NHS
Heywood, Middleton and Rochdale
Clinical Commissioning Group

Rochdale Borough Mental Health and Wellbeing Commissioning Strategy

2014-2017

Developed in Partnership with

Heywood, Middleton and Rochdale Clinical Commissioning Group

&

Rochdale Borough Council

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Foreword

NHS HMR CCG and Rochdale Borough Council are committed to supporting the population of our borough to live healthier lives. We recognise that we face some major challenges in Mental Health and Wellbeing within the borough but also acknowledge that the national commitment to ensuring parity of esteem for Mental Health represents a real opportunity to deliver change.

We are committed to working together to make the best use of our resources to deliver service transformation which improves outcomes and service quality and productivity, reducing unwarranted variation and tackling inequalities.

We believe that Mental Health is everybody's business and we are committed to working together, with our local services, communities, the third sector, service users and carers to build integrated, safe and accessible services which meet the needs of all our population. In delivering this strategy we will work with our communities to support them in mobilising local community assets and realising social capital in our existing formal and informal networks. The Rochdale Borough has a rich history of co-operation and we will nurture this legacy in the coming years.

The Mental Health and Wellbeing Commissioning Strategy 2014-17 has been jointly developed between NHS Heywood, Middleton and Rochdale CCG and Rochdale Borough Council in response to the Mental Health and Wellbeing Needs Assessment 2014. It sets out our commissioning priorities for children and young people, adults and older people, and describes how we will deliver our vision for Mental Health and Wellbeing for the population of the borough. The priorities identified in this strategy have been co-produced with service users, carers and key stakeholders.

In compiling this strategy we are conscious that borough population health needs cannot always be answered by commissioned health and social care services, our people need access to sustainable employment, affordable and local leisure facilities, affordable housing and vibrant social networks. This strategy is written in this important context: we will continue to deliver success through partnership working with local and regional public sector agencies and will set out plans to further develop and enable more community based solutions to traditional statutory services.

Section 1: Introduction

1.1 Vision and Purpose of the Strategy.

Everyone has a mental health status which changes dependent on their life circumstances, where they are on their life journey and what support they receive.

There are many ways that mental health can be defined. The World Health Organisation defines mental health as:

'*Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.'*

Ensuring good mental health within the population throughout the life course is, therefore, a major contributor to overall wellbeing and success within the population.

This strategy has been developed to outline the all age commissioning approach for mental health and wellbeing being services in the borough. Early Help is 'Everybody's business' particularly if we are to intervene at the first sign of potential issues. All children and families have a right to receive appropriate high quality services to achieve the best possible outcomes from services to provide a solid foundation from which to continuously develop as individuals and as a family unit. Mental health problems affect about one in ten children and young people. They include depression, anxiety and conduct disorder, and are often a direct response to what is happening in their lives. The emotional well-being of children is just as important as their physical health. Good mental health allows children and young people to develop the resilience to cope with whatever life throws at them and grow into well-rounded, healthy adults.[1] This understanding is reflected in a myriad of health and social care literature such as, the 2010 Marmot review:

'The foundations for virtually every aspect of human development – physical, intellectual and emotional are laid in early childhood. What happens during those years , starting in the womb, has lifelong effects on many aspects of health and wellbeing, form obesity, heart disease and mental health, to economic

[1] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/C/children-young-people/ (Accessed on 30/10/14)

achievement….Later intervention, although important, are considerably less effective if they have not had good early foundation."[2]

50% of all lifelong mental illness will develop by the age of 14, and 75% of all lifelong mental illness by the age of 25.[3] Evidence shows that only 25% of children with a mental illness can access mental health care.[8] In order to deliver the objectives of our strategy, we will need to invest in services for children, to where possible prevent mental illness, but also support children and young people to develop resilience and promote mental wellbeing throughout the life course. The 2011 report, 'Mental Health Promotion and Mental Illness prevention: the economic case' highlighted the economic benefits of investing in support for post-natal depression, parenting interventions for the prevention of persistent conduct disorders and school-based social and emotional learning programmes to prevent conduct problems in childhood. Every £1 invested in parenting interventions for families with conduct disorder resulted in an £8 saving.[4]

Our mental health impacts on all aspects of our lives and it is therefore the responsibility of not only the individual, but also of families, friends, employers and the wider community to enable people to develop and importantly maintain good mental health. Mental health is an essential component of health. It has an impact on every aspect of life, including how we feel, think and communicate. It impacts on our physical health, our employment chances, our educational attainment, our relationships, lifestyle choices, and risk behaviours. It enables us to manage our lives successfully and live to our own potential.

The impact of mental ill health, therefore, is wider than just health related. Costs to the individuals, their families and their communities in lost potential are essentially incalculable. However detailed estimates suggest the overall calculable cost of mental health problems in England to be around £105 billion and around £30 billion of this estimate is work related. This is largely due to sickness absence and reduced productivity. There are also large costs associated with the impact on the criminal justice system and also the housing system and particularly the homelessness services. One of the largest areas of cost is the benefit system. The most common reason for incapacity benefit claims is mental health, with 43% of the 2.6 million

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[2] Marmot, Fair Society, Healthy Lives (2010)

[3] Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence (October 2014)

[4] Knapp et al, Mental Health Promotion and Prevent Illness: the economic case (2011)

people on long-term health-related benefits having a mental or behavioural disorder as their primary condition.[5]

Consequently, this commissioning strategy is not confined to the commissioning of services for people with mental disorders, it has the wider ambition of promoting good mental health and wellbeing for the whole population, across all ages, ethnic origins and social backgrounds; aiming to ensure that everyone, not just those with a defined condition, are experiencing positive mental health and are therefore able to fulfil their potential in relation to academic achievements, productivity, and helping towards experiencing good physical health.

Its aim is to bring together commissioning for the wellbeing of the population and commissioning for people experiencing mental ill health supported by joint commissioning arrangements between Public Health, Health and Social Care based on outcomes co-produced with the relevant population. It is our ambition to ensure that the commissioning outcomes of this strategy align with the Public Service Reform agenda, integrating and aligning support for people who face the most complex needs across a range of partners.

With this in mind our vision for the Strategy is:

To improve the mental wellbeing of the population of the borough, preventing mental ill health where possible and promoting the recovery and wellbeing of those with mental illness.

The Rochdale Borough Mental Health and Wellbeing Commissioning Strategy sets out the commissioning strategy for Mental Health and Wellbeing for NHS Heywood, Middleton and Rochdale (NHS HMR CCG) and Rochdale Borough Council for the next three years. The key aims described are to improve health, reduce health inequalities and improve the quality of life for people of all ages living in the borough. The strategy aims to commission services which address the mental health and wellbeing needs of the population throughout the lifetime journey aiming to support the population to:

- Start and Develop Well
- Live and Work Well
- Age Well

This has to be achieved within the context of reducing funding, consequently the strategy seeks to make the best use of available resources and maximise outcomes.

[5] Department for Work and Pensions (2010) statistical summaries, available at: http://campaigns.dwp.gov.uk/asd/index.php?page=statistical_summaries

The commissioning strategy is a formal statement of our plans for securing, specifying and monitoring services to meet the needs of our population. It applies to services provided by the NHS and Local Authority, as well as other public agencies and private and voluntary sector providers. It also aims to build upon the previous strategy, Rochdale Borough Mental Health and Wellbeing Commissioning Strategy 2010-13, the Rochdale Borough Council Children's Trust Board, Child and Adolescent Mental Health Services Strategy 2010-14 and the Helping People with Dementia Live a Good Quality of Life (Joint Dementia Strategy for Rochdale Borough 2011-13)

This strategy has been developed through consultation and engagement with a wide range of mental health stakeholders. The outcomes of this consultation have informed the Mental Health Needs Assessment, and determined the objectives required for delivery of our strategic aims.[6]

Section 2: Policy and Context

2.1 National Policy and context

The Coalition Government has committed to ensuring the wellbeing of the whole population setting out their priorities in relation to Mental Health and Well Being in the following key pieces of legislation and Government policy;

- **The Health and Social Care Act 2012:** establishing Health and Well Being boards to improve integrated working between NHS and Local Authorities to improve Health and Well Being Outcomes for local communities. Also, secured the explicit recognition of the Secretary of State for Health's duty towards both physical and mental health. In conjunction with a clear legislative requirement to reduce inequalities in benefits from the health service, these duties place an obligation on the Secretary of State to address the current disparity between physical and mental health. The concept of 'Parity of Esteem' underpins all six objectives of the English Mental Health Strategy, 'No Health without Mental Health'.

- **Public Health White Paper: Healthy Lives, Healthy People, (December 2010):** outlines a new approach to reducing health inequalities acknowledging that this is a shared responsibility across society, linked to empowering individuals and communities to improve their own health and wellbeing. A key emphasis from the White Paper is that health and wellbeing throughout life requires a coherent approach to different stages of life and key transitions i.e. starting well, developing well, living well, working well and ageing well. Mental Health will be a key element to this.

[6] See Appendix 1 for Stakeholder engagement summary reports

- **No Health without Mental Health (2011):** In February 2011 the Department of Health published the national public health strategy 'No Health without Mental Health: A cross government mental health outcomes strategy for people of all ages' with 6 key outcomes.

- **Closing the Gap (2014):** This document builds upon 'No Health without Mental Health' and looks at how changes in local service planning and delivery will make a difference, in the next two or three years, setting out 25 priority areas for change.

- **The Mental Health Crisis Care Concordat (February 2014):** The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

- **Achieving Better Access to Mental Health Services by 2020 (October 2014):** This Department of Health policy paper report shows what action the government is taking to provide better access to care in mental health services within the next year, including national waiting time standards for the first time. It also sets out its vision for further progress by 2020.The waiting time standards for mental health that come into effect from 1 April 2015 are:

    - Treatment within 6 weeks for 75% of people referred to the Improving Access to Psychological Therapies programme, with 95% of people being treated within 18 weeks treatment within 2 weeks for more than 50% of people experiencing a first episode of psychosis.
    - Targeted investment will also help people in crisis to get effective support in more acute hospitals. This plan will start to ensure that mental and physical health services are given equal priority by 2020.

- **National Suicide Prevention Strategy for England (2012)**: The National Suicide Prevention Strategy for England, launched in September 2012, aimed to support the achievement of the target set in the White Paper by developing a comprehensive, evidence based and coordinated approach to preventing suicide.

- **Care Act 2014:** This legislation places a duty on local authorities to provide prevention services, information and advice and a range of high quality providers for people with social care needs.

- **Children and Families Act 2014:** The Children and Families Act will mean changes to the law to give greater protection to vulnerable children, better support for children whose parents are separating, a new system to help children with special educational needs and disabilities, and help for parents to balance work and family life.

The above build on the following strategic documents which were issued prior to the Coalition coming into power:

- **Living Well with Dementia: A National Dementia Strategy – Putting People First (2009):** providing a strategic framework within which local services can deliver quality improvements to dementia services and address health inequalities relating to dementia.

- **Fair Society, Healthy Lives 2010:** The Marmot review into health inequalities in England proposed an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities. The report proposes a new way to reduce health inequalities in England and focuses on giving every child the best start in life and enabling all children, young people and adults to maximize their capabilities and have control over their lives**.**

- **People with Mental Health Problems or Learning Disabilities in the Criminal Justice System (Bradley 2009):** In December 2007 the Government undertook a six-month independent review to determine to what extent offenders with mental health problems or learning disabilities could be diverted from prison to other services and what were the barriers to such diversion.

Our commissioning intentions, as outlined in this strategy, take into account these pieces of legislation and government policy documents which establish a set of shared objectives to improve mental health outcomes for service users, and the population as a whole, identifying key priorities for change, and a strategy for delivery.[7]

2.1a National campaigns and reports

Legislation outlines the mandated requirements for health and social care commissioners. In developing this strategy we have also been advised by:

Time to Change: Time to Change is currently in its second phase which began in October 2011 with funding from the Department of Health, Comic Relief and the Big Lottery Fund. Current funding is due to end on 31 March 2015. The project aims to tackle stigma and discrimination. This really matters because stigma ruins lives. For some, it means not only having to deal with a serious illness, but also having to keep it a secret. This can be an incredibly isolating experience and lead to people feeling cut off from society. It also means people with mental health problems are less likely to get support and treatment. Shifting these attitudes is the work of a generation and there is still a long way to go, but funding means the campaign will be able to keep moving forward and build on the incredible success it has already had. The campaign released data which showed significant improvements to public attitudes, with the biggest annual improvement in the last decade taking place in 2013.The most recent data shows that since the beginning of the current programme of Time to Change (2011) an estimated two million people – or 4.8% of the population - have

[7] Please see Appendix 2 for further details of National Policy and Guidance.

improved attitudes towards people with a mental illness. It also shows that there was a 2.8% improvement in attitudes between 2012 and 2013 – the biggest annual shift in the last decade. While direct comparisons can't be made before 2003, it also likely that this is the biggest annual improvement since the first survey was commissioned 20 years ago. The commitment from the Government to funding Time to Change is very welcome, and will make a real difference to the millions of people experience mental health problems each year. There have been some encouraging signs of change including last year the biggest improvement in attitudes in at least a decade. Ending discrimination for good is still a long term goal, and there's still a lot more work to be done before everyone with a mental health problem can live life free from discrimination. The second phase of the campaign has been 'Time to Talk' about mental health.

- **From the Pond into the Sea: Children's Transition to Adult Health Services (CQC 2014):** This document is a review of the experiences of young people and their families regarding transition into adult health services, and the difficulties which this presents. The review highlighted that whilst there is an expectation that professionals across health services for both children and adults would work together to promote effective, timely and well-managed transition, this is not currently the experience of many. The Children's and Families Act and the Care Act, include specific provisions designed to support more effective transitions to adult services for young people with special educational needs or disability, in health and social care respectively. The changes to the legislation provide an opportunity to ensure that the wealth of existing information and guidance to support good transition to adult services is at last heeded and implemented.

2.2 Local Policy and Context

The development of this strategy has also taken account of local strategic documents including:

- NHS HMR CCG Strategic Commissioning Plan (2014-19)
- Rochdale Borough Council Adult Care Vision and Blueprint
- Joint Health and Wellbeing Strategy 2012-15
- Integrated Early Help Strategy 2013-16 (Rochdale Borough Children and Young People's Partnership)
- Helping People with Dementia Live a Good Quality of Life (Joint Dementia Strategy for Rochdale Borough 2011-13)
- Integrated Neglect Strategy 2014-16 (Rochdale Borough Children's Safeguarding Board)
- Rochdale Joint Carer's Strategy (2013-16)
- Rochdale Borough Children and Young People's Plan 2014-2017

Section 3: Rochdale Borough Mental Health and Wellbeing Needs Assessment

To support the development of this strategy, a Mental Health Needs Assessment was undertaken for Rochdale Borough.

