

**North Yorkshire County Council
Scrutiny of Health Committee
23 June 2017**

Transforming Mental Health Services in Hambleton and Richmondshire

Purpose of Report

The purpose of this report is to provide Members of the Scrutiny of Health Committee with an overview of the proposed options to change mental health services in Hambleton and Richmondshire.

Background

Our CCG has an ambition to improve the health and well-being of its population through its 'Fit 4 the Future' programme. One aspect of that ambition is to transform the way that mental health and well-being is supported and managed. The purpose of this presentation is to set the scene for open debate and the priorities for developing adult and older person's mental health and social care services in the area over the coming years.

The aim of this paper is to outline the options proposed for the transformation of adult and older person's mental health services across Hambleton and Richmondshire, in line with the CCG vision.

It also identifies opportunities to ensure the CCG's vision is achieved.

Work to date demonstrates compliance with the Department of Health four test criteria for service change which include:

- Support for proposals from clinical commissioners
- Strong public and patient engagement
- A clear clinical evidence base
- Consistency with current and prospective need for patient choice

NHS England is responsible for the review of evidence presented to them by the CCG as part of their service change assurance process to ensure that the CCG has complied with all requirements.

The CCG has also sought independent clinical advice from the clinical senate through the process of transformation. The clinical senate supports the health economy to improve health outcomes of the community by providing impartial, independent and evidence-based clinical advice to the CCG on major service changes and transformation.

From significant engagement, we have identified some of the main issues and priorities of our patients, their carers and our partners. It is clear that with an ever increasing prevalence of people with mental health problems and the health needs associated with them that services need to change.

We have a great opportunity to improve the services that we provide to our

population while following our general principles of providing care closer to home wherever appropriate, enabling people to remain at home as long as possible and putting quality of care, patient safety (delivered by skilled practitioners) and experience at the heart of what we do.

As a result of engagement with service users, partners and clinicians to date, we are able to describe the evidence base for change and the options that could be implemented and will ensure local NHS services are the best they possibly can be to meet future healthcare needs. These options are:

Option 1 – Do Nothing

To retain the current specialist mental health service with access to the two wards for adults and older people at the Friarage Hospital.

Continuation of the current level of community service delivery for adults of working age and older people. Provision of the memory service and community mental health teams working five days a week and seven day crisis support for people over 16 with functional mental health presentations only. The ability to provide intensive home support seven days a week for adults only.

Option 2 – 7 day enhanced community and crisis service. Inpatient care will be provided in the service users nearest neighbouring assessment and treatment mental health bed at West Park Hospital, Darlington, Roseberry Park Hospital, Middlesbrough or Bishop Auckland General Hospital

To provide an enhanced specialist mental health community service, providing access to adult and older person community mental health teams and crisis response for people over 16years up to seven days a week.

People requiring specialist inpatient care will have access to the nearest purpose built specialist adult and older person inpatient wards, as close to their home as possible.

This will mean no assessment and treatment beds, for adults or older people, will be available at the Friarage Hospital.

Option 3 – 7 day enhanced community and crisis service. Inpatient care will be provided from a single site at either West Park Hospital, Darlington, Roseberry Park Hospital, Middlesbrough or Bishop Auckland General Hospital

To provide an enhanced specialist mental health community service, providing access to adult and older person community mental health teams and crisis response for people over 16 years, up to seven days a week.

People requiring specialist inpatient care will have access to purpose built adult and older person inpatient beds in either Teesside or Darlington.

This will mean no assessment and treatment beds for adults or older people will be available at the Friarage Hospital.

Summary:

Based on the valuable information received during our engagement with members of the public, clinicians, voluntary sector, social care and other local stakeholders, the CCG has developed a set of criteria to assess each option against. This can be found in the table below.

Criteria	Option 1	Option 2	Option 3
Care closer to home for the majority of our population	✗	✓	✗
Convenience and accessibility of services, especially for people who may find it difficult to travel	✗	✓	✗
Improved integration in the provision of physical and mental health and social care	✗	✓	✓
Enables GPs to better support out of hospital care	✗	✓	✓
Provides support for our population to maintain independence	✗	✓	✓
Retains wards 14 and 15 at the Friarage Hospital in Northallerton	✓	✗	✗
Creates opportunities for the better use of technology	✗	✓	✓
Tried and tested model of service delivery in our CCG area	✓	✓	✓
High quality care with good clinical outcomes	✗	✓	✓
Would actively reduce long lengths of stay in hospital	✗	✓	✓
Equality in retention to service access for the majority of the population of Hambleton and Richmondshire	✗	✓	✗
Maintains a sense of familiarity of services being delivered in known facilities	✓	✗	✗
Financial sustainability	✓	✓	✓

Therefore, based our full analysis, option 2 is the preferred option.

Further information

Recommendation

That Members give consent to HRW CCG to enter into a period of public consultation commencing on Monday June 26th 2017 and concluding on Friday September 15th 2017.

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DATE: Wednesday June 14th 2017.

Hambleton and Richmondshire: Transforming Mental Health Services

Consultation Document

14 June 2017

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Executive summary

The aim of this document is to outline proposals for the *transformation of adult and older person's mental health services* that have arisen from engaging with service users/carers, partners and members of the public across Hambleton and Richmondshire, in line with the Clinical Commissioning Group's (CCG) vision for improving community services. It also identifies opportunities to ensure the CCG's vision is achieved. This document also demonstrates compliance with the Department of Health's four test criteria for service change which include:

- Support for proposals from clinical commissioners
- Strong public and patient engagement
- A clear clinical evidence base
- Consistency with current and prospective need for patient choice

NHS England is responsible for the review of evidence presented to them by the CCG as part of their service change assurance process to ensure that the CCG has complied with all requirements.

The CCG has also sought independent clinical advice from the clinical senate through the process of transformation. The clinical senate supports the health economy to improve health outcomes of the community by providing impartial, independent and evidence-based clinical advice to the CCG on major service changes and transformation.

Foreword

Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) has an ambition to improve the health and well-being of its population through its 'Fit 4 the Future' programme. One aspect of that ambition is to transform the way that mental health and well-being is supported and managed.

From significant engagement, we have identified some of the main issues and priorities of our patients, their carers and our partners. It is clear that with an ever increasing prevalence¹ of people with mental health problems and the health needs associated with them, that services cannot remain as they are. We have a great opportunity to improve the services that we provide to our population while following our general principles of providing care closer to home wherever possible. In taking this approach, we are enabling people to remain at home as long as possible and putting quality of care, patient safety (delivered by skilled practitioners) and experience at the heart of what we do.

As a result of engagement with service users and their families and carers, partners and clinicians to date, we are able to describe the evidence base for change and the options that could be implemented and will ensure local NHS services are the best they possibly can be to meet future healthcare needs.

Acknowledgements

The writing and development of this document has been carried out as a partnership involving representatives from HRW CCG, the Partnership Commissioning Unit (PCU), Tees, Esk and Wear Valley NHS Trust (TEWV), North Yorkshire County Council (NYCC) and NHS England.

¹ North Yorkshire County Council Joint Strategic Needs Assessment 2015

Glossary of Terms

Table 1: Glossary of terms

Description
<p>Adult Mental Health Service (AMH): Services provided for people between 18 and 64 – known in some other parts of the country as “working-age services”. These services include inpatient and community mental health services. In practice, some patients younger than 64 may be treated in older people’s services if they are physically frail or if they have Early Onset Dementia. Early Intervention in Psychosis teams (EIP) may treat patients younger than 18 years old as well as those over that age.</p>
<p>Care Quality Commission (CQC): the independent regulator of health and social care in England who regulate the quality of care provided in hospitals, care homes and people's own homes by the NHS, local authorities, private companies and voluntary organisations, including protecting the interests of people whose rights are restricted under the Mental Health Act.</p>
<p>Clinical Commissioning Groups (CCGs): NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. CCGs are clinically led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs are overseen by NHS England.</p>
<p>Commissioners: The organisations that have responsibility for buying health services on behalf of the population of the area work for.</p>
<p>Crisis Care Concordat: 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.</p>
<p>Early Intervention in Psychosis (EIP): Early intervention in psychosis is a clinical approach to those experiencing symptoms of psychosis for the first time. It forms part of a new prevention paradigm for psychiatry and is leading to the reform of mental health services especially in the United Kingdom. This approach centres on the early detection and treatment of early symptoms of psychosis during the formative years of the psychotic condition. The first three to five years are believed by some to be a critical period. The aim is to reduce the usual delays to treatment for those in their first episode of psychosis. The provision of optimal treatments in these early years is thought to prevent relapses and reduce the long-term impact of the condition.</p>
<p>Friends and Family Test: A survey question put to patients, carers or staff that asks whether they would recommend a hospital / community service to a friend or family member if they needed that kind of treatment.</p>
<p>Functional (MHSOP): Older people with a decreased mental function which is not due to a medical or physical condition.</p>

Description

General Medical Practice Code: is the organisation code of the GP Practice that the patient is registered with. This is used to make sure that our patients' GP practice is recorded correctly.

IAPT (also known as 'Talking Therapies'): IAPT stands for "Increasing Access to Psychological Therapies".

Local Authority Overview and Scrutiny Committee: All "upper-tier" and "unitary" local authorities are responsible for scrutinising health services in their area, and most have a Health Overview and Scrutiny Committee (OSC). Darlington, Hartlepool, Middlesbrough, Stockton and Redcar & Cleveland Councils have formed a joint Tees Valley OSC.

Localities: services in TEWV are organised around three Localities (i.e. County Durham & Darlington, Tees, and North Yorkshire). Our Forensic services are not organised as a geographical basis, but are often referred to a fourth "Locality" within TEWV.

Mental Capacity Act (MCA): is a framework to provide protection for people who cannot make decisions for themselves. It contains provision for assessing whether people have the mental capacity to make decisions, procedures for making decisions on behalf of people who lack mental capacity and safeguards. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their **best interests**.

Mental Health Act: The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. In most cases, when people are treated in hospital or another mental health facility they have agreed or volunteered to be there. However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act (1983) and treated without their agreement. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

Mental Health Services for Older People (MHSOP): Services provided for people over 65 years old. These can be to treat 'functional' illness, such as depression, psychosis or anxiety, or to treat 'organic' mental illness (conditions usually associated with memory loss and cognitive impairment), such as dementia. The MHSOP service sometimes treats people younger than 65 with organic conditions such as early-onset dementia.

Monitor: the independent economic regulator for NHS Foundation Trusts.

Multi-agency: this means that more than one provider of services is involved in a decision or a process.

Multi-disciplinary: this means that more than one type of professional is involved – for example: psychiatrists, psychologists, occupational therapists, behavioural therapists,

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nurses, pharmacists all working together in a Multi-Disciplinary Team (MDT).

National Institute for Clinical Excellence (NICE): NHS body that provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. NICE works with experts from the NHS, local authorities and others in the public, private, voluntary and community sectors - as well as patients and carers - to make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties.

National Strategic Executive Information System (STEIS): a new Department of Health system for collecting weekly management information from the NHS.

NHS England Commissioners: The part of NHS England responsible for commissioning specialist mental health services – e.g. Adult Secure (Forensic), CAMHS Inpatients and Inpatient adult and Children and Young Peoples Eating Disorders.

NHS England – Area Teams: The teams with NHS England responsible for commissioning specialised services and monitoring our performance against our specialist services contracts.

NHS Service User Survey: the annual survey of service users' experience of care and treatment received by NHS Trusts. In different years this has focused both on inpatient and community service users.

NHS Staff Survey: an annual survey of staffs' experience of working within NHS Trusts.

Organic (MHSOP): Older people with a decreased mental function which is due to a medical or physical condition. This includes dementia-related conditions.

Paris: Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust's electronic care record, product name Paris, designed with mental health professionals to ensure that the right information is available to those who need it at all times.

Patient Advice & Liaison Team (PALs): The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers. TEWV has its own PALS service as do all other NHS providers.

PPI: Patient and Public Involvement.

Project: A one-off, time limited piece of work that will produce a product (such as a new building, a change in a service or a new strategy / policy) that will bring benefits to relevant stakeholders. In TEWV projects will go through a Scoping phase, and then a Business Case phase before they are implemented, evaluated and closed down. All projects will have a project plan, and a project manager.

Description

Purposeful Inpatient Admission and Treatment: This is TEWV's method for ensuring that all patients receive assessments and treatments as quickly as possible so that their length of stay in hospital is kept as short as possible.

Recovery Approach: This is a new approach in mental health care that goes beyond the past focus on the medical treatment of symptoms, and getting back to a "normal" state. Personal recovery is much broader and for many people it means finding / achieving a way of living a satisfying and meaningful life within the limits of mental illness. Putting recovery into action means focusing care on what is personally important and meaningful, looking at the person's life goals beyond their symptoms. Helping someone to recover can include assisting them to find a job, getting somewhere safe to live and supporting them to develop relationships.

Recovery College: A recovery college is a learning centre, where service users, carers and staff enrol as students to attend courses based on recovery principles. Our recovery college, called *ARCH*, opened in September 2014 in Durham. This exciting resource is available to TEWV service users, carers and staff in the Durham area. Courses aim to equip students with the skills and knowledge they need to manage their recovery, have hope and gain more control over their lives. All courses are developed and delivered in co-production with people who have lived experience of mental health issues.

Resilience: Resilience in the context of this Quality Account is the extent to which patients can cope, and maintain their own well-being when they can feel their mental health worsening. TEWV works with patients to build up their resilience as part of the recovery approach, and often develop Resilience Plans with them.

Safeguarding Adults / Children: Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to creating high-quality health and social care.

Scrutiny of Health Committee (SoHC): These are statutory committees of each Local Authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the Local Authority area. All local authorities have a SoHC that focusses on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar & Cleveland Councils have a joint Tees Valley Health SoHC that performs this function.

Section 136 of the Mental Health Act: The police can use section 136 of the Mental Health Act to take a person to a place of safety when they are in a public place. They can do this if they think the person has a mental illness and are in need of care. A place of safety can be a hospital or a police station. The police can keep the person under this section for up to 72 hours. During this time, mental health professionals can arrange for a Mental Health Act assessment.

Section 136 Suite: A "place of safety" where people displaying behaviours that are a risk to themselves or to the public can be taken by the Police pending a formal mental

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health assessment. This procedure is contained within Section 136 of the Mental Health Act.

Serious Incidents (SIs): defined as an incident that occurred in relation to NHS-funded services and care, to either patient, staff or member of the public, resulting in one of the following: unexpected / avoidable death, serious / prolonged / permanent harm, abuse, threat to the continuation of the delivery of services, absconding from secure care.

Specialities: The new term that TEWV uses to describe the different types of clinical services that we provide (previously known as “Directorates”). The Specialities are Adult Mental Health services, Mental Health Services for Older People, Children and Young People’s Services and Adult Learning Disability Services.

STP: Sustainability and Transformation Partnership - place-based, multi-year plan built around the needs of the local populations to enable the implementation of the Five Year Forward View (5YFV).

Trust-wide: This means across the whole geographical area served by the TEWV’s 3 Localities.

Unexpected Death: a death that is not expected due to a terminal medical condition or physical illness.

1. Introduction

The purpose of this consultation document is to evidence the case for change regarding our intentions to transform adult and older people's mental health services across Hambleton and Richmondshire to our service users/carers and partners.

Together with the people of Hambleton, Richmondshire and Whitby we want to radically reimagine how care and support for the local population is provided in order to make it 'Fit 4 the Future'. By doing this we believe in taking a whole life and integrated approach, with the needs of the individual and the community at its heart.

The CCG whilst retaining our organisational autonomy is now also part of a wider footprint for planning purposes – the Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby Sustainability and Transformation Plan (STP). The key ambition of our STP is to ensure sustainable, evidence based transformation is taken forward at pace and scale, cutting across organisational boundaries, to deliver an integrated health and social care system which achieves this aim.

However, whilst our STP faces north, we remain resolutely within North Yorkshire and are committed to supporting the local model of care based at The Friarage Hospital as the hub for the rural population and renewed services.

The main population being focused on for this change is that of Hambleton and Richmondshire. As the population of Whitby and the surrounding is served mainly by the Teesside and Scarborough mental health teams, this area is not included in this consultation. However, developments that arise from this system transformation will be considered for the whole CCG population.

We are also committed to realising the General Practice Five Year Forward View and making the vision of General Practice which is articulated therein a reality for the people of our localities. The primary themes of redesigning to deliver sustainable services today and transformed services tomorrow, greater use of self-care, technology and a wider workforce, and other actions to address challenges with general practice capacity, all underpin the proposals we have set out in this document.

Feedback from the inspectorates, patients and clinicians tells us that the model of mental health provision currently at The Friarage Hospital in Northallerton needs to change and what we articulate here is a whole system change within existing commissioning arrangements.

In response to this, the document will address the following areas:

- The national and local drivers for change
- The population affected by the proposed service change
- The current mental health picture
- Existing secondary care commissioned service provision and service standards
- Wider mental health provision

- How we have engaged with people to understand patient need and generate service change ideas
- Transforming mental health services – the evidence base for change
- System impact of proposed change
- Engagement and consultation requirements
- Mobilising change

2 Clinical commissioning background and context

Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) is responsible for commissioning the majority² of the healthcare services received by its population. Ensuring that people receive the best possible care within the resources available is a complex task and HRW CCG is committed to undertaking this in partnership with patients, their carers, partner organisations and local stakeholders.

At our inception in 2013 we launched the 'Fit 4 the Future' programme to involve local people and service users in the commissioning of services and to prepare the local health and social care system to meet the challenges of meeting its populations needs now and in the future.

The 'Fit 4 the Future' over-arching mission is to develop a beacon of rural health and care services. The CCG serves a deeply rural community, who are passionate about local services. However, it is recognised that the traditional way of organising and delivering services is not sustainable and together the CCG and our partners across the health economy want to radically reimagine how care and support for the local population is provided. By doing this, the CCG believes in taking a whole life and integrated approach to the needs of the individual and with the community at its heart.

Our population tell us that they want to be cared for as close to home as is possible, so our vision is ***'to create high quality care, closer to home for the people of Hambleton, Richmondshire and Whitby'***. We do this by being responsive to the health needs of the local population and commissioning high quality services in a timely and cost effective way. In doing this, it is our aim to maintain and improve the already high standards and clinical outcomes for patients through a combination of integration, partnership working, a greater emphasis on prevention and redesigning the way services are provided so that more services are delivered in community settings. Where care is required in specialist centres we will continue to access the appropriate services. In addition, we aim to constantly improve the quality of care through active engagement with our service users and all stakeholders throughout the commissioning process.

We have a strong focus on integration and joined up working between health and social care teams ensuring appropriate care is delivered outside hospitals. Our plans seek to ensure that hospitals are used only when appropriate in order to provide urgent and specialist treatments for those that will benefit most. The integration of physical and mental health needs and services is also key to the successful implementation of whole person care and is a golden thread which runs throughout our transformation work.

Above all we work to ensure that the patient is at the heart of everything we do.

