Appendix 1

DRAFT VERSION 14

North Yorkshire and York Primary Care Trust

City Of York Council

North Yorkshire County Council

MENTAL HEALTH COMMISSIONING STRATEGY

DRAFT VERSION 14

CONTENTS

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1. Introduction

This document outlines the North Yorkshire and York PCT, City of York Council and North Yorkshire County Council commissioning strategy for people with mental health problems, over the age of 18, who reside in the North Yorkshire and York PCT area. The PCT has accepted delegated responsibility from City of York and North Yorkshire County Councils for leading on the commissioning of functional mental health services. Organic mental health problems are commissioned jointly by health and social care organisations on a partnership basis.

This strategy aims to ensure all people living within North Yorkshire and York have access to services which are responsive to their needs. Both service provision and commissioning should enable and empower people to access generic community services including appropriate health care, social care, accommodation, education, employment and day time activities.

Essentially mental health service users should be able to access the same level of generic service provision as the rest of the North Yorkshire and York population is able. All people living within North Yorkshire and York should be able to live their lives to the full regardless of other challenges presented by their mental heath condition.

Health and Social Care investments should aim to deliver the outcomes people want for themselves these include:

- a shift towards services that are personal, sensitive to individual need and maintain independence and dignity
- a strategic reorientation towards promoting health and well-being, investing now to reduce future ill health
- a stronger focus on commissioning the services and interventions that will achieve better health, across health and local government, with everyone working together to promote inclusion and tackle health inequalities.

Therefore the PCT and Local Authorities expect all those people living in North Yorkshire and York to get the maximum out of life, free from discrimination, disability, and poverty - 'well being 'for all' is our outcome'. The PCT and Local Authorities will commission services which treat all people with dignity and respect and which provide value for money.

Mental health services in England have changed considerably over the past 20 years. Community services have developed, asylums have closed and mental health has become an NHS priority area for development. The present Government first set out its view of modern mental health services for adults of working age in the White Paper *Modernising Mental Health Services: Safe, sound and supportive* (1998). The White Paper built on already published documents detailing intended reforms to health and social services including: *Our Healthier Nation* (1998); *The New NHS: Modern and dependable* (1997); *Modernising Social Services* (1998); and *A First Class Service: Quality in the new NHS* (1998).

The publication of the *National Service Framework for Mental Health* (1999) set out for the first time a set of officially sanctioned minimum standards which mental health services were expected to attain. The *NHS Plan* (2000) amplified these by specifying the number of new community teams that were to be developed, linked

developments with additional funding and reiterated that mental health was to be one of the three priority areas alongside cancer and coronary heart disease. The subsequent *Mental Health Policy Implementation Guide* (2001) was published with the intention of supporting local implementation teams in the delivery of adult mental health policy and set out service specifications for crisis resolution/home treatment teams, assertive outreach teams and early intervention teams.

The five-year review of the NSF-MH (2004) showed progress towards some of the targets but acknowledged that more needed to be done in some areas. In addition to reviewing the progress towards targets over the first five years, it set some priorities for the next five years:

- Inpatient care
- Dual diagnosis
- Social exclusion
- Ethnic minorities
- Care of long-term mental disorders
- Availability of psychological therapies
- Better information and information systems
- Workforce redesign with new roles for key staff.

It also put mental health services in the context of overall developments in health and social services:

> **"We now need to plan for the next five years in a way that re-casts our NSF in line with the direction that the NHS as a whole is taking – towards patient choice, the care of long-term conditions and improved access to services" (Department of Health, 2004).**

Following on from the NSF for Mental Health, the *National Service Framework for Older People (2001)* was published with specific recommendations for older people with dementia and depression.

This *NSF* is a ten-year programme that aims to increase access to, and the quality of, health and social care services for older people on a national basis and aims to address issues of race and culture as well as old age. It emphasises that all services must be able to offer effective support irrespective of ethnic background. This requires that older people who have mental health problems have access to integrated mental health services, provided by the NHS and Local Authorities, to ensure effective diagnosis, treatment and support for them and for their carers. There are joint commissioning work streams in York and North Yorkshire for Older People's services and this strategy links to the work of those work streams.

Everybody's Business (2005) was a service development guide which sought to integrate mental health services for older adults. The document looked at meeting the complex needs of older people in a more co-ordinated way. Exploring the provision of a person centred approach to care, the document also promoted issues around age equality and set out the key components of a modern service for older people.

> **'Older people with mental health problems want to exercise control over their lives and make choices, including decisions about their own care.'**

1. Involving service users and their carers
2. Health promotion
3. Assessment and Care planning
4. Developing culturally appropriate services
5. Workforce development
6. A whole systems approach to commissioning integrated services
7. Leadership: champions, managers and leaders

The White Paper "Our Health, Our Care, Our Say" sets out a vision to provide people with good quality social care and NHS services in the communities where they live. The document highlights seven outcomes:

1. Improving health and emotional well-being
2. Improved Quality of Life
3. Making a positive contribution
4. Increased choice & control
5. Freedom from discrimination & harrassment
6. Economic well-being
7. Maintaining personal dignity & respect

These outcomes are relevant to a range of health and social care services including mental health.

This strategy aims to ensure links between health and social care for the delivery of Local Strategic Partnerships and Local Area Agreements which should be the mechanism for making links between broader Local Government activities.

This strategy supports mental health services being based on the recognition that it is the quality of the interaction between the individual and his or her social context that is important for mental health. Negative interactions are associated with poor mental and physical health, positive interactions with good mental and physical health. There are likely to be evolving models of provision that provide accessible, navigable services that meet the specific needs of individuals and the factors that influence their health.

What is commissioning?

Commissioning in the NHS is the process by which we ensure the health and care services provided, most effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs and prioritising health outcomes, to procuring products and services and managing service providers.

The NHS Plan in 2000 set out a 10-year programme of reform for the NHS, through which we will be developing an NHS characterised by free choice across a range of providers, competing on quality and outcomes as money follows the patient.

The proposals in the White Paper *Our health, our care, our say* set the strategic direction for delivering healthcare with a greater focus on prevention, on promoting well-being and on delivering services in settings that are more convenient to the people that use them. This new NHS – locally driven, looking outwards not upwards – is designed to dramatically improve the quality of care and the value we get from the public resources invested in health and care services. The interim report from the

NHS Next Stage Review signalled where we are going in the journey towards an improved NHS. It talked about an NHS that is fair, personalised, effective and safe, and which is focused relentlessly on improving the quality of care.

Improving commissioning is at the heart of delivering this agenda. The NHS has real potential to develop world class commissioning – investing NHS funds to secure the maximum improvement in health and well-being outcomes from the available resources. As world class commissioners, primary care trusts (PCTs) must take on the mantle of trusted community leaders, working with their local population, partners and clinicians, leading the local NHS.

Ultimately, good commissioning in the NHS will help ensure people live healthier and longer lives. *World Class Commissioning – Vision Department of Health December 2007*

Why is a commissioning strategy needed?

This Strategy will link to the overarching North Yorkshire and York PCT Commissioning Strategy and other relevant strategies including; the North Yorkshire and York Personality Disorder Strategy, the North Yorkshire and York Dual Diagnosis Strategy, North Yorkshire and York CAMHS Strategies, the North Yorkshire and York Practice Based Commissioning Strategies and Local Authority Long Term Conditions and Prevention Strategies. This document will ensure that services:

- Promote prevention and mental health well-being
- Are appropriate to needs
- Are purchased in the most effective and efficient way
- Achieve positive results for people who use the services
- Are planned and delivered within an overall strategic framework

2. Mental health policy: a context in brief

The White Paper *The New NHS: Modern and Dependable* (1997) set out the Government's overall strategy for modernising the health service and ensuring that the NHS provides fair access to effective, prompt and high quality care to all patients, wherever they live. It addressed a variety of themes relevant to mental health, including the integration of services across health and social care, human resources, the more effective use of information technology and improving the quality of care.

A First Class Service: Quality in the new NHS (1998) outlined a strategic framework to monitor, evaluate and improve on the quality of individual and organisational working practice and performance within the health service. It crucially established the principle that the delivery of healthcare against national standards is a matter of local responsibility. Service governance is part of the overall programme of performance management of *National Service Framework* and *NHS Plan* implementation.

Modernising Mental Health Services: safe, sound and supportive (1998) identified seven priority areas for development:

- Strengthening comprehensive care
- Providing 24-hour access to services

- Developing, training and recruiting staff with the skills and motivation to deliver modern services
- Improving the planning and commissioning of services
- Developing partnership working
- Improving the use of Information Technology
- Developing mental health promotion

Our Healthier Nation (Department of Health, 1999b) detailed action to tackle poor health by improving the health of everyone, especially the health of the most disadvantaged by tackling the biggest killers - cancer, coronary heart disease, stroke, and accidents. There are also targets for mental health which are to reduce the death rate from suicide and undetermined injury by at least a fifth by the year 2010. *The Health Act* (1999) provided the legislative changes required by the policy reform outlined above, including: -

- Operational flexibilities to allow joint working between NHS bodies and local authorities for the commissioning and delivery of health services
- Placing a statutory duty of quality on NHS Trusts and Primary Care Trusts
- Change in the system of regulation and the bodies responsible for devising standards and creating monitoring mechanisms to evaluate and improve the quality of health care.

The *National Service Framework for Mental Health* was the first of a series of national Government frameworks that set the policy context, values, standards and implementation programme for mental health services in England. It addressed the full range of agencies responsible for mental health care of people of working age across the health and social care fields and the statutory, voluntary and private sectors. The seven standards of the National Service Framework are outlined below:

Mental health promotion (Standard One): *Requires health and social care organisations to develop and facilitate delivery of a local strategy that 'promotes mental health for all, working with individuals, organisations and communities.' Additional to this standard is goal two of the National Suicide Prevention Strategy for England, DOH (2002) which highlights the requirement 'to promote mental well-being in the wider population.'*

Primary care and access to services (Standards Two & Three): *to deliver better primary mental health care and to ensure consistent advice and help for people with mental health needs, including primary care services for individuals with severe mental illness.*

Effective services for people with severe mental illness (Standards Four & Five): *to ensure that each person with severe mental illness receives the range of mental health services they need: that crises are anticipated or prevented where possible; to ensure prompt and effective help if a crisis does occur; and timely access to an appropriate and safe mental health place or hospital bed, including a secure bed, as close to home as possible.*

Caring about carers (Standard Six): *to ensure health and social services assess the needs of carers who provide regular and substantial care for those with severe mental illness, and provide care to meet their needs.*

> **Preventing suicide** (Standard Seven): *to ensure that health and social services play their full part in the achievement of the target in Saving Lives: Our Healthier Nation to reduce the suicide rate by at least one fifth by 2010.*

Whilst it is acknowledged these are standards from the overall NSF for Mental Health the essence of the standards is applicable to both working age and older peoples mental health services. Older Peoples mental health services are also supported by the NSF for Older People, Standard 7 and Everybody's Business, the forthcoming National Dementia Strategy and other national and local strategies for the provision of services to older people. The strategy for Child and Adolescent Mental Health Commissioning (CAMHS) is covered by the North Yorkshire and York PCT and Locality Authorities CAMHS Strategies 2007-2010.