3.1 Purpose and Methodology of Needs Assessment

The needs assessment was undertaken to contribute to the Rochdale Borough Mental Health and Wellbeing Commissioning Strategy and inform the priorities set out within Clinical Commissioning Group and Local Authority commissioning plans and integrated health and social care plans. The needs assessment will also be used to inform the wider Public Sector Reform work.

The needs assessment mainly focuses on the epidemiological approach using the most current available data. Stakeholder engagement has also been utilised in order to establish key areas of focus. It has included participatory appraisal findings previously identified.

3.2 Data findings summary

A summary of the key data findings is detailed below.

3.2a General findings:

The needs assessment was supported by a review of performance data, and a Commissioning for Value Deep Dive.

The key summary points from this review were as follows:

- Recorded prevalence of mental health and depression was in the highest quintile of the benchmark group and England.
- The CCG was in the highest quintile in the benchmark group and England for prescribing spend in 2012/13. If the CCG were to move to the benchmark group average, there would be £1.1m reduction on prescribing spend
- Emergency hospital admissions for Dementia (65+ and 75+ years) and Schizophrenia were in the highest quintile in the benchmark group and England
- Both the number of items prescribed for mental health conditions in Primary care and their cost put the CCG in the ‘worst’ quintile compared to the comparison group
- There was concern about the uptake / follow up of physical conditions and illnesses for example cervical screening test in last 5 years amongst patients on the Mental Health register.

- The CCG has a higher than peer average level of Hospital admissions for Mental Health, particularly for Schizophrenia and Delusional Disorder.

- For 2013/14 HMR CCG commissioned 1598 Psychiatric Intensive Care Unit bed days, from NHS and private providers. This is significantly above the activity levels of CCGs in the Pennine Care footprint and is currently under review.

Mental illness makes up the largest proportion of the UK disease burden (22.8%). However only 25% of adults with mental illness receive care, compared to 80% of those with diabetes. There are a broad range of impacts of mental illness which include:

- Self-harm and suicide
- Health risk behaviour; smoking, alcohol and drug misuse, sexual risk, nutrition, physical activity
- Physical illness, long term (physical) conditions and premature death
- Educational outcomes
- Employment
- Antisocial behaviour/offending
- Social skills

People with serious mental illness do not access the best available health care and on average people with severe mental illness die 25 years earlier than the general population.

Mental Health conditions present and need treatment in a variety of NHS settings, and represents 30-50% of primary care daily workload. It also accounts for 40% of acute trust bed day activity, along with 40% of acute trust long term conditions clinic activity. Evidence also suggests that 40% of all presentations in long term community providers are as a result of Mental Illness. [8]

Evidence shows that different ethnic groups have different rates and experiences of mental health problems, reflecting their different cultural and socio-economic contexts and access to culturally appropriate treatments. In general, people from black and minority ethnic groups living in the UK are:

- more likely to be diagnosed with mental health problems
- more likely to be diagnosed and admitted to hospital
- more likely to experience a poor outcome from treatment
- more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health.

[8] Dr Geraldine Strathdee, National Clinical Director, Mental Health, Yorkshire and Humber SCN http://mentalhealthpartnerships.com/wp-content/uploads/sites/3/3%2520GS% (accessed 29/10/14)

The needs assessment identified that Rochdale has a very ethnically diverse population with over 150 different ethnicities being identified in the borough from the 2011 Census. The percentage of the population that comes from BME communities (i.e. all non-white British) is 21.4% with the Asian/Asian British Pakistani group representing the next largest ethnic group with 10.5%. In total ethnic groups of south Asian origin account for 13.1% of the borough population.

In 2009 and 2013, the North West Public Health Observatory (NWPHO) was commissioned to undertake a survey to measure levels of wellbeing across the North West. Between 2009 and 2013 the wellbeing score for Rochdale declined from 28.4 to 26.3. The North West average for both surveys was 27.7.

The Centre Forum Atlas of Variation analyses variation at the districts and regions of England to identify matters of unwarranted variation in mental health and wellbeing. Key areas for consideration for Rochdale borough include:

- High level of domestic abuse incidents
- High level of emergency admissions for acute conditions which should not normally require hospitalisation
- High number of young people not in education, employment of training
- Low adult happiness, worthwhile, and life satisfaction scores
- Excess mortality for those under 75 with a serious Mental Health illness
- Level of hospital admissions caused by unintentional and deliberate injuries
- High Numbers of children who are receiving additional services for childhood neglect, parental substance misuse and mental ill health

3.3 Key data findings by age group:

3.3a Starting Well and Developing Well: Children (0 -15)

Based on 2013 ONS mid-year estimates 21.1% of Rochdale's population is under 16 which is higher than the figure for Greater Manchester and England. The populations of Kingsway (10.1%), Milkstone and Deeplish (9.9%) and Central Rochdale (9.3%) are all fairly young and have the lowest proportion of over 65s in the borough. Smallbridge and Firgrove joins the aforementioned wards in having the highest proportions of young people in the borough with all four ward populations consisting of at least 25% of people aged 0-15 years old.

- Mental health problems in children are associated with underachievement in education, childhood neglect, family disruption, disability, offending and antisocial behaviour, placing significant demands on families, social and health services, schools and the youth justice system. Untreated mental health problems create distress not only in the children and young people, but also for

their families and carers, and the wider community, continuing into adult life and affecting the next generation.

- Mental health problems and disorders in childhood can have high levels of persistence: 25% of children with a diagnosable emotional disorder, and 43% with a diagnosable conduct disorder, still had the problem three years later according to a national study. Persistence rates in both cases were higher for children whose mothers had poor mental health (37% and 60% respectively). Young people experiencing anxiety in childhood are 3.5 times more likely than others to suffer depression or anxiety disorders in adulthood. A number of disorders are persistent and will continue into adult life unless properly treated – it is known that 50% of life-time mental illness (except dementia) begins by the age of 14 years.
- 25.2% of children living in Rochdale are classified as living in poverty. The impact of deprivation upon Mental Health is well documented. The areas which have a high level of Child Poverty, (Balderstone, Kirkholt, Kingsway, Smallbridge and Firgrove, Central Rochdale, West Middleton and West Heywood), correlate with areas of high deprivation and an above average proportion of residents under the age of 15.
- Prescribing for ADHD-related drugs has seen a year on year increase since 2011/12. Some GP practices have seen large increases in 2013/14 and these tend to be in more deprived areas.
- The most deprived wards in the borough have an above average population below the age of 15. These areas also correlate with the wards which have a high level of Adult Mental Health prevalence. Not only does this indicate that these children will experience the impact of parental mental ill health, but it also indicates that these areas will continue to see a high level of Mental Health need as this cohort of children reach adulthood. This suggests that more targeted early interventions will be required in these areas to address the future risk.
- Whilst Children and Young People represent 21.1% of the population, they represent 16% of admissions for Self Harm.
- A study was undertaken by the Rochdale Healthy Schools Team in 2013 to collect robust information about young people's lifestyles. 3% of pupils aged 8-11, and 2% of pupils aged 12-15 had low self-esteem scores.
- Bullying: 31% of Year 6 pupils reported that they felt afraid of going to school because of bullying. This falls to 28% in Year 8 and again to 17% in Year 10. The impact of adult mental ill health, domestic abuse and substance misuse on the mental and physical health of children and young peoples' own mental and physical health have been recurring themes in the serious case reviews which have been carried out within the Rochdale borough and is reflected in national data.
- Perinatal mental health problems are very common, affecting up to 20% of women at some point during the perinatal period from national estimates. They are also of major importance as a public health issue, not just because of their adverse impact on the mother but also because they have been shown to

compromise the healthy emotional, cognitive and even physical development of the child, with serious long-term consequences. Taken together, perinatal depression, anxiety and psychosis carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK. This is equivalent to a cost of just under £10,000 for every single birth in the country. Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother. Over a fifth of total costs (£1.7 billion) are borne by the public sector, with the bulk of these falling on the NHS and social services (£1.2 billion).

- Perinatal anxiety (when it exists alone and is not co-morbid with depression) costs about £35,000 per case, of which £21,000 relates to the mother and £14,000 to the child.
- Perinatal psychosis costs around £53,000 per case, but this is almost certainly a substantial under-estimate because of lack of evidence about the impact on the child; costs relating to the mother are about £47,000 per case, roughly double the equivalent costs for depression and anxiety.[9]

3.3b Living and Working Well: Adults (16 – 64)

Within this age group there are comparatively fewer 16 – 44 year olds compared to the rest of Greater Manchester and England whilst the largest age group for the borough is the 45 – 64 age group. The key facts for this age group in relation to mental health are:

- Studies show that people experiencing poor quality of life are more susceptible to developing mental health problems. The areas of highest deprivation in Rochdale Borough are found in Central Rochdale, Langley (West Middleton), Darnhill (West Heywood), Kirkholt, Newbold (Kingsway), Spotland and Failinge and Smallbridge. The needs assessment highlights that some estimated prevalence data for mental health conditions correlate with these areas of deprivation.
- The highest estimated prevalence for General Neurotic Disorders is found in Kingsway which includes Newbold. Also, substantially more women than men across the whole borough are affected by this condition.
- The highest estimated prevalence of personality disorders is in Milkstone and Deeplish and a far higher proportion of men are affected across the borough than women.
- The highest estimated prevalence of probable psychotic disorder in males is found in the Milkstone and Deeplish ward and women and men are affected at a similar rate. The highest estimated prevalence of probable psychotic disorder in females is found in Kingsway.
- The highest estimated prevalence of major depression in adults is highest in Kingsway and women are more affected than men across the borough.

[9] Centre for Mental Health, The Costs of Perinatal Mental Health Problems (2014)

- Unemployment is associated with social exclusion, reduced psychological wellbeing, and a greater risk of self-harm, depression and anxiety. Unemployed people are twice as likely to suffer from depression as those who work. Two thirds of men under 35 years who commit suicide are unemployed. Youth unemployment in particular carries a significant mental health risk. Long-term unemployed young people are more than twice as likely as their peers to have been prescribed anti-depressants, one in three has contemplated suicide and one in four have self-harmed (Princes Trust, 2014).
- Employment and Support Allowance (ESA) replaced Incapacity Benefit (IB) for new claimants in 2008, with the remaining IB claimants being gradually phased onto the new benefit over the next few years. The areas with the highest percentage of claimants are in the wards of Central Rochdale (29.5%), West Middleton (28%), Milkstone and Deeplish (26.4%), Smallbridge and Firgrove (26.3%), Kingsway and Balderstone and Kirkholt (both 24.8%). Norden has by far the lowest percentage of claimants (7.3%) with the Pennine Township wards following on 11-12%.As of November 2013 there were 13,020 people claiming IB/ESA in Rochdale Borough 48% of these were claiming for a mental or behavioural disorder.
- Accident and Emergency attendances that are recorded as having a primary diagnosis of a mental health condition have the highest rates in the most deprived wards. Males account for 55% of attendances, with females 45%. 85% of attendances are for the white population despite prevalence data for some mental health conditions e.g. psychosis being high in area of with a significant BME population.
- Admissions for all mental health diagnoses show that the wards with the highest admission rates tend to be areas with relatively high deprivation with the more affluent wards having lower rates. 52% of admissions are for females, with 48% males. 90% of admissions are for the white population.
- From GP records, the prevalence of major depression among 16-65 year olds (males 17, females 25/1000 population) UK average with mixed anxiety and depression is prevalent in a further 10/1000 population and is set to be the second after cardiovascular disease by 2020 in terms of the world's most disabling diseases. Comparing statistics for Rochdale of percentage of adults over 18 years with depression the figure of 12 per 1000 population compared against the England Average is 11.68 per 1000 shows that the Rochdale population is significantly worse. Spend in the Borough is significantly more (£211/household) than the England average (£183/household).
- Residents using adult and elderly secondary mental health services are above England average (2.5/1000 population, North West 2.7/1000 population) at 3.7 per 1000 population. In-year bed days for mental health are significantly above England average 0f 193 /1000 population, North West 178 / 1000 population) at 239 /1000 population, making exposure likely with increases of mental health needs.

- There is a correlation between wards with a high level of Accident and Emergency Admissions and hospital admissions for mental health diagnoses and a low level of GP practice registration for mental health conditions.
- The highest rates of hospital admission for Self Harm are found in Smallbridge and Firgrove, West Heywood, West Middleton, Balderstone and Kirkholt. These are all areas of relatively high deprivation. Admissions are fairly evenly split between the sexes (54% females and 46% of males) and 87% of admissions are for the White population.
- Rochdale is the 12th highest CCG for anti-depressant prescribing in England. The Commissioning for value Deep Dive highlighted that if Rochdale were to move to the benchmark average for Mental Health prescribing in primary care, this would result in a potential £1million financial saving.
- Mortality rates from suicide and injury undetermined in Rochdale currently stand at 14.66 per 100,000 for males, 5.52 for females and 10.15 overall There are on average 20 deaths each year in Rochdale, although since 1993 there has been a small increase in the overall rate compared with a steady decrease across England and Wales. The age distribution of suicides shows rising numbers up to the ages of 40 to 49, which is the highest risk age group for both males and females. Around three quarters of all suicides in Rochdale occur in the male population and this (together with the age distribution) reflects the pattern for England as a whole.
- The highest levels of eating disorders are seen in young women, over 20% of 16-24 year old women would be expected to screen positive for a possible eating disorder. If the national prevalence were applied to Rochdale then that figure would be 5,295 people (based on the 2013 Mid-year Estimates). Lifetime prevalence rates for full and partial anorexia nervosa in the general population range from 0.9 to 4.3% in females, which for Rochdale Borough would be between 972 and 4,646 incidences. In the case of Bulimia the rates are thought to be between 4% and 7%, so for Rochdale this would be between 4,322 and 7,563. The lifetime prevalence of binge eating disorder is 3.5% in women (3,781 for Rochdale) and 2.0% (2,081) in men.

3.3 c Ageing Well: Adults (65 and over)

Rochdale's population is expected to grow to 222,959 by 2037, an increase of 5.2% on the current number of residents. The graph in Figure 6 shows that while most broad age groups will experience a decline over the next three decades the number of over 65s is expected to soar from 32,228 to 50,500, an increase of 56.8%. The South Middleton and Bamford wards have the highest proportions of over 65s, but there are Lower Super Output Areas (LSOAs) in other wards that also contain significant populations of older people

- Depression in older people is expected to increase with the ageing of the population.

- Conversely to the 16-64 age group, more affluent areas have highest rates of older people depressed possibly reflecting social isolation and lack of community support. However this may also reflect the lower life expectancy in areas of deprivation.
- Dementia prevalence rates are highest in the more affluent areas (Bamford, South Middleton and Castleton) and lowest in areas of high deprivation (Kingsway, Milkstone and Deeplish, Central Rochdale). In addressing the mental health needs of the Older People's age group it may be appropriate to undertake targeted work with these communities.