² NHS England have responsibility for commissioning forensic & specialist mental health services

Following the foundations laid in 2013, in 2014 the CCG worked with local stakeholders to define the 'Fit 4 the Future' vision and the direction of travel:



Figure 1: HRW CCG: Fit 4 the Future vision

Extensive public and stakeholder engagement enabled our population to influence the direction of travel for the whole health economy. This involved a formal 14 week consultation process in 2016 which included 33 public consultation events, two public meetings, numerous other stakeholder meetings and an online survey.

Emerging themes and issues were also raised through the *DISCOVER!* engagement programme. *DISCOVER!* is an innovative engagement tool set up by the Partnership Commissioning Unit (which is a North Yorkshire wide mental health commissioning team) to support the commissioning of local mental health services. *DISCOVER!* events were undertaken during summer 2015 to look at mental health services in rural communities.

Public and stakeholder engagement undertaken during this time demonstrated support for the case for change, with a real understanding from the public for the need to change. This included a rich source of evidence gathered from the consultation undertaken on the development of the North Yorkshire Mental Health Strategy and in addition the North Yorkshire Dementia Strategy.

Table 2: Summary of CCG engagement activity to date

Date	Activity
2013	Vision for Hambleton & Richmondshire laid out in the Fit 4 The Future discussion document
2014	Initial stakeholder and patient engagement
2014	Development and understanding of our strengths, weaknesses and opportunities available to us, forming an intended direction of travel.
2015	<i>DISCOVER!</i> engagement programme of events to look at mental health services in rural communities.
2015/16	Public and staff engagement – Summer Shows and Clinical Summit. Testing the direction of travel and asking what matters most
2015/16	Understanding the outcomes of the engagement thus far and forming our over-arching strategy. Key strategic direction formed from ideas from local community, GPs, nurses and front line staff.
2016/17	Transforming our communities consultation and service change
2016/17	Collation and analysis of engagement and consultation evidence from Fit 4 the Future, <i>DISCOVER!</i> , the North Yorkshire Mental Health and Dementia Strategies and Transforming our Communities to inform the Transforming Mental Health proposal
2017	Pre-consultation engagement discussions for Transforming Mental Health Services

Feedback from all engagement was broadly similar and can be summarised in the following themes:

- Keep people in their own homes for as long as possible
- Care close to home
- More information for patients and their carers
- Better patient transport
- Facilitating social interaction
- More support for carers
- Utilise new technologies as part of the solution

In line with 'Fit 4 the Future' and the outcomes of the 'Transforming our Communities' consultation, it is now the ambition of the CCG to transform working age adults and older peoples mental health services aimed at developing a modern and recovery-focused model of care.

It is widely recognised that improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include;

- improved physical health and life expectancy,
- better educational achievement,
- increased skills,
- reduced behaviours that pose a risk to health such as smoking and alcohol misuse,
- focus on sustainable recovery
- reduced risk of mental health problems and suicide,
- improved employment rates and productivity,
- reduced anti-social behaviour and criminality,
- and higher levels of social interaction and participation.

All these factors have an impact across all statutory and non-statutory providers. It is important therefore, that services work together across the system to shift the focus from illness to wellness.

Our local evidence shows us:

- There may be an opportunity to support more people with mental health diagnoses at home by enhancing community services and social care.
- That access to residential or nursing homes for people with dementia is limited, which means that people are spending longer than they should in hospital (mental health and general acute hospitals).
- The inpatient care environment is not appropriate for this cohort of patients.

In this document we aim to describe the key components of a successful mental health care system and explain why (using a range of indicators) at this time our system is not yet optimally established to meet the current and future mental health need in Hambleton and

Richmondshire. This information is intended to form the basis of our consultation with people about the services that should be developed and commissioned for the future.

In addition, patients have clearly articulated to the CCG, throughout the last four years, that they expect care as close to home as possible. GP colleagues have long identified deficiencies in the community mental health system and realised that if more services were available they could support a greater level of care in a primary care and in the community environment.

Colleagues from Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) have identified that significant numbers of patients are being admitted and remain in hospital for too long; because the services available in the community are either currently not available or not easily accessible.

Colleagues working in community mental health services also identify that there are opportunities for greater integration and more flexible working, but the organisational systems, processes, structures and pathways limit the way teams are historically organised to benefit patients.

Following the 'Fit 4 the Future' engagement and feedback the CCG surmised that there was a need and appetite for transformation of mental health services in our area and have positioned it as a strategic priority for 2017/18. The governance and assurance process for the programme has already been established and the accountability for the project rests with HRW CCG.

It is important that this project is clinically led and a project team has been established to support the development of this transformation project. The project development will be monitored through the Transforming Mental Health Programme Board; the terms of reference of the group can be found in Appendix 1.

This Board reports into the HRW Transformation Board which in turn reports to the CCG Governing Body and the governing bodies of all other represented parties.

3 National and local strategic alignment

As well as local commissioning knowledge, there is a wide range of policy, evidence and good practice drivers emerging nationally, which are influencing our local plans. These include the local Sustainability Transformation Plan (STP) which is informed by the Five Year Forward View for Mental Health (2016), the Mental Health Crisis Care Concordat (2014), the Prime Minister’s Challenge on Dementia 2020 (2015), the North Yorkshire Mental Health Strategy 2015-2020 (2015) and Building the Right Support (2015).

Specifically what we are required nationally to deliver is shown in Table 3 below:

Table 3: National mental health delivery requirements

• Implementation plan for the Mental Health Five Year Forward View for all ages
• 2020 goal - To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole
• Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals
• Increase baseline spend on mental health to deliver the Mental Health Investment Standard
• Ensure delivery of the commitment to treat an additional one million people with mental illness by 2020/21

The CCG has already identified a range of overarching programme objectives in the transformation of mental health services which align fully with national guidance and locally with the North Yorkshire Health and Wellbeing Board Strategy. These include:

- ‘Living well’ – Fewer hospital admissions and increased life expectancy linked to better management of physical health issues associated with mental health
- ‘Ageing well’ – Patients should be able to make choices to self-manage their mental health and wellbeing where appropriate in order to help them stay independent for longer and their carers’ are supported to live their own life. More health and social care staff will be working together across local GP surgeries and primary health care centres to support working age and older people with a mental health diagnosis in the community.
- Improved experience of care based on the National Voices “I” statements.
- Delivery of care in the most appropriate place – there is potentially up to a ward worth of patients at any one time being cared for at a higher level of care than is necessary. This programme should enable this cohort of patients to be cared for in a more appropriate community or home location.

- Financial efficiencies, such as reductions in emergency admissions, more effective use of the spend on the acute mental health budget, increased productivity of commissioned services.
- Up-to-date commissioning specifications to ensure the delivery of services are in line with need.

3.1 Rationale for change

According to the NHS England Five Year Forward Plan for Mental Health:

‘In its recent review of **crisis care**, the Care Quality Commission found that only 14 per cent of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service.... Many acute (mental health) wards are not always safe, therapeutic or conducive to recovery. Pressure on beds has been exacerbated by a lack of early intervention and crisis care.’

This is a picture that we recognise all too well in Hambleton and Richmondshire and we very much want to change this for the people of our area.

Patients tell us that they want to be cared for as close to home as is possible but accept that clearly, when a patient needs acute care they ought to be in hospital. However there is also a weight of international evidence on the adverse impact of hospitalisation on patients – both physical and mental – no matter what their primary diagnoses. Hospitalisation can also be followed by an irreversible decline in ability to carry out Activities of Daily Living (ADL) and quality of life. Decompensation can occur as early as the second day of admission into Hospital. A functional decline can lead to³:

- Increased risk of illness and death
- Diminished quality of life
- Less autonomy and greater dependence
- Admittance to nursing and residential homes
- Increased lengths of hospitalisation
- Readmission to hospital

There are a number of national factors which inform how care should be delivered in the future. These include:

1. **NHS system changes** – the NHS is facing large and complex changes in the way it delivers care. The length of time patients stay in hospital is decreasing but at the same time there is a growing expertise required in many specialities, meaning to deliver the best quality care some services can only be delivered in specialist hospitals where the right clinical teams, nursing teams and medical equipment is available.

³ Creditor MC. Hazards of hospitalization of the elderly. *Ann Intern Med* 1993;118(3):219-23

A key outcome of 'Fit 4 the Future' has been to invest more in community services; enabling the CCG to focus on providing much more care to people in their own homes or close by, and relying less on inpatient hospital beds.

2. **High quality care for all** – In recent times the NHS has had to address the outcomes of multiple reviews into significant failures of the health and care system. There are a number of significant reports published, including; Transforming Care, the Government's final report on Winterbourne View; and the public inquiry chaired by Robert Francis QC on Mid Staffordshire NHS Foundation Trust and Patients First and Foremost, the Government's initial response.

HRW CCG is fully committed to responding positively to these important reviews, ensuring that a culture of compassionate care is fostered in which patients are genuinely and consistently at the centre of everything the service provides.

An approach which brings together all commissioners and those providing care creates a platform to improve patient experience and provide safe and clinically effective care.

3. **Prioritisation of prevention and early intervention** – This is widely recognised as being essential to improving health and well-being and in securing a sustainable health and care system for the future. A range of current national policies have given renewed emphasis on the promotion of wellbeing, the prevention of ill health and early intervention.

The Marmot Report highlighted the crucial importance of prevention and early intervention in the early years as this sets the foundation for health in later life, improves individual life chances and can help in breaking the cycle of health and social disadvantage across the generations.

4. **Provision of more personalised care** - The Government and the Department of Health is rolling out a personal health budgets policy nationally in the NHS. A personal health budget is an amount of money to support a patient with identified healthcare and well-being needs and is planned and agreed between the patient and their local NHS/social care team.

At the centre of a personal health budget is a patient care plan. This plan helps patients decide on their health and well-being goals together with the local care team who support them. For the care plan to be effective, it needs to form part of an integrated health care record that can be shared across a multi-agency care team to ensure the co-ordination of care from a cross-organisational basis.

The CCGs' strategic planning approach is to enable people with all long term conditions and disabilities, including mental health, to have greater choice, flexibility and control over the health care and support they receive and to enable sustainable recovery.

Research undertaken by the Kings Fund on community transformation highlights the importance of place based systems of care working together to improve health and care for populations. This means organising and collaborating resources, ensuring appropriate governance and leadership is in place all of which need to be supported by a sustainable financial model of community care.

The Kings Fund⁴ also talk about the importance of ensuring that the NHS and other national bodies remove barriers to ensure the success of place based systems of care, ensuring a co-ordinated approach to the development of local systems.

The ambition to move care closer to home has resulted in some reduction in lengths of stay in hospital settings but it is evident that further significant changes are needed in the way that care is delivered – most particularly for mental health patients.

A report published by the NHS Confederation supported by the Royal College of General Practitioners (RCGPs) in 2012 “Making Integrated Out of Hospital Care a Reality” describes the foundations for integrated care with a focus on implementing out-of-hospital care, and connecting primary, community and social care. It highlights key evidence and draws on learning from partners across health and social care and explains how a set of principles, each underpinned by a range of drivers and enablers at primary and secondary levels, can support the effective delivery of integrated out-of-hospital care.

3.2 Five Year Forward View for Mental Health Priorities: prevention and early intervention

In line with the NHS Five Year Forward View, prevention and early intervention is widely recognised as being essential to improving health and wellbeing and in securing a sustainable health and care system for the future. A range of current national policies, including Sir Michael Marmot’s report on health inequalities (‘Fairer Society, Healthy Lives’ February 2010) has given renewed emphasis on the promotion of wellbeing, the prevention of ill health and early intervention. Evidence shows that partnership working between primary care, local authorities and the third sector to deliver effective universal and targeted preventive interventions can bring important benefits. Public health services have transferred to Local Authorities and North Yorkshire County Council is leading the development of a prevention strategy, which includes access to information and advice at an early stage at its heart.

3.3 Management of Crisis

In 2014, the CCG as one of the partner organisations in North Yorkshire and York made a declaration to put in place the principles of the national Crisis Care Concordat to improve the system of care and support so that people in crisis because of a mental health condition are appropriately supported and are kept safe. The aim is to help them to find the help they need – whatever the circumstances – from whichever of our services they turn to first.

Partner organisations agreed to work together to prevent crises happening whenever possible, through intervening at an early stage. A commitment was made to ensure the needs of

⁴ Ham C & Alderwick H, Place Based Systems of Care: A Way Forward for the NHS in England, The Kings Fund, November 2015

vulnerable people in urgent situations are met, getting the right care at the right time from the right people to make sure of the best outcomes and avoiding hospitalisation where possible.

3.4 Provide sustainable housing models to meet future needs of local communities

Vulnerable and older people require homes and opportunities that meet their particular needs, foster self-determination and support a good quality of life. The needs of older and vulnerable people can be met in a variety of settings, such as shared specialist supported housing, extra care housing, care settings, as well as through general housing. We recognise that vulnerability can be a temporary or a permanent state and therefore a wide range of solutions need to be available.

3.5 Continue to improve financial efficiency of services

Poor mental health carries an economic and social cost of £105 billion a year in England. Analysis commissioned by NHS England found that the national cost of dedicated mental health support and services across government departments in England totals £34 billion each year, excluding dementia and substance misuse. Nationally, both the NHS and Local Authorities face pressure on budgets and the need to make continued efficiencies if they are to remain in financial balance. In times of financial constraints, public services, including mental health services have to make efficiency savings at a time when demand for services is likely to rise. It is imperative that the CCG, together with its partners, ensures that each pound that is spent on mental health services delivers the maximum amount of value possible for the people who access services. A key way in which to do this is to ensure that existing investment is targeted at evidence-based prevention and early intervention for mental disorders. This can have economic benefits that go far beyond the health sector and present opportunities for innovation within mental health service provision; for example rebalancing services towards cost-effective community-based care alternatives.

Beyond the economic cost of £105 billion a year, poor mental health is destroying lives. Prevention was the public's number one priority for NHS England's Mental Health Taskforce in its public engagement stage. The Taskforce reported that 75% of people experiencing mental health problems are not using health services. This may be due to stigma, inadequate provision and people using their own resources to manage their mental health. The wider determinants of mental health issues are evident in schools, workplaces, communities and housing.

In summary we need to maximise opportunities to get better value from the NHS budget, delivering services of high quality with improved outcomes.

3.6 Local Sustainability and Transformation Partnership - mental health ambitions

The NHS Shared Planning Guidance asked every local health and care system in England to come together to create their own ambitious local plan for accelerating the implementation of the Five Year Forward View (5YFV). These blueprints, called Sustainability and Transformation Plans (STPs), are place-based, multi-year plans built around the needs of local populations. They provide the local vehicle for strategic planning, implementation at scale and collaboration between partners.

The STP which includes Hambleton and Richmondshire acknowledges that services cannot continue to be delivered in their present form. The strategy is a 'system-wide' solution based on effective earlier intervention and prevention through to more integrated community models of care. During 2016, NHS staff, including doctors and hospital consultants talked to local people about NHS services at over 50 events. What became clear is how passionate people are about NHS services, and how much they value them. But people also expressed their frustrations at the way some services work, and concerns about some of their experiences, including how some services are used. The NHS in Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby has been working together looking at how we provide acute services under a programme called 'The Better Health Programme'.

Our STP identifies four areas for improvement:

1. Preventing ill health and increasing self-care

This involves helping to stop people from becoming poorly and helping to manage their health and any medical problems they already have.

2. Health and care in communities and neighbourhoods

Supporting people to stay well and independent for as long as possible by improving health and care services within their area.

3. Quality of care in our hospitals – “Better Health Programme”

This is about improving the quality of care in hospital and reducing the distance you have to travel for routine appointments e.g. blood tests, but making sure that people get the best treatment and see the right specialist when they need to.

4. Use of technology in health care

Using technology to improve our ability to determine what the problem is e.g. what is making you poorly, decide with you on any treatment you might need and to make sure this treatment or care is given to you in a convenient way.

In respect of mental health, priority two highlights the key areas for improvement

1. NHS organisations will share things they have done that have worked well, so that other neighbouring areas can learn from and benefit more people.
2. We plan to increase the number of NHS services provided in the community so people can come home from hospital more quickly, and have their care needs assessed at home, rather than having to stay in hospital when they are well enough to go home.
3. We plan to improve access to mental health support locally, including services such as talking therapies and greater involvement of the voluntary sector.
4. We are improving access to services locally by developing community based care arrangements in Darlington, Durham and Tees. These will bring together local NHS services with social care and voluntary sector services to improve the range and convenience of services available locally.

5. In Hambleton and Richmondshire, we will be implementing the proposals for developing care outside hospital that have been consulted on in “Transforming our Communities”.

3.7 Contractual and QIPP requirements

Alongside delivery of the CCG strategic priorities (summaries in Figure 2), the contractual arrangements over the next two years are designed to secure the current mental health investment and a programme of innovation that will release mental health funding to further improve service delivery, patient experience and outcomes.

The local Quality, Innovation, Productivity and Prevention (QIPP) programme is fundamental to securing an improved patient experience and best use of resources across the health system.

In summary the QIPP initiatives relate to:

- Resource utilisation
- Total mental health spend impact – open/locked services, rehabilitation services, independent funding requests, continuing health care
- Improving access
- Improving patient experience
- Improving value for money
- Integrating physical and mental health services and care
- Eliminating unnecessary out of area placements and associated cost
- Maintain existing commissioning standards and address gaps

In order to meet the requirements of the mental health investment standards it is required that any service redesign remains within the existing financial envelope for this service. In order to also support commissioner financial sustainability the totality of spend is subject to the 2% efficiency saving which has been have applied to the whole of Mental Health service provision.

Health & Wellbeing Gap	CCG Transformational programme 1 – Primary and Community Care (incl. Forces Family Health)	Transformation Scheme	EARLY INTERVENTION AND PREVENTION (STP priority)	17/18	18/19	Estates
		HWB strategy – starting well, living well, dying well, connected communities	Develop integrated services to improve health awareness in order to improve screening, encourage earlier diagnosis and avoid emergency admission including primary prevention interventions i.e. smoking, alcohol, obesity Improved support for all children, with focus on vulnerable and disabled children and the SEND agenda			
		Self care	Improve quality of education and support offered to patients with long-term conditions so that they feel confident in managing their own condition and avoid admission Introduce predictive risk modelling			
Quality & Care Gap	CCG Transformational programme 2 – Urgent and Emergency Care	Transformation Scheme	INTEGRATION (STP priority)	17/18	18/19	Workforce
		Friarage hospital front of house – urgent / emergency care	Integrated Front of House at Friarage hospital – ambulatory care, CDU, GP in and out of hours, liaison psychiatry and short stay paediatrics			
		Transforming our communities & new models of care	Radical new model of health & social multidisciplinary care working in deeply rural area Frailty pathway redesign incl. intermediate care services closer to home, step up / step down beds to pull people home, improved end of life, delirium, dementia, falls			
		Primary and Community integration - New model of care	MCP - Primary care-based out of hospital services built from 3 pillars: • Integrated diabetes pathway, including education, foot care, treatment processes • Extended access to primary care (Prime Minister’s Challenge Fund pilot) • Frailty pathway and community services redesign			
Funding & Efficiency Gap	CCG Transformational programme 3 - Planned Care	Mental health & LD	Close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole			Engagement
		Transformation Scheme	RECONFIGURE HOSPITAL-BASED SERVICES (STP priority)	17/18	18/19	
		Sustaining the Friarage Hospital as the hub of local services	Improve outcomes for service users & carers through clearer / simpler pathways of care New services / clinics established close to home to reduce patient need to travel Secondary care acute and elective surgery pathways (critical care level 2) Continue development of SSPAU and midwifery service to improve children’s health			
		Planned Care & LTCs	Reduce outpatient demand and transfer work to primary care by specialty redesign, benchmarking, and referral processes; impact on RTT and FA:FU ratios Cancer earlier diagnosis / recovery packages ; impact on survivorship and waiting times			
	CCG Transformational programme 4 – Mental health and learning disability	Transformation Scheme	TECHNOLOGY (STP priority)	17/18	18/19	Governance
		Local Digital Roadmap	Technology-driven model to meet needs of rural population Improving communication - E records, e prescriptions and e referrals Driving clinical services - Telemedicine cart at FHN, connecting care homes to hubs			

Figure 2: CCG strategic plan on a page

4 Understanding the local population's health

The main population being focused on for this change is that of Hambleton and Richmondshire, as Whitby and the surrounding area is served in the main by Teesside and Scarborough mental health teams. However, developments that arise from this system transformation will be considered for the whole CCG population.