The *National Service Framework for Mental Health* (Department of Health, 1999a) and the *NHS Plan: A Plan for Investment A. Plan for Reform* (Department of Health, 2000) represented the culmination of several years of Government policy aimed at developing inclusive and modern health and social care services to achieve consistency of access to high quality services. Since then, *Improvement, Expansion & Reform* (DoH, 2002) suggested that planning in the past has been done annually and had been constrained by time pressures and the requirement for multiple plans. Health services were required to plan on a longer term basis with local health services receiving three-year budgets. This would allow organisations to look in-depth at their services, plan change with confidence and implement improvements year on year. Against this background planning consists of the following six steps, which need to be followed through in each organisation and community:

- Identifying the national and local priorities and the key targets for delivery over the next three years
- Agreeing the capacity needed to deliver them
- Determining specific responsibilities of care organisations
- Creating robust plans which show systematically how improvements will be made and which are based on the involvement of staff and the public
- Establishing sound local arrangements for monitoring progress and NHS performance management which link into national arrangements
- Improving communications and accountability to the public locally so as to demonstrate progress and the value added year on year

Mental Health was identified as one of five national priority areas for improving services and outcomes for service users. Improvement, Expansion and Reform: The Next 3 years-Priorities and Planning framework 2003-2006 included requirements to: -

- Reduce the suicide rate and deaths by undetermined causes by 20% by 2010.
- Improve access to general community mental health services.

Services were to be delivered in line with the standards in the Mental Health NSF, Older Peoples NSF, Everybody's Business, the Mental Health Implementation Guide, national mental health strategies and compliance with NICE appraisals/guidance. Comparative clinical audit and information from the Mental Health Minimum Data Set (which should have been implemented in all trusts by 03/2003) should be used to develop services, and the National Institute for Mental Health England will support development work. Modernisation will be supported by a new mental health legislative framework. NHS and Social Services joint responsibility will be delivered through Local Implementation Team partnership.

The Operating Framework for 2007 highlights one of the key targets for the NHS as reducing health inequalities and promoting health and well-being, raising the importance of ensuring through commissioning that patients receive high quality healthcare, no matter where they live in the country, and that where inequalities exist, they are dealt with. It goes on *"For 2007/08, PCTs need to focus on the interventions that evidence shows can have the biggest impact on reducing health inequalities. This builds on the recommendations in a review of the life expectancy target. The introduction of local data on all age all cause mortality, introduced in both LDPs and local area agreements, provides the incentives for effective partnership working with local authorities and the other partners that need to deliver the life expectancy aspect of the health inequalities target. It will also give flexibility for organisations to focus on the interventions that are most important to their local population. The health inequalities national support team is currently being developed to provide intensive support to those areas that are most challenged".*

In July 2008 the Yorkshire and Humber Strategic Health Authority published *Healthy Ambitions* which summarizes and makes recommendations following the Prime Minister and Health Secretary announcement that Prof. Lord Darzi would lead a review of the NHS that would advise on how to meet the challenges of delivering health care over the next decade in July 2007.

Mental Health is one of the 8 Clinical Care groups included within the review and the Clinical Pathway Group describes the key features of a generic mental health pathway as:

- Integrated primary/secondary and health and social care
- Care planning supported by 'advocate' challenged care navigation
- Single point of access
- Open access to a range of supportive interventions provided by a range of providers
- NICE guideline/good practice/evidence underpins the care packages
- Care elements/packages can be allocated a cost so that individuals can have their own budget
- Personal advisors or advocates are available to support people in accessing the appropriate support
- National standards for services which enable benchmarking to take place

These key features are consistent with the PCT aspirations for mental health services and will be incorporated into existing and any new commissioning arrangements for mental health service delivery.

3. Overall Vision for the Mental Health Commissioning Strategy

The Government's vision is for a patient–led NHS (Delivering the NHS Improvement Plan), where "the starting point is the principle that everyone in society has a positive contribution to make and they have a right to control their lives". This aspiration should feature in our Local Strategic Partnerships and Local Area Agreements.

Services commissioned should demonstrate they are designed to:

- Promote improvement of people's overall health and well-being
- Promote mental health well-being

- Provide access to a range of services that prevent or delay the on-set of severe and enduring mental health problems and deliver clear generic pathways of care
- Support people experiencing mental health difficulties to maintain their lives in the community with dignity and independence, and improve their quality of life
- Ensure that people experiencing mental health difficulties will be viewed holistically with open door services that are coherent with simple care plans that can be understood and changed
- Improved information about possible solutions and the journey of care for people with mental health problems and ensure that they are consulted about their recovery and care pathway
- Ensure that services will be needs-led defined by emerging new strategies, that are reviewed in consultation with service user and/or their representatives
- Provide a seamless service underpinned by single assessment, effective sign posting, clear triggers for appropriate interventions and clear pathways into specialist services
- Geographically sensitive to the patients home to support the promotion of social inclusion

Principles

This Mental Health Commissioning Strategy is based on a set of values, principles and philosophy to underpin service planning, service delivery and help shape the direction of services for the future.

The following list of principles is intended to provide a foundation for the future and become part of the way the Mental Health Partnership works jointly and is able to review the effective commissioning of services:

Commissioned Services should adopt a positive and hopeful recovery perspective, seeking outcomes that promote good health, wellbeing and a capacity to optimise individual functioning and integration within local communities;

Commissioned Services should be guided by transparency of purpose for users and carers, with good information and a clear expectation of different interventions and possible outcomes, where services are clear how they fit within the overall joint service system;

Commissioned Services should link with and influence broader services and strategies, for example in education, housing, leisure, transport and drug and alcohol areas and other changes in the organisation of care and health services;

Commissioned Services should have a focus on delivering effective and safe mental health services with robust governance systems dedicated to service improvement, through training, staff development, clinical and corporate risk management, effective use of information and clinical audit;

Commissioned Services should ensure no harm is done to users, carers or communities as a consequence of action and intervention, with no needless deaths, no needless distress, no ensuing disability or unwanted delay or waste in the use of resources;

Commissioned Services should offer the minimum level of intervention possible compatible with meeting needs. The aim is to minimise intrusion and sustain users within as normal a setting as possible and at an appropriate level in terms of prevention, primary care support, intermediate support and acute intervention within the whole service system;

Commissioned Services should assess risk with the person concerned, in an open and sharing manner. This includes assessment of risk to self and others. Wherever possible the assessment of risk should be done jointly with the service users;

Commissioned Services should acknowledge that mental health problems may be complex and multifaceted and require complex responses drawing on a range of perspectives, disciplines, knowledge and expertise, where there is mutual respect and tolerance of different contributions that different perspectives are integrated to offer holistic solutions and whole person outcomes;

Prevention of mental health problems and promotion of mental health should be a priority in delivering support and interventions;

Success criteria and outcome measures should be determined in conjunction with service users;

Joint approaches between Local Authorities and the PCT in planning and delivery should become the norm in providing support and services to people in North Yorkshire and York;

Commissioned Services should promote awareness of the new Mental Capacity Act and promote access of Independent Mental Capacity Act Advocacy when required;

Commissioned services should offer stability in terms of financial management and avoidance of unnecessary service upheaval. There must be a continuous review of all service provision to maintain financial balance and ensure effective and appropriate use of the financial budget available.

4. Performance Management

Performance management is crucial to demonstrate efficient and effective provision of care services. It is the intention that commissioners and providers will work closely to ensure that accurate and robust performance management information is available to audit service provision and the effective use of public money. Commissioners and Providers should adhere to the requirement of National and Local Performance Management requirements and targets which apply to Mental Health and Social Inclusion.

The comprehensive performance of mental health services can be considered in 3 distinct dimensions:

1 Responsiveness and accessibility – this refers to the extent to which those who must look to a service for care and support get it, when they need it. This issue is of particular relevance for hard to reach groups. The similarity or fit between the service being used and the locally assessed need, cultural

appropriateness to relevant minority groups and the promptness and sensitivity of response to clients are all measures of this issue.

2 Efficiency – this refers to the levels of productivity, cost effectiveness, occupancy rates and other measure of efficient use of resources.

3 Effectiveness – this refers to User and system based outcomes. User's outcomes encompass health and mental health status (functional levels, presence/absence of symptoms and substance misuse), quality of life, and satisfaction with treatment. Provider outcomes cover satisfaction of staff with their working environment. Commissioning outcomes include improvement in the quality of life of Users and increase in users accessing, for example mainstream resources.

An important part of the commissioning cycle is gaining relevant information about the performance of current and future services. There has been a recent shift towards the monitoring of quality life outcomes, also referred to as Commissioning for Quality, in mental health services rather than just group-based outcomes for example increase in numbers of users gaining employment. Research has shown that individual outcomes are a more effective and accurate measure of quality of care and therefore the effectiveness of service provision. Unfortunately at present there is limited national Department of Health guidance for Outcomes in Mental Health and within North Yorkshire and York providers and commissioners are committed to working together to develop appropriate meaningful outcome measures.

The PCT and both Local Authorities have agreed to develop comprehensive performance management indicators which support the implementation of this strategy, the commissioning priorities and intentions, Local Area Agreements and other relevant NHS and Local Authority performance management priorities, this work will be undertaken during the lifetime of this strategy.

5. Social Inclusion and Effective Community Services

The Mental Health and Social Exclusion Report – June 2004 – advises of a sustained programme of change to challenge discriminatory attitudes and significantly improve opportunities and outcomes for adults with mental health problems. The report sets out an action plan within a multi-agency framework. It aims to go beyond statutory health and social care organisations, to include partnership working with employment and education organisations, employers and the voluntary sector to tackle all areas of social exclusion. The Action Plan covers six categories –

- Stigma and discrimination
- The role of health and social care in tackling social exclusion
- Employment
- Supporting families and community participation
- Getting the basics right
- Making it happen

The report outlines that opportunities in education, training and employment greatly enhance the quality of life of service users. The driving vision of the report is a 'future where people with mental health problems have the same opportunities to work and participate in the community as any other citizen'. There is also a requirement to 'transform day services into community resources that promote social

inclusion through improved access to mainstream opportunities'. This is to be achieved through commissioned services providing:

- Access to supported employment opportunities where appropriate; this will be delivered through collaborative working with Local Authority and Employment Agencies
- Access to appropriate housing; this will be delivered through collaborative working with Local Authority
- Person centred provision that caters appropriately for the needs of all individuals; this will be delivered by ensuring service users are involved and consulted in the development of their individual Care Plan
- Developing strong links and referral arrangements with community services and local partners
- Providing or Commissioning befriending, advocacy or support to enable people to access local services
- Involving people with mental health problems in service design and operation; this will be delivered through the Local Implementation Team and Local Implementation Advisory Groups
- A focus on social inclusion and employment outcomes

In line with the social inclusion agenda the PCT is very keen to ensure that we build on the strong existing partnership arrangements between health and social care and that we continue to develop processes for the joint commissioning of services, which utilise the community as a potential resource with the aim of supporting users in accessing mainstream services, to prevent mental health problems and to influence mainstream service providers and employers to promote easier access to people with mental health problems. The PCT and Local Authorities are committed in promoting Direct Payments and Individual Budgets as a key delivery mechanism for personalisation.

