outcomes.  **3.8 Advice Information and Guidance**  This strand is about ensuring access to information and support for people within MHSS and across Aligned, Wider Network and Partnership elements. Included in this are several areas for consideration:   * Mental Health Support Services   should be a combination of physical, virtual, and/or co-located spaces. They should leverage existing community resources and be able to flexibly provide a safe space for people to get information or deliver group or one-to-one interventions. * Service and system promotion should be a key element to ensure people are aware of the opportunities available to them and where and how to access support. As NMHTs advance this will be a key feature to ensure the broader population is aware of these changes. * A centralised communications platform that is easy for individuals and partners to access (i.e. phone/email/web-chat), this is not aimed at duplicating other services such as Sussex Mental health Line. * An on-line or digital offer that may provide self-help resources which can empower individuals to manage their mental health independently * Access to advice on subjects important to the community, this could include debt and welfare/benefit advice and links to aligned mental health services and wider community networks to offer support e.g. housing, substance misuse with co-working where needed to avoid duplication and offer joined up support. * Outreach offers to bring advice, information, guidance, supportive self help, peer support, to communities and groups that may not easily access services. * Providing the opportunity to connect people to appropriate interventions within and outside of MHSS   **3.9 Getting Support**  This strand consists of activities within the Core NMHTs and activities that will be delivered as part of the Aligned and Wider Network and Partnership elements of the NMHT.  The provider will need to commit a team to be part of the core NMHT including leadership, admin and peer support to provide the following functions:   * Triage as part of a coordinated NMHT triage function * Assessment, development of care support & crisis plans * Care coordination and navigation to appropriate services * Support for behaviour change through motivational interviewing and support for people who are at increased risk of poor physical health e.g. behavior change interventions using motivational interviewing and signposting to appropriate services and activities such as weight management, smoking cessation, and other healthy living initiatives (consistent with physical health checks for people with serious mental illness).   The Provider will deliver a psychosocial support offer comprised of a range of interventions and activities that relieve stress, promote resilience, sustain wellbeing and prevent mental health conditions. It can be provided at the community or group level, from a physical building or via a digital offer. For example:   * Delivery of one-to-one and group psychosocial support and education (e.g. self-management, problem solving, bereavement, behaviour activation, post diagnostic support, etc.) * Support to access local activities and groups (e.g. cooking, gardening, physical health activities, faith-based groups, etc.) * Links to Aligned services and Wider Networks and Partnerships to offer support or joint working (e.g. crisis provision, NHS Talking Therapies, housing, and substance misuse)   The Provider will deliver employment support through the Individual Placement and Support (IPS) model as an integral component of NMHT’s. Access to the right job with the right support plays a key role in recovery, confidence and expanding social networks.  **3.10 Placed Based Flex Offers**  There are additional services that will be delivered alongside the MHSS Offer (referred to as MHSS Placed Based Flex), due to the specific funding arrangements or identified areas of need.  In Brighton and Hove there is an expectation that the following activities will be delivered:   * Tier 3 Complex Emotional Needs Service MHSS Support Offer as part of an integrated service with SPFT. (See appendix 11 for specification)   **3.11 Population covered**  People aged 18 and over who are registered with a Brighton and Hove or West Sussex irrespective of whether they are registered with a GP.  Although this is a service for 18 and over the service will need to ensure offers to those recently turning 18 and transitioning from the youth system, are youth focused and include an emphasis on continuity of support.  **3.12 Any acceptance and exclusion criteria and thresholds**  Eligibility Criteria  MHSS will be available to those with wellbeing and/or functional mental health needs (i.e. those mental health presentations where no organic cause, such as a brain injury or hormonal abnormality has been identified) including those who:   * Are at risk of mental health problems and who need support to maintain wellbeing and resilience including protected characteristic groups * Have common (clinically diagnosed or self/un-diagnosed) mental health conditions such as anxiety and depression, who may need variable, lower intensity support to stop them reaching a crisis point * Have more serious mental health problems (e.g. psychosis), and may need a more clearly defined care programme of support to avoid relapse and promote recovery * Are at risk of developing a mental health crisis * Are at higher risk of suicide and/or self-harm * Are families and carers of those who have mental health problems * Are part of identified communities of interest (i.e. Ethnic Minorities, Refugee and Asylum Seekers, Neurodivergent/ce, those aged 18 to 25, learning disability, LGBTQ+, Gypsy, Roma Traveler, Carers, Armed Forces, those with experience of the care system, people who misuse drugs and alcohol and people who are homeless)   Exclusion Criteria   * Those requiring a specialist dementia service * Those under 18 years of age (unless in a transitional capacity) * Those in need of secondary care and treatment, e.g. people in acute mental health need (unless currently receiving support from MHSS before requiring secondary care and there is an identified need for continuity of care through joint working).   