3.4 Stakeholder engagement summary

The needs assessment has been supported through a comprehensive consultation process with a wide range of stakeholders. This was delivered through a series of three engagement events. Attendees at all three events were asked to discuss the same themes, to ensure a wide spectrum of response.[10]

A summary of the key themes identified at the three events is as follows:

3.4a More Effective Prevention Services

- Mental Health Awareness Raising and addressing stigma and discrimination in Mental Health
- Signposting and raising awareness of available services and pathways
- Improving Mental Health Information and Advice, to promote self-management and improve service user experience, and signpost staff to available services and pathways
- Improved prevention and early intervention services
- Mental Health Education for staff, service users and schools

3.4b Better access to Services

- Improving Access to services
- Enabling fast track re-entry into services, particularly at points of crisis

[10] Full details of the outputs of these events is provided at Appendix 1.

- The need to increase the presence of, and access to, low level support so that GPs are not the front door to mental health services.

3.4 c Improved Service Delivery for people with a mental illness

- Improved service transition to support the life journey
- Importance of peer support and Mental Health Champions
- Promotion of a recovery ethos through personalised care and improvement of community resilience and support
- Co-production of services with service users and carers as partners

3.5 Recommendations from Rochdale Borough Mental Health and Wellbeing Needs Assessment 2014

The Rochdale Borough Mental Health Needs Assessment was supported by consultation with Commissioners, Providers, Service Users and Carers. The outcomes of this consultation combined with the data gathering and intelligence required to develop the Needs Assessment, informed the recommendations below:

1. Ensure that we meet the needs associated with the projected increasing number of people living with Dementia
2. Ensure that we meet the physical health needs of people with mental health problems and Illness
3. Ensure that we meet the mental health needs of people with long term conditions or acute physical health issues
4. Identify and develop linked services to meet the needs of people claiming Employment Support Allowance/Incapacity Benefit due to a mental health diagnosis or need
5. Work across partners to increase wellbeing levels in the borough
6. Further improve services to meet the increase in admission and attendance at A&E due to a mental health problem
7. Further develop the early help offer for Children, young people and families (at Tiers 1 and 2)
8. Increase the work to develop service models to address mental health needs for individuals /families with complex needs

9. Develop the work to address mental health and drugs and alcohol needs and services and work within the criminal justice system

10. Develop clear strategy and services to tackle the isolation and the needs of older and vulnerable people

11. Ensure all services complete an annual equity audit and take action that is monitored to improve equity and reduce inequalities

12. Ensure that we address the specific needs of known vulnerable groups including looked after children, BME groups, people living with disabilities, drug and alcohol users, LGBT people, homeless people

13. Continue to develop action to prevent self-harm and suicide for children, young people, men and women

14. Improve integrated and joint service models to address the needs of residents at the point of a mental health crisis in and out of usual working hours

15. Develop a clear commissioning strategy to develop a baseline of spend, clear strategy and a more equitable distribution between physical and mental health issues

16. Develop joint training strategies to develop and build the capacity and capability of front line staff to deal with mental health needs

17. Ensure that the mental health needs of carers is built into service plans and provision

18. Developing alternative models of service to reduce the prescribing of drugs for depression and anxiety

19. Continuing to develop approaches to improving access to psychological therapies across services outside of specialist mental health services

20. Ensuring that people are able to transition between services well including child to adults services and acute to community and recovery/aftercare services

21. Continue to provide leadership and programmes to tackle stigma and discrimination

22. Continue to increase awareness of mental health, wellbeing, mental illness and available services across the borough

23. Develop a clear point of entry to the range of mental health services and share information on how people can access different services

Section 4: Performance, Challenges and Risks

In addition to undertaking an assessment of the Mental Health and Wellbeing Needs of the borough's population, this strategy has been informed by a review of performance information, and the local and national strategic landscape to assess the challenges and risks which we will need to consider in order to deliver our strategic aims. With regards to key challenges and risks for the delivery of this strategy this review has highlighted the following key areas for consideration:

4.1 Collaborative working

Successful delivery of this strategy is dependent on ensuring that organisations work together in order to collaboratively deliver required outcomes. We will need to ensure that our commissioning, contract and performance monitoring processes support and enable this, and embed robust governance processes in order to provide assurances of delivery.

4.2 Payment by Results

The CCG currently commissions the majority of Mental Health services using block contracting arrangements. RMBC also utilises these arrangements for a number of service areas. With the increasing determination of the NHS to gain maximum value for money, the existing system of Block Contracts will be updated to a new system called Payment by Results (PbR).

The main advantage of PbR is that commissioners will be able to have greater insight and more control over how the level of funding provided is matched to the level of service that is delivered. A concern however is that when a new local tariff of payments for services is agreed, this will place financial strain on either the commissioner, the provider, or indeed both. To minimise risk to patient services, we are committed to working in an open and transparent manner. This is supported by the Greater Manchester Mental Health PbR Steering Group.

The complexity of mental health service delivery results in similar financial complexity. This has further increased with the introduction of 'any qualified provider', extension of Patient Choice to Mental Health service users, and with the take up of personalised budgets by those with psychological infirmity.
The future impact of the implementation of Payment by Results will need to be considered within our plans to deliver services through provider partnership models. Delivery of local integrated services will be reliant on understanding the resources available to deliver. We will need to ensure that our partnership model is established within robust contractual and governance arrangements which mitigate the impact of a tariff based system.

4.3 Unemployment

There are very large (and growing) numbers of people with a mental illness who, despite wanting to work, find themselves unable to do so. Health related issues are amongst the greatest barriers to work in Greater Manchester. The Government acknowledges the cost to individuals and the economy and is investing growth money in Greater Manchester to test out new ways of working to support individuals with a mental illness to return to work.

We recognise that work is good for health, and that employment is an integral part of recovery from mental ill health. Only 8% of people with schizophrenia or psychosis are in employment.[8] 48% of all ESA/IB claimants in Rochdale are claiming for a mental or behavioural disorder. We will work to address this inequality, recognising the positive impact which work has on wellbeing. Supporting those with a mental illness to return to work, not only reaps benefits for the individual, it also supports the local economy and reduces the economic impact of mental ill health.

We are engaged in Greater Manchester wide plans to address the level of unemployment amongst those with a mental illness, the CCG's Social Investment Fund has brought jobs to the borough, and we will continue to work with our service providers to support those in services to return to work, whilst also continuing to engage in workplace wellbeing schemes.

4.3a The Welfare Reform Act

The Welfare Reform Act (2012) is considered to be the biggest change to the welfare system for 60 years, with this act the Coalition Government aimed to reform the benefit system to make it "fairer, more affordable and better able to tackle poverty, worklessness and welfare dependency".

The act introduces Universal credit, to replace a range benefits and tax credits, as well as for a new benefit, personal independence payment, which will replace the existing disability living allowance for those of working age.

People with a Mental Illness are often amongst the most vulnerable members of our society. The impact of the implementation of the Welfare Reform Act on the wellbeing of this vulnerable group will need to be considered and our strategy will need to ensure that we support our local population in adapting to these changes, mitigating the risk of a negative impact.

4.4 Personal Health Budgets

Personal health budgets are currently provided through social care and are slowly being introduced into health services, clearly these budgets can provide opportunities to improve individual engagement with services they can however also present a range of challenges including a fragmentation in the delivery of services.

4.5 Financial challenges

Mental health services will need to respond to financial challenges over the next three years, the public sector financial constraints means that we will need to make significant efficiencies over the course of the next 3 years.

The document 'A Manifesto for Better Mental Health – The Road to 2020' advised that Mental Health accounts for 24% of the healthcare burden, but that on average receives 11% of healthcare funding. Spend for HMR CCG is approximately 10.7% of the total CCG Spend.

The NHS Atlas of Variation (2010) identified Mental Health Expenditure by PCT at 2008/09. For Heywood, Middleton and Rochdale this was identified as £189,061per 1000 of population, placing HMR at the lower end of the third quintile in England.[11]

Pennine Care NHS Foundation Trust provides the majority of local secondary mental health services for Rochdale Borough. The Trust undertook a stocktake in 2011/12 which compared how much each commissioner paid compared to the amount they should have paid by service activity. This report indicated that HMR CCG's contract value was roughly commensurate to the actual cost of service activity delivered, indicated that local funding in secondary care services is sufficient to meet the needs of the local population. This also indicated that the implementation of Payment by Results should not lead to a local financial deficit.

4.6 Patient Choice

As of April 2014 the legal right to choice in Mental Health services has been extended to allow a patient to choose for their 1st Outpatient appointment both:

1. Any clinically appropriate provider that has a contract with any NHS commissioner and has a team in place that provides the care and treatment required.
2. Which team within that organisation provides the care and treatment

[11] NHS Atlas of Variation, Mental Health Expenditure per 1,000 population weighted by age, sex and need, by PCT, 2008/09
http://www.sepho.org.uk/extras/maps/NHSatlas/atlas.html

This choice can be exercised

- At a point where the patient is able to make a meaningful and informed choice
- For an elective referral
- For any mental health condition regardless of care setting (including an unknown mental health condition)

Our strategy must consider the impact of this right to ensure that our future service model is fit for purpose.

Guidance issued by NHS England has advised that the implementation of Patient Choice in Mental Health is reliant on ensuring that money follows the patient to incentivise providers to improve their services to meet patient needs. Work is continuing to develop and implement nationally consistent payment approaches for MH services. HMRCCG's current contracting mechanisms do not support the money following the patient. The financial impact of Choice will need to be considered in the delivery of our strategy to ensure that HMR CCG and RMBC make the best use of their collective resources. In ensuring that our local services are of optimum quality this will mitigate the impact of Patient Choice by ensuring that the majority of service users elect to access care within the borough, and reducing the financial impact upon commissioners.

4.7 Comorbidities and Mental Health

The Government's Mental Health Strategy, 'No Health Without Mental Health' emphasises the importance of improved services at the interface between mental and physical health where comorbidities present a broad spread of specific problems. The financial impact of comorbidity can be significant. It is estimated that more than 4 million people in England who have a long-term physical health condition, will have a Mental Health condition. This is associated with significantly poorer health outcomes and reduced quality of life. In terms of NHS spending at least £1 in every £8 spent on long-term conditions is linked to poor mental health and wellbeing. This equates to between £8 billion and £13 billion annually in England.[12]

The health of people in Rochdale is generally worse than the England average. Deprivation is higher than average and about 26.7% (11,900) children live in poverty. Life expectancy for both men and women is lower than the England average. Life expectancy is 9.7 years lower for men and 7.9 years lower for women in the most deprived areas of Rochdale than in the least deprived areas.[13]

The incidence of patients with multiple LTC also increases with age and in Rochdale the expected increase in prevalence of people with long term conditions is 40%. (JSNA 2012)

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[12]The Kings Fund, Long term Conditions and Mental Health (2012)

[13] Public Health England, Public Health Observatories Health Profiles (August 2014)

In addressing the mental health and wellbeing needs of our local population all health and social care service delivery models will be required to recognise the interconnection between physical and mental health, and that mental ill health can be a cause and effect of physical ill health.

We will work to integrate physical and mental health commissioning to ensure that patients being treated for conditions such as stroke, cardiology and cancer, have their psychological needs met as part of their care delivery, recognising that to treat one's physical and mental health in isolation does not meet the needs of the patient as an individual.

We will work with our providers to ensure that our acute service pathways are designed to meet physical and mental health needs, in an integrated person centred approach.

We also recognise that long term physical health conditions can result in patients experiencing anxiety, which may lead to patients frequently accessing Emergency Departments. We will develop strategies to support these patients, in order to reduce frequency of attendance, and provide support for management of anxiety, particularly where this does not meet the threshold for mental health services.

Liaison psychiatry will be implemented at our acute hospital sites, but we will also need to ensure that where patients do not have a defined mental illness, anxiety management support is offered.

4.7a Physical health monitoring for people with a mental illness

The 'parity of esteem' vision advocates that mental health issues should be treated on an equal footing with physical health issues. According to The National Audit of Schizophrenia (2012) people affected by severe mental illness can die up to 20 years younger than everyone else because of poor physical health.

The audit made the following recommendations:

- The Royal College of General Practitioners (RCGP), the Royal College of Nursing (RCN) and the Royal College of Psychiatrists (RCPsych) should drive forward the recently agreed Integrated Physical Health Pathway, developed by Rethink Mental Illness, for the physical health care of people with schizophrenia. Practitioners should collaborate to develop and implement this or similar local protocols for the monitoring of physical health, communication of results and responsibility for intervention.

- The RCGP, the RCN, the Royal College of Physicians and the RCPsych should promote the collaboratively developed Positive Cardiometabolic Health resource (CMH-resource) for the monitoring and management of cardiometabolic problems associated with the use of antipsychotic medications.

In delivering the parity of esteem vision we will work to integrate mental health services, with physical health services, whilst also addressing the physical health inequalities experienced by those with a mental health illness.

4.8 Information Technology systems

Successful delivery of a cohesive service model will be reliant on ensuring that the Information Technology utilised by our providers, supports joint working. This strategy will need to address the situation whereby our health and social care staff are required to update multiple systems with the same information to ensure the best use of our staff time and resources.

We will require our providers to accept electronic referrals from GP systems using agreed proforma to support improved referral quality and support acceptance. We will require our service providers to implement the Choose and Book System in line with the Choice in Mental Health agenda. Providers will be required to utilise Electronic Clinical Correspondence.

We will require all parties, including GP practices, primary and secondary care providers (including RMBC) to move towards the development of an integrated care record. Commissioners will work with providers in order to ensure that this is achieved.

Commissioners will work with providers to explore innovative service delivery models, making use of the advancements in information technology systems available.

4.9 Increasing demand on Mental Health Services

The Mental Health and Wellbeing Needs Assessment highlighted that the overall wellbeing score for Rochdale fell between 2009 and 2013. This strategy is concerned with improving the mental wellbeing of the population of the borough. The current economic climate has evidentially impacted upon the wellbeing of the local population and this impact is likely to continue to be felt within the coming years. Socio-economic factors are amongst the wider determinants of mental health and mental illness, and our strategy will need to ensure that it is capable of addressing the ongoing impact of the national economic decline, and the austerity measures implemented by the Coalition government, within a diminishing pool of public sector resources.

4.10 Understanding our collective resources and performance

In delivering this strategy we will need to undertake a review of our collective spend, along with mapping all services and pathways. Work has begun in these areas including a Programme Budgeting exercise with our main provider of Mental Health Services, Pennine Care NHS Foundation Trust, and a benchmarking exercise of all individual Mental Health Placements.