6. Primary Care

Mental health problems are common and primary health care services provide the majority of health care help that people require. Up to 40% of patients attending their GP for any reason have a mental health problem and in 20-25% of patients a mental health problem will be the sole reason for attending. Throughout Europe, 57% of people with depression consult for that reason alone, and most consult with a GP initially.

Whilst primary care is often able to offer and provide care for people with mental ill health it is acknowledged by many GPs that they do not have the specialist training required to provide a full range of mental health care interventions within primary care, therefore it is vital that primary care is provided with adequate training, advice and support to be able to support patients with mental ill health. The role of primary care counsellors, primary mental health workers and gateway workers can support mental health care provision within primary care, however it is accepted that access to these services is not equitable across the PCT geographical area. Therefore a key action plan of this strategy is to review and enhance the current primary mental health care service in North Yorkshire and York to enable patients to be provided with increased support within primary care settings and reduce the reliance on secondary care provision.

7. Homelessness and Housing

An essential element of Social Inclusion is people having access to appropriate housing and accommodation. People can become homeless due to poor health. Poor health in turn is likely to be exacerbated by homelessness. Homeless people are more likely to suffer from physical health and mental health problems. About 30 – 50% of people sleeping rough suffer from mental health problems, which, for about 88% existed before they went on the street *Source: Social Inclusion Unit.*

A key barrier to accessing primary health care for homeless people are the transient and chaotic lifestyles of homeless people and a general lack of confidence to access mainstream health care services. Key barriers to accessing secondary health care include the lack of medical history for a patient registered temporarily meaning that GP's are not always aware of any treatment that the patient has received previously.

The PCT is committed to improving the healthcare of people who are homeless or who are living within temporary accommodation. The PCT is working closely with, City of York Council and North Yorkshire County Council regarding the housing, homeless and Supporting People Agenda and there are plans for further mental health training to be provided to Local Authority Homeless workers and Housing providers regarding the recognition and support required for mental health service users.

8. BME

In relative terms, the population of minorities – though still small - is growing more rapidly in many rural areas than in urban areas. In 2006 in North Yorkshire and York the total resident population of BME communities was approximately 15,000; this number will be significantly higher for those working in the area as opposed to resident.

In some areas of the UK one in five mental health in-patients comes from a black and minority ethnic (BME) background, compared to about one in ten of the population as a whole. In January 2005, the Department of Health published a five-year action plan, Delivering Race Equality (DRE) in Mental Health Care. DRE aims to help mental health services provide care that fully meets the needs of BME patients and build stronger links with diverse communities.

This strategy aims to adhere to the principles of DRE and to also respond to the diverse and changing local population. This strategy aims to ensure all people living within North Yorkshire and York have access to mental health services which are responsive to their needs regardless of their ethnicity, gender, religious belief, domestic circumstances or sexual orientation.

9. Public Health

There is evidence that there is a strong correlation between poverty and poor mental health. The recent report of the Chief Medical Officer's Project to *Strengthen the Public Health Function* outlines why a robust and effective public health function is essential to help change the social, economic and environmental factors that lead to poor health. It is argued that strengthening the public health function helps address social exclusion, inequalities in health and provides support to local authorities and a re-oriented NHS in ensuring that local partners focus on improving health as well as service quality. The public health agenda originally set out in *Saving Lives: Our Healthier Nation* (1999) is huge, challenging and complex. The *NHS Plan* (2000) affirms the place of public health in the mainstream of NHS activity and, at the same

time, acknowledges that it is everyone's business and is a corporate responsibility, not just the province of specialists. Choosing Health (2004) reinforces these messages. For a breakdown of Public Health demographic data please see Appendix 1.

This strategy promotes actions to improve mental well-being, ameliorate symptoms of mental distress and promote recovery and reduce the prevalence of mental illness diagnosis. The promotion of mental health can have positive outcomes which include, improved physical health, health behaviours, education, employment, parenting, relationships and crime.

Nationally, work is currently taking place to develop a sustainable set of indicators to measure Mental Well-being. However, there are a number of indicators that impact on mental health and well-being across the four blocks of Local Area Agreements and therefore a 'basket of proxy indicators' can be utilised to demonstrate improvements in mental health and well-being

The key elements of effective commissioning and strategies to promote mental health needs to consider:

- Are informed by local needs assessment
- Outline a clear statement and vision of what success will look like and how it will be measured
- Illustrates cross-sector involvement, ownership, governance and resourcing
- Illustrates links to wider initiatives to improve health, social, economic and cultural outcomes and links between key themes such as mental health benefits pf participation, physical activity, access to green open spaces
- Offer added value by supporting policies with complementary goals
- Informed by evidence-based practice
- Encourage public mental health capacity and skills
- Develop public mental health intelligence

It is suggested that in order to ensure improvements in mental health, public mental health promotion needs to be mainstreamed. Mechanisms also need to be in place to engage and establish formal links with stakeholders across all sectors and a system of governance linked to wider local targets needs to be ensured and resources drawn from a variety of areas to which mental health promotion contributes.

Although there are gaps in the data, the economic benefits of improving positive mental health maybe extensive. While the best outcomes are generally associated with the absence of mental illness, the presence of positive mental health brings additional benefits, including for people with mental health problems.

10. Service User Involvement

Mental health policy documents over the past decade have almost without exception highlighted the need for users of services and, more recently their informal carers, to have their voices heard by the mental health system. This has been reinforced of late through the *National Service Framework for Mental Health* and the *NHS Plan*, both of which encourage the active participation of service users and carers in service development and delivery. Where as at one time simply listening to what users and carers had to say was considered radical in the mental health world, this is no longer

acceptable. Active participation with greater opportunities for users and carers to be increasingly representative of others is now the expected standard.

It is important to recognise that many users and carers do not want, or have the time, to participate in mental health service development and delivery and therefore there is an increasingly critical need to develop the widest possible range of access routes to true participation. However, where people are prepared to give time and energies it is essential that they be supported to do so as effectively and acceptably as possible. Collaborative working with Voluntary Sector or other Service User Groups provides an opportunity to ascertain service users and/or carer's views and it is the intention to continue to work with and develop further service user and carer involvement in the North Yorkshire and York PCT area this will be done in the context of the overall Joint Strategic Needs Assessment.

11. Non Statutory Providers

Third Sector

Hearts and Minds: Commissioning from the voluntary sector Audit Commission July 2007 provides a recommendations and advice for commissioning from the voluntary (Third Sector) this strategy recognises that nationally, voluntary sector, or not for profit providers, are an increasing part of the overall range of provision for people with mental health problems, and are commonly the subject of formal contracting relationships in the same way as any other NHS or Local Authority contracted provider. One of the reasons for their success lies in their ability to respond to need in a way that is accessible and acceptable to the people who need the services they offer. Some successfully bridge the range from social to psychological needs whilst others exist specifically to meet one of these dimensions. The PCT, City of York and North Yorkshire County Councils recognise that a thriving Third Sector can contribute to community engagement and are committed to further service development and collaborative working with the Third Sector; this is included in the Priorities and Commissioning Intentions.

Independent

Providers of Independent mental health care are relatively limited in the North Yorkshire and York however the PCT and both Local Authorities do commission with Independent providers outside of the North Yorkshire and York geographical boundary. The majority of these placements are for; Mentally Disordered Offenders, Psychiatric Intensive Care and Specialist Continuing Care placements. There is a significant expenditure on such placements. However, the spirit of collaboration applies equally to all provider services and the need to develop appropriate mechanisms to ensure that Independent sector services are considered within a whole systems approach.

12. North Yorkshire and York Local Implementation Team

The North Yorkshire and York Local Implementation Team (LIT) will lead and co-ordinate the effective implementation of the Mental Health National Service Framework for Mental Health (NSF), Older Peoples NSF Standard 7 and other relevant Local and National Priorities and Policies for Mental Health Care for people aged over 18 years old who reside in the North Yorkshire and York locality.

Due to the large geographical area of North Yorkshire and York and the recognition of the 2 Local Authorities the North Yorkshire and York Local Implementation Team will be supported by 5 Locality Implementation Advisory Groups which will provide input into the North Yorkshire and York LIT ensuring local priorities and input from local stakeholders. Terms of Reference for the LIT can be found at Appendix 3.

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13. Geography and Rurality

North Yorkshire is England's largest county and includes some of the most diverse landscape in the country. The County includes dramatic coastline including the towns of Scarborough and Whitby as well as the large urban areas of York and Harrogate. To the south of York lies the former mining area of Selby. The County also covers some of the most remote and rural areas in the country, which are sparsely populated and access to services in these areas is a particular challenge.

The North Yorkshire and York PCT was established on 1 October 2006 and is geographically the largest in England covering 3,2000 square miles and is the third largest PCT in England in population terms with a total population of 765,000.

There are few pockets of severe deprivation in North Yorkshire, with less than 5% of the population living in neighbourhoods among the 20% most deprived in England. The proportion of children living in poverty is well below average.

Life expectancy in North Yorkshire and York as a whole is significantly higher than average for both males and females.

The 10 High Impact Changes, Making Them Relevant for Mental Health NIMHE (April 2005) included the priority to *"Treat home based care and support as the norm for delivery of mental health services"*. The difficulties of providing modern mental health care in the rural areas of North Yorkshire and York are considerable and there is a need in taking forward this Commissioning Strategy to address the issues mental health provider services incur when providing care to remote rural areas.

The size of the North Yorkshire and York area and rural transport difficulties means that local services are essential in ensuring patients are supported locally and have access to general psychiatry services in the locality that they live. Specialist psychiatry services e.g. Forensic in-patient, PICU and CAMHS Tier 4 should be provided in central easily accessible areas – historically this has been in York.