Hambleton and Richmondshire is a predominantly rural area with a local population that is increasing and ageing, with significant in-migration from other parts of the UK in the pre-retirement and the recently retired age groups.

Hambleton is a large mainly rural district, running from York in the south to Darlington in the north.⁵ Approximately 10% falls within the North York Moors National Park. There are five market towns, Bedale, Easingwold, Northallerton, Stokesley and Thirsk, and 130 villages. Just over half of the population live outside the market towns and population density is one of the lowest in the country. Richmondshire is one of the largest districts in England, covering an area of just over 500 square miles (1319 square kilometres) two thirds of which is in Yorkshire Dales. Main centres include Richmond, Catterick Garrison, Leyburn, Hawes and Reeth. Outside of urban centres and market towns, the areas are sparsely populated with 70.6% of the population living in rural areas and 15.3% of the population living in areas which are defined as super sparse (less than 50 persons/km).

Much of the population is healthy and well and makes a major contribution to the health and wellbeing agenda as direct carers, as volunteers in their local voluntary organisations and through silent, often un-noticed work both with families, their neighbours and their faith groups.

However, a significant number of people also face barriers in accessing and receiving high quality support and information; managing their own support as much as they can; maintaining a family and social life; work and education and contributing to community life. The effects of loneliness on mental health and overcoming isolation is a major challenge across a rural and sparsely populated area and is an issue frequently raised by the people who use services and those who care for them. This case for change describes an opportunity to consider the wider needs of people who experience mental health problems, for example those with long term conditions, learning disabilities and dementia, frailty and social isolation.

4.1 Health Needs Assessment and Commissioning Vision

The joint strategic needs assessment (JSNA) for North Yorkshire brings together local authorities, the community and voluntary sector service users and NHS partners in research to show a comprehensive picture of local health and wellbeing needs. The process of developing the JSNA also supports and encourages organisations to work together when developing services.

North Yorkshire's JSNA looks at what is known about the population and their current and future health and well-being needs. It does not look at the particular needs of individual people; it

⁵ North Yorkshire County Council Joint Strategic Needs Assessment 2015

looks at the 'big picture' of people's needs and where needs are not being met as well as they could be.

The CCG has used the North Yorkshire JSNA to establish its commissioning priorities and reviewed the issues mentioned during the engagement events for the Hambleton and Richmondshire areas and North Yorkshire.

In summary, HRW CCG is expecting:

- The number of people in Richmondshire District aged 65 and over to increase from 9,200 to around 12,300 by 2021.
- The number of people in Hambleton District aged 65 and over to increase from 19,400 to around 25,400 by 2021.
- The number of people in Scarborough District aged 65 and over to increase from 25,500 to around 31,300 by 2021.

The population profile in Hambleton, Richmondshire and Whitby CCG is markedly different to England. Compared to the national population, the area is below the percentage average for those aged < 45 and over the percentage average for those aged > 50s. In support, the State of the Region report highlights this marked increase in older population which, is also predicted by Office for National Statistics (ONS). This is shown in Figure 3. A major component of this is that the baby-boomers are moving into retirement. This is not an increase in population; rather the ageing of the existing one. These older people are generally healthier than previous generations.

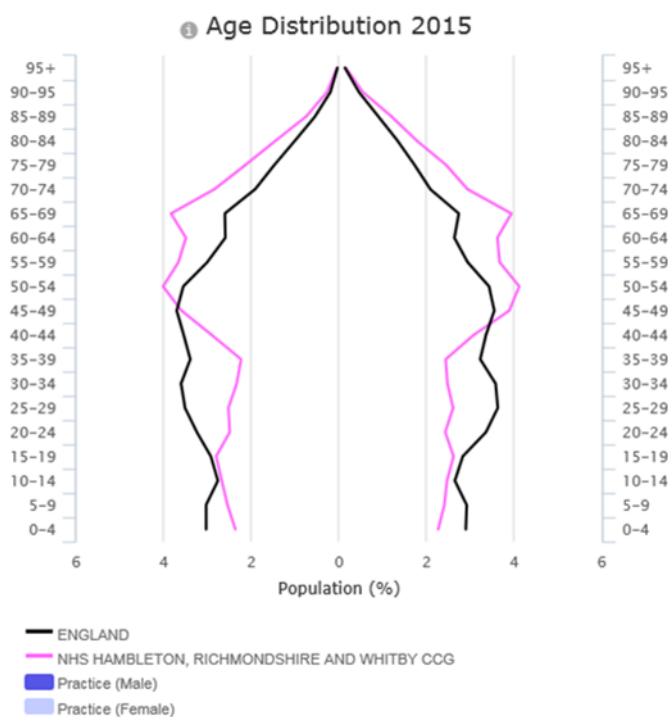


Figure 3: CCG Age Distribution

The higher proportion of older people in the CCG is leading to higher demand for services and a requirement for the CCG to ensure that it is appropriately commissioning services that are fit for an ageing population.

4.2 The 'local' mental health picture

According to the latest Joint Strategic Needs Assessment (JSNA), both Hambleton and Richmondshire mortality from suicide and undetermined injury is higher than that of the national average; although the numbers are small the impact to people is evident. In addition, the population experiences a worse picture against the national of levels of mental health and illness and the percentage with dementia aged 18 plus (not age standardised) and percentage with depression aged 18 plus (not age standardised).

In respect of the current provision of mental health services, the majority of people with mental health needs receive their care in the community. Adults and older people requiring in-patient services are admitted, in the main into The Friarage Hospital in Northallerton. More specialised mental health services are provided in Teesside or Darlington.

The essence of mental health care is that there is much we can do to help people to self-manage and prevent deterioration of conditions through better education and awareness and putting plans in place to help people respond in a crisis. We can also provide better support for family and carers to help them understand and be part of the new approaches we are using to support people with mental health conditions, for example earlier recognition of issues, access to support services sooner, such as the voluntary sector, and using new technologies and caring for more people at home where possible.

In this process therefore, it is vital that we do not just consider the treatment of those already diagnosed with mental health conditions. Supported by Public Health, we must also consider what preventative strategies we can employ to keep people mentally healthier for longer and invest in work with the younger population, who are both able to support the older generation now and who will also become the adult and elderly population of the future.

5 Engaging with patient, partners and staff

The CCG as commissioners for local services are required to assess whether the four tests for service reconfiguration (set down by the Secretary for State in 2010) have been met:

- Support for proposals from clinical commissioners
- Strong public and patient engagement
- A clear clinical evidence base
- Consistency with current and prospective need for patient choice

Through the engagement process the CCG will seek to ensure all of the four tests are met fully, this will also be assessed during the formal consultation.

5.1 Purpose of Engagement

The CCG has already undertaken significant public and stakeholder engagement over the last four years, particularly under 'DISCOVER!' and 'Transforming Our Communities'. To assist us in scoping out feasible options and in preparation for the formal consultation a series of pre-consultation listening events took place. The purpose of this period of engagement exercise was to ask the following questions:

- 1. What can your local NHS do to care for more people with mental health problems in the community?**
- 2. How can we improve the standard of care for those who are in crisis?**
- 3. What can we do to reduce the need for hospital admission and to keep the length of stay to a minimum?**

The focus of the pre-consultation engagement has been to gather views from service users and their carers, NHS staff and community groups using the following methods:

- Pop-up events in The Friarage Hospital and GP practices
- A large-scale event with service users and voluntary sector organisations (over 100 attendees)
- Two further large-scale events with services users, voluntary sector organisations and staff (one in Northallerton and another in Richmond)
- Posters in key locations
- Briefings to key stakeholders
- Website page
- Feedback email address

A full review of local voluntary sector organisations and service user groups identified a number of opportunities to further engage prior to formal consultation. These can be found in appendices 4 and 5 of the Communications and Engagement Strategy (Appendix 2).

5.2 The Engagement Process

A communications and engagement strategy has been developed to outline the range of methods and opportunities to communicate and engage with local stakeholders. This can be found in Appendix 2 of this document.

6 GP and primary care

GP practices across the CCG have the highest patient satisfaction rating in the country and are working efficiently to provide a wide range of services in primary care. Nevertheless, practices will need to undergo some significant development in the next few years. There is a national move through the updated GP contract towards some level of seven day working, proactive identification of at-risk individuals through risk profiling, and identifying lead professionals for complex vulnerable patients. There are also drives elsewhere in the country for primary care to support more early mental health interventions in the primary care setting by up-skilling their own staff.

Currently adult and older people's mental health support in general practice and community settings include:

- GP support
- Access to psychological therapy services
- Cognitive behavioural therapy trained primary care nurses
- Long term condition nurses
- 7/7 services

The CCG has led organisational development work to start to build functionally integrated health and social care teams across primary care. There has also been a continued emphasis on discharge to the community through a discharge steering group that has connected acute, community and social care colleagues and it is envisaged that in the future mental health services will be included in these teams.

In Hambleton and Richmondshire, the integrated locality teams are being developed to wrap around clusters of GP practices as detailed in Table 4 below. The clustering of GP practices has self-formed as a result of other transformation work, where practices have been looking at ways to meet some of the challenges they face in terms of resources by testing new ways of working in a more integrated way.

Table 4: Primary care provision

Team	GP Practice Cluster
Northallerton Integrated Locality Team	Mowbray House, Northallerton Mayford House, Northallerton
Stokesley Integrated Locality Team	Stokesley Health Centre Great Ayton
Bedale Integrated Locality Teams	Glebe House Surgery
Thirsk Integrated Locality Team	Lambert Medical Practice Thirsk Health Centre Topcliffe Surgery
Catterick Integrated Locality Team	Catterick Village Health Centre Colburn Medical Centre Harewood Medical Centre
Richmond Integrated Locality Team	Aldbrough St John

Team	GP Practice Cluster
	Quakers Lane Scorton Medical Centre Friary Medical Centre
Dales Integrated Locality Team	Leyburn Practice Dales Medical Practice Aysgarth Practice Reeth Practice

The Integrated Locality Teams will coordinate integrated care planning with a wide range of local services including Community Mental Health Teams, GP Practice Nursing, GPs, community therapy, crisis response, social care, voluntary services, housing providers and the North Yorkshire County Council Living Well Team. This will provide a vehicle to agree proactive care planning for patients in the community.

7 Improving Access to Psychological Therapies (IAPT)

A key relationship with general practice is the provision of Psychological Therapies in primary care. The primary function of IAPT is to provide a responsive and accessible service within primary care to people experiencing common mental health problems in collaboration with existing primary care teams.

Referral demand

In the 10 month period from April 2016 to January 2017 the HRW IAPT service received 2,351 referrals, an average of 235 a month. If this demand continues for the final two months of the year this would amount to 2,804 referrals in the year.

Service contacts

Almost 2,000 people entered into Treatment in the first 10 months of the financial year (1,966), with 1,366 completing treatment in the same period, with a recovery rate of over 52%.

Compliance with performance standards

Our current IAPT service delivers NICE-compliant treatment for people suffering from depression and anxiety disorders, based around a flexible stepped-care approach, delivered in a variety of settings close to people's homes.

Through this work we have an opportunity to create stronger links with general practice staff in managing the mental ill-health and wellbeing needs of people with long-term conditions, simplifying access into IAPT and equipping staff in practice with a greater skill to recognise and manage low level mental ill-health whilst retaining the expertise that is within IAPT.

GP and Patient experience feedback

In the 2016 GP Survey, feedback from Hambleton and Richmondshire GPs showed that 78% of GPs rated the IAPT service as 'Very Good' or 'Good'.

8 Current secondary mental health care provision

The current mental health provision is orientated around the district general hospital, the Friarage in Northallerton in the district of Hambleton. Aspects of secondary care mental health services are co-located on the same site as The Friarage Hospital (namely inpatients, Section 136 suite and crisis services) and are primarily commissioned from Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) and North Yorkshire County Council (NYCC) who provide an integrated response to patient need and are organised into three main response areas:

- 1 Triage and access to community services
- 2 Crisis response and intensive home treatment
- 3 Inpatient care

In order to understand the current service model, Figures 4 and 5 provide a helpful overview of the current operating model across Hambleton and Richmondshire.

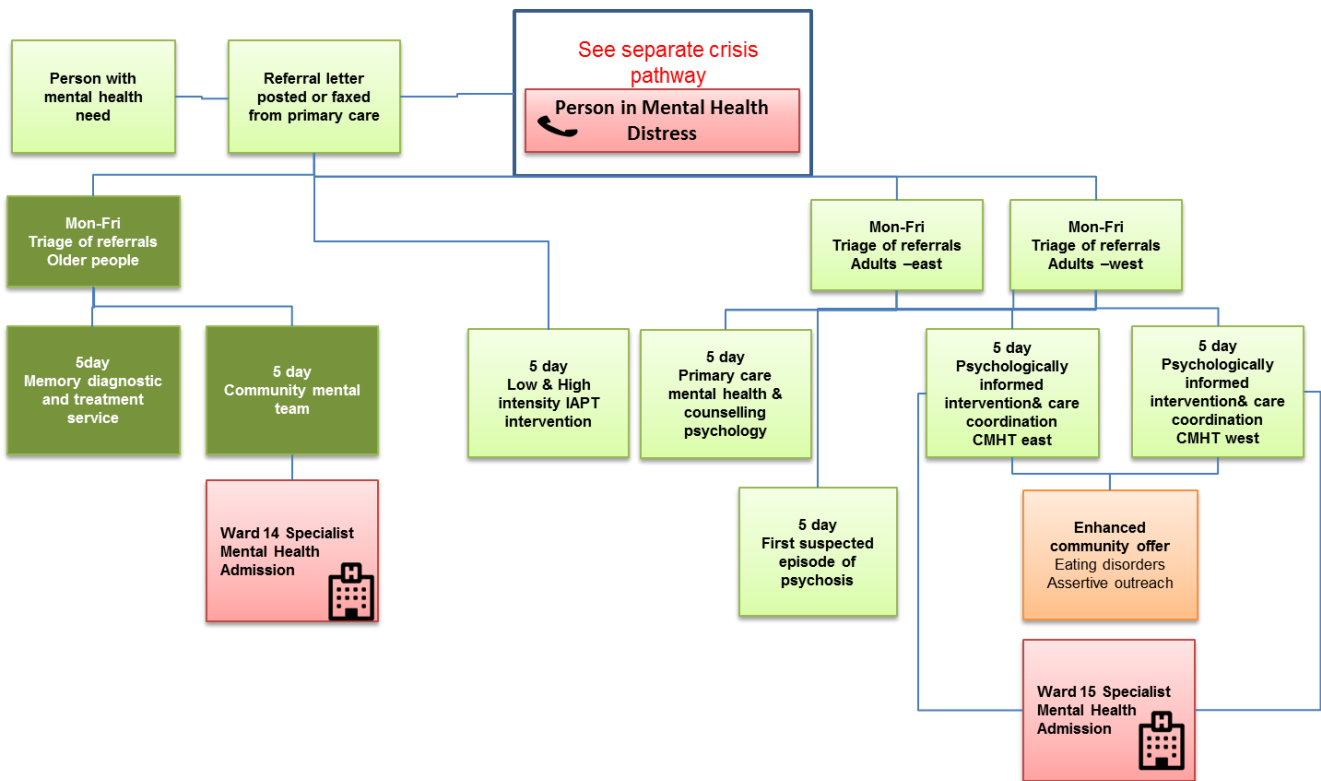


Figure 4: Current out of hospital secondary care mental health provision

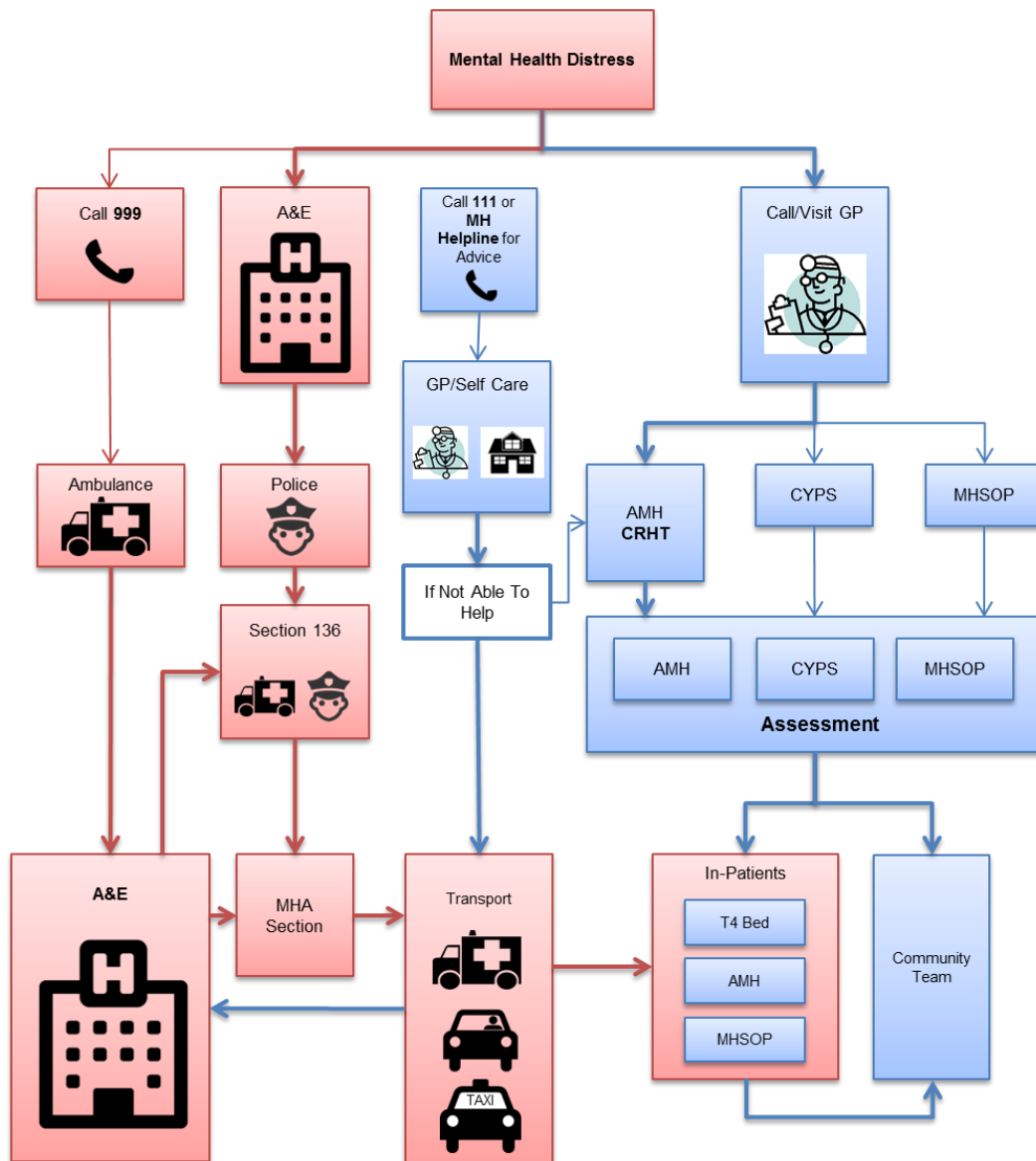


Figure 5: Current crisis response pathway

The following sections provide further narrative regarding the key parts of the current service offer and performance against key quality and performance standards.