4.11 Hospital Admissions

Data provide by Pennine Care NHS Foundation trust, indicates that for 2013/14 Heywood, Middleton and Rochdale CCG processed 525 Mental Health admissions. This is significantly above the Pennine Care footprint benchmark average at 439. Further information provided in this report is as follows:[14]

ADMISSIONS LESS THAN 7 DAYS	ADMISSIONS LESS THAN 2 DAYS	AVERAGE LENGTH OF STAY	AVERAGE LENGTH OF STAY BETWEEN 3 AND 90 DAYS
150	**60**	**32**	**25**

This represents a significant challenge for the borough. We want to ensure that our services support people to receive the care they need in the commitment and prevent crisis points and readmissions where possible. The CCG Strategic Commissioning Plan is built upon 7 ambitions. One of these areas is a commitment to reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital. The CCG will reduce its emergency admissions by 5% per year. This equates to a 25% reduction from our current position, against the composite indicator, over 5 years. This equates to moving from 3459.5 to 2594.6. The Mental Health and Wellbeing Commissioning Strategy will support delivery of this ambition by improving access into services, addressing revolving door readmissions and provide Crisis Care which treats a Mental Health Crisis with the same urgency as a physical health emergency.

In addition to considering admissions to secondary mental health trusts for the borough, we must also address the volume of Mental Health attributable admissions to A&E, Emergency Departments and Acute Hospitals. Many people attend emergency departments in acute mental distress, or with mental health problems including self-injurious behaviours, psychotic illnesses, depression and substance misuse. Many patients are distressed as a consequence of the illness or injury that has brought them to hospital. Among people with a physical illness or injury serious enough to require admission, a high proportion of them have a mental health problem, frequently masked or overlooked. National evidence suggests this is 60% of acute hospital inpatients.[8] Further exploration of the level of acute admissions in Heywood, Middleton and Rochdale attributable to Mental Health and Wellbeing, will need to be undertaken in order to understand the level of impact for the borough.

[14] Pennine Care NHS Foundation Trust, Report AD0963 (21/5/2014)

4.12 Psychiatric Intensive Care (PICU) and Out of area placements

For 2013/14 HMR CCG commissioned 1598 PICU bed days, from NHS and private providers. This is significantly above the activity levels of CCGs in the Pennine Care footprint and is currently under review. In addition our local provider does not offer female psychiatric intensive care. A collaborative piece of work is currently underway between the Pennine Care Footprint CCGs to assess local need for Female PICU and establish a potential model to provide this service.

We also commission out of area mental health placements from a number of private providers, both as individual organisations and through a collaborative commissioning approach. We are currently undertaking a benchmarking exercise with neighbouring CCGs to assess our comparative usage, and are developing joint quality assurance processes for collaboratively commissioned placements, to ensure that care is of the highest quality and represents value for money. We will continue to monitor activity, performance and quality, and where possible will seek to provide care closer to home.

4.13 Carers

Carers provide an important role in supporting vulnerable people with both health and social care needs across the borough. It is recognised nationally that Carers save the government, and therefore the council and the NHS, a substantial amount of money through caring for their ill and disabled relatives. The economic value of the contribution made by carers in the UK is estimated to be £119 billion per year which is equivalent to £2.3 billion per week. Based on these figures, in 2007 and 2011, respectively carers in Rochdale provided care valued at £333.9million and £426.7 million per year.

Caring can be physically and mentally demanding. Carers providing substantial care can suffer physical strain due to the associated tasks, 24 hour on call, lack of sleep or disturbed sleep as well as mental health problems including depression.

Carers are twice as likely to suffer mental ill health if they do not get a break from caring. 36% of Carers providing substantial amounts of care and who did not get a break suffered ill-health compared to 17% of those who accessed a break. The same study found a third of carers (35%) without good social support suffered ill-health compared to those with good support (15%)[15]

In addition, the Joint Carers Strategy (2013-16) identified that 24.6% of the ‘cared for’ population of Rochdale have a Mental Health condition.

[15] In Poor Health - the impact of caring on health, Carers UK 2004

Delivery of this strategy will require effective identification of carers within our borough. This will enable us to provide targeted wellbeing support and health screening to carers. We will aim to empower carers to continue to care.

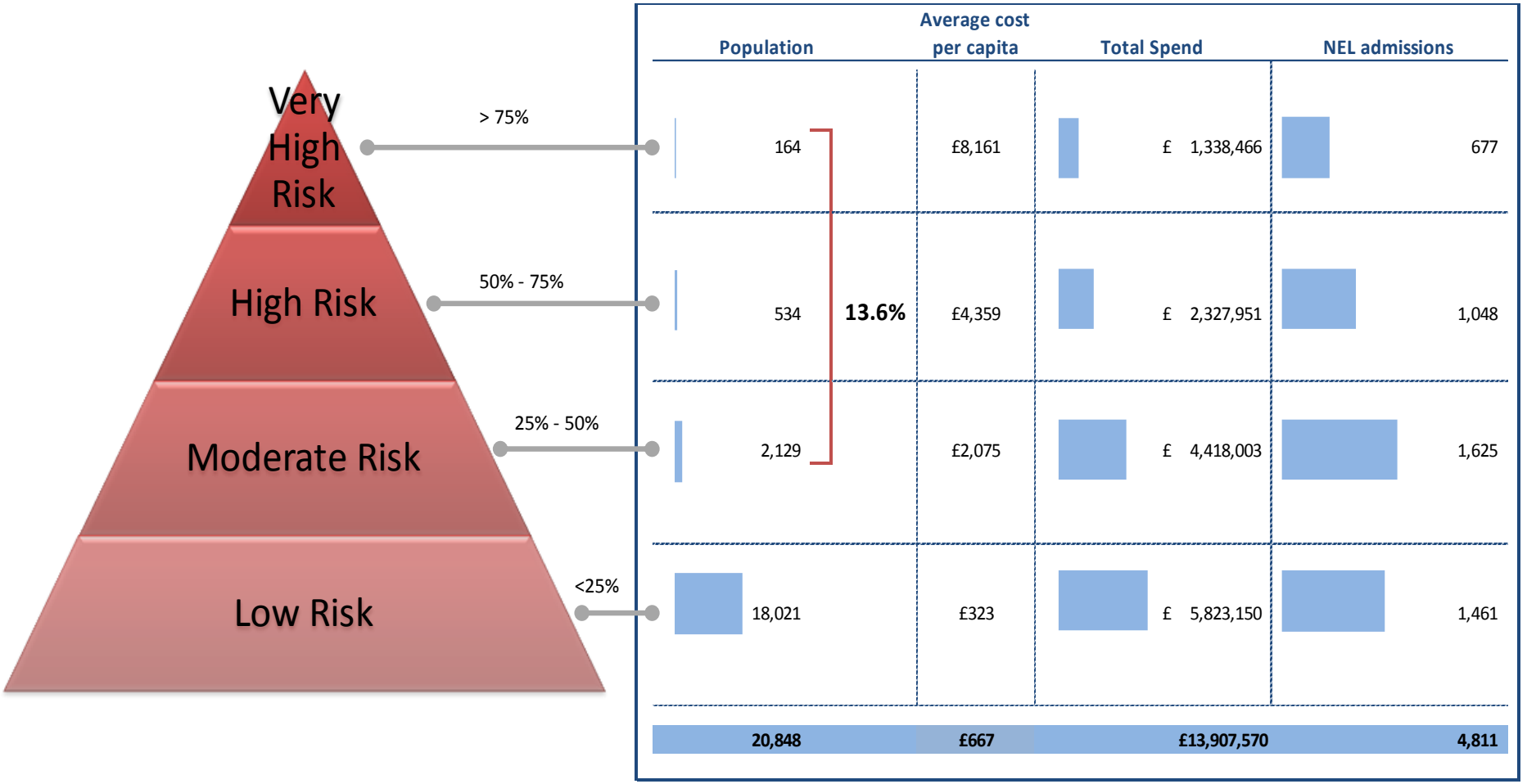
4.14 Risk Stratification

The development of this strategy has been further supported by risk stratification based on the Combined Predictive Model which uses information about admissions, outpatient attendances and A&E attendances to calculate the risk of future admissions for Serious and Enduring Mental Illness and Depression.

We have undertaken a risk stratification to inform the impact for our risk stratified approach to targeting care.

The diagram below provides a breakdown of the population in the risk group for Mental Health, the total spend these attribute to and the number of non-elective admissions associated with the cohort of population. All patients included in the report are identified as being on the depression register within HMR. The 'Risk Stratification' scoring for each patient is based on how likely they are to end up in a hospital bed as an emergency admission. The 'Average cost per capita' within the report is the average cost per patient across A&E, Inpatient and Outpatient within the twelve month period, July 13 – June 14.

Figure 1: Depression Register Emergency Admission Risk Stratification (Heywood Middleton & Rochdale July 2013-June-2014



4.15 Quality

4.15a Patient Safety incidents

The National Patient Safety Agency (NPSA) defines a patient safety incident as any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare, and states that trusts that report incidents regularly suggest a stronger organisational culture of safety. They take all incidents seriously and link reporting with learning.

NPSA Data for September 2013-March 2014 identified Pennine Care NHS Foundation Trust, our main mental health services provider, as being in the lowest 25% of incident reporters for similar sized Mental Health providers. This data also showed a 4% reduction in reporting against the period April- September 2013. We will work with PCFT to identify the reasons for this apparent reduction in reporting. NPSA data for the same period has also shown an increase in Serious Incidents. We will also work with our provider to explore this and better understand the reason for this increase compared to other benchmarks.

We will work in partnership with NHS England and other CCGs to standardise incident and reporting policies and guidance to enable better benchmarking between providers.

We will expect providers to demonstrate effective learning from incidents and serious incidents, and to demonstrate that this is being embedded within the organisation.

We will work with providers to develop frameworks for identifying lessons learned from Serious Incidents to ensure that organisations appropriately manage these incidents, and ensure that change methodology is embedded to prevent recurrence of the same or similar incidents.

The impact and effectiveness of this approach will be monitored through HMR CCG's governance processes. The mechanisms for monitoring adverse incidents within provider organisations are monthly commissioner led quality monitoring meetings, monthly Serious Untoward Incident review panel meetings and scrutiny of published National Reporting & Learning System (NRLS reports). Incident monitoring is also supported by other mechanisms e.g. GP quality feedback review, complaints/PALS data, CQC reports & GM Quality Surveillance Group. Within HMR CCG, the Quality & Safety Committee is responsible for ensuring that commissioned services are safe and provide high quality care. This is a sub-committee of the HMR CCG Governing Body.

(Please see section 6.4 for further details regarding Quality and Efficacy).

4.16 Mental Health Emergency Care

The Mental Health Crisis Care Concordat requires that agencies work together to deliver a high quality response when people with mental health needs require help urgently. The aims of the concordat are centred on:

- Access to support before crisis point
- Urgent and emergency access to crisis point
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises.

The Concordat establishes a national agreement of principles, and includes the ambition that each local area will commit to agreeing and delivering their own Mental Health Crisis Declaration.

Caring for those with mental health problems is one of the key presenting challenges for all NHS services, both currently and for future generations. In health economic terms the provision of care to those experiencing mental distress is growing and will become of even greater financial significance with an increasingly aging population. Staff witness mental distress and mental illness daily, in people of all ages and in many different circumstances, yet in our society they command less priority than those with physical problems[16].

Many people attend emergency departments in acute mental distress, or with other mental health problems including self-injurious behaviours, psychotic illnesses, depression and substance misuse. Many patients are distressed as a consequence of the illness or injury that has brought them to hospital. Among people with a physical illness or injury serious enough to require admission, a high proportion of them have a mental health problem, frequently masked or overlooked. National evidence suggests this is 60% of acute hospital inpatients.

Mental Health Crisis management presents a challenge for a wide number of agencies. 35-40% of all Mental Health admissions are not known to services. Locally we are working to develop a Crisis Care Concordat action plan. Nationally pilot schemes have been funded to trial 'street triage – services in which mental health professionals support and advise police officers in their work protecting and helping people in mental health crisis. The 'Achieving Better Access to Mental Health Services by 2020' policy, states a commitment to work with NHS England how to ensure that street triage is commissioned wherever it is needed, and how to link most effectively with liaison and diversion services.

Locally, a Street Triage Telephone Pilot will be delivered in Rochdale borough between November and March 2015. This has been developed in collaboration between HMR CCG, GMP Rochdale Division, NWAS and Pennine Care NHS Foundation Trust. The Street Triage role enhances the current RAID (Rapid Access

[16] Managing Urgent Mental Health Needs in the Acute Trust, A Guide by practitioners, for managers and commissioners in England and Wales, Academy of Medical Royal Colleges, 2008

Interface and Assessment) Service and will allow police officers from both Rochdale and Bury GMP divisions, and NWAS paramedics from the same geographical area, to be able to contact a qualified Mental Health Practitioner, by telephone, at any time within the 24 hour cycle for help, advice and signposting. This service will be accessed by police officers and paramedics attending mental health emergency episodes. The aim is, where possible, to help police officers and paramedics make appropriate decisions based on a clear understanding of the background to these situations. This should lead to people receiving appropriate care more quickly, leading to better outcomes for service users and a reduction in the use of section 136. This pilot will be subject to a robust evaluation, which will advise our future commissioning intentions.

In their 2015 election manifesto 'Making parity a reality' the RCPsych called on the next Government to ensure that:

Every acute hospital should have a liaison psychiatry service which is available seven days a week, for at least 12 hours per day. This service should be available to patients across all ages. Emergency referrals should be seen within one hour, and urgent referrals within five working hours.[17]

We will continue to deliver emergency mental health response for those in need and to work with public sector organisations to improve the borough's crisis response and outcomes for service users. We will also continue to deliver psychiatry liaison services to provide mental health service delivery within acute hospital settings.

Section 5: Key achievements from the Rochdale Borough Mental Health and Wellbeing Commissioning Strategy 2010-13

In developing this strategy we felt that in addition to identifying the challenges of the future, it was important to review the achievements that have been made in local service provision. A review of the Rochdale Borough Mental Health and Wellbeing Commissioning Strategy 2010-13 was undertaken in 2013. Some of the key achievements from the last strategy are:

5.5a Mental Health awareness and training

- Mental health awareness training for front line, non-mental health staff, has been rolled-out by the Five Ways to wellbeing programme.
- Training and guidance for workplace wellbeing has been developed and implemented, along with the provision of targeted support for those with vulnerable employment status.

[17] *RCPsych,* Making Parity a Reality: 6 asks for the next Government to improve the nation's mental health' *(September 2014)*

- Delivery of training for staff in mental health services to identify and deal with abuse and bullying experienced by the client group.
- Staff have been trained to support emotional and social resilience of children, and to promote good parenting skills.
- The Five Ways to Wellbeing Programme has been rolled out to increase population wellbeing and support a reduction in stigma and discrimination.