The national 'Safe, Sound and Supportive', agenda and the National Service Framework, through the policy guidance is requiring comprehensive, round the clock services. The key issues to be addressed are:

- Tackling discrimination and stigma
- Change managing to implement comprehensive services
- Developing appropriate organisational models
- Getting the right number of staff with the right skills
- Developing adequate local leadership
- Developing the infrastructure to support change

14. Key Objectives

Given this overall policy context and the direction of travel set by national expectations of high quality, fit for purpose Mental Health Services, the key broad objectives for the Mental Health Commissioning Strategy are: -

- That there is **equal access** to services for those people who need them

- That the majority of mental health care should be provided in community settings as **close to peoples homes** as possible
- That the PCT and Local Authorities will commission services that promote a model of **recovery** and that enable people to **live independently** as far as possible.
- There will be concentration on reducing reliance on institutional care by commissioning suitable accommodation and packages of care for people in the **community**.
- There will be an emphasis on **prevention** and mental health promotion.
- That commissioning plans will proactively grow and **develop capacity**, including in primary care and from the voluntary and independent sector in order to offer people **choice**.
- The development and maintenance of **sustainable communities** will be supported in order to address social exclusion.
- The partnership work underway will be further developed to deliver better **outcomes** and economies of scale.
- The **highest standards** and performance will be expected.
- That there will be a focus on **efficiency and productivity** through the application of the Best Value and other processes.
- That to assist with delivering this, there will be a strong **joint commissioning** relationship with Local Authorities that promotes the well being of individuals and communities.
- That there will be a strong and positive relationship with Mental Health Care provider services that enables and supports **sustainable provision.**

It is acknowledged that effective partnership working between the PCT, Local Authority, statutory Mental Health provider services and the Third Sector are crucial.

The opportunity of investing to save is recognised as institutional care or out of area care is being decommissioned. This strategy recognises the crucial part the Local Authority, statutory Mental Health provider services and the Third Sector will play in jointly developing service solutions and opportunities for investment to save.

The PCT and Local Authorities are committed to working jointly to develop a range of services which support the prevention of hospital admission and promote social inclusion, these include; development of meaningful day time activities, employment, education, training and enhancing the provision of Telecare, Community Alarms, Helplines and warden support.

The Mental Health Commissioning Strategy also supports a Needs Based Approach to providing effective mental health care based on Best Practice and Clinical Evidence. The strategy intends to build on historical good practice whilst ensuring services delivered are appropriate to ensure the delivery of modern mental health care.

15. Delivering the strategy

The Strategy will be delivered by both Health and Social Care organisations in North Yorkshire and York and work will be overseen by the York Mental Health Partnership Board and the North Yorkshire Mental Health Partnership Board. Terms of reference for the Partnership Boards and membership can be found in Appendix 2.

16. Service Mapping

North Yorkshire and York PCT Mental Health provider services provide a range of community and in-patient mental health services to the Hambleton and Richmondshire, Selby & York and Harrogate and rural district localities. The PCT commissions' community and in-patient mental health services for the Craven locality from Bradford District Care Trust and Scarborough, Whitby & Ryedale services are commissioned from Tees, Esk & Wear Valleys NHS Trust.

Due to the diverse geographical area of North Yorkshire and some areas of the county being sparsely populated provider services have adopted the Fidelity and Flexibility approach to providing mental health care in rural areas, primarily Hambleton and Richmondshire and Craven. North Yorkshire and York is fortunate to have a range of specialist in-patient mental health units including; Perinatal (mother and baby), Low Secure Forensic, Child & Adolescent Mental Health, intensive rehabilitation unit and Psychiatric Intensive Care Unit; which is under development following the receipt of new Department of Health capital monies.

It is acknowledged that further work needs to be undertaken to understand and describe the whole mental health system and this work will be developed further by Mental Health Commissioners, Statutory and Third Sector Providers and Locality Authority Commissioners.

As of the 1st April 2008 all parties to this strategy are required to commence the process of producing a Joint Strategic Needs Assessment (JSNA). As a consequence of undertaking the JSNA we have a further detailed understanding of the care needs of the residents of North Yorkshire and York and the local communities in which they reside. The development of the JSNA will be reflected in the ongoing development and review of this strategy as we respond to the data received and listen to the voice of the people within our localities.

17. Priorities and Commissioning Intentions

Policy guidance from the Department of Health routinely refers mental health being split into working age adult 18-65 and older people 65. However this strategy is for people over the age of 18 with mental health problems and therefore services commissioned and developed will be responsive to service user's needs and will not discriminate against a service users age or gender. Services will be commissioned which ensure effective transitional arrangements for service users as they progress through or enter the Mental Health Care pathway.

The following outlines the overarching priorities and commissioning intentions that will be taken forward by Mental Health Commissioners over the period 2008 – 2011. This list is not exhaustive and will be expanded to respond to other commissioning priorities which may arise during the lifetime of this strategy and the Local Area Agreement indicators for both Local Authorities This work will be developed further within individual localities and work will be overseen by the Mental Health Partnership Boards and the North Yorkshire and York LIT.

Priorities and Commissioning Intentions
Review the outcomes of the 2007 Mental Health Autumn Assessment and agree an action plan within each Local Implementation Advisory Group local area

Implementation of the Improving Access to Psychological Therapies guidance which will link with an overarching review of and development of a range of Primary Care based services to enable patients to be provided with increased support within primary care settings and reduce the reliance on secondary care provision
Further development of services which improve the quality and experience of BME service users and carers and the Commissioning of a new Community Development Workers service
Development of effective Crisis Resolution Services to 'Gate Keep' admissions to acute hospital in-patient services and in conjunction with Community Mental Health Teams promote timely discharge from mental health acute or community hospital services
Development of a PCT wide multi agency Suicide Prevention Strategy
Maximize the potential of Individual Budgets/Direct Payments
Development of multi-disciplinary Memory Clinics / Memory Assessment Services
Enhance and develop primary and social care and Third Sector service delivery: • To improve the social inclusion of people with mental health problems and as an alternative to specialist services and • To support open access through the assessment service to a range of supportive interventions provided by a range of providers
Carer recognition and support, including the development of contingency plans
Implementation of the forthcoming National Dementia Strategy and further development of Services for Younger People with dementia
Development of meaningful day time activities for mental health services users and their carers, within the community, by providing multidisciplinary social and health care services over 7 days per week
Development of CMHT's to increase the provision of care co-ordination capacity that matches needs assessment and the variations in demand arising from demographic factors
Development of effective Assertive Outreach Services
Development of effective Early Intervention in Psychosis Services
Effective liaison with acute hospitals for people with mental illness
Access to appropriate housing and/or supported accommodation
Access to Education, Training and Employment opportunities
Local education and training to raise the profile of people with mental illness, which support the work of National Strategies
Care elements/packages allocated a cost so that individuals can have their own budget
Development of a new Secure in-patient service for women with complex needs
Development of a new North Yorkshire and York Psychiatric Intensive Care Unit

Joint development of specialist NHS continuing care facilities for people with complex care mental health needs
Joint development of Autistic Spectrum Disorder Care Pathways
Review of the Mental Health Estate and development of an action plan for the future.

18. Signatures

This Mental Health Commissioning Strategy is supported by North Yorkshire and York Primary Care Trust, City of York Council and North Yorkshire County Council and has been adopted by the City of York Council Mental Health Partnership Board and North Yorkshire County Council Mental Health Partnership Board.

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Signature **Name** **Date**

On behalf of: North Yorkshire and York Primary Care Trust

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Signature **Name** **Date**

On behalf of: City of York Council

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Signature **Name** **Date**

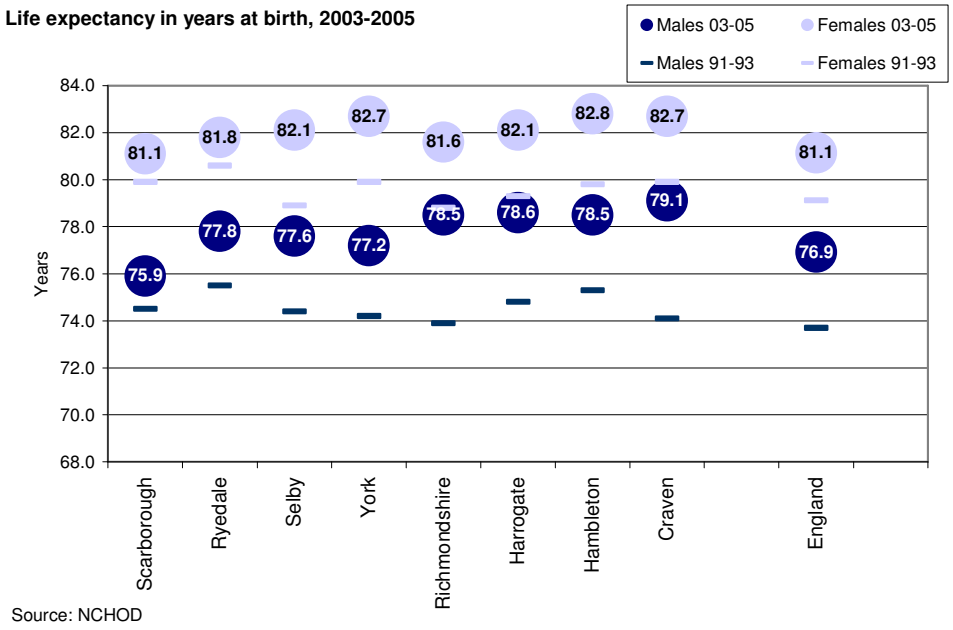
On behalf of: North Yorkshire County Council

Appendix 1

Public Health Demographics

Life Expectancy and Mortality in North Yorkshire and York

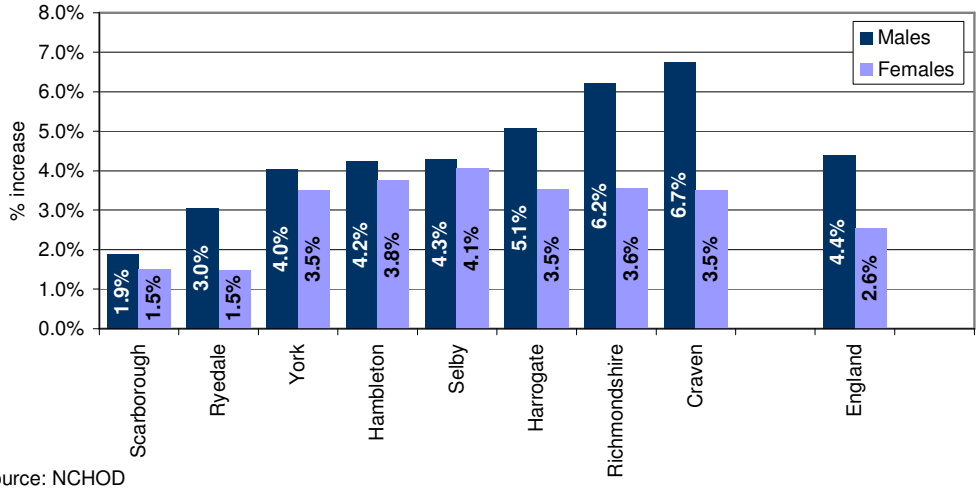
Nationally, the Department of Health are responsible for the delivery of a target to improve the health of the population demonstrated by an increase in life expectancy at birth to 78.6 years for men and 82.5 years for women by 2010. At the same time, health inequalities in life expectancy are to be reduced by 10% between spearhead areas and the national average.