8.1 Triage and access to community services

Primary access into secondary mental health services is via the patient's general practitioner into the respective age/specialist community teams. The primary purpose for community mental health services is to provide a recovery-focused specialist mental health service for adults experiencing a moderate to severe or enduring mental health problem of an acute or remitting nature within the categories of mood, psychotic, neurotic or personality disorders.

Table 5 shows a summary of the access and current community provision.

Table 5: Triage and access community services

Working Age Adult 18 to 65 years	Older persons 65years Functional and organic mental disorders
Operates 5 days a week offering: <ul style="list-style-type: none"> • Daily triage of referrals. • Assessment by primary mental health care and community teams. • Lead referral point for people with first suspected episode of psychosis (EIP) - 14-65years. • NICE approved interventions for early psychosis presentations. • Additional capacity to support those with long-term mental health. • IAPT offers a service to those with high and low intensity needs meeting the expected prevalence standards and close to the national average for recovery. • Armed forces and veterans have access to a dedicated resource based with the Military campus. • Psychologically informed interventions. • Physical health management. 	Operates 5 days a week offering <ul style="list-style-type: none"> • Daily triage of referrals. • Assessment and treatment by community teams. • Community memory diagnostic and treatment service. • Physical health management. • Additional support for older people with mental health conditions.

In order to understand the quality and experience of service users, the following information provides details of performance including demand on services, patient feedback, quality inspections and compliance against key quality standards.

Referral demand

Between April 2016 to February 2017, 1690 external referrals were received across services, of those Table 6 shows what number were accepted into service:

Table 6: Accepted referrals into services

AMH	Total	Per Month	Full Year*
CMHT	383	34.82	419
Primary Care	386	35.09	422

MHSOP	Total	Per Month	Full Year*
CMHT	439	39.91	480
Memory Service	361	32.82	395

Service contacts

In the same time period, a total of 42,092 contacts were delivered across the two specialities. Table 7 details the activity carried across AMH and MHSOP, including;

- Community Mental Health Teams,
- Primary Care Mental Health Team
- Memory Service.

Table 7: Total service contacts

AMH	Direct Contacts			Full Year
	F2F	Telephone	Total	
CMHT	14,593	3,626	18,219	19,910
Primary Care	3,227	426	3,653	3,992

MHSOP	Direct Contacts			Full Year
	F2F	Telephone	Total	
CMHT	7,790	1,252	9,042	9,881
Memory Service	6,262	1,341	7,603	8,309

First presentation psychosis

Table 8 shows the current referral demand across the locality.

Table 8: First suspected episode referral demand

Count of Patient ID	Column Labels											
Row Labels	Jan	Feb	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Grand Total	
<input type="checkbox"/> AMH HHR EARLY INTERVENTION PSY	4	3	2	2	8	4	7	3	9	4	46	
Hambleton	1		2		4	1	4	1	5	1	19	
Harrogate	3	1		1	1	2	2	2	1	1	14	
Richmondshire			2	1	2		1		3	2	11	
(blank)					1	1					2	
Grand Total	4	3	2	2	8	4	7	3	9	4	46	

Compliance with performance and quality standards

Over 96% of all patients referred to the AMH CMHT and over 99% of all patients referred to the MHSOP CMHT are seen within 4 weeks of referral. In comparison, performance in our primary care mental health teams and Memory services achieve the following:

- 26% of all patients referred to the Primary Care service are seen within 4 weeks of referral.
- 14% of all patients referred to the Memory Service are seen within 4 weeks of referral.

Reasons for this are influenced by the stand alone nature of the primary team to meet demand and access to diagnostics with the acute hospital impact on the ability to offer same day testing that other dementia pathways can.

Patient experience feedback

The patient feedback demonstrated in Table 9 shows that only 60% of all AMH patients and only 75% of all MHSOP patients reported, that their overall experience of the services was rated as excellent in the last 12 months; in part impacted by the reliable access to services and the ability of small teams to maintain delivery during staff absence or vacancies.

Table 9: Patient overall experience rates

	Actual	%age
AMH	1011	60.90%
MHSOP	438	75.13%

In addition, Table 10 demonstrates that the patient friends and family test (as defined by the national process) shows the community service as a positive picture.

Table 10: Patient friends and Family Test

		Extremely Likely	Likely	Total	%age
AMH	H&R East	60	34	104	90.38%
	H&R Primary Care	26	7	34	97.06%
	H&R West	21	8	30	96.67%
	H&R IHT	25	12	41	90.24%
	H&R IAPT	41	45	91	94.51%
	H&R AOT	3	4	8	87.50%
	H&R EIP	3	2	5	100.00%
MHSOP	H&R Care Home Liaison	1		1	100.00%
	H&R Memory	66		76	86.84%
	H&R CMHT	20		22	90.91%

The numbers of complaints received by AMH and MHSOP services are shown in Table 11, for the period April to November 2016, both as an absolute number and per 10,000 open caseload.

Table 11: Patient complaints

	Number	Per 10,000 Open Caseload
AMH	16	29.35
MHSOP	4	9.57

While there are no themes across the complaints, key factors that have arisen include:

- Communication
- Clinical care
- Attitude of staff

Each of which needs to be taken into account in any service change.

GP feedback

In the 2016 GP Survey, feedback from Hambleton and Richmondshire GPs showed that: -

- 48% of GPs rated the AMH CMHT as 'Very Good' or 'Good'.
- 71% of GPs rated the MHSOP CMHT as 'Very Good' or 'Good'.

The three main learning themes that need to be taken into account with this service changes are linked with:

- Improved access and clearer referral pathways
- Reduced waiting times
- Improved frequency of communication

Delivering safe and effective care

In the last 10 months a total of 123 moderate harm and above incidents (as defined by the national serious incident framework) were reported. See Table 12, data shown as an absolute number and per 10,000 open caseload.

Table 12: Moderate harm incidents reported

	AMH		MHSOP	
	Actual	Per 10,000 open caseload	Actual	Per 10,000 open caseload
Exc Self Harm	29	53.2	31	74.18
Self-Harm	54	99.05	9	21.54

Of the total moderate harm and above incidents; nine are significant in nature or are a reported unexpected death related to patient safety issues. Table 13 provides the break down across services.

Table 13: Community reported significant harm and unexpected deaths

		Level 4	Level 5
AMH	CMHT	1	3
	EIP	1	
	Inpatient		
	Total	2	3
MHSOP	CMHT	1	1
	Inpatient	1	1
	Total	2	2

According to benchmarking data our services appear to have a positive reporting culture and are not an outlier compared to their peers.

Workforce

The current adult community services is organised into four teams with integrated support from North Yorkshire County Council. The current skill mix allows access to the following roles;

- Consultant psychiatrists
- Clinical psychology
- Counselling psychologist
- Registered nurses
- Registered social workers
- Housing support
- Support workers
- Carer leads
- Admin and secretarial support

The current older person community services is organised into three teams. The current skill mix allows access to the following roles;

- Consultant psychiatrists
- Clinical psychology
- Registered nurses
- Support workers
- Carer leads
- Admin and secretarial support

8.2 Crisis response and intensive home treatment

The role of a crisis team is to provide assessment and safety plans for those experiencing severe mental health difficulties in the least restrictive environment; that is consistent with the need for their own safety and the safety of others, offering a genuine alternative to the traditional response of inpatient care. In addition, the service is charged with providing a “gate-keeping” role, by which all potential admissions to adult acute in-patient care are considered and assessed by the crisis teams to establish whether a viable alternative to admission exists.

Intensive home treatment is a resource to offer step-up care (nationally defined as providing twice daily visits for three days) or step-down care, either following discharge from hospital or a crisis assessment as an alternative to acute psychiatric admission.

For those people who require detaining by the Police under Section 136 of the Mental Health Act (MHA), the crisis team support patient assessment and ongoing care through the Section 136 suite at the Friarage Mental Health Unit. Table 14 provides a summary of the current provision.

Table 14: Current crisis and home treatment service offer

Working Age Adult	Acute hospital liaison
16 to 65 years functional and organic	16 and above acute liaison
<p>Operates 7 days a week offering:</p> <ul style="list-style-type: none"> • Consultant - led • 4 hour response to people in crisis 24/7 for people aged 16-65 years • Gatekeeping assessment prior to admission to adult bed • Lead service for the assessment under Section 136 of the Mental Health Act. • Benefits of integration with social care staff and appropriate mental health practitioner (AMHP). • 7 day service to provide Intensive home support • Health based-place of safety (Section 136 suite) 	<p>Operates 7 days a week offering</p> <ul style="list-style-type: none"> • 1 hour crisis response to Emergency department (8am-8pm) • Inpatient liaison within 72 hours of referral
<ul style="list-style-type: none"> • Joint consultant and junior doctor on call 	

In order to understand the quality and experience of service users, the following information provides details of performance including demand, activity, patient feedback, quality inspections and compliance against key quality standards.

Referral demand

The Working Age Adult Crisis and Home Treatment service shows in Table 15 that 448 referrals were accepted into service up to the end of February 2017. This is directly in line with the expectation that crisis and home treatment keeps people out of hospital.

Table 15: Crisis and home treatment referrals

AMH	Total	Per Month	Full Year*
Crisis/Home Treatment	448	40.73	490

(Note tables below only include external referrals that have been accepted into service)

Table 16 shows that the Acute Hospital Liaison Service has received over 280 external referrals into the service up to the end of February 2017.

Table 16: Acute hospital liaison referrals

MHSOP	Total	Per Month	Full Year*
AHLS	281	25.55	307

Currently, there is no commissioned crisis or intensive home support for people under 16 or with organic presentations who present in crisis or to the emergency department.

Section 136 assessment and outcomes

Table 17 shows the S136 demand and the number of S136 presentations that resulted in admission between February 2016 to January 2017.

Table 17: Section 136 activity and outcomes

Total Referrals	61		5.1	Per month
Formal Admissions	13	21.31%		
Informal Admissions	6	9.84%		
		31.15%		

For 12 month period up to and including October 2016

Total Referrals	79		6.6	Per month
Formal Admissions	18	22.78%		
Informal Admissions	10	12.66%		
		35.44%		

For 3 month period from November 2016 to January 2017

Total Referrals	7		2.3	Per month
Formal Admissions	2	28.57%		
Informal Admissions	2	28.57%		
		57.14%		

The most recent data shows a significant reduction in S136 activity, which is being driven by the closure of the Police custody suite in Northallerton. With this in mind the new model of care must take this change in Police practice into account regarding the need of a health based place of safety.

Service contacts

The AMH Crisis and Home Treatment service have undertaken over 3,300 ‘direct’ contacts in the period April 2016 to February 2017 (which includes face to face and telephone contacts). This is approximately 300 per month, which would equate to around 3,650 contacts per year.

The Acute Hospital Liaison service have delivered just under 2,200 direct contacts over the same period, which would equate to around 2,400 per year.

Compliance with performance and quality standards

In respect of compliance with key quality indicators the services current performance is:

- 86% of patients referred to the Crisis Service are seen within 4 hours of referral.
- 97% of patients have a 'gatekeeping assessment prior to admission to an adult inpatient bed
- 98% of all patients referred to the Acute Hospital Liaison (AHL) service from ED are seen within 1 hour
- 99% of all patients referred to the AHL service from an acute ward are seen within 72 hours.

Patient experience

Table 18 shows the positive experience from the current crisis service.

Table 18: Crisis FFT

	Extremely Likely	Likely	Total	%age
AMH Crisis	25	12	41	90.24%

Workforce

The crisis and home treatment service is currently supported by the following workforce:

- 1wte consultant
- 1wte team manager
- 13.41wte crisis clinicians
- 1.1wte admin and secretarial support

8.3 Inpatients

The inpatient provision for adults and older people is to provide those who require assessment, care and treatment of a nature that cannot be provided in a community setting. This includes:

- People who are experiencing acute distress and present with significant risk of harm to self, harm to others, deterioration in mental health, deterioration in physical health associated or secondary to mental health or self-neglect.
- People in a mental health emergency who need intensive assessment and immediate intervention.
- People who are refusing community treatment.

Figure 6 shows the number of patients admitted across the last three years, showing a broadly static picture:

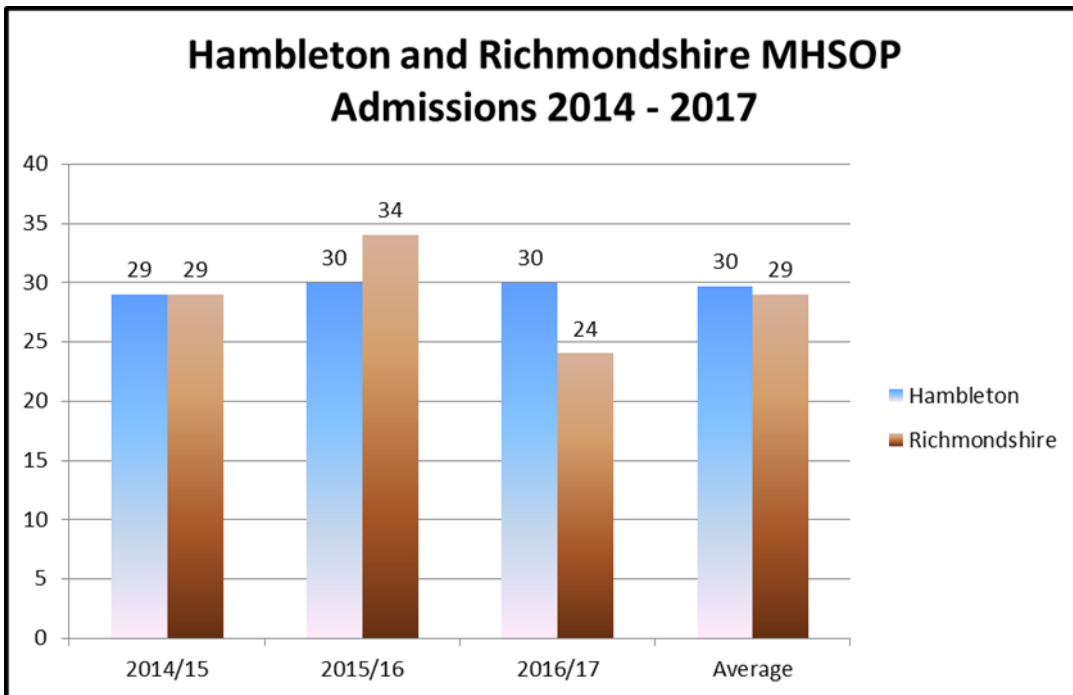
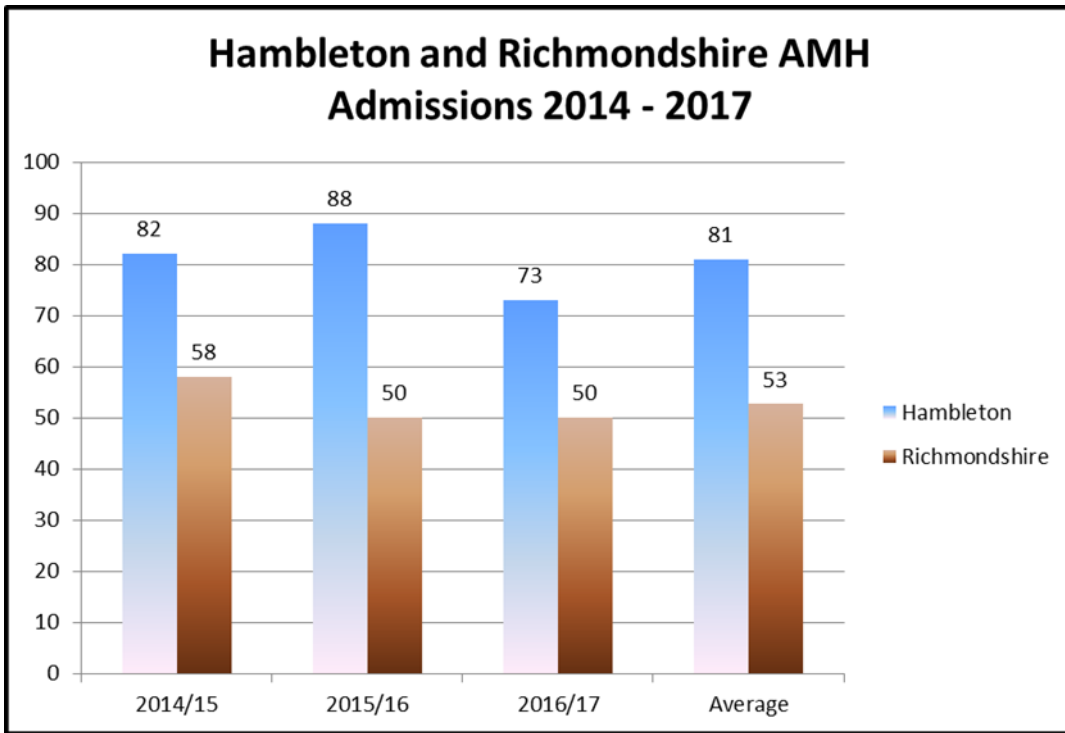


Figure 6: Number of patients admitted

Figure 7 shows in more detail where our patients are admitted from, showing the highest number of presentations from Northallerton:

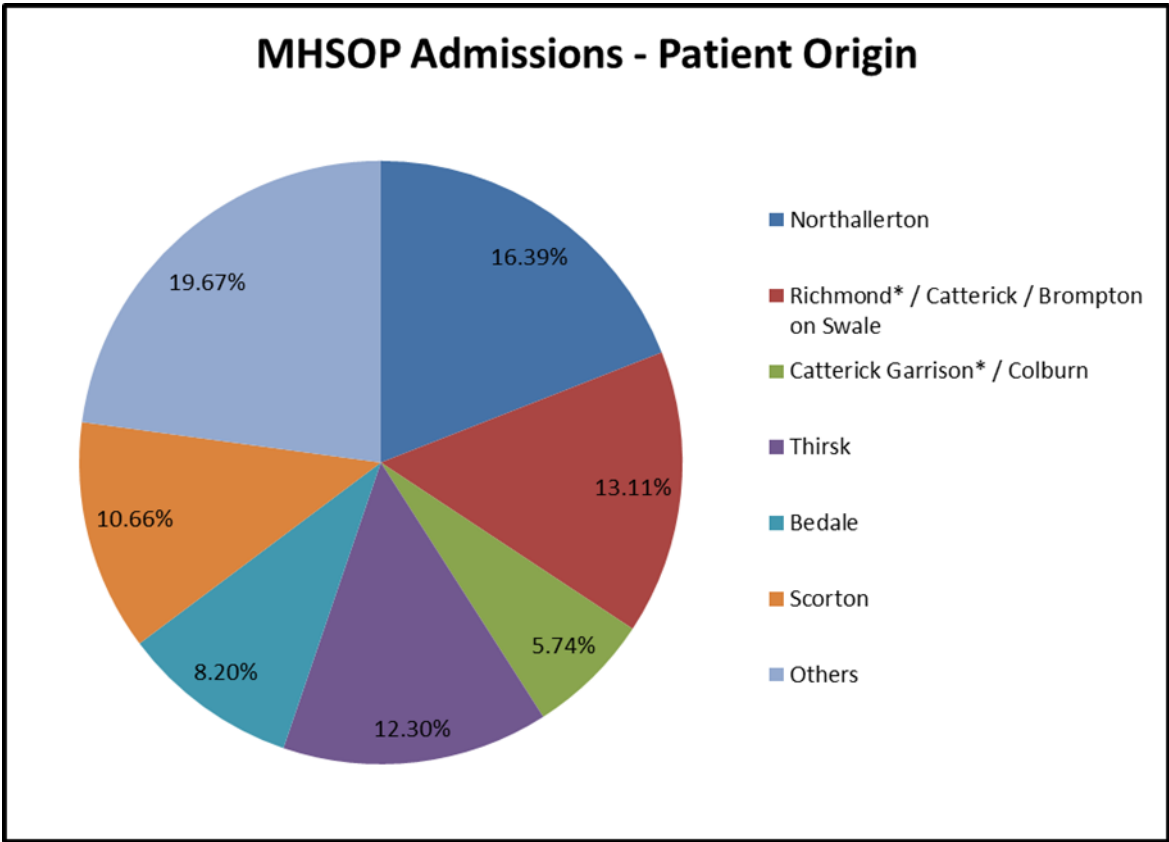
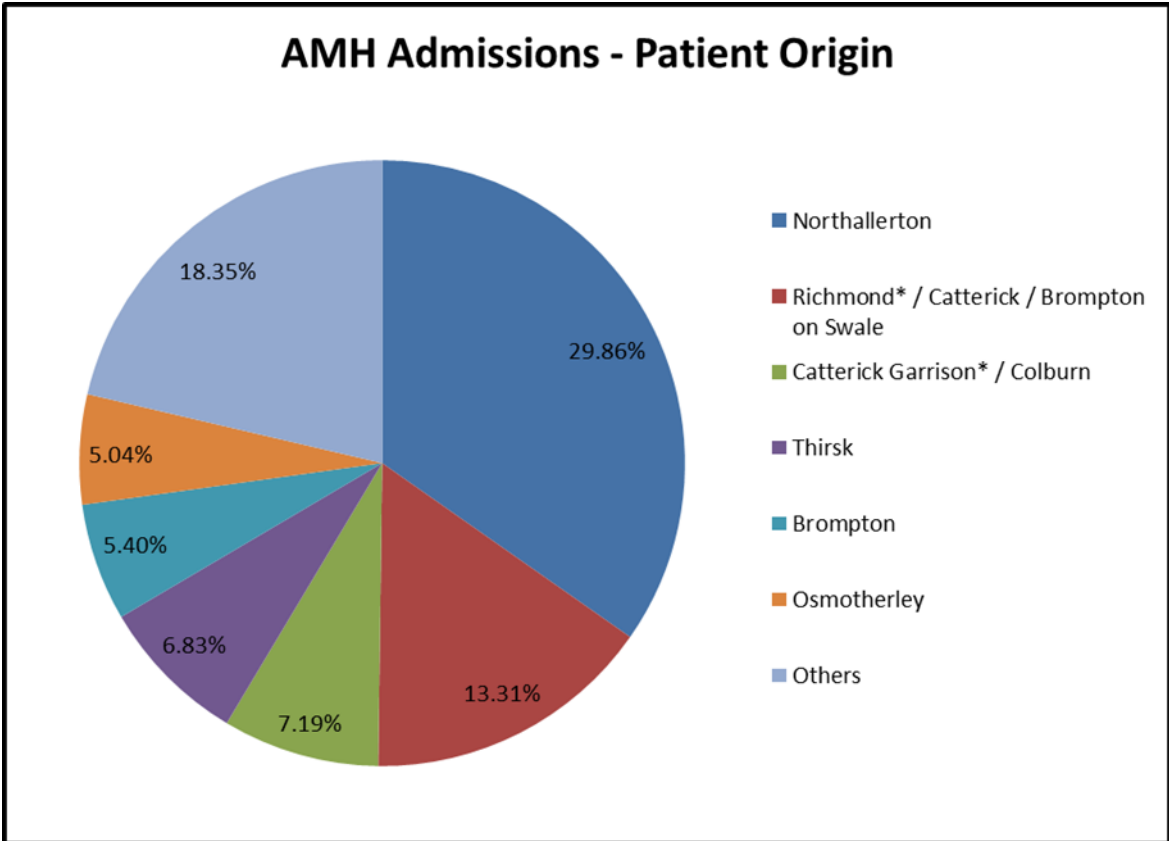


Figure 7: Admitted patient origins

The current patient flow of where people are admitted to is shown in Figure 8, showing that only 44.39% of adults currently flow to the Friarage hospital:

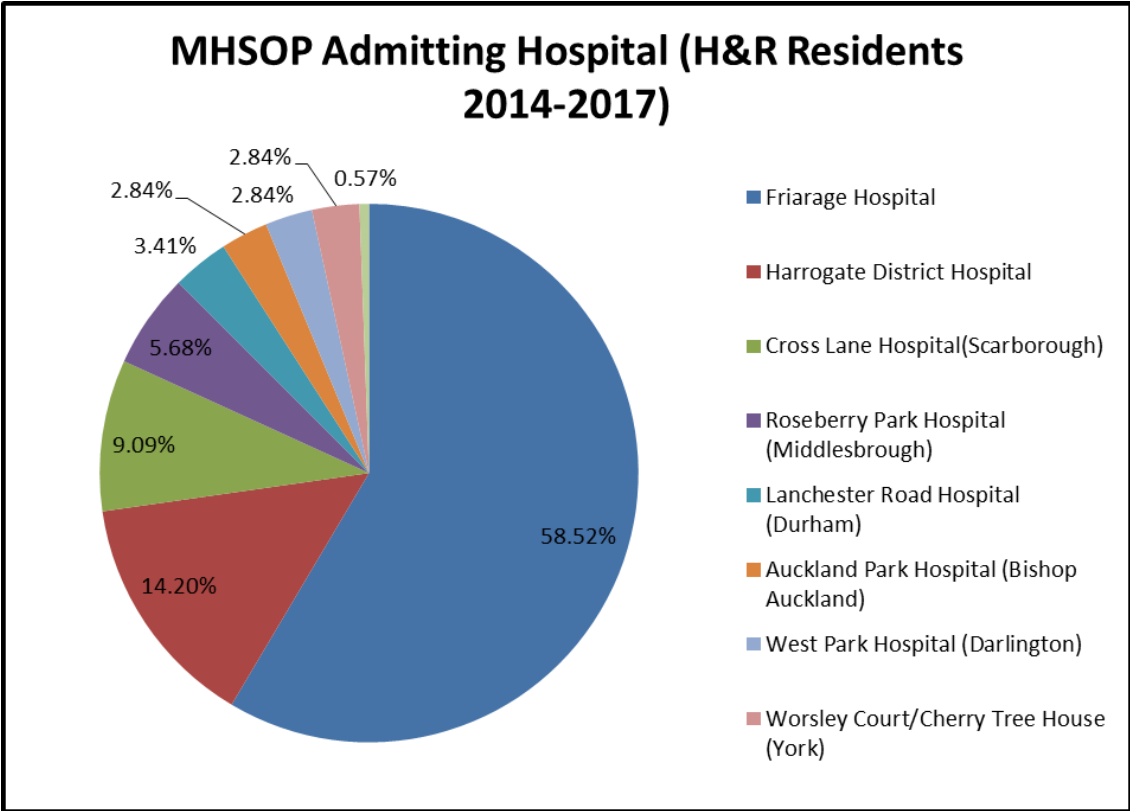
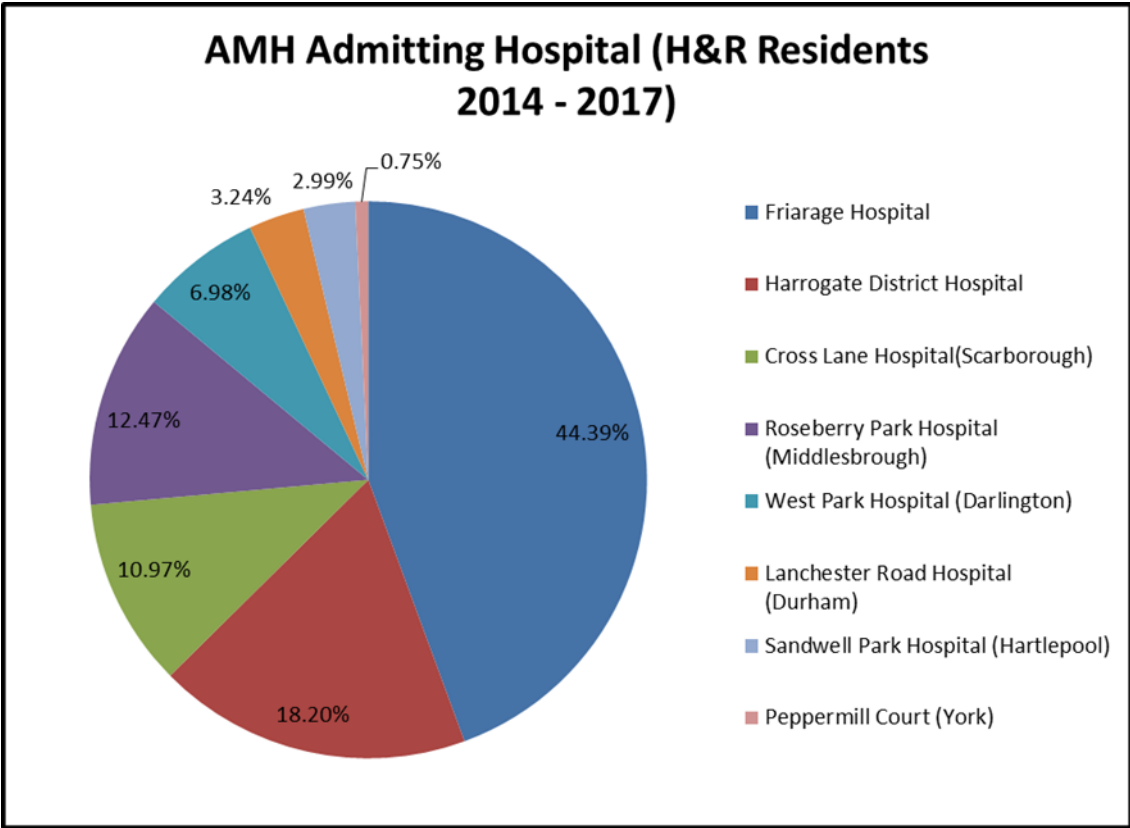


Figure 8: Location of current admission

When our patients are admitted into an assessment and treatment bed, their average lengths of stay are shown in Figure 9, highlighting variation linked to where people live:

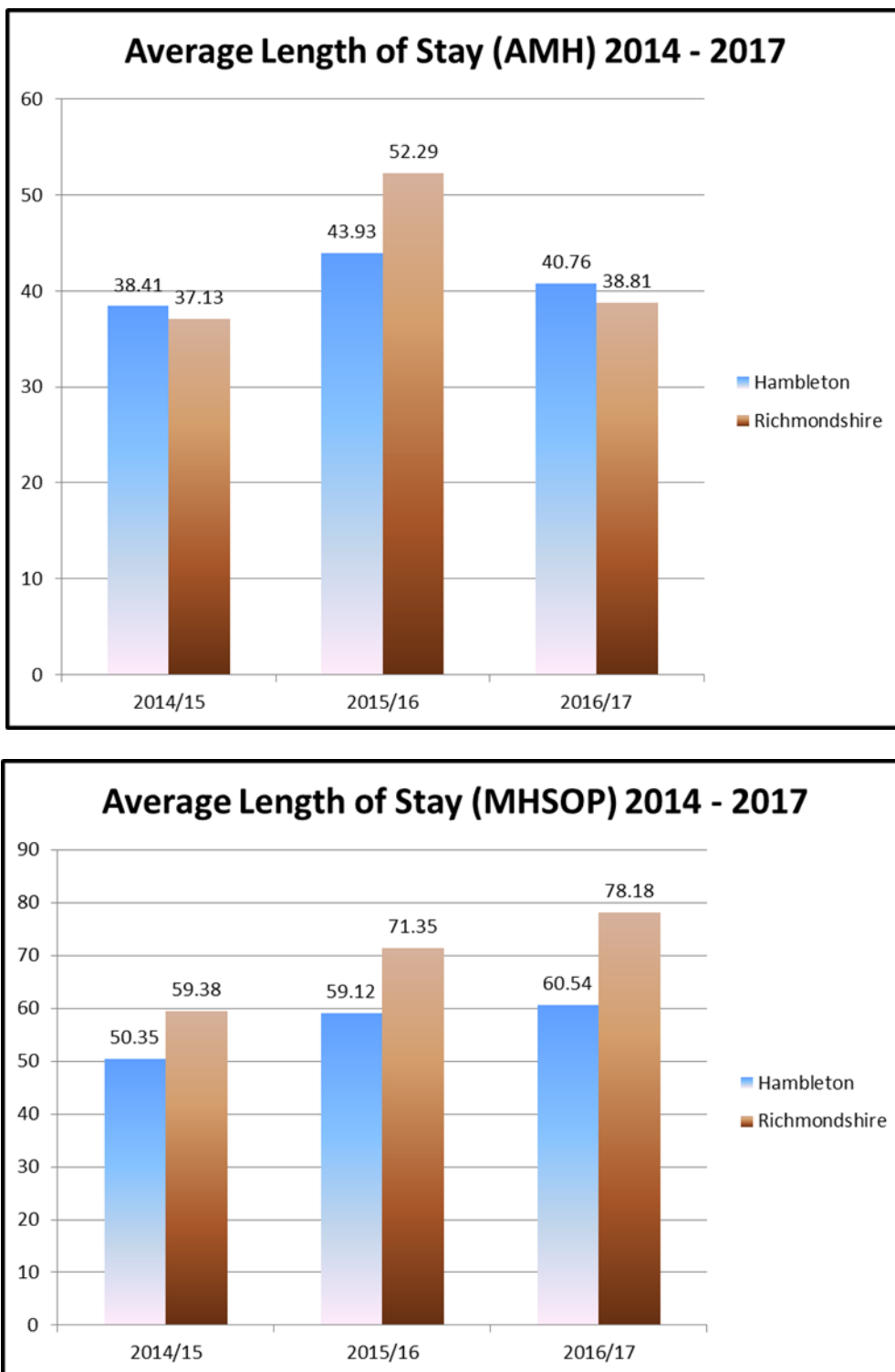


Figure 9: Length of stay

For each person admitted, they will each require 24 hour nursing and medical care (including that for organic and functional presentations and co-morbid substance misuse / dual diagnosis). The current configuration of provision is summarised in Table 19:

Table 19: Current mental health inpatient offer

Working Age Adult	Older persons
18 to 65 years	65years Functional and organic mental disorders
Operates 7 days a week 24hours a day <ul style="list-style-type: none"> • Consultant-led • 12 Beds – mixed sex accommodated • Junior doctor rotation 	Operates 7 days a week <ul style="list-style-type: none"> • Consultant-led • 10 Beds – functional organic mixed sex accommodated • Junior doctor rotation
<ul style="list-style-type: none"> • Joint consultant and junior doctor on call • Specialist psychiatric intensive care (PICU) – Darlington and Teesside • Open rehabilitation beds – Orchards, Ripon • MHSOP access to Complex Care/Challenging behaviour inpatients from Springwood Malton • Locked rehabilitations – individually funded 	

In order to understand the quality and experience of service users, the following information provides information about this aspect of the services in respect of demand, activity, patient feedback quality inspections and compliance against key quality standards.

Referral demand

In the 11 months from April 2016 to February 2017 there were a total of 164 Hambleton and Richmondshire patients admitted to an Assessment and Treatment (A&T) Ward, a Psychiatric Intensive Care Unit (PICU) or a Rehabilitation Unit.

Details of these admissions, together with the average length of stay of these patients are shown in Table 20:

Table 20: Admissions to mental health beds

A&T Admissions	Total	Full Year*	Ave LoS
AMH	114	125	37.39
MHSOP	47	51	61.73

PICU Admissions	Total	Full Year*	Ave LoS
Roseberry Park	3	3	25.5
West Park	0	0	7

Rehab Admissions	Total	Full Year*	Ave LoS
AMH	0	0	357

Using the latest published national benchmarking data (2015/16) in adults it can be seen that the admission rate for HRW CCG residents, of 243.81 per 100,000 weighted population, is significantly higher (23%) than the national average (median), of 198 per 100,000 weighted population, and slightly higher (5%) than the trust average (232.32). The time patients spend in hospital (average length of stay) is broadly in line with the national average (36 days), but this is 33% higher than the trust average of 27 days. The highest rate of admission is from the Richmondshire area.

Using the latest published national benchmarking data (2015/16) for older people it can be seen that the admission rate for HRW CCG residents, of 117.50 per 100,000 weighted population is over 25% higher than the national average (median) of 93.50 per 100,000 weighted population, and over 17% higher than the trust average (100.17). The time patients spend in hospital (average length of stay) is marginally higher (3%), at 64.74 days, than the trust average (63 days) but 18% lower than the national average (79.3 days).

Access to alternative care settings for older people with organic mental health problems is limited in the area, resulting often in failures in packages of care. This has subsequent knock – on effects relating to inappropriate admission to acute and mental health secondary care beds and delayed transfers of care from these settings. Work is needed to look at how services can deliver enhanced care to support patients and carers in the place where people want to live, as it is widely recognised that admission to hospital is detrimental to patients with organic mental ill health. This is an area of particular importance as the North Yorkshire prevalence is higher than the national average.