For those that may be excluded from MHSS, the service will ensure that people and their carers are supported to connect with the appropriate services and/or pathways.  **3.13 Days/Hours of Operation**  The service will operate 5 days per week (in general) Monday to Friday however the service will be flexible and responsive to remove barriers of access to those who work or have caring responsibilities which prevent them from accessing services between 9-5 Monday-Friday.  **3.14** **Location of Service**  The MHSS could be provided from a variety of different places. Co-location with other community-based services and NMHT’s should be prioritised in order to increase cross-system coordination. The emphasis is on optimised accessibility for everyone, especially those with disabilities. Consideration should be given to delivery via a digital offer, pop-ups and/or co-location.  **3.15 Care Pathway**  The MHSS will be Open Access at point of entry, meaning that individuals can self-refer or enter the system from any point, whether they seek help through social services, primary care, mental health, or other channels.  The provider will be required to work as an integral part of the Neighbourhood Mental Health Teams to establish effective pathways, referral guidelines and protocols in association with primary and secondary care clinical colleagues.  **3.16 Patients who do not respond to contact**  People who contact the service requesting support will receive a response within 2 working days.  People who do not attend agreed appointments or sessions will be contacted by phone within 2 working days of the missed appointment/session and offered a second appointment/session with full consideration given to individual circumstances and any adjustments that could be made to enable and support attendance at future appointments/sessions  Where the Provider is unable to make contact or three appointments are missed the Provider will notify the client (along with original point of referral if appropriate) with details on how to get in touch again in the future. In all cases where someone does not attend agreed appointments or sessions the Provider will consider the risks and needs of the individual and consider whether the lack of contact requires a safeguarding concern to be raised, a referral to an outreach service or an escalation to the coordinated triage within the neighbourhood mental health teams.  **3.17 Access & Co-ordinated Triage**  MHSS will be open access to people needing Advice, Information and Guidance, and Support.  Where More Support is required, a coordinated triage will ensure everyone receives an offer suitable for their needs.  It is critical that processes increase ease of access and choice, local and national feedback is that people wish to maintain choice in which services they access. Therefore, it is imperative that self referral routes are maintained, and people continue to have a choice of which services to access. Additionally, for some it may be useful to have someone support a ‘referral’ into services to assist them in accessing the right support. The MHSS must ensure that these pathways and processes are clearly identified and support increased access and ease of access.  Each MHSS will need to work within the developed structure within place to support high quality coordinated triage.  **3.18 Accessibility/Equality of Access**  Services will be accessible to all, regardless of age, disability, gender reassignment, race, pregnancy and maternity, race, religion or belief, sex or sexual orientation, and deal sensitively with all service users and potential service users and their family/friends and advocates.  The service should engage with service users via several mediums including utilising digital solutions and make any other reasonable adjustments as requested by service users.  The Provider will actively work to ensure there is equitable access for all including by protected characteristics. The Provider will utilise the community development and engagement strand, alongside targeted campaigns, to improve access for unserved or underserved communities. Consideration should be made to focus on digital inclusion.  Where physical space is utilised, it should be accessible and safe for all.  The service will provide access to appropriate language, translation, and interpreting services and signposting to advocacy services for patients and carers for whom English is not their first language, or those who have sensory disabilities. Information promoting the service will be made available in alternative formats (i.e. brail, easy read, British Sign Language interpreted videos for people who are Deaf), to ensure equity of access.  The Provider will ensure that people who are homeless or not registered with a GP are able to access the service.  The Provider should consider utilising the Lived Experience Advisory Group and other partners/stakeholders to conduct accessibility audits.  