5.5b Lifestyles and community support

- Targeted lifestyle programmes for vulnerable groups, including the elderly, those at risk of mental illness, and hard to reach communities have been developed and implemented, and the opportunities for participation have been increased.
- A supportive community infrastructure, which enables meaningful participation and targets hard to reach groups, has been developed. This has been enhanced by the development of the HMR CCG Social Investment Fund.

5.5c Commissioning

- Personal Health Budgets have begun to be implemented for Adult Social Care in mental health services, and the numbers with personal budgets is increasing.
- Development of joint commissioning service specification for CAMHS Tier 3 Services
- Implementation of collaborative commissioning for individual Mental Health Placements

5.5d Prevention and recovery

- A range of early interventions to prevent people developing significant substance misuse problems has been developed, including Earl Break, a substance misuse service for young people.
- Front line service awareness of substance misuse has been improved and screening and brief intervention in primary care has been increased.
- Adoption of a recovery approach in substance misuse services has been achieved, and 15.8% of those exiting services do so drug free, compared to a national average of 14.8%.
- A local Suicide Prevention strategy has been developed, and there has been a reduction in the local suicide rate, in line with national expectations.
- Early Help offer, direct training for families and children about child sexual exploitation

5.5e Carers

- Carer support groups have been increased, promotional work has been undertaken with primary care to improve identification of carers, and services are supporting an increased number of carers with mental health conditions.

5.5f Secondary services

- A Single Point of entry for access into adult Mental Health Services has been developed, and a wellbeing directory of services has been published.
- The Mentally Disordered Offenders service has been redesigned in line with the recommendations of the Bradley report.
- Dementia Locality Care Centres have been developed to ensure that older people have equity of access to good quality primary and secondary mental health services.

Section 6: Strategic Aims and Objectives

This strategy outlines the ambitions for mental health care shared by Heywood, Middleton and Rochdale CCG and Rochdale Borough Council, and the outcomes which we will jointly deliver during the period November 2014 – March 2017.

As noted above our vision for the strategy is:

To improve the mental wellbeing of the population of the borough, preventing mental ill health where possible and promoting the recovery and wellbeing of those with mental illness.

6.1 Aims

This will be achieved through the following 6 strategic aims which are based on those in 'No Health Without Mental Health':

1. More People will have good Mental Health

2. More people with Mental Health problems will recover

3. People with mental health problems will have good physical health, and people with physical health problems will have good mental health

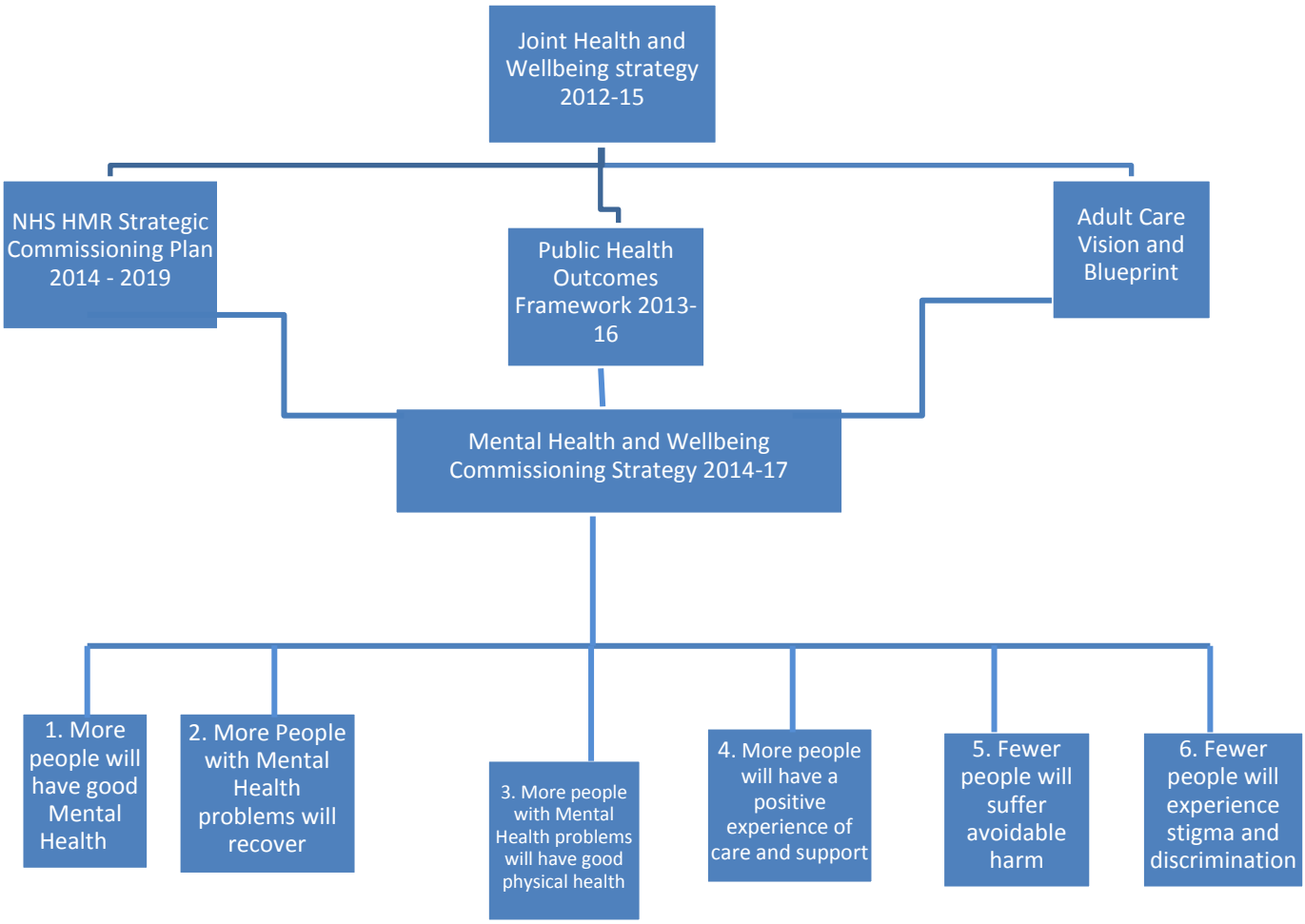
4. More people will have a positive experience of care and support

5. Fewer people will suffer avoidable harm

6. Fewer people will experience stigma and discrimination

6.2 Outcomes framework

The Outcomes to be delivered by the Mental Health and Wellbeing Strategy have been developed from the framework below:



6.3 Objectives

Through our work with Stakeholders we have developed the following objectives to achieve our Strategic aims:

Aim
1. More people will have good mental health
Objectives
• We will take health and mental health into schools and colleges through education and awareness-raising. • We will develop an information, advice and access service to increase the population's mental health awareness and ability to self-manage conditions. This service will be the first point of contact for people with mental health concerns, providing clinical triage and acting as a navigator around the whole system. • We will ensure that our mental health services offer equity of access for the borough's population, and also ensure that patients with a Learning Disability, who experience mental illness, are able to access the care and support that they need. • We will develop community resilience including community assets to provide locally based prevention and recovery utilising people with lived experience to act as Mental Health champions and provide peer support. • We will enhance primary care understanding of mental health issues and access pathways to promote alternatives to prescribing. • We will implement the Five Ways to Wellbeing Programme for Adults, Children and Young People and workplaces. • We will facilitate a Mental Health Champion programme within the public and voluntary sectors. • We will provide targeted wellbeing support to carers within our borough. • We will ensure early help interventions and resources are available to support children, young people and families
Aim
2. More people with mental health problems will recover
Objectives
• We will develop a recovery model of service delivery promoting a recovery ethos amongst the workforce. • We shall improve entry and re-entry into the secondary care services with particular attention to points of crisis to remove "revolving door" of service access and reduce emergency hospital admissions. • We will co-produce the service delivery model based on pathways designed around service users and families using the working together for change approach. • We will work with our providers to promote employment opportunities for service users, recognising the positive impact of work on mental wellbeing.
Aim

3. People with mental health problems will have good physical health, and people with physical health problems will have good mental health

Objectives

- We will promote awareness of parity of esteem issues across all health care staff in all sectors.
- We will undertake a targeted physical health screening programme with patients with a severe and enduring mental illness.
- We will evaluate the impact of primary care psychological therapies on improving the mental health of people with long term conditions.
- We will design our acute health pathways to include mental health support and work with mental health providers to ensure that the physical health needs of service users are addressed

Aim

4. People will have a positive experience of care and support

Objectives

- We will develop a co-ordinated multi-agency approach to service delivery with a clear holistic person-centred focus on early interventions, prevention and recovery.
- We will implement an integrated health and social care quality assurance process
- We will ensure that a mental health crisis is treated with the same urgency as a physical health emergency so that vulnerable people get access to the right care and support at a time when they most need it.
- We will implement a system of managed and seamless transition of care, with an effective step-up and step-down pathway.
- We will work strategically with local partner agencies, including housing and police to implement a system which supports those with a Mental Illness to have their needs met by public services with whom they come into contact
- We will continue to monitor and review out of area mental health placements to ensure that care is of the highest quality, value for money, and where possible provided closer to home

Aim

5. Fewer people will experience avoidable harm

Objectives

- We will aim to reduce the number of suicides within the borough through suicide awareness campaigns and training.
- We will ensure that our services safeguard vulnerable individuals.
- We will work with our partner agencies to implement an out of hours working model which supports front line staff in dealing with mental health problems.
- We will review our service delivery model for crisis services.
- We will ensure services support the needs of survivors of Child Sexual Exploitation and undertake targeted work within communities to reduce

criminal activity • We will aim to minimise the impact that parental mental health issues have on children's and young people's outcomes
Aim
6. Fewer people will experience stigma and discrimination
Objectives
• We will reduce stigma and social exclusion of MH by targeted awareness training.

6.4 Enablers

Delivery of our objectives will be reliant on the following enablers:

Enabler	Objectives
Quality and efficacy	Quality of care is at the heart of every commissioning decision and is inherent throughout this strategy. Ensuring the delivery of safe, clinically effective high quality care is a key priority for Heywood, Middleton & Rochdale CCG and Rochdale Metropolitan Borough Council. We want service users to be cared for; • **in the right way** (developing and maintaining a workforce that is highly skilled, motivated and competent to deliver the care required) • **at the right time** (accessible services available 7 days a week providing treatment when the patient needs them) • **in the right place** (provision of treatment/services locally wherever possible and in specialist centres where necessary). • **with the right outcome** (improving health, reducing variation in clinical outcomes, reduction in potential years lost to conditions amendable to treatment) We will do this by combining the RMBC and HMR CCG Quality Assurance processes to deliver the following: 1. Developing our staff to ensure they have the skills to commission services with effective systems for managing and

	improving quality and safety with a focus on continuous improvement 2. Embedding quality standards & key performance indicators into all of our contracts with providers of mental health services 3. Actively seeking the views of patients, carers, member Practices and the wider community about their experience of NHS services and how they can be improved 4. Capturing patient & public experience data from complaints and concerns and using their experience to drive service improvements 5. Developing effective systems for monitoring the quality of care to include process for capturing and triangulating information from a range of sources 6. Encouraging the reporting of errors and "near misses" and using them as a basis of learning and continuous improvement 7. Developing an on-going programme of safety walk-rounds at provider organisations 8. Promoting a culture of continuous improvement in provider organisations through contracting and monitoring arrangements e.g. requirement to comply with NICE Guidance 9. Working closely with other organisations – including the Care Quality Commission and Health Watch to share information about the quality and safety of health services We will measure Quality of Mental Health services in terms of; • **Patient outcomes** (the extent to which the services improve a patient's situation or condition) • **Patient experience** (feedback from patients about how they were treated by the services, and how satisfied they were with their experience of NHS healthcare.) • **Patient Safety** (incidence of adverse incidents & errors resulting in harm to patients)[18]

[18] Further details of key documents regarding Quality and Safety are available at Appendix 3

Best use of resources	We as commissioners recognise that the traditional "top-down" model of service commissioning and provision is outdated and no longer fit for purpose at a time when resources are diminishing across all Public Service agencies. When resources have been cut across every sector, it is essential that the remaining resources are shared in order to make best use of them. To support delivery of this strategy we will undertake a joint review of our collective commissioning arrangements to ensure that what we commission meets the needs of the population and makes the best use of our resources. The CCG and RMBC will also undertake a review of joint staffing arrangements, including social worker and health practitioner posts as part of the Mental Health Strategy in order to resolve any outstanding issues with legacy funding and to ensure that the staffing and recharge arrangements meet the requirements of both organisations and are of optimum benefit in terms of service delivery.
Information sharing	System Intelligence, is not discrete or standalone but will permeate and suffuse the whole of the system. Information developments will be required in the wider system to ensure seamless flow of information into, throughout and out of the care delivery by the Provider(s) to ensure services are able to access the right information at the right time, to meet the needs of service users, with a partnership working model.
Integrated commissioning	The CCG and RMBC already have some areas of joint commissioning which we are working to develop into an integrated commissioning model. This includes the care and support of people with the most complex needs. The commissioning of mental health services is a key part of this with joint commissioning of most elements of prevention and wellbeing level mental health services. HMR CCG and RMBC public health and health and social care commissioners, will review the whole mental health pathway from prevention through to recovery, across health and social care with a view to integrating commissioning and potential pooling of budgets. This will be achieved in close partnership with all providers and we anticipate a shift in investment from acute crisis care to extended prevention and recovery.