Service contacts

In respect of inpatient interventions with patients within our inpatient wards at the Friarage, Table 21 shows the following:

Table 21: Inpatient interventions

	F2F	Full Year
AMH	3,665	4,005
MHSOP	8,382	9,160

Compliance with performance and quality standards

A key measure is that of the patient family and friend test: the inpatient results are shown in Table 22, showing a positive patient experience.

Table 22: Inpatient FFT

		Extremely Likely	Likely	Total	%age
AMH	Ward 15	25	16	43	95.35%
MHSOP	Ward 14	13	5	20	90.00%

In addition, there have been recent quality inspections at the Friarage Hospital mental health inpatient unit:

- Unannounced on Ward 14 – November 2014
- Unannounced on Ward 15 – January 2015
- Unannounced on Ward 15 – April 2016
- Unannounced on Ward 14 – December 2016

In addition, there have been Trust-wide inspections in January 2015 and November 2016, both included visits to W14 and W15. Comments from the CQC inspection in January 2015 relate to the following learning points:

Adult mental health

- Privacy and dignity was not always respected due to shared single sex bed bays and environments posed ligature risks. On Ward 15 there were a number of environmental concerns identified with the seclusion room and recording of seclusion episodes.
- There were thin curtains around each bed bay which did not minimise light or sound effectively. At Ward 15 the bay bedroom windows did not provide reflective glass to provide privacy from the outside where other acute hospital wards and offices were located. Curtains were in place across the windows however these were thin and did not always obscure the view into the ward bedrooms.

Comments from CQC following inspection in November 2016:

Adult mental health

- The limitations of the environment on Ward 15 at The Friarage Hospital mental health unit meant that staff could not always ensure patient's privacy and dignity were maintained.
- We also told the trust that it should take the following actions to improve: The provider should ensure that privacy and dignity is maximised in the bed bays of ward 15
- The provider should ensure systems are in place to capture the shortfalls in the Mental Health Act and Mental Capacity Act as identified by the MHA reviewers at Ward 15,
- The inspection team undertook a tour of each of the 17 ward environments. The wards were modern and purpose built, with the exception of Cedar Ward at the Briary Unit and Ward 15 at The Friarage Hospital mental health unit. These wards were located in older medical wards on acute hospital sites and consequently the environments had limitations. At the time of the previous inspection, the trust had plans in place to relocate these wards, but this had not yet happened. It was always the Trust intention to re-provide the inpatient facilities (as outlined in the tender submission in 2011).

- The patient led assessment of the care environment scores for condition, appearance and maintenance and cleanliness in 2016 were as follows: The Friarage Hospital Mental Health Unit scored 86% for condition, appearance and maintenance and 97% for cleanliness
- The compliance rates for medicines management (63%) were below the NHS Standard of 75%

Older persons

- Ward 14 at The Friarage Hospital used dormitory style accommodation which patients told us made them feel unsafe and had a negative impact on their recovery.
- Patients at Ward 14 at The Friarage Hospital did not feel safe. They felt that the use of dormitory style accommodation compromised their privacy and dignity.
- Patients told us that at ward 14 at The Friarage Hospital and Rowan Ward, they shared dormitory style accommodation (bed bays) with other patients. They told us that it disturbed their sleep and recovery when another patient in their room was unwell. They also told us that it had an impact on their privacy and dignity and that they would prefer single rooms.

In addition to the CQC visits inpatient units are regularly inspected against the Mental Health Act standards. Comments from these inspections included:

Adult mental health

- We were concerned that some aspects of the environment did not promote patient privacy and dignity. These were:
 - The mixed sex nature of the ward; whilst the male bedrooms are along one corridor and the female bedrooms along another, patients need to walk through all areas of the ward in order to access the communal areas. This was a particular concern along the female corridor where the female bathrooms are located in close proximity to the communal lounge.
 - In the four-bedded bays, there was only a curtain to divide the area between beds.
- The seclusion room did not appear to provide the patient with any means of calling for attention or an intercom system. The nurse in charge confirmed that patients would be expected to shout through the door if they wanted to speak to the observing staff. The observation panels were placed in such a way that staff would be unable to observe a secluded patient without standing up and peering through the panels, which may prove quite intrusive for the patient.

Older persons

- The four-bedded bay areas were not mentioned in care plans, in terms of how the patients' dignity could be respected as far as possible.

Comments from these inspections are common to those directly from patients and carers.

Patient safety – inpatient serious incidents

Inpatient incidents, reported against the national serious incident framework, account for nine incidents in the last 11 months. Table 23 shows the breakdown of reported incident across adults and older people.

Table 23: Inpatient related serious incidents

		Level 4	Level 5
AMH	CMHT	1	3
	EIP	1	-
	Inpatient	-	-
	Total	2	3
MHSOP	CMHT	1	1
	Inpatient	1	1
	Total	2	2

Patient safety – Falls management

The management of falls in inpatient settings is a key indicator across both adults and older persons. Table 24 the number of incidents relating to inpatient falls (witnessed and unwitnessed) in each area.

Table 24: Falls management

	Witnessed	Unwitnessed	Total
Ward 15 (AMH)	0	1	1
H&R Community	0	1	1
Ward 14 (MHSOP)	7	30	37
H&R Memory Service	2	0	2
Total	9	32	41

[Witnessed and Unwitnessed slips/trips/falls between 1 February 2016 and 31 January 2017]

A key expectation of this change to service delivery is expected to see a reduction in inpatient related significant incidents, brought about by the anticipated reduction in admission rates and keeping people safe in their own homes.

8.4 Voluntary sector / local communities

Services provided from the voluntary sector play a vital role in supporting people in their own communities. However, services may often be fragmented, disconnected and dependant on short-term funding. The result is that services do not always work effectively together and staff working in statutory organisations may not know what services exist and so are unable to signpost patients to them effectively. Services are also patchy or incomplete in some areas, with unequal access depending on where a person lives such as: voluntary transport, support for shopping or home laundry, social opportunities, befriending, etc.

In Hambleton and Richmondshire the offer by the voluntary sector is limited by many of the national partners not having a presence in the locality. There is an opportunity through work with our housing partners to look at alternative supported living settings for people with enduring mental health needs, as well as working with them to provide supportive places for people to attend when they have emerging mental health needs.

The CCG will continue to work with North Yorkshire County Council's Stronger Communities programme to strengthen community capacity through innovative approaches to prevention and early intervention.

8.5 Service enablers

The health system already benefits from the use of smart information technology, allowing staff to function 'online' with patients in the community.

8.5.1 Information management and technology

While in recent years there have been great advances in the opportunities available through IM&T, some significant obstacles remain. Currently there are no consistent systems and processes for using the NHS number as a single patient identifiable number across all health and social care organisations to help co-ordinate care, using safe and secure e-mail addresses to share information, obtaining shared consent, and limited capability to access different provider record systems in common locations, let alone a single common shared IM&T solution between health and social care.

8.5.2 Transport

Funded transport to access health and social care services is not an automatic right and is dependent on clinical need. Patients and service users therefore need a range of options to access available services, dependant on circumstance.

In Hambleton and Richmondshire, emergency and patient transport services are provided by Yorkshire Ambulance Service NHS Trust. There are also voluntary transport schemes operated by the voluntary sector and partners are exploring opportunities to better promote the use of voluntary transport schemes and to extend their coverage within the area.

In addition, the rural nature of Hambleton and Richmondshire is a particular issue for many people in accessing services and activities in the absence of regular public transport. The North Yorkshire Mental Health Strategy recognises the need to improve existing support networks

and that community services should be provided in neighbourhoods and wherever possible directly to people's homes.

8.5.3 Police partners

Our Police partners play a vital role in responding to people who are in need of mental health support, not only through the help they give through 101 or 999 calls but also as a primary response to those with high risk behaviours and those require detaining under the Mental Health Act. Through the local Crisis Care Concordat, work is ongoing with the police and partners to work together to help vulnerable people in times of greatest need. This includes ensuring that frontline staff have appropriate training and are properly supported by professional mental health colleagues. Closer working with police partners will be an essential part of this transformation agenda.

8.6 Current mental health spend

The current total mental health spend in Hambleton, Richmondshire and Whitby is in excess of £20 million, comprising largely of two envelopes of spend:

- **£15,306k Secondary and community mental health services**
- **£ 3,101k Mental Health Out of Contract**

In addition the CCG also incurs significant mental health expenditure in other areas including continuing health needs.

Any future model of mental health services must be underpinned by a resilient interface with community and neighbourhood services - building capacity within community-based services to reduce demand and release capacity from the acute sector and in-patient beds – whilst in parallel moving towards a 'place-based' approach where health and social care mental health services intervene earlier to prevent escalation and direct people to a broad range of appropriate provision; including social, private and third sector. Therefore, in respect of any service transformation, it is expected that the following parameters are delivered against:

- Service user feedback drives the service change
- Patient experience is sustained if not improved
- Patient safety and expected quality standards are not compromised
- Patient outcomes are enhanced
- Funding remains within the total mental health allocation

9 Quality and economic argument for change

In response to the information about services and feedback from partners and services users there are five key arguments that substantiate why changes in the current service model are required. Primarily they are:

- 1 Patient experience and safety
- 2 Workforce
- 3 Quality of estate
- 4 Gaps in current service provision
- 5 Financial

To take each in summary:

Patient experience and safety

- Our engagement with patients tells us that they want to be cared for as close to home as is possible.
- Inspections from the CQC and feedback from our patients tells us that our current inpatient service does not afford patients the privacy and dignity that they rightly expect.
- Engagement work with our clinical partners and the GP survey results tell us that we could care for more mental health patients in the community with the right infrastructure to support them.

Workforce

- Our current staffing model is expensive and inflexible
- We struggle to recruit staff to the area evidenced by the number of vacancies which have remained open over the last 12 months.
- There is little or no career progression or diversity of experience available to develop staff or provide opportunity due to the service configuration.

Quality of estate

- Several CQC inspections have told us that our inpatient facilities are not fit for purpose. We are also only able to offer accommodation to one person with a physical disability at any one time due to the nature of the estate.
- We currently have and need to eliminate mixed sex accommodation.
- Absence of single person accommodation as reported by the inspectorates and patients.

Gaps in current service provision

- The Hambleton and Richmondshire population experiences a worse picture against the national of levels of mental health and illness and the percentage with dementia⁶ aged

⁶ North Yorkshire County Council Joint Strategic Needs Assessment 2015

18 plus (not age standardised) and percentage with depression aged 18 plus (not age standardised).

- Our primary and community provision and physical and mental health services are not integrated.
- Access to residential or nursing homes for people with dementia is limited, which means that people are spending longer than they should in hospital (mental health and general acute hospitals) which is qualified by our length of stay and admission rates.

Financial

- We need to ensure that existing investment is targeted at evidence-based prevention and early intervention for mental disorders.
- Our model is old fashioned, expensive to staff, expensive to house and does not provide value for money.

In summary we have a compelling case for changing our current commissioned services and a real opportunity to create a new, fit for purpose and fit for the future mental health system for the people of Hambleton and Richmondshire.

10 Ambition and evidence base for transforming mental health services

The purpose of section 10 is to show what an alternative model of secondary mental health care could look like across Hambleton and Richmondshire. It is evident from the engagement already undertaken that there are opportunities for change and that the ambition to deliver an improved system offer is achievable and affordable. Through changing the way we use the resource available to us, we are able to rethink the way that secondary care mental health services are provided; strengthening the community offer to reduce the need for secondary care admissions. Figure 10 provides the overarching service ambition.

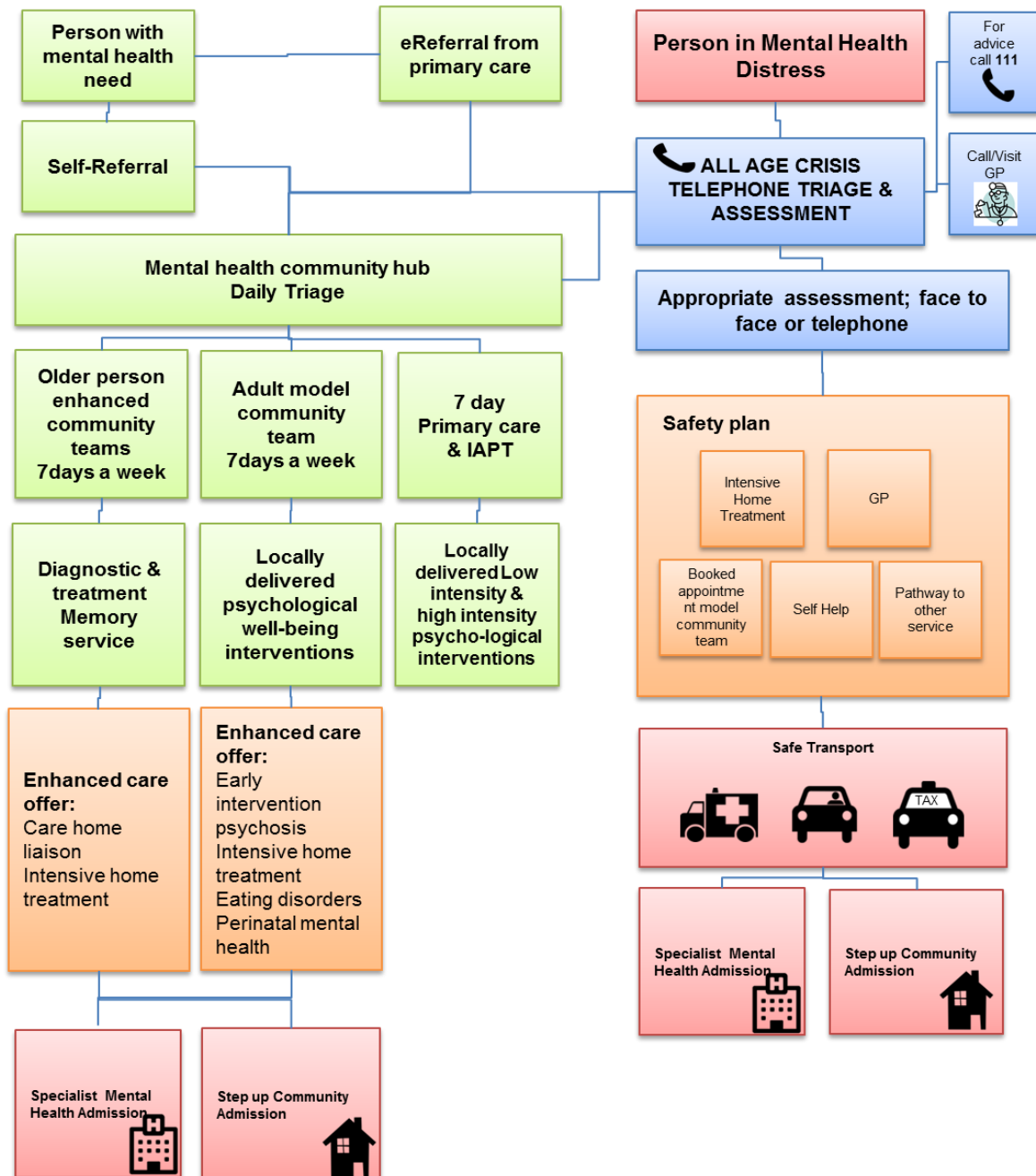


Figure 10: Alternative mental health model

This level of ambition seeks to offer patients:

- Simplified access through a single point of access in the respective locality
- Provision of care at the point of need
- Care as close to home as possible for the majority of people
- Access to specialist acute care when required
- Resources used more effectively in the locality
- An increase in the management of deteriorating patients in the community
- A sustainable service offer
- Delivery of an evidence-based and recovery-focused intervention

Clinically led by our consultant psychiatrists in adults and older persons, the new model of service is supported by the following operating principles:

- Care as close to home as practically possible
- Community service that is 7 days a week providing extended hours aligned to primary care
- Crisis response and intensive support for all age groups regardless of condition
- More care in the community as opposed to in specialist mental health beds
- Skilled workforce that is able to deliver evidence-based interventions
- Delivers care in partnership with third sector, statutory and primary care partners
- Improved access to social care
- Integrates service delivery through social care and health pathways of care
- Access to specialist beds in fit for purpose buildings when required
- Sustainable and affordable offer (costed options are shown in Appendix 4)

In using the benchmarking information from across TEWV, and knowledge that the locality of Hambleton and Richmondshire⁷ is an outlier in the rate of admissions and length of stay, there are a number of working assumptions that we can use to demonstrate the benefit of what an enhanced community team would have on the wider healthcare system. Those being:

- A reduction in presentations to emergency departments
- A reduction in Section 136 presentations
- A 20% reduction in length of stay adults and older persons
- A 50% reduction in admission to adult secondary care beds
- A 20% reduction in admission to older person secondary care beds
- A reduction in the length of community episodes of care

Following on from the engagement phase it is clear the intentions of an alternative model of all age secondary mental health service needs to make a real impact on population and system health outcomes, that:

- Enables people to enjoy the maximum good health for as long as possible.
- Increases community productivity and improved patient outcome.

⁷ JSNA benchmarked against national average

- Reduces the overall number of admissions to hospitals and average bed days (and lengths of stay) for those admissions.
- Reduces the number of long term placements in residential and care homes.

The introduction of a new working model that enhances community teams and enables delivery seven days a week is expected to have a significant impact of the health system as a whole. With an assumed shift of inpatient activity to community case management and change or reduction in bed base, it is this change that will allow investment (see indicative costings in Appendix 4) in community and crisis services which is summarised further in the following sections.

10.1 Triage and access to community services

Instead of multiple community and primary care teams operating in isolation, Figure 11 shows our intention to establish a purpose built mental health community hub that operates seven days a week offering daily triage of referrals and ongoing assessment and treatment requirements, which is in line with the national drive to have seven day working. Triage will be supported by the multi-professional team.

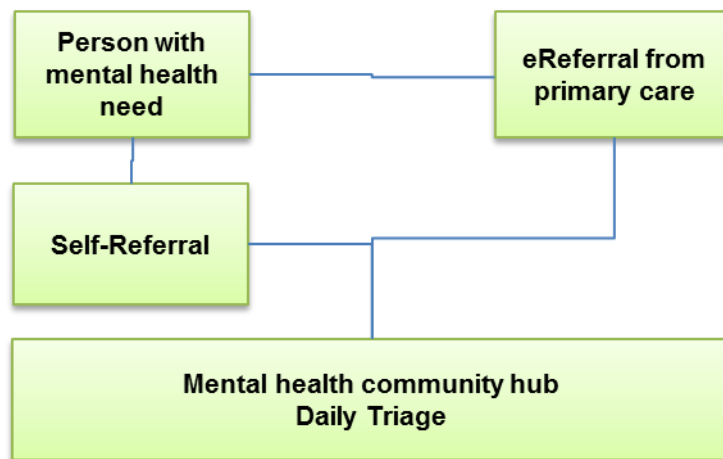


Figure 11: Triage and access to community services

The role of the mental health community hub is to allow the respective service multi-disciplinary teams to consider the daily electronic and self-referrals, identify the first available appointments and offer choice to patients for their initial assessment within four weeks.