The Provider will also use complaints, plaudits and other feedback to continually develop and improve the quality of the service.  **3.19** **Interdependence with other services/providers**  The provider of MHSS is required to work in partnership, forging close links with Aligned and Wider Networks and Partnerships to create a joined-up system that seeks to provide support in the most efficient way for the individual. These key interfaces include, but are not limited to services such as those provided by:   * Neighbourhood Mental Health Teams (PCN, SPFT and VCSE) * PCNs General Practices and staff working there * Adult Social Care (BHCC and WSCC)) * Healthy Lifestyles Team (Public Health BHCC & WSCC) * Sexual Health Services (Public Health BHCC & WSCC) * Family Hubs (Public Health BHCC & WSCC) * The Carers Hub (Brighton & Hove) * NHS Talking Therapies (SPFT in BH and SCFT in WSx) * Responsive Services at Sussex Community Foundation Trust (SCFT) and any other community health care professionals * Substance misuse / alcohol services (VCSE) * Housing Services (BHCC, West Sussex Borough Councils and VCSE) * Criminal justice and probation services. * Wider Network and Partnership VCSE provision outside of the MHSS network |
| **4.0 Data** |
| **4.1 Record Keeping, Information Governance and Confidentiality**  Integrated working will be key to the success of the service. Shared support plans are a key indicator of success. The Provider is required to work with Commissioners and SPFT to move toward a single Electronic Patient Record to facilitate shared patient information and data and improved reporting to the Mental Health Services Data Set (MHSDS) for all required service(s)/interventions, whilst being mindful of General Data Performance Regulations and best practice.  Commissioners will work with providers to identify and address challenges and opportunities as this develops. In the interim we would expect the Provider to have their own Client Management System.  The Provider will need to be a member of the Neighbourhood Mental Health Team Data Recording and Reporting Strategic Group.  The provider will ensure that all staff have the appropriate IT skills and training to use the technology and to use appropriate strategies to find relevant information on a topic to support good quality care.  **4.2 Information Governance and Confidentiality**  The Provider will complete a Data Protection Information Assessment during mobilization and will maintain regular checks to ensure compliance.  The provider will ensure high standards of information governance for the service and reassure the community of the importance of confidentiality.  The provider will also maintain high standards in relation to “Information Sharing Protocols” which may exist between agencies to ensure the appropriateness of the information to be shared with other agencies. |
| **5.0 Governance** |
| **5.1 Overall responsibility**  The provider will need to have a robust governance framework in place as part of the oversight and delivery of services:   * Be responsible for the delivery of all elements of the services, including those services for which it may sub-contract with other providers for their direct delivery or are delivered by an Alliance member. * Provide due diligence on any/all sub-contracted providers or Alliance members on request. * Seek approval from Commissioners prior to awarding or ending any sub-contracts or activities or re-designing service offer * Be accountable for compliance with all contractual obligations, including monitoring and reporting levels of activity delivered by services, ensuring:   + data flow to the Mental Health Services Data Set (MHSDS) for all required services (including those sub-contracted, or provided by any Alliance member)   + meeting all quality and other standards set for the purposes of governing their provision,   + partnership working with other organisations identified as critical to their success,   + upholding the reputation for integrity of NHS Sussex (and BHCC and WSCC ) as Commissioner and itself as Contractor. * Commit to working collaboratively with system partners to utilise an Electronic Patient Record system that is aligned with Sussex Partnership Foundation Trust * Where changes in scope or service model, changes required to improve delivery, or additional funding is made available, Commissioners will expect the provider to actively engage with the market to determine which service provider may be best placed to deliver recommended changes and seek commissioner approval prior to any changes being initiated. * Maintain and develop a Lived Experience Advisory Group (LEAG) that is representative of the communities within Brighton and Hove and West Sussex. The Lived Experience Advisory Group will bring together people from different backgrounds and experiences of mental health and the mental health system to support planning, operations and management of the MHSS. * Provide strategic leadership to system initiatives. |
| **6.0 Finance** |