	Our intention is to at least retain the current resource in mental health services, but through integrated commissioning we aim to improve service user outcomes significantly within available funding. During 2014/15, a further investment of £500k has been added to mental health commissioning schemes to address parity of esteem.
Safeguarding	Learning lessons from local safeguarding serious case reviews have identified the need to ensure a multi-agency approach is adopted if there are to be positive health outcomes for vulnerable people. Examples of development of good social and health pathways have been with respect to the management of Child Sexual Exploitation as a Greater Manchester priority, domestic abuse and its impact on the long term mental and physical health of both vulnerable children and adults. The impact of childhood neglect on the health of vulnerable adults has also been identified. The mental capacity of vulnerable adults to consent to health interventions and to understand how to take measures to prevent ill health is a key consideration in planning of health care for the local population who may be elderly, suffer from chronic ill health or who may have a learning disability.
Competent and capable workforce	New models and approaches to Mental Health and Wellbeing services are required to meet the workforce challenge and the new demands of integrated system. We will explore new organisational models and partnerships to strengthen integration between health and social care. Delivery of our aims will also be reliant on ensuring that our workforce are sufficiently skilled and aware of Mental Health issues, in order to meet the challenges presented by the vision in Parity of Esteem. Recognising the interconnection between physical and mental health, and that mental ill health can be a cause and effect of physical ill health ,the system which we implement will need to be easily navigable in order to support all front line agencies in accessing the services which meet the needs of the service users they support.
Communication	This strategy aims to ensure that our Mental Health and Wellbeing services offer holistic care which wraps around the service users. Delivery of this will be reliant of partnership working between all stakeholders in Mental Health and Wellbeing services. Clear and effective communication will be pivotal to the successful delivery of this model. We also aim to develop a system which views service users as

	an equal partner in service delivery.
Community assets and social capital	We understand that one of the greatest resources we have is the knowledge, experience and creativity of our stakeholders and partners – this includes service users, carers, service providers from every sector, faith and community leaders and other community groups. We recognise that delivery of this strategy will be supported by strengthening community resilience and building on the rich legacy of cooperation within the borough, using our community assets wisely to help improve the health and wellbeing outcomes of all our communities. For the past two financial years HMRCCG has invested £2.5m in a Social Investment Fund. The SIF is a joint commissioning programme with strategic intent aligned between the NHS and RMBC. Non-recurring grants are available for organisations providing locally based services to improve health and wellbeing in their communities. Grants are available for both capital and revenue costs to support projects that can demonstrate health and community benefits which enhance the aspirations of HMRCCG and RMBC, strengthen community resilience and build social capital. Social Capital can be described as "anything that generates or enables individual or collective action, generated by networks of relationships, reciprocity, trust, localised and acknowledged social norms, in other words it is propelled by networks of commonality with one general goal in mind." We will continue to develop our networks and relationships with the wider voluntary, charities and community groups to realise opportunities for service delivery and diversity in supply across the borough's service spectrum.
Equality and Diversity	Effective delivery of this strategy will require the promotion of equality for all and valuing diversity within our communities. As part of the implementation process for this strategy an Equality Assessment will be undertaken to ensure that delivery of this strategy pays due regard to our legal duty to embed equality at strategic and operational levels.

Section 7: The Case for Change

Collectively, the CCG, Adult Care and Public Health spend approximately £35.8m on mental health service provision the bulk of which is spent in secondary care services.

Based on the performance information and the areas of need identified from the needs assessment the work to date suggests that a whole system approach to commissioning mental health services should be developed based on outcome based commissioning to enable the shift of resources from the acute end to prevention and the adoption of a recovery ethos to service delivery within mental health services.

A programme of transformational change needs to be developed to deliver this vision including:

- Integrated commissioning between the CCG, Adult Care, Children's services and Public Health with a shared vision and strong leadership
- Establishing clear outcomes with services users, carers and key stakeholders as equal partners with commissioners utilising the Working Together for Change approach
- Further analysis of data to develop metrics and cost benefit analysis to support the reallocation of resources from acute services to prevention and recovery.
- Service Redesign of adult pathways
- Development of an innovative procurement vehicle that supports a partnership and co-production approach to service delivery
- Further work to identify commissioning priorities for children and young people to support a lifetime approach to commissioning for mental health service delivery
- Developing a Dementia Action Alliance to support the commissioning priorities for older people

An integrated commissioning approach supports the Greater Manchester Combined Authority Public Service Reform agenda programme which is about a range of local services working together to provide public services in new ways, delivering lasting change, improved services and more efficient and effective use of resources. The reform programme is focused on ensuring that as many people as possible are able to benefit from the opportunities of economic growth, and reducing levels of dependency on public services. One of the main work-streams in the programme is the integration of health and social care services. The goal of reform is to develop integrated care services which contribute to greater out of hospital care. The vision is that effective prevention and management of long-term conditions will reduce demand on services.

An integrated approach to commissioning and redesigning mental health services supports this goal.

Section 8: Commissioning Priorities

The initial priorities for the integrated commissioning change programme based on the information gathered for the development of the strategy are detailed below.

8.1 Enhanced Prevention and Early Intervention Services

There is a need to raise the awareness of mental health across all agencies so that signs and symptoms can be identified at an early stage and appropriate support and signposting to services is provided. The provision of an effective information and advice service at the front door to support people and their carers to understand mental health conditions and access self-help would also strengthen prevention services as would the further development of community resilience and social capital.

50% of all lifelong mental illness will be experienced by the age of 14.Our vision for mental health services cannot be delivered without earlier and stronger investment in children and young people. The NHS Five Year Forward View (2014) indicates that there will be greater investment in early intervention for mental health services. The Government has also made a commitment to introduce waiting times for Earlier Intervention in Psychosis Services. To prevent lifelong mental illness developing we will need to ensure that we have invest in early help offer for children, young people and their families and target mental well-being and prevention services in deprived areas.

8.2 Improve Access to Services

A key commissioning intention in this respect is the development of a comprehensive first point of contact to support people to achieve mental wellbeing and to triage people who are mentally unwell and sign post them to the appropriate service to meet their needs. The service would provide a broad range of support to help people to improve their mental health status and cope with the stresses of their particular life situation. The service could offer information and advice, self-help options and peer support and support groups to prevent people with low level needs from needing to access more acute services. It could also offer the opportunity of an appointment with a navigator who would help them to work out what support they need and signpost them to that support and even support them to attend if confidence or anxiety is a presenting need. Navigators will be trained in motivational interviewing and the recovery ethos to help people to help themselves. The service will be advertised as a first point of contact and could be used by GPs as an alternative to prescribing. If higher level interventions are required e.g. counselling and there is a waiting time the wrap around services will provide support the individual in the interim. Successful implementation of this model will require that we ensure equitable access to our mental health and wellbeing services for the borough's population. An Equality Impact Assessment has been completed for this strategy, in

order to provide recommendations to support this. We will also need to ensure that service users with a Learning Disability, who experience mental illness, are also able to access the services they need, ensuring reasonable adjustments are made, and that service users are not excluded from services, as a result of having multiple needs.

It would be an opportunity for people with lived experience on the road to recovery to support other service users and act as mental health champions, giving meaning and purpose to their lives and hopefully leading to employment.

The service could combine the IAPT service and third sector provision as well as medical professionals to triage those service users who are mentally ill and need medical intervention. This would improve access and support those service users who were previously known to get back into service when they are becoming unwell which is a particular concern for service users. It would also offer choice to service users who are mentally ill by offering a range of provider options to meet their needs.

8.3 Improved Service Delivery for people with a mental illness

Both the White Paper “No Health Without Mental Health” (2011) and more recently ‘Closing the Gap (2014) are guided by the recovery approach (or recovery model) of mental health care, which moves away from a medical, treatment-centred model structured around maintenance and the relief of symptoms and towards an individualised approach structured around each person’s goals and priorities.

Features of this approach include:

1. Improved social inclusion
2. Greater personal independence and self- management of their condition
3. Client centred care
4. The “expert patient”/ Peer Support approach

In addressing the wellbeing needs of the population as a whole, and also promoting the positive wellbeing of those with a Mental Illness, developing a service model which delivers aspirations for recovery will be essential.

Our commissioning priority in relation to improving service delivery, therefore, is to develop a recovery model of service delivery for community mental health services. Work in relation to this commissioning priority has already commenced with our secondary mental health care provider, Pennine Care, who are beginning to reshape community services to have a recovery ethos rather than being a ‘service for life’. This approach needs to be carefully managed to ensure service users who are a risk to themselves or others are effectively managed to mitigate the risks of harm. However, the need to manage risk should not lead to a risk averse culture within the acute end of the service delivery model, positive risk taking and ‘just enough’ support

need to be key elements of these areas of service delivery. Service users need to be supported to access community services that support them to manage their long term condition and to play an active part in the wider community. The development of community resilience and community services/ networks that support people with mental ill health is a priority in relation to the development of a recovery model in community mental health services.

Further work is required to co- produce with service users and carers the recovery model for the delivery of community mental health services.

8.4 Co-production

The NICE Quality Standard 14 on people's experience of adult mental health services, developed with people who use and work in the services, includes the quality statement:

"People using mental health services, and their families or carers, feel optimistic that care will be effective."

To be optimistic about their care and support, people who use services want to see joined-up, preventive approaches that do not abandon them at key stages.
They want their mental and physical health needs to be addressed together in a whole person approach. This means mental health provision sits squarely within 'integrated care', which is defined as 'person centred coordinated care' in the Narrative coproduced by National Voices and Think Local Act Personal and adopted by all system leading organisations.

The guidance states that, 'A personalised care and support system will not be successful if it remains separate to the NHS, deals with people's needs in silos and maintains a cliff edge between health and care. Integration that addresses the fragmentation between health and care without recognising the role people can play in managing their own needs and encouraging self-determination will also fall short.

Any co-commissioning of services should seek to improve and facilitate easily negotiated patient care pathways and should take into account:

- Economies of scale particularly in relation to establishing areas of overlap
- Engagement of key stakeholder groups
- Clear understanding of where service delivery needs to be flexed and changed to prevent replication of delivery
- Clear understanding of what services are commissioned, whether they demonstrate value for money, are clinically effective and improve the patient experience

- The interconnection between physical and mental health and that mental ill health can be a cause and effect of physical ill health.

The challenge for commissioners with this increasing shift to community orientated self-care, will be how collaboratively commissioners and providers work together to restructure services to meet national outcomes and indicators, improve patient experience and move to a more “early intervention” focus to prevent the perpetuating cycle of mental illness.

To support the delivery of the commissioning priorities detailed above further work, therefore, needs to take place with service users and carers as equal partners. This should build on the input service users and carers have had into the development of the strategy by holding outcomes workshops to identify the outcomes they would want from each element of the mental health pathway. Adopting the ‘Working Together for Change’ approach would also support the co- production agenda.

8.4 Outcomes based contracting

The engagement which has been undertaken in support of this strategy has highlighted that what matters to service users is the results, or outcomes, which the services they access deliver. This approach is described as outcomes based contracting (OBC – previously outcomes based commissioning) and is supported by NHS England and is being adopted by a growing number of CGGs.

By adopting OBC, the success of healthcare provision will be measured by results that matter to the patient not by numbers of patients seen. Patients will have more influence over how their healthcare is delivered by helping to shape the outcomes that are included in the contracts and by making informed decisions about how their care is delivered.

Delivery of our strategic vision will be reliant on shifting from our current activity based commissioning approach to Outcomes based delivery.

The NHS is facing unprecedented challenges to its sustainability – demographic change, increasing demand, and pressure on resources. The Mental Health and Wellbeing Needs Assessment has highlighted the increasing challenges and demands which Mental Health and Mental Illness present and the responsibility which we have to act to deliver better value and outcomes for patients. A move to OBC will help to achieve this.

Organisations that provide healthcare across Rochdale borough will need to work together to deliver those patient led outcomes, and will be rewarded based on the on-going improvements in health, support and patient experience.

Adopting OBC will mean that:

- Patients will no longer have to navigate an uncoordinated fragmented system
- Funding will be linked to the achievement of outcomes, rather than activity and processes.
- There will be more freedom to design services to suit the needs of patients, under a single contract, with fewer process targets
- There will be better planned care packages for the patient to reduce number of visits and time in hospital
- By sharing data on patients with GPs there will be transparency in reporting on whether over time, patients are getting better treatment and the outcomes measures are being met
- There will be continual improvement for patients

Section 9: Monitoring success

It is our shared ambition that the objectives established in section 6 will be implemented in our borough to ensure that our vision becomes a reality for the people of Rochdale. In order to achieve this we will work with providers and service users to develop a clear action plan which sets out the timetable for change.

The action plan implementation will be monitored by the Joint Mental Health and Wellbeing Strategy Group. This group has established terms of reference and governance structures, with a reporting line up to the Health and Wellbeing Board. The group will establish Task and Finish Groups to deliver the strategy action plan, and updates on progress will be provided by the group to the Health and Wellbeing Board.

Successful implementation will be reliant on establishing a robust performance monitoring framework, which judges success by the outcomes which we deliver. These outcomes will be determined through robust engagement with all key stakeholders, including providers, service users and carers.

Effective commissioning and successful delivery of services is reliant on timely access to performance information which supports evaluation and assessment of strategic outcomes. As commissioners we need to define the data which we need to support our commissioning decisions and interpret and understand what it is telling us about the effectiveness, quality and performance of the services we commission, to ensure that we are meeting the needs of our population.

In order for performance monitoring to be accurate and meaningful, it is essential that we improve the quality of information and data that we collect. This will be done in the following ways:

- Improve the monitoring of admissions to measure the impact of intervention services and inform strategies, including admissions relating to alcohol, drugs and suicide.
- Work with providers to implement data recording systems which, ensure that accurate information informs commissioning intentions and work plans.
- Develop outcome based indicators as a measure of delivery and performance
- Benchmarking data to identify best practice, lessons learned and areas for improvement
- Develop reports that evaluate Improving Access to Psychological Therapies (IAPT), which will allow us to set baselines and monitor improvements.
- Improve the monitoring of specialist inpatient services such as PICU to ensure we receive value for money. We will also work in partnership with NHS England regarding monitoring of specialist commissioning services, including Tier 4 CAMHS Inpatient services.
- Move towards datasets that will allow us to review care pathways and understand individual patient journeys. This will support commissioners in implementing Patient Choice in Mental Health, and will become increasingly important as services move toward Payment by Results rather than block contracts.
- Robust reporting of Patient and Service User Satisfaction and Experience will be required to monitor the impact and effectiveness of the strategy.

Section 10: Action Plan

The oversight for delivery the Mental Health and Wellbeing Commissioning Strategy will be retained by the Joint Mental Health and Wellbeing Strategy Group. It is our intention to develop an action plan which sets out how we will deliver the commissioning priorities and strategic objectives for the borough. This will be developed in partnership between HMR CCG and RMBC and key stakeholders. We will work with service users and carers to agree the outcomes through which will we deliver our strategic objectives for the borough.

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30. HM Government, Preventing suicide in England A cross-government outcomes strategy to save lives. 2012, HM Government http://www.dh.gov.uk/health/2012/09/suicide-prevention/
31. Department of Health, Living Well with Dementia: A National Dementia Strategy – Putting People First (2009)
32. Bradley, People with Mental Health Problems or Learning Disabilities in the Criminal Justice System (2009)
33. Department of Health, Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing mental health Crisis (2014)
34. The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013 (S.I. 2013/2891) amended the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (S.I. 2012/2996).
35. NHS England, Implementing patients' right to choose any clinically appropriate provider of mental health services (May 2014)
36. Department of Health, Liberating the NHS: No decision about me, without me - Further consultation on proposals to secure shared decision-making (2012)
37. Cheshire West and Chester Council v P (2011) EWCA Civ 1257
38. http://www.familylaw.co.uk/news_and_comment/cheshire-west-department-of-health-guidance-on-deprivation-of-liberty-safeguards?
39. Francis, The Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013)
40. Department of Health, Berwick Review into Patient Safety (August 2013)
41. Keogh, Review into the quality of care and treatment provided by 14 hospital trusts in England (July 2013)
42. Department of Health, Transforming Care: a national response to Winterbourne View Hospital (June 2013)

Appendix 1

Stakeholder engagement summary

1: HMR Mental Health Symposium

The Symposium Evaluation writing group, reviewed the outputs from the Mental Health Symposium, and agreed that the key points for consideration are as follows:

Access

- Information and advice
- Entry and re-entry into system
- Improving pathways
- Widening access to pathway
- Equitable access

Prevention

- Awareness raising – Media campaigns
- Health trainers having MH and wellbeing as part of portfolio
- Education – training and self-help (staff and service users and schools)
- Transition from children to adult services - long terms costs reduced if focus on young i.e. include as element of citizenship
- Peer support and social connections/networks
- Access to housing
- Low level universal services
- Early help

Recovery

- Community resilience and social value
- Peers and peer support
- Individualised wellbeing plans tailored to individuals
- Realistic and personalised goal setting
- Outcomes based services/commissioning
- Range of personalised services
- Self help
- Enablement services
- Group work
- Explore use of WEMWBS and Star Tool to measure recovery
- Development a whole-system
- Co-production and Collaboration between services.