In respect of **adult services**, the model community team will work alongside IAPT and EIP staff to ensure that referrals are entered onto the right pathway from the outset.

Within **older persons** there will be a flexible response to carer and service user referrals that provides an assessment of need and opportunities for ‘drop in’ services. The ambition for the service response to both formal and self-referrals will be responsive to changing demand and allocated to the next available appointment with a maximum three day response, to ensure that care is delivered in the least restrictive environment and prevents the potential for a breakdown of care and treatment to support people in their homes. The needs of the patient identified at the point of assessment will then be allocated within the service, adopting the principle of ‘your patient is my patient’ throughout the pathways.

10.2 Enhanced Community teams and intensive home support

The introduction of enhanced community teams operating seven days a week looks to integrate the aspects of intensive home support into the community infrastructure; responding to the patient feedback of 'strangers' delivering their step-up care needs into the community.

Aspects of mental health services require specialist enhanced care, and it would be our intention to preserve that through the required specialist eating disorder and early intervention psychosis. The introduction of a rapid access pathway for perinatal mental health needs will also pave the way for compliance with the forthcoming NICE standards of care.

Figure 12 provides the summary overview of the intended enhanced community offer.

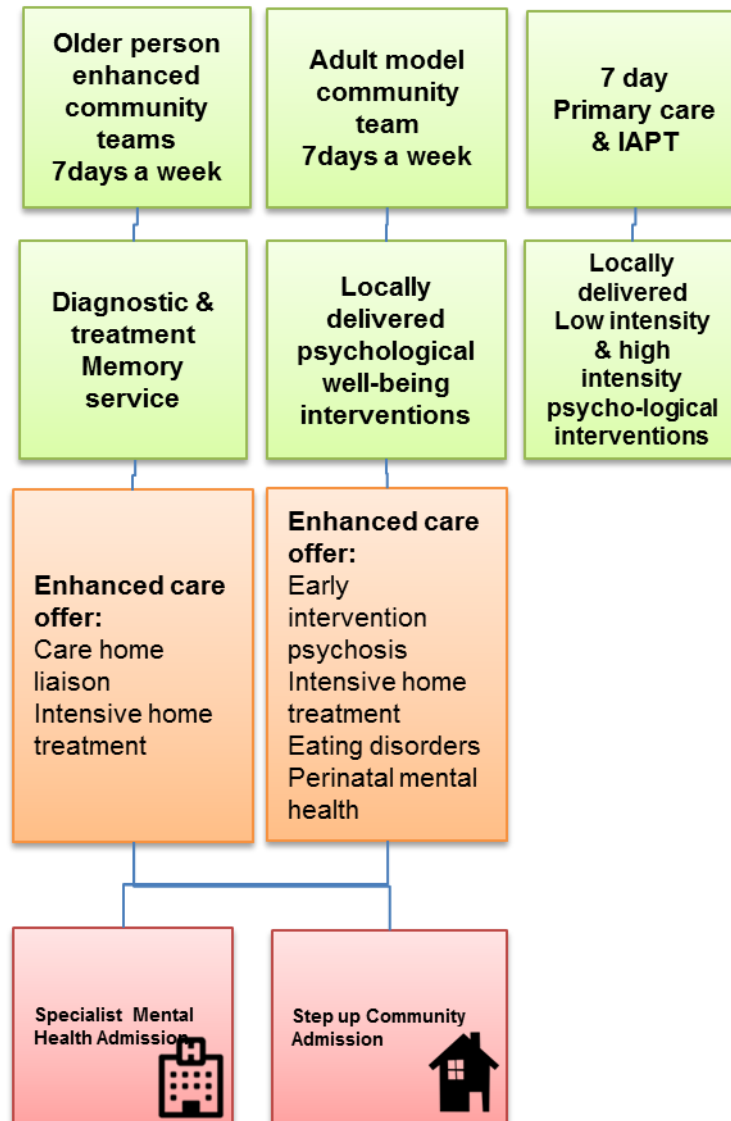


Figure 12: Enhanced community services

Services for older people will bridge the gap in providing enhanced services and intensive support to care homes, individuals and their families and escalating clinical involvement with deteriorating levels of need and circumstance. The service will be able to provide holistic care and a multidisciplinary skill base to patients in their homes over a seven day period and as part of an intensive home support package. Intensive care home liaison will be developed in

partnership with the care home sector to ensure that the potential for placement breakdown is minimised and timely access to social care pathways are available to adapt care delivery to meet the needs of the patient. Skills development, including non-medical prescribing, will be key to ensuring adequate capacity in supporting patients in their homes alongside psychosocial and allied health professional treatments and interventions. Focus will also be maintained on managing behaviours that challenge and delivering robust carer support. Extending the core service across seven days will support improved planning, risk assessment and management with the ability to support reduced length of stay in hospital, where an admission is required.

The model community team in adults will provide integrated resources across health and social care, removing the silos that currently exist across assertive outreach, primary care and community teams. Working together the single managed team will provide a needs-based assessment service and treat patients with psychologically informed interventions. Changes to the team configuration will see the introduction of allied health professionals and support staff and will continue to retain expertise to support those in need of an assertive outreach approach. An important aspect of the adult community teams will be to support the transitions of young people into adult services, using the current commissioning quality and innovation (CQUIN) mechanism as the route to improved patient experience.

The retention of the IAPT, EIP and eating disorder teams is critical to the clinical expertise being available to general practice and the enhanced community teams.

Currently there is limited partnership provision with our third sector partners to provide step-up community beds with specialist in reach from secondary mental health services. The anticipated reduction in admissions to secondary care beds will release funding to invest in a new community model, increasing service capacity and will address gaps in the current skill mix and service availability.

The proposals around enhancing the community offer will enable effective step-down and step-up to take place in the community and, if preferred, in the person's own home. There may be times where this is not possible, not appropriate, nor the person's wishes. In these circumstances we need to be able to rely on suitable accommodation that supports the proposed enhanced community team offer, to continue to deliver the support required without risking existing important relationships and community connections. Therefore the accommodation needs to be locality based, accessible to all and be in the community.

Access to accommodation is only one element and partnerships with existing housing providers; extra care schemes and the voluntary sector will be developed to ensure accommodation is being planned for this purpose, with reference to new developments and therefore available on a short to medium term basis. Commissioners from Health and Social Care are reviewing existing arrangements with a plan to increase the availability and quality of accommodation available. It will be necessary to have a community workforce that can respond to the support required whether at home or in temporary accommodation. This workforce will be different to what exists now as it will need to be able to embed support into individual lives and situations in order to not only support recovery but also to prevent deterioration in mental ill health. It will need to be able to provide intensive short term support but also in the longer term.

It is vitally important that support is provided consistently around the individual rather than transferring to different teams or provision.

The voluntary sector partners will be supported to develop a wider range of services than at present, aimed at prevention and recovery, exploring options of “crisis café’s” and focussing on maximising what the voluntary sector is good at delivering. Again these services will need to be locality based, accessible and wherever possible in familiar communities.

It is expected that these changes in service delivery will:

- Improve patient and carer experience
- Reduce risks to patients associated unnecessary acute mental health admissions
- Increase the likelihood of recovery and better outcomes

In this new way of working, access to psychiatric intensive care and specialist open and locked rehabilitation beds will continue under the supervision and case management of the community team care coordinator.

10.3. All age crisis response

In response to the national drive to improve crisis response across all ages, a dedicated improvement week, using Lean principles, was held in March 2016. It brought together 51 people from across patients and partners to describe what was needed to deliver an all age crisis response, regardless of condition, 24 hours a day 7 days a week.

In addition to the response to people in services, mental health crisis lines (which will continue to be commissioned by Public Health) will provide a single point of contact across North Yorkshire for members of the public to access.

As a result, a North Yorkshire-wide ‘pledge’ was generated; formulating a unique bond across professional and organisational boundaries that will help people in mental crisis.

Our pledge is that we will:

- *Never decline a triage assessment to any person, professional or practitioner.*
- *Offer assessment within an hour of first contact, when it is required.*
- *See all ages, regardless of condition.*
- *Be available 24/7.*
- *Provide a response that is proportionate to need – face to face or phone.*
- *Provide users with the same response regardless of where they live.*
- *Work together to prevent ‘crisis’ presentations, self-harm & suicide.*
- *Strive to continuously improve our service.*

By working together we established a suite of ‘operating principles’ that are based on need as viewed by the person in need and not the professional and are summarised below:

1. Triageing telephone calls and understanding risk.
2. Assigning the right response timescale proportional to risk.
3. Assessing need and ongoing care via the mode that best suits the need of individuals.
4. Assessing risk in places other than secondary care.
5. Detailing individual safety plans that users can understand and follow.
6. Providing short term support when core services are not available.
7. Providing certainty through booking the next appointment following a crisis event.
8. Handing over care and care records to the core team.

It is expected that the Hambleton and Richmondshire population will benefit from this wider service change summarised in Figure 13.

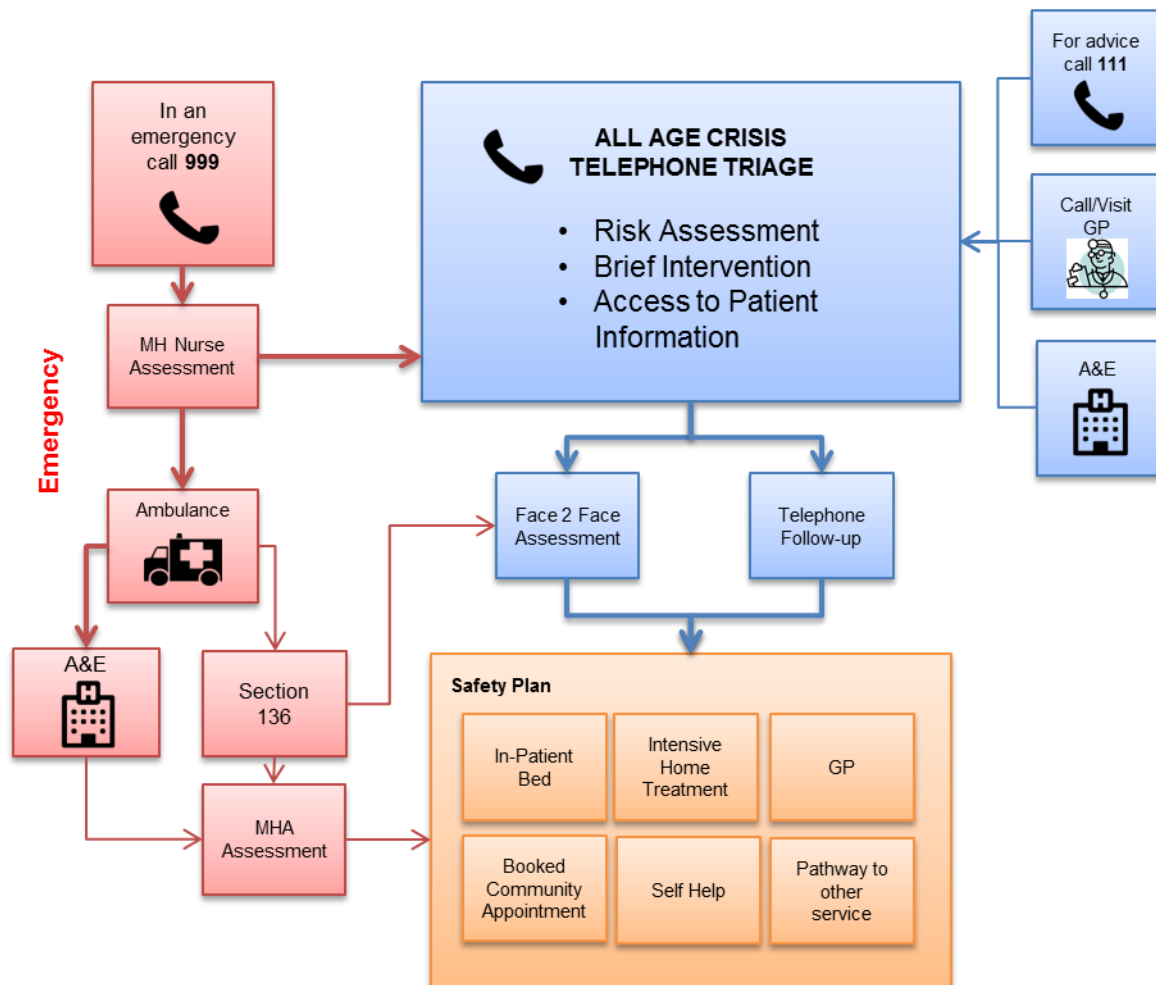


Figure 13: All age crisis service model

A key benefit of working in this way will be the standardisation of decision-making across the service as a whole, assisting our Police and ambulance colleagues to manage public need in a consistent way. It will also bring a significant degree of service resilience, meaning that a telephone assessment is provided at the point of need.

Enhanced community services for older people will benefit partner agencies across the health and social care sector. In preventing and delaying admissions to both acute and mental health specialist hospital beds, it is envisaged that delayed discharges will reduce alongside the

subsequent demand for complex and specialist community placements. It is evidenced that older persons physical health and mobility is adversely affected during any admission to hospital and therefore, may inadvertently increase levels of need for both social care and health in primary and secondary care settings as a consequence. Additionally, benefits in sustaining care delivery at home and in the care home sector reduces the pressure on unplanned pathways of care in social care and health.

Access to Health Based Places of Safety, for those who warrant assessment under section 136 of the Mental Health Act will continue, but depending on the outcome of the consultation and decision of the North Yorkshire Police not to reopen the custody suite in Northallerton, this will have a bearing on whether there is a suite maintained within the locality. The Police will review the use of the custody suite in June 2017.

10.4 Access to stepped care and specialist beds

Working with our voluntary sector partnership provides us with value for money options that are more in line with the recovery philosophy of mental health. The reduction in the use of secondary care beds releases investment to work with partners to offer a community beds provision.

Enhanced community services and intensive treatment delivery for **older people** will be supported by access to step-up/down beds in the community, preventing unnecessary admission to hospital. This will be developed in partnership with the local authority and care home sector and will support care delivery being as near to a patients home as possible. The service will have the flexibility to provide in reach services to step-up beds including the patient's own bed adapting a 'hospital@home' philosophy. Opportunities to utilise step-up approaches with extra care housing, independent sector and care home liaison will also be provided and subsequently will also offer the opportunity to support step-down at the earliest opportunity as part of the recovery journey. This service will also be able to maintain stability in the patients' needs and circumstances whilst alternative arrangements in the community, as described in section 8, are sought in the longer term where this is unavoidable.

Similar to that of older person, adult patients can benefit from step-up care in supported community housing with specialist in reach from community staff. There are good examples of voluntary sector supported housing for our most vulnerable and enduring mental health patients. In the service offer we will look to secure community facilities with our voluntary sector partners which will avoid unnecessary admissions to acute care where possible.

10.5 Access to secondary care and specialist inpatient beds

Regardless of the enhanced community model there will be a continued need to access secondary care beds along with access to intensive care, open and locked rehab. It is anticipated that the provision of intensive care will continue to be accessed from Teesside and Darlington and access to rehabilitation beds will remain within the Trust, with the exception of specialist placements such as; brain injury, neuro-rehabilitation, autism and specialist learning disabilities where individual funding requests from the CCG will be secured.

In respect of inpatient provision, there is commitment to admit patients to a fit for purpose inpatient environment, whether that be in the locality or from the neighbouring sites in the Trust

– where there is sufficient capacity to accommodate an increase in demand. It is expected that any patient flow to Teesside or Darlington will be financially supported from the current funding stream. Where secondary beds are situated is a key part of the formal consultation.

10.6 Fit for purpose estate

Our Mental Health Act and Care Quality Commissioner visits, combined with our patient complaints, continue to report concerns regarding first floor inpatient accommodation, patient privacy and dignity and the current dormitory accommodation and managed mixed sex environments. Although not critical to this service change, TEWV has committed to investing in the Hambleton and Richmondshire estate in the development of a community hub, with the expectation that the outcomes of the formal consultation be taken into account in any proposed change. At this stage, no external capital funds are required for this development.

11 System wide benefits and implications of change

Mental health services have gone through a radical transformation over the past 30 years with a model of long-term institutional based care replaced by one in which most care is provided in community settings. The concept of mental illness and perception of needs has also evolved with increasing awareness on early intervention, recovery and managing illness.

As we now move the system in Hambleton and Richmondshire forward the introduction of enhanced community teams operating seven days a week is expected to have a significant impact on the health system as a whole. In using benchmarking information from across TEWV there are a number of working assumptions that we can use to demonstrate the benefit of enhanced community teams and the impact on the wider healthcare system. Specifically:

11.1 Primary care

- Simplified access to services 24/7 for all age groups
- Greater integration of IAPT and general practice clinicians

11.2 Neighbouring CCGs

- Where there is a change to patient flow there is a commitment to also move the flow of the relevant funding

11.3 Ambulance transport

- A reduction in call outs and conveyances to emergency departments

11.4 Police

- A reduction in call outs, detentions and Section 136 conveyances

11.5 Acute Hospitals

- A reduction in presentation to Emergency Departments driven by a 7 day community enhanced offer
- A reduced average length of stay because of 7 day working and access to mental health community beds

11.6 Local authority

- Enhancement of the adult and social care integrated teams and their offer
- Increased access to social care provision
- Development of all age crisis response, including benefit to children's social care

11.7 Clinical Senate support

A desktop review of this document was undertaken by the Yorkshire and Humber Clinical Senate in April 2017. The review was proportionate with the scale of the change and amount of information provided and overall the panel found no "red-flags" that would prevent the programme from moving to consultation from their perspective. There have been no further comments from the clinical leads with TEWV regarding the comments from the Senate.

11.8 Local Health Resilience

It is our assessment that the proposed change will not impact on the ability of the local health economy to plan for, and respond to, a major incident. We will ensure that as the transformation process progresses a business impact analysis is conducted for all impacted organisations and appropriate changes are made to business continuity plans. We will also consult with the Local Health Resilience Partnership and undertake an impact assessment on resilience.

12 Consultation requirements

It is important that this consultation process is transparent and that the NHS is accountable for the decisions it makes. We have gathered useful feedback from service users, carers and NHS staff with support from local community groups via pre-consultation engagement. However there are aspects of transforming secondary mental health services that require consulting with our patients, public and partners as there are two main options, in addition to the doing nothing option, to consider regarding how we organise mental services, what is delivered locally by enhanced services and where we access specialist care.

12.1 What we will want to consult on with our patients, public and partners

It is important that we describe the overarching strategy for the integration of mental health services with primary, community, secondary and social care services. This will provide the context for changes and enable a broader description of how the options outlined interface with other services within the localities.