| **6.1 Finance, Activity and Growth**  Payment for the MHSS is funded as a block contract.  The percentage dedicated to the Lead Provider role, management fee and contract overheads should not exceed 17% of the funding envelope.  The entity entering into the contractual relationship with the ICB will be able to deliver services as part of this contract but will be restricted on the percentage of services they can deliver themselves. This will help to maintain a diverse market and offer choice for people who use the service. Up to 50% of service delivery may be provided by the lead entity within the funding dedicated to service delivery.  It is recognised that there may be exceptional circumstances when the lead entity may deliver a higher proportion of the service for a short time, as a last resort and after exhausting all other avenues. For example, failure of a Delivery Partner. These arrangements would need to be agreed with the Commissioners. The Lead may also choose not to deliver any services or to deliver less than 50%.  The Lead must not deliver the Lived Experience Advisory Function itself to ensure an arm’s length relationship and support autonomy to the lead Provider. The Lead Provider must sub-contract an organization with the capacity to deliver this  The budgets below are indicative and represent an allocation based on explicit budget elements (i.e. IPS and Community Development).  **Brighton and Hove Indicative MHSS Operating Budget (FYE)**   |  |  | | --- | --- | | **Element** | **Indicative Budget for FY 25/26** | | MHSS | £1,281,191\* | | IPS | £374,595 | | Community development, prevention and promotion | £270,000 | | Total | £1,925,786 |   *\*Please note the current arrangement for delivery of the MHSS element is a joint funding arrangement for some (7x WTE) of the Mental Health Support Coordinator roles within the Getting Support element (that will form part of the new Neighbourhood Mental Health Teams). The direct salary costs for these posts are funded by Primary Care Networks under the Additional Roles Reimbursement Scheme (ARRS) under the Health and Wellbeing Coach (*[PRN01583-network-contract-des-spec-24-25-pcn-requirements-entitlements.pdf](https://www.england.nhs.uk/wp-content/uploads/2024/03/PRN01583-network-contract-des-spec-24-25-pcn-requirements-entitlements.pdf) *table with reimbursable amounts is listed from page 66) at a maximum reimbursement amount of £42,437 per annum per role (as of 1st October 2024 to 31st March 2025, updates to reimbursable rates are issued annually). The provider will be required to enter a separate contract with the lead practice for each Primary Care Network for the provision of these Mental Health Support Coordinator roles and invoice the PCNs directly for these salary costs. The funding for all non-direct salary costs for these roles are funded within the MHSS element of this Mental Health Support Services contract.*  **West Sussex Indicative MHSS Operating Budget (FYE)**   |  |  | | --- | --- | | **Element** | **Indicative Budget for FY 25/26** | | MHSS | £4,257,805 | | IPS | £779,500 | | Community development, prevention and promotion\* | To be determined in coordination with Commissioners on award | | Total | £5,037,305 |   *\*Provider is only expected to deliver community development element* |
| **7.0 Voice of the People Using the Services** |
| **7.1 Involvement**  The provider must ensure that:   * Services are co-produced in partnership with people who use services and their friends and family carers. They will be co-produced with people who are representative of the communities they serve. * Community engagement and development is used to improve and inform on the delivery of services, using intelligence and guidance to support changes to under-represented communities Services offer a range of effective engagement opportunities for people that include various communication methods, media and formats. * Individuals receiving a service are involved in and consulted on all decisions about their care and treatment. * Services understand why individuals may not be accessing MHSS and develop engagement opportunities to seek feedback and influence how, where and what services are delivered, as well as participate in or co-design new service developments. * It encourages and enables all people using MHSS (including those not on the LEAG) and their friend/family carers, to influence how, where and what services are delivered, as well participate in or co-design new service developments. * They maintain and develop a Lived Experience Action Group (LEAG) that is representative of the communities within Brighton and Hove and West Sussex. * The LEAG will support the development and implementation of local changes to mental health services and support. This group should offer a voice of lived experience to support and influence a range of mental health system priorities including the development, mobilisation, and ongoing management of the MHSS. * Consideration is given to how LEAG members are incorporated into the overall operational decisions of the MHSS.   The provider is required to monitor and evidence improved experience (Patient Reported Experience Measure – PREM) of services throughout the term of this contract and must demonstrate what processes are in place to do this. |
| **8.0 Workforce** |
| **8.1 Workforce Plan**  The provider will have a workforce plan that recognises the specific challenges that staff face in working with people with mental health issues.  