Enablers

- Work force strategy and training
- Joint commissioning & partnership working
- Information technology and management

2: Rochdale Boroughwide User Forum Involvement day

The key recommendations RBUF Service User Consultation 10th July 2014 were as follows:

- **Improve Awareness**
    - There is a lack of awareness in mainstream society both of mental health conditions, and the ways in which these can be prevented or treated. For parity with physical health, education should begin in schools and continue throughout life. Information should be targeted towards at risk groups and people who work with them e.g. Job Centre staff who work with the recently unemployed. This would also help to reduce the stigma and discrimination suffered by those with poor mental health.
    - All services should make publically available information about what the service can offer, what the criteria are to be eligible for the service, and how to refer in to the service. A database of this information would be helpful to referrers, and also would help to identify gaps in services.
- **Local and Accessible**
    - Many services are only available during office hours and at a single location. This makes them difficult for some people to access. Taking services to community locations at diverse times would help to counter this. Services also need to make themselves accessible to people from different ethnic backgrounds.
    - There is an identified demand for more wellbeing activities and groups across all age ranges within local communities. This would help to reduce social isolation and encourage informal peer support and information sharing.
- **Open the Single Point of Entry**

  Currently for the majority of people the only way to access the Single Point of Entry service is via GP. This creates problems as GPs themselves can be hard to access, their level of knowledge is inconsistent and they can be reluctant to refer. Opening access routes to other service providers alongside proper training and clearer referral criteria would help to alleviate this problem.
- **Seamless Services**
    - Communication between services generally appears to be poor and needs to be improved. Transitions between services need to be better managed so that nobody is left “in limbo” between services whilst communication and handover takes place. Statutory services need to be more open to joint working with private and voluntary sector organisations.
    - There is an identified lack of good aftercare and step down services for people who are discharged from inpatient care. This contributes to a large

proportion of readmissions within weeks of discharge. A service which provides step down care, re-enablement and which links service users into other available support would be beneficial.

- **Welfare Rights**

  Welfare Rights advice services have been cut in recent years while demand has greatly increased. With Universal Credit now being introduced this demand will certainly increase further. Unless extra support is put into place as a matter of urgency, we will see increasing levels of debt and homelessness particularly amongst the most vulnerable members of society.

- **Service Users as Partners**

  People who use services should be more involved, in service design, delivery and feedback. As resources diminish it is essential that all services listen to their users and make sure the service meets their needs. Peer support should be encouraged and facilitated wherever possible. Quality monitoring should be less about statistical outcomes and more about capturing the service user experience.

3: Health and Wellbeing Board Mental Health Assembly 15th August 2014

The Health and Wellbeing Board held a Mental Health Themed Assembly on the 15th August with over 100 delegates attending from a wide variety of agencies and services. Discussion took place with a focus on No Health Without Mental Health: A Cross-Government Mental Health Strategy for People of All Ages, with the notion that Mental Health is ‘everybody’s business. The following points summarise the key themes from the discussions on the day:

- Mental Health Awareness training – including signs and symptoms
- Signposting and raising awareness of available services and pathways
- The need to increase the presence of, and access to, low level support so that GPs are not the front door to mental health services.

Appendix 2

National Policy and Context

The Health and Social Care Act (2012)[19]

The Health and Social Care Act 2012 established Health and Wellbeing Boards as a key mechanism for improving joint working between the NHS and local authorities, bringing together key commissioners to encourage integrated working and provide local leadership to improve health and wellbeing outcomes for local communities.

Under the 2012 Act, Health and Wellbeing Boards are required to undertake a local assessment of the current and future health and wellbeing needs of the borough through a Joint Strategic Needs Assessment (JSNA) process, and produce a Joint Health and Wellbeing Strategy setting out how it intends to meet the key needs identified through the JSNA.

Fair Society, Healthy Lives (February 2010)

In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010.

The final report, 'Fair Society Healthy Lives', was published in February 2010, and concluded that reducing health inequalities, and improving mental health and wellbeing, would require action on six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention.

The Marmot review into health inequalities in England proposed an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities. The report proposes a new way to reduce health inequalities in England and focuses on

[19] HM Government, The Health and Social Care Act 2012

giving every child the best start in life and enabling all children, young people and adults to maximize their capabilities and have control over their lives.[20]

Public Health White Paper: Healthy Lives, Healthy People, (December 2010)[21]

The Public Health White Paper*: 'Healthy Lives, Healthy People'*, set out a new approach to improving health and wellbeing and reducing health inequalities. It acknowledged the need to empower people and communities to make healthier choices and to reprioritise funding to prevent ill health. The paper acknowledged that delivering improvements in health and wellbeing and reducing health inequalities needs to be a shared responsibility across society, with individuals, families, local and national government, the NHS, and the private, voluntary and community sectors all taking a key role in tackling the issues and deciding how best to improve the health and wellbeing of their communities.

A key emphasis from the White Paper is that health and wellbeing throughout life is taking a coherent approach to different stages of life and key transitions. Mental Health will be a key element to this. The following are key points and stages in people's lives when mental and physical health outcomes can be most strongly influenced:

- **Starting well** – early intervention and prevention is a key priority for the government. There will be opportunities to develop integrated local strategies between public health and children's services with an increased focus on disadvantaged families.
- **Developing well** – schools are expected to increase their role in provide age-appropriate teaching health issues including school based mental health promotion. For children and adolescents with mental health problems, central government will support interventions that promote mental health resilience and effective early treatment.
- **Living well** – the government is turning to local communities to devise local solutions which work for them. A key component of the approach is the Public Health Responsibility Deal.
- **Working well** – the Department of Health will work in partnership with employers, through the Public Health Responsibility Deal, to improve health at work. Employers have the opportunity to improve health outcomes in areas from obesity to smoking, substance misuse and physical activity in their employees, employees' families and wider local communities.
- **Ageing well** – The role of Public Health services in supporting 'active ageing' and 'ageing well' is emphasised, with all local partners expected to support a local infrastructure that should support people to continue to be independent and active.

[20] Marmot M, The Strategic Review of Health Inequalities post 2010 (2010)

[21] Public Health England, Healthy Lives, Healthy People: Our strategy for Public Health in England (2010)

Care Act (2014)[22]

The Care Act represents the most significant reform of care and support in more than 60 years, putting people and their carers in control of their care and support. Under the Care Act, local authorities will take on new functions. This is to make sure that people who live in their areas:

• receive services that prevent their care needs from becoming more serious, or delay the impact of their needs;
• can get the information and advice they need to make good decisions about care and support;
• have a range of high-quality care providers to choose from.

The Care Act will help to improve people's independence and wellbeing. It makes clear that local authorities must arrange services that help prevent or delay people deteriorating such that they would need ongoing care and support.
Local authorities will have to consider various factors:

• what services, facilities and resources are already available in the area (for example local voluntary and community
• groups), and how these might help local people;
• identifying people in the local area who might have care and support needs that are not being met;
• identifying carers in the area who might have support needs that are not being met.

Welfare Reform Act (2012)[23]

The Government is currently undertaking the biggest shake up of the UK's welfare system in over fifty years. In the eyes of the Government, the system has become mired in complexity, subject to fraud and operating to maintain people on benefit rather than in employment. The Welfare Reform Act 2012 is now in force and through a series of legislative measures contained within it, Government is seeking to reduce the UK's welfare benefit costs by £18 billion over the next five years and promote work as more beneficial than claiming benefit. Embedded in the Act are a range of measures designed to simplify, streamline and reform the payment of out of work, income, housing and disability related benefits; re-assess the fitness or otherwise of claimants to work; and provide employment related support.
There are four key elements to the welfare reform programme, which follow on from reforms that were introduced under the previous government:

- to replace the complex mix of out of work benefits and working tax credits with a single Universal Credit;

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[22] HM Government (2014) Care Act
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[23] HM Government (2012) Welfare Reform Act.
http://services.parliament.uk/bills/2010-11/welfarereform.html

- to introduce a single welfare to work programme (the Work Programme), designed to support longer term unemployed people back to work;
- to reassess claims of disability and incapacity related benefit, and particularly individuals' capability to work;
- to cap the total amount of benefit that working age people can receive so that workless households should no longer receive more in benefits than the average earnings of working households.

Children and Families Act (2014)[24]

The Children and Families Act will mean changes to the law to give greater protection to vulnerable children, better support for children whose parents are separating, a new system to help children with special educational needs and disabilities, and help for parents to balance work and family life.

The act also ensures vital changes to the adoption system can be put into practice, meaning more children who need loving homes are placed faster. Reforms for children in care can be implemented including giving them the choice to stay with their foster families until their 21st birthday.

The Act reforms legislation relating to the following areas:

- adoption and children in care
- aspects of the family justice system
- children and young people with special educational needs
- the Office of the Children's Commissioner for England
- statutory rights to leave and pay for parents and adopters
- time off work for ante-natal care
- the right to request flexible working

National Mental Health Policy Context

Current national policy around mental health has an emphasis on identifying what actually happens to the health of the patient, the outcome, as a result of the treatment and care they receive. Mental health policy also highlights the major importance of the voice of patients and service users, as well as the move toward GPs having a central commissioning role.

Over recent years there has been a consensus that mental health should broaden from improving mental health services to including public mental health and mental wellbeing. Mental Health policy cannot be devised and implemented by any single government department or the NHS alone but requires collaboration across central government, local government and the independent sector.

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[24] HM Government (2014) Children and Families Act. http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

The previous National Service Framework (NSF) for Mental Health has delivered sustained development and improvement across England. The implementation period of the NSF ended in 2009 and the health and social care landscape is now very different.[25] CCGs are now focused on the commissioning of healthcare services and ensuring the quality of local provision. Integrated health and social care and the joint work between CCGs and local authorities on developing joint commissioning has developed more widely. The nature of provision has also been altered with the advent of Foundation Trusts and the greater engagement of the independent and voluntary sector in the provision of services.

The environment in which commissioners and providers operate is now one that is more fluid and dynamic than ever before and has rapidly transformed over the last three years as part of the Government White Paper – *Equity and Excellence: Liberating the NHS (2010)*[26]*.*

Parity of Esteem

The Health and Social Care Act 2012 secured explicit recognition of the Secretary of State for Health's duty towards both physical and mental health. In conjunction with a clear legislative requirement to reduce inequalities in benefits from the health service, these duties place an obligation on the Secretary of State to address the current disparity between physical and mental health. The concept of 'Parity of Esteem' underpins all six objectives of the English Mental Health Strategy*, 'No Health without Mental Health'.*

The principles which underpin 'Parity of Esteem' are as follows:

- Mental illnesses are very common
- Among people under 65, nearly half of all ill health is mental illness
- Mental illness is generally more debilitating than most chronic physical conditions
- Mental health problems impose a total economic and social cost of over £105bn a year
- Only a quarter of all those with mental illness such as depression are in treatment
- We tend to view physical and mental health treatment in separate silos in health services
- People with poor physical health are at higher risk of experiencing mental health problems and people with poor mental health are more likely to have poor physical health

[25] Department of Health, The National Service Framework for Mental Health (1999)

[26] Department of Health, Equity and Excellence: Liberating the NHS (2010)

Parity of esteem is best described as valuing mental health equally with physical health and giving both equal status. When compared with physical health care, patients accessing mental health care will have:

- Equal access to the most effective and safest care and treatment
- Equal efforts to improve the quality of care
- The allocation of time, effort and resources on a basis commensurate with need
- Equal status with healthcare education and practice
- Equally high aspirations for service users and
- Equal status in the measurement of health outcomes[27]

No Health without Mental Health (2011)[28]

Mental health has been high on the agenda with both the last and current governments. In February 2011 the Department of Health published the national public health strategy 'No Health without Mental Health: A cross government mental health outcomes strategy for people of all ages.'

This document identified six outcomes:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a good experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination.

No Health without Public Mental Health: the case for action (2010) [29]

Prior to this publication the Royal College of Physicians identified the importance of public mental health, particularly in the early identification and early intervention at the start of the life-course. It also discusses the uses of universal and targeted approaches to prevention and how these need to be applied to the population. It highlights the importance of dual diagnosis, and identifies areas where there are inequalities that need to be addressed. It also emphasises the need for providers to be involved in commissioning of services to ensure need is identified and met, the need for commissioners to consider the effects of mental health and mental illness

[27] https://www.rcpsych.ac.uk/policyandparliamentary/whatsnew/parityofesteem.aspx)

[28] Department of Health, No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages. 2011

[29] The Royal College of Psychiatrists, *No Health without Public Mental Health:* the case *for action.* 2010.

across the life course and also the wider economic impact of promoting positive mental health and wellbeing.