Source: NCHOD

During 2003-2005, the national average life expectancy for males was 76.9 and for females, 81.1 years. All districts except Scarborough compared favourably to the national average, particularly in Craven where it exceeded the 2010 national targets for both males and females. During 1991-1993, life expectancy in Scarborough was above the national average, and not dissimilar to the other localities within North Yorkshire and York. However, since 1991-93, the increase in life expectancy in Scarborough has not occurred at the same pace as its neighbouring localities highlighting inequalities within North Yorkshire and PCT.

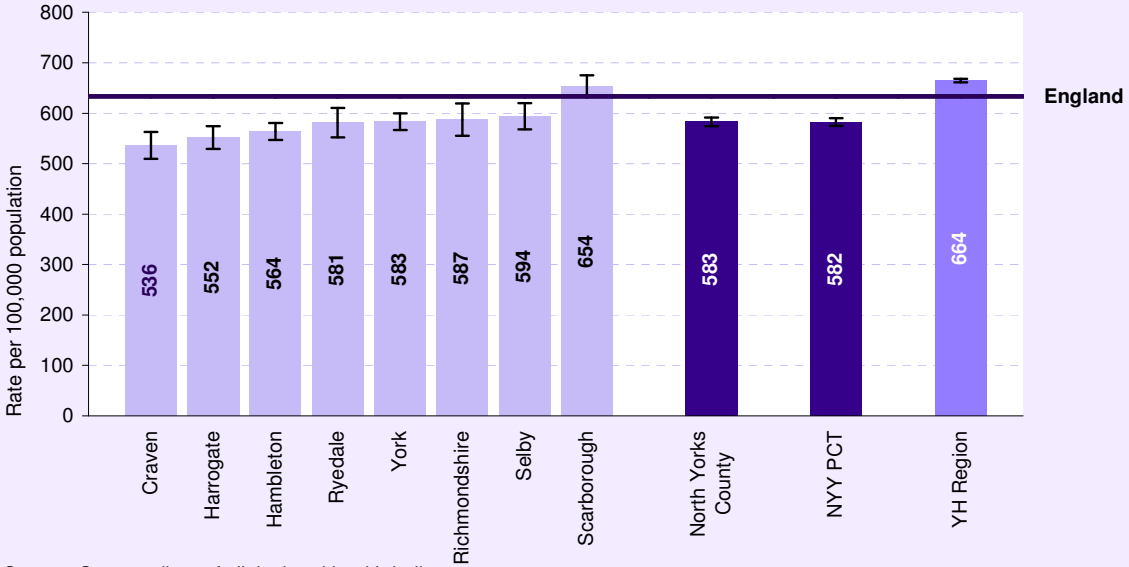
% increase in life expectancy at birth from 1991-1993 as at 2003-2005



Source: NCHOD

The latest available data indicate that seven of the eight districts within North Yorkshire and York had an all age, all cause mortality rate that was significantly lower than the national average. Although the rate in Scarborough was above average, this difference was not significant.

All age, all cause mortality (people), DSR, with 95% confidence limits, 2003-3005, North Yorkshire and York, Yorkshire and the Humber region and England



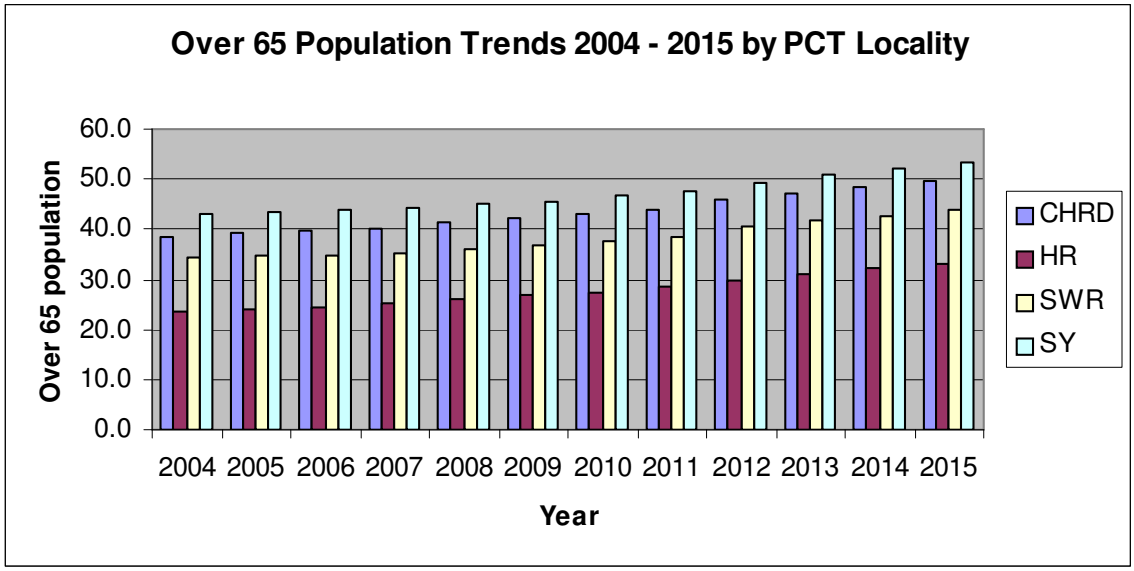
Source: Compendium of clinical and health indicators

However, there are pockets of deprivation within the PCT, predominantly in Scarborough, but with patches distributed throughout the PCT, and analysis of mortality rates for the fifth most deprived areas of the PCT (based on lower level super output areas) indicate that:

- The all age, all cause mortality rates in the deprived areas of the PCT are around 20% higher than that of the PCT as a whole
- The deprived areas of the PCT have observed mortality rates that are not dissimilar to spearhead areas within Yorkshire and the Humber

- The relative inequalities gap between the most deprived areas of the PCT and the PCT average fluctuated around 1.2 (20%) between 2001 and 2005

Over 65 Population



The over 65 population is estimated to increase by 25.8% over the period 2006-2015. Therefore it is imperative that mental health services work collaboratively with Local Authority and Third Sector Providers to respond efficiently to this growing population, ensuring effective services are in place to support the growing older people population to remain supported at home and to prevent hospital admission.

- By 2020 there will be 50% more people over 65 and they will represent 25% of the total population (growing from 18% in 2001).

- By 2020 there will be 65% more people over 85 representing 4% of the population.

*Source: NYCC Adult & Community Services, Strategic Commissioning Strategy for Independence, Well-being and Choice 2007-2022

Deprived areas in North Yorkshire and York

- Where are our most deprived areas?

Appendix 1 shows a map of North Yorkshire and York with those areas in which the most deprived fifth of our population reside shaded This is based on the Index of Multiple Deprivation 2004 scores at Lower Super Output Area (LSOA) level.

- Which practices have the most deprived populations?

Using the Index of Multiple Deprivation 2004 scores at Lower Super Output Area (LSOA) level, and registered practice population counts by LSOA, population weighted average IMD 04 scores were calculated for each practice in North Yorkshire and York.

Appendix 2 shows the IMD scores for all practices and identifies to which deprivation quintile each practice belongs. The list below are those practices with the highest levels of deprivation in North Yorkshire and York (making up one fifth of the registered population). They are all located within Scarborough/Whitby and York.

B82056	Scarborough	Dr DJ Knowelden & Partners, Claremont Surgery, Scarborough
B82024	Scarborough	Eastfield Medical Centre, Scarborough
B82088	Scarborough	Dr IF Fettes & Partners, Trafalgar Medical Centre, Scarborough
B82611	Scarborough	Dr DA Moederle-Lumb, Peasholm Surgery, Scarborough
B82092	Scarborough	Dr Laljee & Partners, Belgrave Surgery, Scarborough
B82038	Scarborough	Prospect Road Surgery, Scarborough
B82087	Scarborough	Dr S Chawla & Partners, South Cliff Surgery, Scarborough
B82058	Scarborough	Dr Coppack & Partners, Norwood House Surgery, Scarborough
B82001	Scarborough	Dr Oldroyd & Partners, Falsgrave Surgery, Scarborough
B82046	Whitby	Dr Croft & Dr Johnson, Staithes Surgery
B82017	Whitby	Whitby Group Practice
B82639	York	Dr J A Boffa (PMS Pilot)
B82037	Scarborough	Dr JFP Garnett & Partners, Filey Surgery
B82628	Scarborough	Drs Meeson & Penfold, Hunmanby Surgery
B82606	Whitby	Dr Suckling, Sandsend Surgery
B82006	York	Dr ASC Calder & Partners, Clifton Health Centre, York
B82095	York	Dr S Schofield & Partner, Acomb Health Centre (Beech Grove)
B82043	York	Minster Health, York
B82051	York	Abbey Medical Group, York
B82062	Whitby	Dr JS Fester & Partner, Egton Surgery
B82048	York	Dr Kemp & Partners, The Surgery, 32 Clifton, York
B82083	York	York Medical Group, Acomb
B82082	York	Dr RWM Wright & Partners, Gillygate Surgery, York

Registered prevalence of dementia and severe mental health

The Quality and Outcomes Framework incorporated the collection of disease registers for dementia and mental health during the financial year 2006/07. Appendix 3 and 4 show funnel plots of this data by practice across North Yorkshire and York. Using a funnel plot (for methods, see www.erpho.org.uk – funnel plot template for proportional data used), it is possible to identify outlier practices compared to the PCT average taking into account the size of the disease register. Where a practice falls outside of the control limits (dotted lines), it may be worth further investigation as to why this practice behaves differently to others.

Using these charts, the following practices have been identified as potential outliers with particularly high or low prevalence rates. They are displayed in tables below – those shaded are also practices that fall into the most deprived group within NYY. Appendix 5 lists practices by name for reference.

Mental Health 2006/07 registered prevalence

Outlier practices with high prevalence rates:

	Count	Population	Prevalence
B82006	109	5132	2.1%
B82092	65	3989	1.6%
B82087	75	5009	1.5%
B82056	86	6436	1.3%

B82043	80	6513	1.2%
B82076	52	4936	1.1%
B82082	68	6070	1.1%
B82038	80	8076	1.0%
B82017	129	15176	0.9%

Outlier practices with low prevalence rates:

	Count	Population	Prevalence
B82063	29	7808	0.4%
B82066	39	9247	0.4%
B82073	36	9268	0.4%
B82080	64	16899	0.4%
B82105	35	8160	0.4%
B82003	16	6276	0.3%
B82018	18	5836	0.3%
B82071	22	6912	0.3%
B82097	35	10247	0.3%
B82102	10	3322	0.3%
B82104	10	5608	0.2%

The overall prevalence of mental health in NYY PCT was 0.7% (the same as the regional and national averages).