The provider must:   * Recruit and retain a resilient, flexible and trauma informed workforce of sufficient size * Recruit a diverse workforce reflective of the population they serve * The workforce should have the necessary knowledge, skills, and experience to deliver the specified services and the wider service aims and outcomes * Provide appropriate staffing levels and skills mix to flexibly delivery all elements of the specification * Continual Professional Development for all staff delivering or supporting the service. * Embed Psychologically Informed Environment/Trauma Informed Care into the work force plan. * Ensure staff are supported with Occupational Health support and vaccinations. * Develop the skills and knowledge of the workforce using best practice approaches to training, including induction and regular refresher courses covering key priority areas, including (as appropriate):   + Trauma Informed Care and Psychologically Informed Environments   + Common and Serious Mental Health Needs   + Safeguarding   + Neurodivergent/ce (Autism, Attention Deficit Hyperactivity Disorder)   + Complex Emotional Needs   + Eating Disorders   + Housing and homelessness   + Co-occurring substance misuse   + Suicide prevention, self-harm reduction   + Mental health first aid   + Linking with other Public Health priorities, e.g. reducing loneliness / social isolation   + Equalities and diversity, including intersectionality, in relation to mental health   + Older people’s mental health   + Armed Forces support   + Health Inequalities, including for people with Severe Mental Illness (SMI)   + Data protection (GDPR) * Ensure all staff receive statutory and mandatory training. * Ensure all staff receive regular supervision and reflective practice   Indicative Workforce Plans should be in place for the entire workforce. |
| **9.0 Quality Assurance** |
| **9.1 Quality Governance and Assurance**    The provider must assure that services provided are safe, effective, well-led, caring, and responsive to people’s needs with clear lines of accountability, supervision and effective systems.  The Provider will:   * Have Human Resources Policies in place that promote good mental health and wellbeing for the workforce. * Demonstrate strong leadership and create a positive, transparent, and clearly defined and understood organisational culture that is evidenced based, values the wellbeing of its staff, where employees feel listened to, both about how they do their job and in broader decision-making about the organisation’s longer-term ambitions. * Engage with partner organisations including clinical leaders, to identify and plan for co-dependencies, changing models of provision and to improve integrated care and individual outcomes. * Immediately inform the commissioners of any business continuity issues including a timed plan to resolve these and ensure there is appropriate communication with people using the service and partners should provision be interrupted. * Comply with national applicable quality standards such as National Institute of Clinical Excellence (NICE) guidance * Comply with other relevant quality standards specific to the delivery of the service, i.e., Housing, Employment, Peer Support, Equal Opportunities - In carrying out the Services the Service Provider will be "exercising public functions" for the purposes of section 149(2) of the Equality Act 2010. As such, the Service Provider is required to pay regard to the Public Sector Equality Duty under section 149(1) of that Act and to deliver Services accordingly. The Equality Act 2010 relates to people who access the service and employees. The Service Provider has responsibilities as a provider to people who access the service and as an employer to its employees. Services will respond positively to the needs of all groups who have a protected characteristic within the Equality Act 2010. These characteristics are race, religion or belief, sexual orientation, pregnancy and maternity, age, disability, gender and gender identity. * Relevant standards to assure safeguarding of vulnerable adults, including DBS checks for staff in contact with, or accessing data about, vulnerable adults (see Key Documents)   The Provider will put in place policies and recording and reporting procedure alongside monitoring to ensure the safe, lawful, and effective delivery of services, including but not limited to:   * Safeguarding Children * Safeguarding Adults * Trauma Informed Care and Psychologically Informed Environments * Patient Recorded Outcome Measures and Feedback Informed Service Delivery * Environmental sustainability and resilience * Complaints and compliments including management and risk and the provider should embed learning from incidents into internal procedures and protocols * Safe employment and recruitment including policy for dealing with positive disclosure * Health & Safety * Workplace Health and Wellbeing including completion of an annual mental wellbeing impact assessment * Governance arrangements including training and any audits * Information Governance Annual Equality Impact Assessment (EIA) * Domestic Abuse Workplace Policy * Complaints and Grievances (staff and people who access/try to access the service and their carers) * Equalities and Diversity * Business continuity plan * Data Protection, confidentiality and Information Security (GDPR) * Patient safety incidents recorded on Learning From Patient Safety Events (LFPSE) * Workforce supervision, appraisal, professional boundaries, performance management and disciplinary * Peer Support and volunteering (including handling of expenses for people who access the service and carers) * Bullying and Harassment * Lone Working * Risk register, risk assessment and risk management protocols including root cause analysis * Infection Prevention and Control * Serious incidents * NHS Sussex incident Reporting [20230202-Reporting-and-Investigation-Guidelines-for-Serious-Incidents-final.pdf (ics.nhs.uk)](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fint.sussex.ics.nhs.uk%2Fwp-content%2Fuploads%2F2023%2F10%2F20230202-Reporting-and-Investigation-Guidelines-for-Serious-Incidents-final.pdf&data=05%7C02%7Cjosh.hall2%40nhs.net%7Cc9554af9283d407554d708dcc3713c9c%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638600141542028530%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=ac96OoRiX4e22kVbuz7AoaL20tBm7FXso9TumNbnF9o%3D&reserved=0)   **9.2 Evaluation and Performance Review**  Commissioners (NHS Sussex and BHCC) will work collaboratively with the Provider to develop locally defined outcomes and Key Performance Indicators (KPIs) to ensure outcomes and KPIs are achievable and in line with the proposed service model.  