Closing the Gap (2014)[30]

This document builds upon 'No Health without Mental Health' and looks at how changes in local service planning and delivery will make a difference, in the next two or three years, setting out 25 priority areas for change:

Increasing access to mental health services:

1) High quality mental health services with an emphasis on recovery should be commissioned in all areas, reflecting local need
2) We will lead an information revolution around mental health and wellbeing
3) We, for the first time, establish clear waiting time limits for mental health services
4) We will tackle inequalities around access to mental health services
5) Over 900,000 people will benefit from psychological therapies every year
6) There will improved access to psychological therapies for children and young people across the whole of England
7) The most effective services will get the most funding
8) Adults will be given the right to make choices about the mental health care they receive
9) We will radically reduce the use of all restrictive practices and take action to end the use of high risk restraint, including face down restraint and holding people on the floor
10) We will use the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children's mental health services
11) Poor quality services will be identified sooner and action taken to improve care and where necessary protect patients
12) Carers will be better supported and more closely involved in decisions about mental health service provision

Integrated physical and mental health care:

1) Mental health care and physical health care will be better integrated at every level
2) We will change the way frontline health services respond to self-harm
3) No-one experiencing a mental health crisis should ever be turned away from services

Starting early to promote mental wellbeing and prevent mental health problems:

4) We will offer better support to new mothers to minimise the risks and impacts of postnatal depression
5) Schools will be supported to identify mental health problems sooner
6) We will end the cliff-edge of lost support as children and young people with mental health needs reach the age of 18

Improving the quality of life of people with mental health problems:

7) People with mental health problems will live healthier lives and younger lives
8) More people with mental health problems will live in homes that support recovery
9) We will introduce a national liaison and diversion service so that the mental health needs of offenders will be identified sooner and appropriate support provided
10) Anyone with a mental health problem who is a victim of crime will be offered enhanced support
11) We will support employers to help more people with mental health problems to remain in or move into work
12) We will develop new approaches to help people with mental health problems who are unemployed to move into work and seek to support them during periods when they are unable to work
13) We will stamp out discrimination around mental health

[30] Department of Health, Closing the Gap: Priorities for essential change in Mental Health (2014)

National Suicide Prevention Strategy for England (2012)[31]

The National Suicide Prevention Strategy for England, launched in September 2012, aimed to support the achievement of the target set in the White Paper by developing a comprehensive, evidence based and coordinated approach to preventing suicide. The strategy aims to:

- Reduce the risk of suicide in key high risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

Living Well with Dementia: A National Dementia Strategy – Putting People First (2009)[32]

The National Dementia strategy provides a strategic framework within which local services can deliver quality improvements to dementia services and address health inequalities relating to dementia. The strategy establishes a five year plan develop services for people with dementia and their carers that are fi t for the 21st century. We want services that meet the needs of everyone, regardless of their age, ethnic group or social status.

People with Mental Health Problems or Learning Disabilities in the Criminal Justice System (Bradley 2009)[33]

In December 2007 the Government undertook a six-month independent review to determine to what extent offenders with mental health problems or learning disabilities could be diverted from prison to other services and what were the barriers to such diversion.

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[31] HM Government, Preventing suicide in England A cross-government outcomes strategy to save lives. 2012, HM Government http://www.dh.gov.uk/health/2012/09/suicide-prevention/

[32] Department of Health, Living Well with Dementia: A National Dementia Strategy – Putting People First (2009)

[33] Bradley, People with Mental Health Problems or Learning Disabilities in the Criminal Justice System (2009)

The key recommendations were as follows:

- The need for a systematic and joint NHS/Criminal Justice system approach to offender health
- Needs Assessments to help inform commissioning decisions about mental health services for offenders, both in the community and for those in prison or in secure mental health services
- A systematic approach to supporting people with mental health problems at police stations and at courts, through liaison and diversion services: provision of high-quality assessments; diversion of people to appropriate health and social care services where that route is appropriate; support decisions about the range of sentencing options by the courts
- Continued investment in mental health awareness training for frontline criminal justice system staff
- Embedding the Care Programme Approach throughout the criminal justice system
- Work to reduce the transfer times from prison to mental health bed for individuals under Section 47/48 of the Mental Health Act

The Mental Health Crisis Care Concordat (2014)[34]

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat. It focuses on four main areas:

- **Access to support before crisis point** – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** – making sure that people are treated with dignity and respect, in a therapeutic environment.
- **Recovery and staying well** – preventing future crises by making sure people are referred to appropriate services.

[34] Department of Health, Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing mental health Crisis (2014)

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. The Concordat builds on and does not replace existing guidance. Current service provision should continue while the Action Plan is being devised.

Signatories to the Concordat agreed the following statement:

"We commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.

We will work together, and with local organisations, to prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards Recovery.

Jointly, we hold ourselves accountable for enabling this commitment to be delivered across England."

The Concordat expects that, in every locality, in England, local partnerships will agree and commit to local Mental Health Crisis Declarations. These will consist of commitments and actions at a local level that will deliver services that meet the principles of the national concordat.

Payment by Results

With the increasing determination of the NHS to gain maximum value for money, the existing system of Block Contracts will be updated to a new system called Payment by Results (PbR).

The main advantage of PbR is that commissioners will be able to have greater insight and more control over how the level of funding provided is matched to the level of service that is delivered. A concern however is that when a new local tariff of payments for services is agreed, this will place financial strain on either the commissioner, the provider, or indeed both. To minimise risk to patient services, we are committed to working in an open and transparent manner. This is supported by the Greater Manchester Mental Health PbR Steering Group.
The complexity of mental health service delivery results in similar financial complexity. This has further increased with the introduction of 'any qualified provider', extension of Patient Choice to Mental Health service users, and with the take up of personalised budgets by those with psychological infirmity. Therefore, we will look to invest in System Dynamics software and system, to gain understanding and control of patient flows and the financial streams which follow, whilst working closely with our providers.

The local NHS family recognises the immense effort which has gone into its creation nationally and its inception locally.

From December 2012 our main provider Pennine Care Foundation Trust is running a shadow exercise in that all patients receiving care have been "clustered" and the financial costs of the elements of their care appropriate for their condition have been calculated. April 2014 was to have been the date when 90+% of all activity would be paid according to these coded elements of care. However such is the complexity and uncertainty of remaining issues that the certainty of the historical "block contract" remains the preferred option nationwide and therefore locally.

Currently, there is a plethora of conflicting opinions and stances on PbR with uncertainty as to the next steps. Clustering may well inform a local tariff, and be more of a guide on capacity and not, as originally envisaged a National Tariff. We may have the local opportunity to determine how best to make the tariff work to support us in commissioning and delivering care rather than becoming a prescriptive national mechanism for payment

Patient Choice

The NHS Responsibilities and Standing Rules Regulations have been amended; removing - with effect from 1 April 2014 - mental health service exemptions from certain of the obligations that previously existed in relation to choice.[35] The 2013 Regulations established patients' right to choose their provider of mental health services in relation to an elective referral to any clinically appropriate:

1. Mental health service provider that has a contract with any CCG or with NHS England for the service required; and

2. Mental health team led by a named consultant or health care professional employed or engaged by that mental health service provider.

These changes mean that a patient who requires an elective referral for mental health services has a right from 1 April 2014 to choose any clinically appropriate health service provider (whether an NHS mental health trust, a Foundation Trust or a mental health provider in the independent or third sector) for their first outpatient appointment, with a consultant or a consultant led team, or with a health care professional or a team led by such a professional as long as the provider has a contract with any CCG or with NHS England for the service required, and that the service or treatment is routinely commissioned by the patient's CCG or NHS England, or is approved by the relevant Independent Funding Review Panel. This brings mental health services a step closer towards 'parity of esteem', or equal status, with physical health services in the NHS. A patient's legal rights to choice do

[35] The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013 (S.I. 2013/2891) amended the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (S.I. 2012/2996).

not extend beyond the first outpatient appointment. The right to treatment within 18 weeks from referral that exists for physical health does not currently apply to mental health services. NHS England is leading a mental health waiting times steering group with Department of Health and other system partners to consider the relevant issues.

Types of mental health conditions and services subject to the right to choice

Choose and Book – Supporting Referrals to Mental Health Services (November 2013) includes the list of Mental Health Clinic Types for adults and children and adolescents specialties that are supported by Choose and Book.

In physical health referrals to outpatient appointments are often to consultant-led teams in hospital settings. Many mental health services are not provided in hospital settings, so in mental health care the right to choice is to a consultant-led or healthcare professional-led team in whichever setting the service is provided.

Consistent with the operation of choice in physical health care, patients cannot generally choose services or treatments which are not routinely commissioned by their local CCG or NHS England. Patients wishing to access services not commissioned by their CCG or (where relevant) NHS England, may seek to demonstrate exceptionality and so access funding for the treatment through the commissioner's Independent Funding Review Panel. Patients should discuss their options with their GP who is required to support such an application.[36]

Patient choice and the Mental Capacity Act 2005

As a guiding principle, patients should be involved, as much as possible, in decisions about their care, as set out in the Government's response to Liberating the NHS: No decision about me, without me (December 2012)[37]. Across the range of mental health conditions that patients might experience, patients may be vulnerable and their ability to exercise choice that is clinically appropriate could be compromised. Referrers are required, under the Mental Capacity Act 2005, to support their patients in making decisions about their care and treatment. The Act requires all health professionals to take 'all practicable steps' to help people make their own decisions, including patients with a mental impairment. The principles of the Act must be adhered to in any decision-making where a patient lacks capacity or their capacity is predicted to deteriorate over time.

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[36] NHS England, Implementing patients' right to choose any clinically appropriate provider of mental health services (May 2014)

[37] Department of Health, Liberating the NHS: No decision about me, without me - Further consultation
on proposals to secure shared decision-making (2012)

Exemptions

The right to choice of mental health service provider for first outpatient appointment does not apply:

•to high secure psychiatric services;

•if the patient is detained under the Mental Health Act 1983;

•if the patient is detained in, or on temporary release from, prison;

•if the patient is serving as a member of the armed forces (family members in England have the same rights as other England residents);

•if a patient is already receiving mental health care as an outpatient.

However, where a mental health consultant or healthcare professional makes an assessment and diagnosis subsequent to the outpatient referral that is different to the assessment and diagnosis for which the patient was referred, under the terms of the NHS Standard Contract the provider may contact the patient's GP and, with the GP's approval, refer the patient to an appropriate provider for treatment. The GP or provider should act with the best interests of patients in mind. They would be expected to support the patient to consider the options for ensuring that the patient's clinical needs are met, including where this might mean offering the patient the opportunity to attend a different outpatient provider, where treatment more appropriate to their needs is available;

•to drug and alcohol misuse services commissioned or provided by local authorities; or

•where it is necessary to provide urgent care or treatment, in the same way that choice of provider does not apply with a physical health care emergency, such as a heart attack or stroke. The Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis sets out an effective approach to ensuring people experiencing mental health crisis can access the support they need, when they need it. [34]

Deprivation of Liberty Safeguards

On 28 March 2014, the Department of Health issued guidance to health and social care organisations on Deprivation of Liberty Safeguards (DoLS) following the recent *Cheshire West* [38]judgment. The guidance sets out the actions that the Department suggests relevant staff should take, including that they should:

- Familiarise themselves with the provisions of the Mental Capacity Act, in particular the five principles and specifically the "least restrictive" principle
- When designing and implementing new care and treatment plans for individuals lacking capacity, be alert to any restrictions and restraint which may be of a degree or intensity that mean an individual is being, or is likely to

[38] Cheshire West and Chester Council v P (2011) EWCA Civ 1257

be, deprived of their liberty (following the revised test supplied by the Supreme Court)

- Take steps to review existing care and treatment plans for individuals lacking capacity to determine if there is a deprivation of liberty (following the revised test supplied by the Supreme Court)
- Where a potential deprivation of liberty is identified, undertake a full exploration of the alternative ways of providing the care and/or treatment, in order to identify any less restrictive ways of providing that care which will avoid a deprivation of liberty
- Ensure that, where the care/treatment plan for an individual lacking capacity will unavoidably result in a deprivation of liberty judged to be in that person's best interests, this is authorised.[39]

[39] http://www.familylaw.co.uk/news_and_comment/cheshire-west-department-of-health-guidance-on-deprivation-of-liberty-safeguards?

Appendix 3

Key drivers for Quality

Events at Mid Staffordshire NHS Trust and Winterbourne View put quality of healthcare in the public spotlight, leading to high profile review and the publication of key reports with far reaching implications for commissioners and providers.

Francis Report[40]

A public enquiry into events at Mid Staffordshire NHS Trust uncovered a catalogue of serious and systemic failings. It led to publication of the Francis Report (Department of Health, 2013) which suggested that a fundamental change in culture was necessary to address the systemic failures and made a number of high level recommendations.

The key aims of the Francis recommendations can be summarised as;

- A common culture which puts the patient first;
- A set of fundamental standards which are easily understood, against which compliance can be measured and breach of which will not be tolerated.
- Openness, transparency and candour throughout the system
- Greater accountability; individual & organisational
- Improved support for compassionate, caring and committed nursing
- Stronger patient centred healthcare leadership
- Accurate, useful and relevant information to allow effective comparison of performance by patients and the public

Berwick Report[41]

Following publication of the Francis Report, the Government commissioned an advisory group in April 2013, to distil the patient safety lessons learnt and specify the changes needed to improve the safety of patients in England. The advisory group was led by Professor Don Berwick, an internationally recognised expert on patient safety and its report was published in August 2013.

The Berwick report highlights the main problems affecting patient safety in the NHS and makes recommendations to address these problems saying that the health system must:

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[40] Francis, The Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013)

[41] Department of Health, Berwick Review into Patient Safety (August 2013)

- recognise with clarity and courage the need for wide systemic change
- abandon blame as a tool and trust the goodwill and good intentions of the staff
- reassert the primacy of working with patients and carers to achieve health care goals
- use quantitative targets with caution - they should never displace the primary goal of better care
- recognise that transparency is essential and expect and insist on it
- ensure that responsibility for functions related to safety and improvement are established clearly and simply
- give NHS staff career-long help to learn, master and apply modern methods for quality control, quality
- improvement and quality planning
- make sure pride and joy in work, not fear, infuse the NHS

Keogh Report[42]

Professor Bruce Keogh carried out reviews of 14 NHS hospitals in England in 2013. The fourteen hospitals were selected by their Summary Hospital-Level Mortality Indicator (SHMI) or the Hospital Standardised Mortality Ratio (HSMR) which had been shown to be higher in comparison to other NHS hospitals over the previous two years.
The report identified common challenges facing the NHS and set out a number of ambitions for the NHS in England to achieve in the next 2 years including;

- The implementation of early warning systems to detect deteriorating in high risk patient's condition especially out of hours and at the weekends.
- Demonstrable progress towards reducing avoidable deaths in our hospitals.
- The utilisation of junior doctors as change agents.
- Patients, carers and the public should be more involved and be able to give "real time" feedback.
- Nurse staffing levels and mix of skills should be appropriate to the patients being cared for on any given ward.

Winterbourne View[43]

An investigation into events at Winterbourne View hospital revealed shocking criminal abuse by staff, and a failure to protect vulnerable people with learning difficulties. It led to the Winterbourne View Joint Improvement Programme which provides leadership and support to transform services locally, building on good practice.

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[42] Keogh, Review into the quality of care and treatment provided by 14 hospital trusts in England (July 2013)

[43] Department of Health, Transforming Care: a national response to Winterbourne View Hospital (June 2013)

HMR CCG will work in partnership with Rochdale Metropolitan Borough Council to deliver the concordat which supports the Joint improvement Programme ensuring that wherever possible, vulnerable patients are care for in local community settings. This will improve the quality of the care offered to children, young people and adults with learning disabilities or autism who have mental health conditions or behaviour that challenges to ensure better care outcomes for them.