Dementia 2006/07 registered prevalence

Outlier practices with high prevalence rates

	Count	Population	Prevalence
B82035	115	3432	3.4%
B82020	133	12124	1.1%
B82076	55	4936	1.1%
B82006	49	5132	1.0%
B82087	48	5009	1.0%
B82001	89	10233	0.9%
B82036	59	6453	0.9%
B82057	55	5945	0.9%
B82038	68	8076	0.8%
B82069	61	8002	0.8%
B82080	124	16899	0.7%

Outlier practices with low prevalence rates

	Count	Population	Prevalence
B82025	66	19013	0.3%
B82032	33	9826	0.3%
B82003	10	6276	0.2%
B82004	21	10052	0.2%
B82011	11	4696	0.2%
B82043	12	6513	0.2%
B82045	8	4521	0.2%
B82047	24	15583	0.2%
B82048	17	7034	0.2%
B82071	16	6912	0.2%
B82073	20	9268	0.2%
B82079	8	3426	0.2%

B82082	10	6070	0.2%
B82083	31	16306	0.2%
B82611	9	4352	0.2%
B82609	4	3394	0.1%

The overall prevalence of dementia in NYY PCT was 0.5% (above the regional and national averages of 0.4%).

Notes on interpretation of prevalence

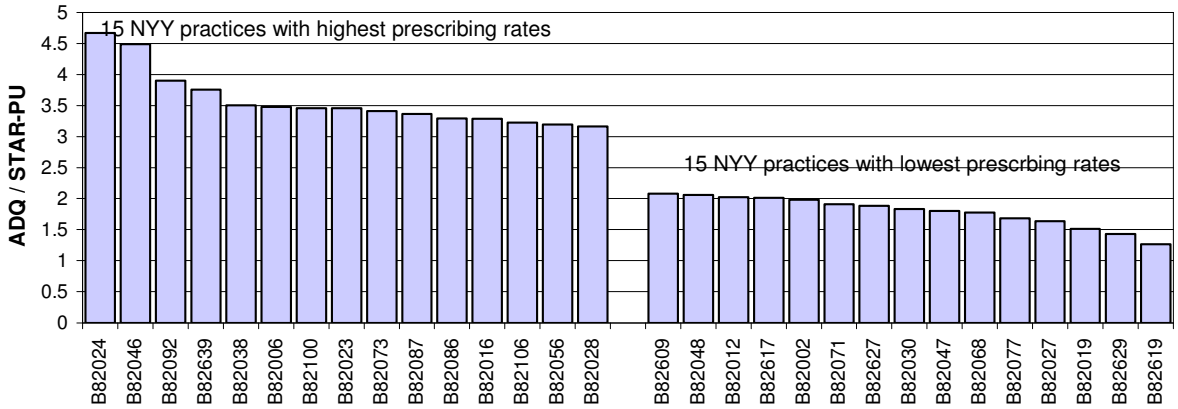
Higher registered prevalence might mean:

- Greater efforts have been made to improve case finding in your area. Some areas might have placed increased efforts into case finding and hence might appear to have higher prevalence than other areas where perhaps there are higher undiagnosed prevalence rates. One way of further understanding this is to compare modelled prevalence of diagnosed and undiagnosed prevalence. Although it's not possible to do this at present for the mental health and dementia disease groups, disease models are currently being developed by the Association of Public Health Observatories to enable such comparisons focusing on those diseases that appear in the QOF.
- Your area has different social and demographic characteristics
- Registered prevalence in QOF is not adjusted for any social and demographic characteristics. Therefore an area with a particularly elderly population for example, would be expected to have higher registered prevalence rates than a younger population
- Population prevalence is higher in your area

Prescribing rates for antidepressants

The overall prescribing rate for antidepressants in NYY PCT during 2006/07 was 2.63 ADQ/STAR-PU, lower than the national average of 2.73. The chart overleaf shows the practices with the highest and lowest prescribing rates for antidepressants. Those practices that fall into the most deprived quintile of NYY are shaded red. Please note that this data cannot be shared externally without express permission of the PPA.

Prescribing of antidepressants (Average Daily Quantity per STAR-PU), 2006/07, outlier practices within NYY PCT



Source: PPA Prescribing toolkit

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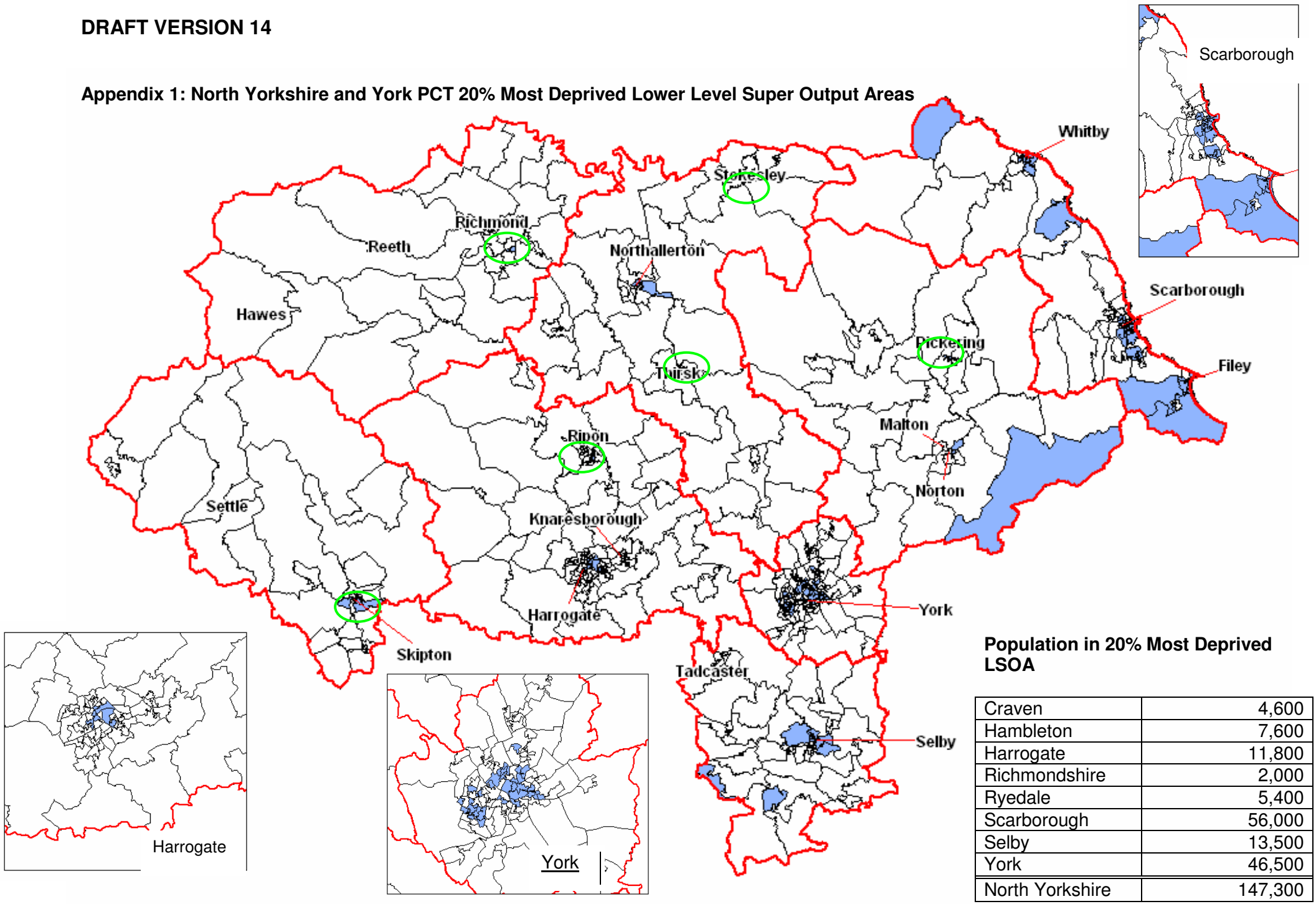
Appendix 1: North Yorkshire and York PCT 20% Most Deprived Lower Level Super Output Areas



Population in 20% Most Deprived LSOA

Craven	4,600
Hambleton	7,600
Harrogate	11,800
Richmondshire	2,000
Ryedale	5,400
Scarborough	56,000
Selby	13,500
York	46,500
North Yorkshire	147,300

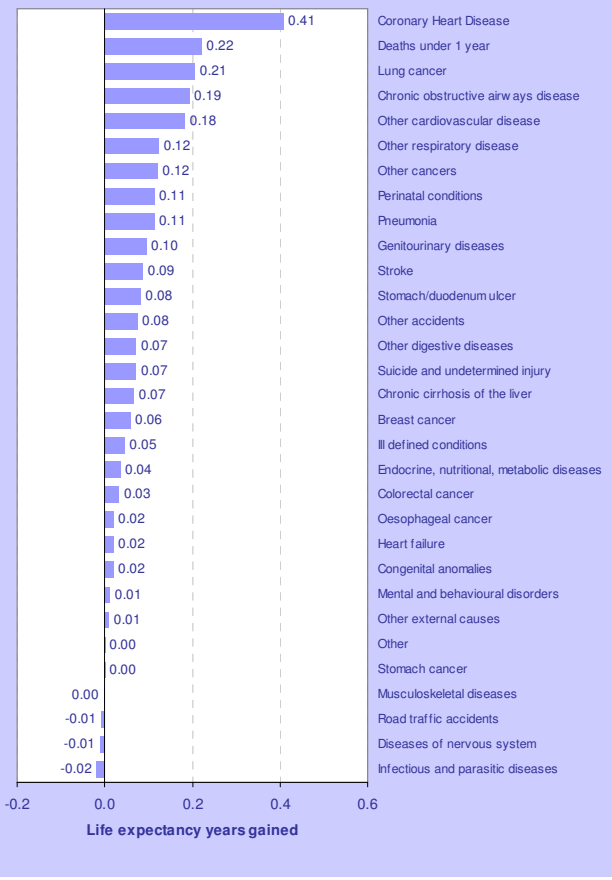
(rounded to the nearest 100)

Source: Yorkshire and Humber Public Health Observatory www.yhpho.org.uk

Most deprived quintile versus PCT as a whole (2001-2005)

Figure 3: Life expectancy years gained (or lost) if males in the most deprived quintile of North Yorkshire & York had the same mortality rate from each cause as males in North Yorkshire & York as a whole

Figure 4: Life expectancy years gained (or lost) if females in the most deprived quintile of North Yorkshire & York had the same mortality rate from each cause as females in North Yorkshire & York as a whole