The provider will recognise and support the need to build an evidence base for best working practice to inform continued service improvements. They will adhere to all local priorities/targets as identified by Commissioners and will work in partnership with other providers to achieve shared outcomes, effectiveness, efficiency and quality.  The provider(s) will be responsible for monitoring delivery to ensure the service is meeting the specification and that all outcomes are being achieved. The service will be reviewed through detailed performance monitoring and an effective partnership approach. The provider(s) will be required to report to the Commissioners on the performance of the service. This will include quarterly reports in line with the agreed key performance indicators. Performance reviews will be held every quarter for the duration of the contract period and will cover, but will not be limited to, compliance with contractual obligations, relationship development with stakeholders and performance against key performance indicators.  The provider(s) will be required to collate Equalities Monitoring for all service provision.  Additional meetings can and will be arranged should performance be a cause for concern.  All providers will have the opportunity to communicate and provide feedback to the ICB Commissioners and opportunities will be made to obtain anonymous feedback from all members of the service. |
| **10.0 Sustainability** |
| **10.1**   * The Service will be delivered flexibly with both online and in-person services. The Provider will be expected to ensure local activities will be accessible by sustainable travel options such as walking, cycling and public transport * The Provider will be expected to put in place environmental sustainability policies and can raise any environmental concerns, feedback or improvement opportunities during performance review meetings * The Provider will be required to demonstrate how they will reduce emissions and air pollution, commit to circular economy principles and reduce consumption and waste |
| **11. Applicable Service Standards** |
| **11.1 Applicable national standards (e.g. NICE)**  The service is expected to comply with the following relevant NICE guidance and any successor or updated guidance issued during the course of the contract:   * [NG222: Depression in adults: treatment and management](https://www.nice.org.uk/guidance/ng222) * [NG225: Self-harm: assessment, management and preventing recurrence](https://www.nice.org.uk/guidance/ng225) * [NG66: Mental health of adults in contact with the criminal justice system](https://www.nice.org.uk/guidance/ng66) * [NG54: Mental health problems in people with learning disabilities: prevention, assessment and management](https://www.nice.org.uk/guidance/ng54) * [CG91: Depression in adults with chronic physical health problem: recognition and management](https://www.nice.org.uk/guidance/cg91) * [CG136: Service User experience in adult mental health: improving the experience of care for people using adult NHS mental health services](https://www.nice.org.uk/guidance/cg136) * [QS189: Suicide Prevention](https://www.nice.org.uk/guidance/qs189)   **11.2 Key documents**   | **Appendix Number** | **Document description** | **Embedded document** | | --- | --- | --- | | 1 | Community Transformation NMHT Framework |  | | 2 | Equality and Health Inequalities Impact Assessment (EHIA)  DPIA |  | | 5 | Patient Recorded Outcome Measures | Developed during mobilisation | | 6 | JSNAs | [B&H](https://www.brighton-hove.gov.uk/sites/default/files/2023-06/Mental%20health%20JSNA%202022%20full%20report%20FINAL.pdf)  [West Sussex](https://jsna.westsussex.gov.uk/updates/public-mental-health-needs-assessment-2024/) | | 7 | Thematic Review |  | | 8 | Safeguarding |  | | 9 | Mental Health Services Data Set | [Mental Health Services Data Set (MHSDS) - NHS England Digital](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set) | | 10 | Induvial Placement Support (IPS) Specification |  | | 11 | Tier 3 Complex Emotional Needs Service Voluntary Community Sector Enterprise – (VCSE) Offer Specification |  | | 12 | MHSS Mobilisation Plan |  | | 13 | MHSS Definitions |  | |
| **12.0 Risk & Business Continuity** |
| **12.1 Business Continuity Plans**  The provider is required to have a business continuity plan. The provider shall provide evidence as to how they have assured themselves that the business continuity and emergency preparedness plans are robust.  The provider must:   * Operate mechanisms for managing risk. * Maintain disaster recovery, contingency and business continuity plans. * Keep the Commissioner fully informed about the provider’s approach to risk management structures and processes that exist and how they are implemented; and * Notify the Commissioner about the resource allocation to risk management (existing/planned) and to put in place individuals for the leadership roles. |
| **13.0 Exit Plan** |
| This plan should detail the key tasks and milestones the provider will complete to transition the services to an alternative provider. Including but not limited to:   * Communications plan * Timescales * Risk register * Service user handover protocol * Properties information * Software and Hardware handover * Information sharing * Staffing and TUPE |