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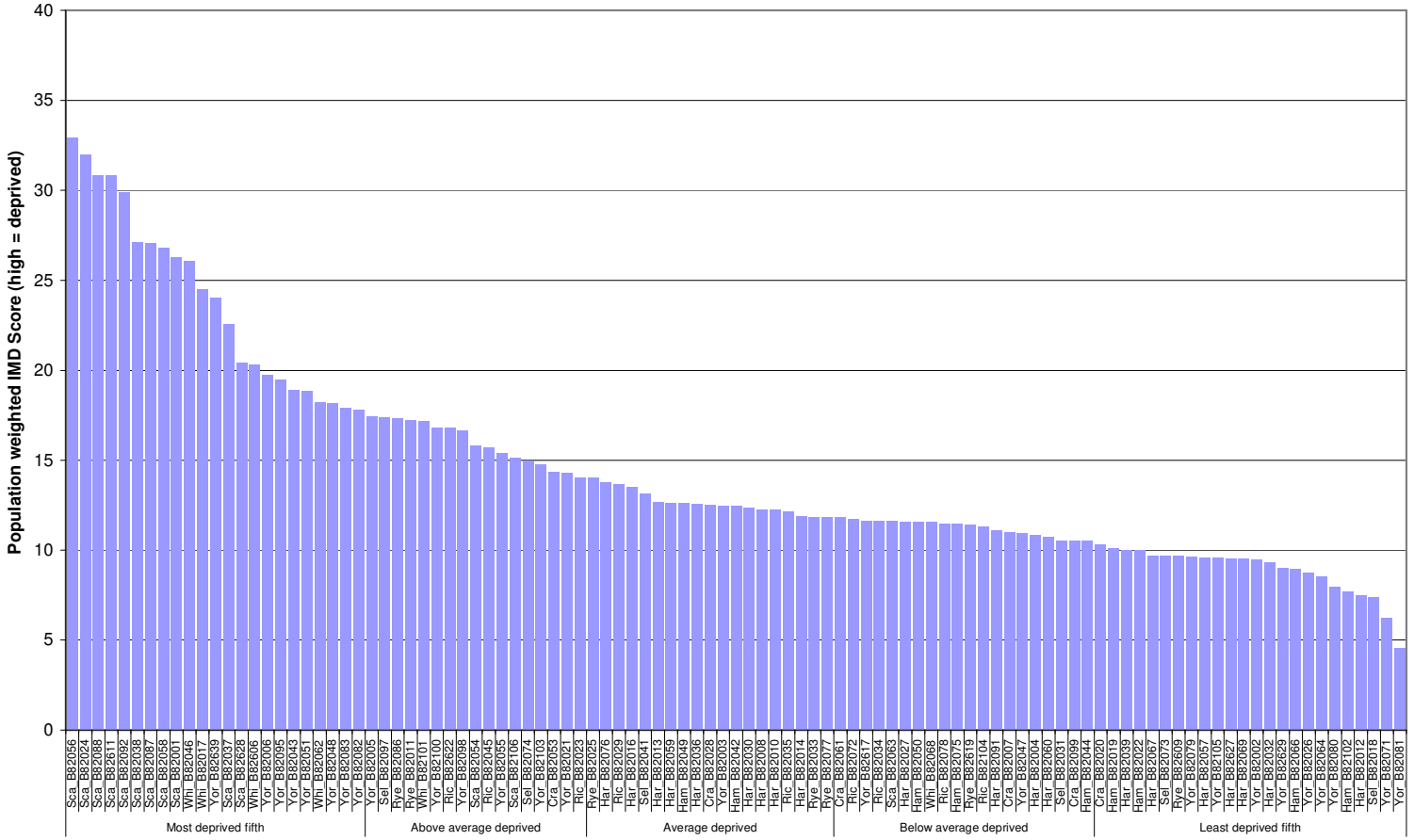
Appendix 2:

Population weighted average Index of Multiple Deprivation 2004 scores, North Yorkshire and York Practices



Source: Exeter population extract Oct 2005, ODPM IMD 04 at LSOA

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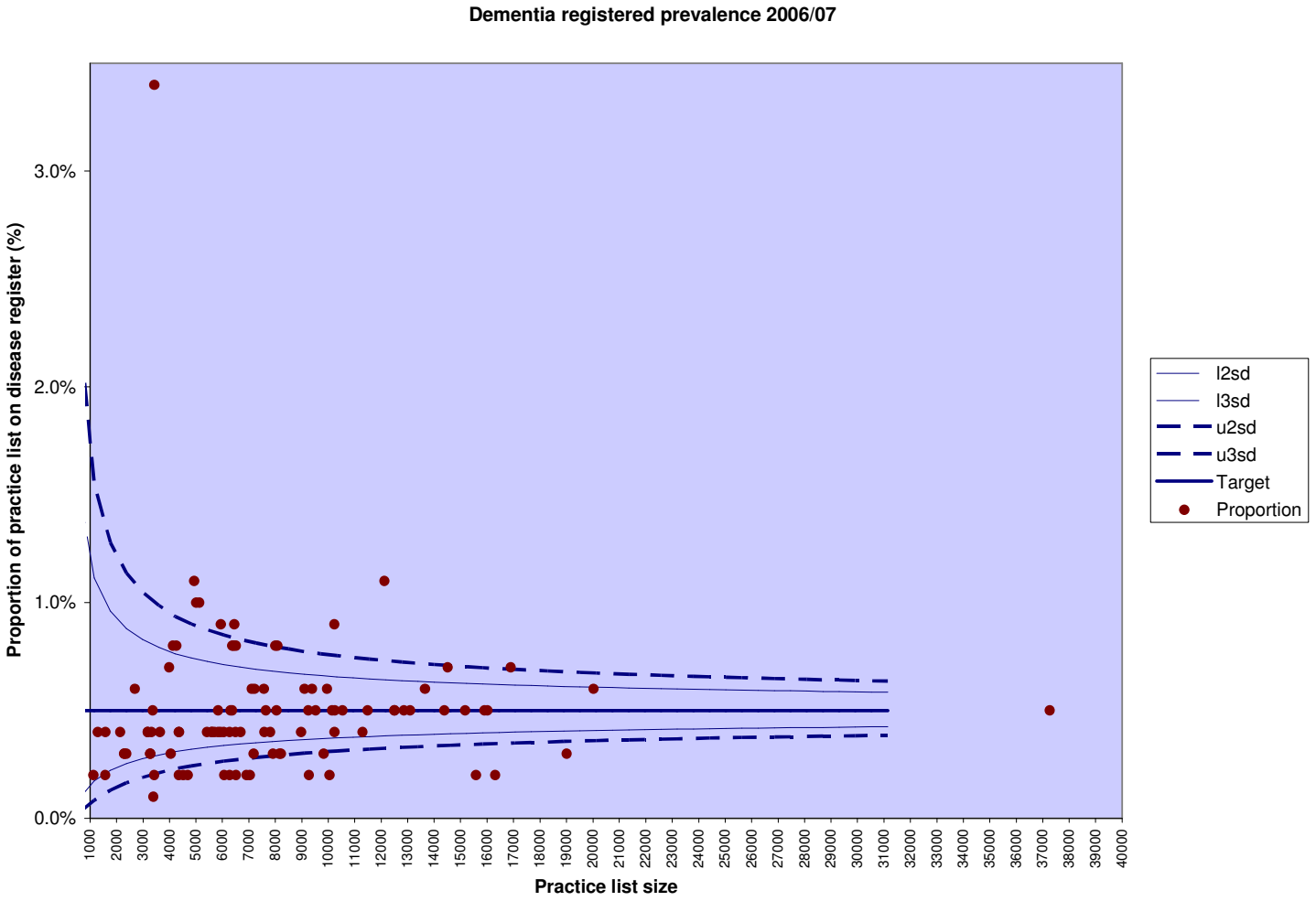
Appendix 3:



Source: QPID database (Information Centre extract from QMAS of QOF data)

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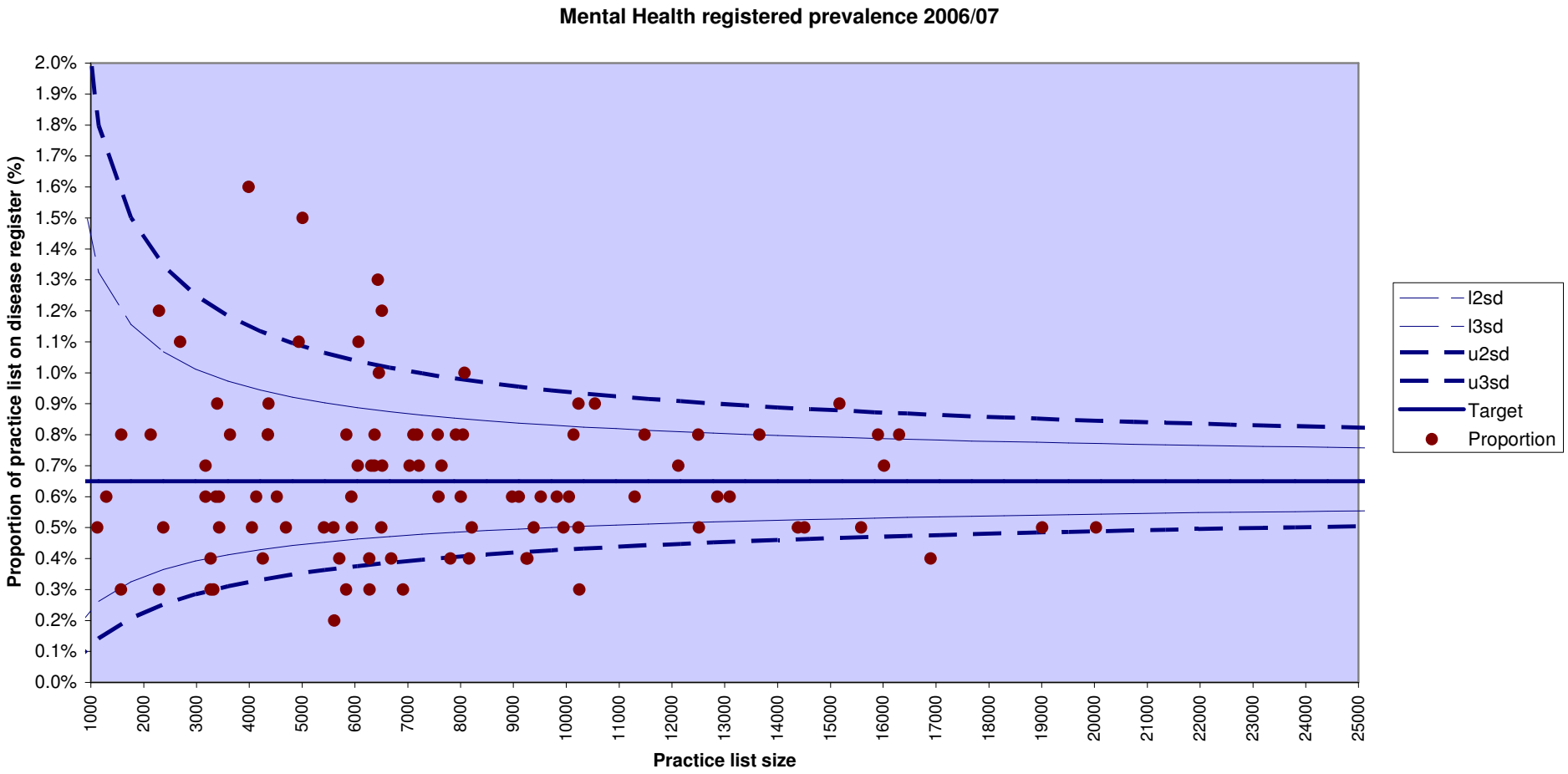
Appendix 4:



Source: QPID database (Information Centre extract from QMAS of QOF data) 2006/07

Appendix 5: GP Practice codes/names

B82001	FALSGRAVE SURGERY
B82002	MILLFIELD SURGERY
B82003	PETERGATE SURGERY
B82004	NIDDERDALE GROUP PRACTICE
B82005	PRIORY MEDICAL GROUP
B82006	CLIFTON HEALTH CENTRE
B82007	TOWNHEAD SURGERY
B82008	NORTH HOUSE SURGERY
B82010	DR LIVINGSTONE & PARTNERS
B82011	ST.HILDA'S SURGERY
B82012	THE LEEDS ROAD PRACTICE
B82013	DR CROUCH & PARTNERS
B82014	KINGSWOOD SURGERY
B82016	EAST PARADE SURGERY
B82017	WHITBY GROUP PRACTICE
B82018	ESCRICK SURGERY
B82019	TOPCLIFFE SURGERY
B82020	CROSSHILLS GROUP PRACTICE
B82021	DALTON TERRACE SURGERY
B82022	GREAT AYTON SURGERY
B82023	CATTERICK VILLAGE SURGERY
B82024	EASTFIELD MEDICAL CENTRE
B82025	DERWENT PRACTICE
B82026	HAXBY GROUP PRACTICE
B82027	THE SPA SURGERY
B82028	FISHER MEDICAL CENTRE
B82029	ALDBROUGH ST JOHN SURGERY
B82030	DR HARFORD-CROSS & PARTNERS
B82031	SHERBURN GROUP PRACTICE
B82032	CHURCH LANE SURGERY
B82033	PICKERING MEDICAL PRACT.
B82034	QUAKER'S LANE SURGERY
B82035	SCORTON MEDICAL CENTRE
B82036	DR FLETCHER & PTRS
B82037	FILEY SURGERY
B82038	PROSPECT ROAD SURGERY
B82041	BEECH TREE SURGERY
B82042	LAMBERT MEDICAL CENTRE
B82043	MINSTER HEALTH
B82044	STOKESLEY SURGERY
B82045	CENTRAL DALES PRACTICE
B82046	STAITHES SURGERY
B82047	WENLOCK TERRACE SURGERY
B82048	32 CLIFTON
B82049	THIRSK DOCTORS SURGERY
B82050	MOWBRAY HOUSE SURGERY
B82051	ABBEY MEDICAL GROUP
B82053	DYNELEY HOUSE SURGERY
B82054	DANES DYKE SURGERY
B82055	GALE FARM SURGERY
B82056	CLAREMONT SURGERY

B82057	SPRINGBANK SURGERY
B82058	NORWOOD HOUSE SURGERY
B82059	DR THORNTON & PARTNERS
B82060	EASTGATE MEDICAL GROUP
B82061	BENTHAM MEDICAL PRACTICE
B82062	EGTON SURGERY
B82063	WEST AYTON SURGERY
B82064	TOLLERTON SURGERY
B82066	GLEBE HOUSE SURGERY
B82067	DR JOBLING & PARTNERS
B82068	HELMSLEY SURGERY
B82069	BEECH HOUSE SURGERY
B82071	OLD SCHOOL MEDICAL CENTRE
B82072	THE FRIARY SURGERY
B82073	SOUTH MILFORD SURGERY
B82074	POSTERNGATE SURGERY
B82075	MAYFORD HOUSE SURGERY
B82076	ST.LUKE'S MEDICAL PRACTICE
B82077	KIRKBYMOORSIDE SURGERY
B82078	LEYBURN MEDICAL PRACTICE
B82079	STILLINGTON SURGERY
B82080	STRENSALL MEDICAL PRACTICE
B82081	ELVINGTON MEDICAL PRACTICE
B82082	GILLYGATE SURGERY
B82083	YORK MEDICAL GROUP
B82086	THE DANBY PRACTICE
B82087	SOUTH CLIFF SURGERY
B82088	TRAFALGAR MEDICAL PRACTICE
B82091	DR CALVERT & PARTNERS
B82092	BELGRAVE SURGERY
B82095	BEECH GROVE MEDICAL PRACTICE
B82097	SCOTT ROAD MEDICAL CENTRE
B82098	JORVIK MEDICAL PRACTICE
B82099	GRASSINGTON MEDICAL CENTRE
B82100	FRONT STREET SURGERY
B82101	CHURCHFIELD SURGERY
B82102	HUTTON-RUDBY SURGERY
B82103	EAST PARADE
B82104	HAREWOOD MEDICAL PRACTICE
B82105	TADCASTER MEDICAL CENTRE
B82106	HACKNESS ROAD SURGERY
B82606	SANDSEND SURGERY
B82609	AMPLEFORTH SURGERY
B82611	PEASHOLM SURGERY
B82617	COXWOLD SURGERY
B82619	TERRINGTON SURGERY
B82622	REETH SURGERY
B82627	JENNYFIELD HEALTH CENTRE
B82628	HUNMANBY SURGERY
B82629	BURGESS PJ
B82639	PMS PILOT

Appendix 2

City of York Mental Health Partnership Board

Membership

City of York Council

Bill Hodson (Chair)	Director of Housing and Adult Social Services
Keith Martin	Head of Adult Services

North Yorkshire and York PCT

Jane Marshall	Director of Commissioning & Service Development
Melanie Bradbury	Assistant Director of Vulnerable People & Third Sector Commissioning
Janet Probert	Director of Operations
John Clare	Assistant Director of Mental Health
Robyn Carter	Assistant Director, Service Development, (Mental Health and Unscheduled Care)
Dr. Tony Rugg	Clinical Director

Terms of Reference *To be agreed*

North Yorkshire Mental Health Partnership Board

North Yorkshire County Council

Derek Law (Chair)	Corporate Director Adult and Community Services
Seamus Breene	Assistant Director of Adult and Social Care Commissioning
Michael Hunt	Senior Commissioning Manager – Mental Health

North Yorkshire and York PCT

Jane Marshall	Director of Commissioning & Service Development
Melanie Bradbury	Assistant Director of Vulnerable People & Third Sector Commissioning
Janet Probert	Director of Operations
John Clare	Assistant Director of Mental Health
Robyn Carter	Assistant Director, Service Development, (Mental Health and Unscheduled Care)
Dr. Tony Rugg	Clinical Director

Terms of Reference *To be agreed*

Appendix 3

NORTH YORKSHIRE AND YORK

LOCAL IMPLEMENTATION TEAM

TERMS OF REFERENCE

1. PURPOSE

The North Yorkshire and York Local Implementation Team (LIT) will lead and co-ordinate the effective implementation of the Mental Health National Service Framework for Mental Health (NSF) and other relevant Local and National Priorities and Policies for Mental Health Care for people aged over 18 years old who reside in the North Yorkshire and York locality.

2. DUTIES AND RESPONSIBILITIES

- ✓ Lead on the implementation of the Mental Health National Service Framework for Mental Health (NSF) and other relevant Local and National Priorities and Policies for Mental Health Care across all statutory mental health services in partnership with service users, their carers and service providers
- ✓ Through interagency planning and commissioning to influence service options so that services are responsive to the needs and aspirations of service users
- ✓ Ensure that strategic and service planning takes place within the legal and statutory framework taking account of relevant guidance and external trends; understand community needs and gaps and identify priorities and opportunities for service development
- ✓ Ensure that robust links are developed with relevant strategic plans produced by partners, for example Housing Services, Supporting People, Education, Youth & Leisure, Police, Probation Service, Sustainable Communities Strategies and the LAA
- ✓ Ensure that key plans are developed and implemented, including the Local Investment Plan and Best Value Reviews, in keeping with government objectives and other local plans such as the Local Development Plan
- ✓ Ensure that the general health care needs of people with mental illness are met
- ✓ Ensure robust transition arrangements are in place between children's, adult and older people's services and dual diagnosis so that service users do not suffer disruption to their care and their future needs are planned for
- ✓ Encourage and promote cross-fertilisation of ideas, shared learning and communication between all stakeholder organisations
- ✓ Ensure any additional investment is applied to achieve the priorities within the NSF and other relevant Local and National Priorities and Policies for Mental Health Care
- ✓ Provide advice to the City of York and North Yorkshire Mental Health Partnership Boards on the future commissioning and development of mental health service provision.

3. MEMBERSHIP

Due to the large geographical area of North Yorkshire and York and the recognition of the 2 Local Authorities; City of York and North Yorkshire County Councils, the North Yorkshire and York Local Implementation Team will be supported by 4 LOCALITY IMPLEMENTATION ADVISORY GROUPS which will provide input into

the North Yorkshire and York LIT ensuring local priorities and input from local stakeholders. The Chair + 2-3 members of each LIAG will attend the LIT.

The LIAG should comprise:

- ✓ Local Authority Representation (City of York or North Yorkshire)
- ✓ Statutory Health Provider
- ✓ PCT Commissioning
- ✓ Third Sector
- ✓ Service Users
- ✓ Carers
- ✓ Clinicians
- ✓ Clinicians with responsibility for the Psychiatry of Learning Disabilities
- ✓ Primary Care

Invited to attend or ensure good links with:

- District Councils
- Housing
- Education
- Employment
- Armed Forces
- Police

The Senior Commissioning Manager – Child & Adolescent Mental Health (CAMHS) is also to be invited to ensure transitions between CAMHS and Adult services are addressed.

4. LIT CHAIR

The Chair of the LIT will be the Assistant Director of Vulnerable People and Third Sector Commissioning, or other Senior Officer within the Commissioning Directorate, who has overall responsibility for the Commissioning of Mental Health Care. It is the role of the Chair to ensure that all LIT members have an equal chance to participate in discussions. The Chair should ensure that meetings run to time.

5. VOTING AT MEETINGS

The ethos of the LIT will be to reach a consensus of opinion where possible. Where this is not possible, decisions will be made based on a voting system. There must be at least 1 representative from each LIAG in attendance for a vote and each locality will have a maximum of 2 votes. The Chair and Vice Chair of the LIT also have voting rights. The outcome of any vote will be recorded in the minutes (co-opted members will not have voting rights).

6. FREQUENCY OF MEETINGS

The LIT meetings will be held quarterly and the LIAGs should aim to meet before the quarterly North Yorkshire and York LIT meeting. LIT meetings can be called by the Chair in order to discuss urgent business. The annual meeting calendar will include time for planning and resource prioritisation and these times will be set prior to the relevant financial year.

7. NOTICE OF MEETINGS, AGENDA AND MINUTES

- User & Care issues will be placed high on the agenda
- Minutes will be taken of all LIT meetings and these distributed to Chair of the LIAG and the LIAG meeting representatives within 10 working days of the meeting.
- Where possible the agenda and papers will be circulated a minimum of 10 days prior to meetings; in exceptional circumstances papers will be tabled on the day.
- Minutes of the previous meeting will be approved and noted at the following meeting

8. STATEMENT OF ADOPTION

The North Yorkshire and York Local Implementation Team has agreed to adopt these Terms of Reference.

Chair:

Date of adoption:

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