There are four main aspects of the consultation with our public, those being:

1. The **enhancement of community and crisis teams** generated from a change to the local bed base that supports care closer to where people live.
2. The potential development of **partnership community beds**, as alternative to secondary care mental health admission, so that patients can be admitted to community beds and still receive specialist care from the local mental health trust.
3. The **Mental Health Inpatient Unit** at The Friarage Hospital currently provides access to inpatient beds for people with adult and older age mental health needs. This consultation includes options that look at providing these beds in a different way as more care will be managed in a community setting where people live.
4. The local provision of a **Health Based Place of Safety**, where people present with significant risk to themselves or others and require short-term assessment under the Mental Health Act, if there is no access to assessment and treatment beds in the locality.

The CCG's proposed options for the transformation of secondary mental health services seek to address the issues that have been discussed in this document and highlighted in our pre engagement. They provide alternative solutions which will allow us to implement the revised service model in full. The proposals will also meet growing public expectation for care closer to home. The three options for consideration are summarised as:

- 1 Do nothing - sustaining current level of service provision**
- 2 Enhanced community and crisis services with access to the nearest neighbouring assessment and treatment mental health beds**
- 3 Enhanced community and crisis service with access to an assessment and treatment bed base in a single neighbouring locality i.e. West Park (Darlington) OR Roseberry Park (Middlesbrough) and Bishop Auckland General Hospital for those patients with organic illnesses such as dementia**

The following summaries show the three options as described by our clinicians and service users and the advantages and disadvantages of each.

Option 1 – Do Nothing

To retain the current specialist mental health service with access to the two wards for adults and older people at the Friarage Hospital.

Continuation of the current level of community service delivery for adults of working age and older people. Provision of the memory service and community mental health teams working five days a week and seven day crisis support for people over 16 with functional mental health presentations only. The ability to provide intensive home support seven days a week for adults only.

Supporting narrative for option 1.

Advantages

Current service users would continue to access services that they are familiar with therefore reducing any potential anxiety as a result of change.

There will be no impact on existing travel times for local residents in terms of accessing local services.

Disadvantages

Inpatient admissions will continue in a managed mixed sex environment, without ensuite accommodation for all patients making it more difficult to protect people's privacy and dignity.

The inpatient facility will remain unfit for purpose in terms of its physical layout, quality of accommodation, type of accommodation and the fact that service users will continue to be cared for in a mixed sex environment, although the area is 'zoned' into male and female areas.

Adults requiring inpatient care will continue to access first floor accommodation that brings risk and limits access to therapeutic outside space.

There is limited scope for remodelling the current facility and even if there was, this would come with additional revenue cost which is not affordable within the contractual and QIPP requirements of this project (see page 25).

People with organic presentations needing admission, will continue to be cared for on a generic older persons mental health ward, increasing risk to patient safety and privacy and dignity due to the clinical mix of patients and lack of access to a more specialist physical environment for those with dementia.

CQC inspectors, when visiting the inpatient units, have repeatedly expressed concerns

Supporting narrative for option 1.

about the physical environment at the Friarage Hospital and the impact that this could have on the safe care and treatment offered to service users. However the current facility presents limited opportunity for remodelling and would incur additional cost which is out with the principles agreed for this service review.

There will be no release of resources to improve the community service and we will be unable to increase our ability to care for more people in community settings or at home and reduce the number of people who need to come into hospital or, when they are in hospital, look to reduce the length of their admission where appropriate.

We would be unable to redirect resources for older people to develop a specialist in reach service for people living in care homes with dementia.

The focus of the service would remain on inpatient provision not on increasing the availability of care in community settings. This is not what service users and the public are asking us to do.

Community services would remain limited to five days per week with no flexibility to provide a community service over an extended period dependent on patient need and demand.

Option 2 – 7 day enhanced community and crisis service. Inpatient care will be provided in the service users nearest neighbouring assessment and treatment mental health bed at West Park Hospital, Darlington or Roseberry Park Hospital, Middlesbrough and Bishop Auckland General Hospital (for those patients with organic illnesses such as dementia).

To provide an enhanced specialist mental health community service, providing access to adult and older person community mental health teams and crisis response for people over 16years up to seven days a bed.

People requiring specialist inpatient care will have access to the nearest purpose built specialist adult and older person inpatient wards, as close to their home as possible.

This will mean no assessment and treatment beds, for adults or older people, will be available at the Friarage Hospital.

Supporting narrative for option 2

Advantages

Patients who require a routine referral to mental health services will be able to access community services up to seven days week, providing first assessment within 4 weeks of referral.

IAPT services will be able to work closely with general practice to support people with long-term conditions and manage service users with NICE approved low and high intensity psychological interventions.

Memory services will be able to consistently provide a diagnosis and access to relevant treatment within 4 weeks of referral.

All service users regardless of age, who present in crisis, will be assessed within 4hours of referral, with triage by more senior clinical staff ensuring service users can access the right level of care, provided by staff with the right skill, in a timely manner, delivered in the right location for them.

Increased investment in home based treatment and intensive home treatment will mean more people are supported at home without the need to be admitted into a hospital bed through increasing the frequency of intervention in the home.

Allows investment in additional community based staff and access to a broader range of skills enabling the provision of more specialist community based services and therapies.

Older people, especially with organic needs, will benefit from dedicated care home liaison to reduce the need for them to be admitted to hospital.

Admissions for adults and older people will be to specialist single sex wards in fit for purpose dedicated mental health hospitals with access to a broader range of specialist

Supporting narrative for option 2

facilities and specialist staff. This will improve the experience of service users from both a clinical and safety perspective but also in terms of the privacy and dignity for service users.

Increased workforce opportunities for support staff and specialist roles, assisting with staff recruitment and retention.

The development of a new mental health Community Resource Centre to replace Gibraltar House, in the Northallerton area. This will give us a better working environment for staff and a better clinical environment for service users in the community.

Disadvantages

There will be no acute inpatient assessment and treatment beds for adults and older people at the Friarage Hospital. This will increase travel requirements for a small number of service users and their families when they need inpatient care. However the overall average distances travelled across all service users will be lower.

Assessment under the Mental Health Act, in a health based place of safety (section 136 suite) will be available in the adjacent Harrogate locality. This will increase the transport time (police and ambulance) for some patients in the Northallerton area.

Medical and nurse staffing will need to be realigned to take account of the move of inpatient facilities and the expansion of community based services.

Based on feedback from engagement with the public, patients, partners and clinicians this is the preferred option.

Option 3 – 7 day enhanced community and crisis service. Inpatient care will be provided from a single site in either West Park Hospital, Darlington or Roseberry Park Hospital, Middlesbrough and Bishop Auckland General Hospital (for those patients with organic illnesses such as dementia).

To provide an enhanced specialist mental health community service, providing access to adult and older person community mental health teams and crisis response for people over 16 years, up to seven days a week.

People requiring specialist inpatient care will have access to purpose built adult and older person inpatient beds in either Teesside OR Darlington and Bishop Auckland General Hospital (for those patients with organic illnesses such as dementia).

This will mean no assessment and treatment beds for adults or older people will be available at the Friarage Hospital.

Supportive narrative for option 3

Advantages

The advantages for this option are the same as option 2 above. In addition patients may find it reassuring that this model replicates the existing 'single site' offer at the Friarage Hospital.

Disadvantages

The disadvantages of this option are the same as option 2 above however, with this option, depending on the site chosen for the inpatient services, more service users and their families will need to travel further to access inpatient care and the overall average travel time for patients will be increased.

Other options considered:

In addition to the three options articulated above we considered carefully a fourth delivery model. This model proposed a 6 day enhanced community and 7 day crisis response, with access to a smaller local, new build, all-age adult functional assessment and treatment facility on the Friarage Hospital site.

However, after much discussion, most notably with our clinical colleagues, it was concluded that this option is not viable to take forward for public consultation for three significant reasons:

Firstly - it is not safe or clinically appropriate and directly contravenes the Royal College of Psychiatry guidance which states that services for adults of working age and older people need to be separated in order to address their very specific and different care needs.

Secondly - it is not financially viable due to the significant additional capital implications associated. Additionally - the release of inpatient investment into the enhanced community model would be reduced by half. This would be largely due to the need for increased staffing required for the inpatient unit, to accommodate caring for young and frail elderly people together and meet their increased needs.

And thirdly - the focus of the service would remain on inpatient provision, not on increasing the availability of care in community settings, and this is in direct opposition to what service users and the public have told us they want.

As a result of this consideration we have agreed to also explore opportunities to remodel provision for people who suffer from **significant physical health issues and 'organic' mental health issues** – i.e. those experienced by older people with a decreased mental function due to a medical or physical condition including dementia-related conditions. People with an organic presentation need to access specialist integrated physical and mental health inpatient care as close to their home as possible and we have committed with our health economy colleagues to develop this.

Summary:

Based on the valuable information received during our engagement with members of the public, clinicians, voluntary sector, social care and other local stakeholders, the CCG has developed a set of criteria to assess each option against. This can be found in the table below.

Criteria	Option 1	Option 2	Option 3	Option 4 (discounted following engagement)
Care closer to home for the majority of our population	✗	✓	✗	
Convenience and accessibility of services, especially for people who may find it difficult to travel	✗	✓	✗	

Improved integration in the provision of physical and mental health and social care	✗	✓	✓	
Enables GPs to better support out of hospital care	✗	✓	✓	
Provides support for our population to maintain independence	✗	✓	✓	
Retains wards 14 and 15 at the Friarage Hospital in Northallerton	✓	✗	✗	
Creates opportunities for the better use of technology	✗	✓	✓	
Tried and tested model of service delivery in our CCG area	✓	✓	✓	
High quality care with good clinical outcomes	✗	✓	✓	
Would actively reduce long lengths of stay in hospital	✗	✓	✓	
Equality in retention to service access for the majority of the population of Hambleton and Richmondshire	✗	✓	✗	
Maintains a sense of familiarity of services being delivered in known facilities	✓	✗	✗	
Financial sustainability	✓	✓	✓	

12.2 Patient travel implications

As part of any service change we need to understand the impact on patients and their families linked to travel. Table 25 shows the potential changes to average patient and family travel distances linked to the three options for consultation.

Table 25: Changes to patient and family travel distances

	Average Distances (Miles)				
	Current	Option 1	Option 2	Option 3a (West Park)	Option 3b (Roseberry Park)
Adult	24.43	24.43	17.41	19.81	24.2
MHSOP	23.39	23.39	17.94	23.6	26.69
Total	24.1	24.1	17.58	20.97	24.96

Average % in/decrease

	Option 2	Option 3a	Option 3b
AMH	-28.74%	-18.91%	-0.94%
MHSOP	-23.30%	0.90%	14.11%
Total	-27.05%	-12.99%	3.57%

To ensure that organic patients are managed by the right level of experience and in the right environment, the travel modelling (linked with Options two and three) assumes that patients requiring an assessment and treatment admission will attend Auckland Park in Bishop Auckland.

As you can see, the 'do something' options will see a decrease in travel for patients with the exception of Option 3b, but as you would expect the one with the all age functional unit in Northallerton see the greatest decrease in distance required. However this option is not clinically supported and not in line with Royal College of Psychiatry guidance in terms of the need to separate care for working age adults and older people.

12.3 Managing the process and outcome of consultation

These options will be taken forward for formal public consultation across Hambleton and Richmondshire. This is anticipated to run for at least 12 weeks through July and August with a recommendation being taken to a CCG Extraordinary Governing Body meeting in October 2017.

- **What happens to the responses?**

During the consultation, all the feedback and responses will be collated, in the same way as we have done with information received during the pre-consultation engagement events. At the end of the consultation a report will be produced identifying the themes and issues raised.

- **Decision making process**

The outcomes report will be discussed with the CCG Council of Members (which is made up of representatives from each of our member GP Practices). The final decision will be made by the CCG Governing Body once they have had time to consider the consultation feedback and responses.

- **The role of the Scrutiny for Health Committee**

The way we have developed our proposals and the way we will reach a decision on them, is being overseen by North Yorkshire Scrutiny for Health Committee, made up of local councillors. The Committee has the power to refer both the outcome of the consultation and the decision making process to the Secretary of State for independent review.

- **Public involvement**

The views of the public are extremely important to the CCG and we would like the public to get involved by telling us what they think of the options listed within this document. The CCG website includes a dedicated page for the consultation, and an online and printed survey will be available to complete.

- **Consistent with rules for cooperation and competition**

Where there are any procurement requirements with this service change we will follow the legal procurement frameworks.

12.4 Managing and understanding risk

Risk Assessments provide an opportunity to consider the likelihood and potential impact of all the elements of a proposed service reconfiguration. The CCG has undertaken risk assessments to diagnose the associated risks and mitigations relating to the pre-consultation and formal consultation process.

The CCG risk assessment process is outlined below:

The CCG has a consistent method of quantifying risk, the results of which can be processed to produce the acceptability of the risk(s) and follow a Risk Matrix methodology to designate each risk with a rating of Low, Moderate, High or Extremely High. Together the CCG/GP Council of Members will assess risks by defining the likelihood of the risk occurring or re-occurring (on a score of 1 to 5) and its consequence (also on a score of 1 to 5). These are defined as follows:

Risk Matrix		Likelihood				
		(1) Rare	(2) Unlikely	(3) Possible	(4) Likely	(5) Almost certain
Consequence	(1) Negligible	1	2	3	4	5
	(2) Minor	2	4	6	8	10
	(3) Moderate	3	6	9	12	15
	(4) Major	4	8	12	16	20
	(5) Extreme	5	10	15	20	25

Details of any associated risks with the mental health transformation programme are discussed, logged and, where possible, mitigating action is agreed at the mental health transformation programme board. Risks are reported through the CCG assurance process and recorded on the corporate risk register.

13 Mobilising the change

On completion and agreement of the consultation outcome there will be a need for a structured project management approach to mobilise this service change. This will be managed via TEWV’s Project Management Framework and a detailed mobilisation/implementation plan will be developed by the Project Steering Group once the outcome of the consultation is known, and a formal decision has been made to identify the preferred option. Table 26 provides the high-level timetable.

Table 26: High-level mobilisation time table

Key action	Timetable
Present outcome of consultation to Programme Board and preferred option agreed.	October 2017
Present Business Case, including detailed implementation plan to TEWV’s Executive Management Team and Programme Board.	October 2017
Implement mobilisation plan as set out in the Business Case (details cannot be determined until outcome of consultation)	November 2017 – June 2018
Revised Service Offer start date	June 2018

14 Assurance against four key tests

This document is intended to provide information and provoke discussion. It starts to set the scope of both the challenge and the opportunity relating to commissioning adult and older people’s mental health services in the Hambleton and Richmondshire area. It also confirms the central idea that people with mental health issues are more likely to remain safe and well in their own homes and communities if we can strengthen the care and support that they receive there. If we do this successfully, then admission to hospital can in some cases be avoided and the overall cost to NHS and social care services is reduced.

The CCG are continually assessing the process against the four reconfiguration tests, a summary of the evidence to date is summarised in Table 27 below:

Table 27: Four key service test assurances

Test Expectation	Summary of evidence
Strong public and patient engagement	<p>2013</p> <ul style="list-style-type: none"> - Launch of Fit 4 the Future with a number of local focus groups to scope a vision for Hambleton and Richmondshire and Whitby. - Vision documents shared with members of the public and used as a further discussion document to seek further views <p>2014</p> <ul style="list-style-type: none"> - Stakeholder and patient engagement to develop an understanding of strengths and weaknesses and explore opportunities, forming a direction of travel for community services - Stakeholder and public engagement informed the launch of a procurement exercise in Whitby for a new community service provider, linking in the vision for Whitby locality <p>2015</p> <ul style="list-style-type: none"> - Testing the direction of travel with members of the public and local stakeholders - Launch of the Dales Project to undertake detailed scoping with clinical teams with a view to piloting new models of care - Clinical summit attended by over 200 stakeholders <p>2016</p> <ul style="list-style-type: none"> - ‘Transforming our Communities’ consultation <p>2017</p> <ul style="list-style-type: none"> - Transforming Mental Health pre-consultation listening events with members of the public
Consistency with current	The range of new models of care seek to ensure that:

Test Expectation	Summary of evidence
<p>and prospective need for patient choice</p>	<ul style="list-style-type: none"> - care closer to home is achieved whilst also commissioning safe and sustainable services which are fit for the future. - The ability for patients to have a wider range of options in relation to the recovery focussed care, retaining the ability to remain in their own community rather than travelling long distances for care - Development of an integrated locality team to ensure that patients are better supported in the community reducing the requirement for admission into hospital
<p>Clear clinical evidence base</p>	<p>A range of clinical evidence has been collated and reviewed in the development of the proposed plans, all options put forward as part of the formal consultation and new models of care will be fully evidence based as referenced in sections 8 and 10.</p>
<p>Support for proposals from clinical commissioners</p>	<p>The pre consultation listening has been led by the CCG with active support from TEWV and primary care. The listening events have been attended by a range of clinical and non-clinical colleagues from all bodies.</p>

Appendix 1: Transforming mental health services terms of reference and governance structure

Transforming Mental Health Programme Board

Terms of Reference

Purpose

The Transforming Mental Health Programme Board will be the strategic oversight board for the transformation of mental health provision in Hambleton and Richmondshire. The Board will develop the transformation programme with mental health provider and local authority partners to strengthen improve and integrate services available to better support patients in the community.

Functions of the Board

The Board will:

- Jointly agree the strategic priorities for the programme of work in line with the local Sustainability and Transformation Plan, the CCG Operating Plan, the HRW Transformation Board and the NYCC Delivery Board
- Oversee all development work streams recognising that the detail of individual projects may be delegated to task and finish groups that will report into the Board
- Review progress against the CCG operating plan and key targets set for the mental health transformation programme
- Strengthen links between physical and mental healthcare delivery and between care provision and mental ill-health prevention
- Drive efficiency in the system and ensure value for money
- Identify, prioritise and develop new schemes and initiatives in relation to the development of community based mental health and social care services using a business case approach
- Ensure broader strategic mental health service development is built into individual Service Development Plans within individual provider contracts which are consistent with the overall strategic direction
- Unblock issues that arise as part of the delivery of mental health transformation, enabling escalation where necessary

Key Principles

The overall goal should be to develop an effective, integrated system evidenced by:

- Safe, effective care
- Positive patient experience
- Predictable throughput
- Predictable outcomes
- Manageable cost

Which ensures:

- Care at home or as close to home as possible
- Equity of outcome
- Equity of access

The principles guiding the Boards ways of working are as follows:

- Collective understanding of the purpose of the whole system approach
- Performing effectively within clearly defined functions and roles
- Establishing and promoting the values of the partnership
- Taking informed, transparent decisions and managing risk
- Developing skills, knowledge and experience in order to govern effectively
- Engaging all partners equally and making accountability real

Frequency of meetings

The Board will meet monthly to progress delivery of its responsibilities.

A schedule of meeting dates will be agreed in advance and these meetings should be treated as a key priority. If a lead is unable to attend they are responsible for ensuring that a deputy can attend and is briefed on any appropriate items.

The CCG Deputy Chief Operating Officer will be responsible for the agenda and for ensuring the timely distribution of supporting papers and action/agreement records. In addition, HRWCCG will provide administrative support to all the meetings, agendas and associated paperwork will be distributed at least one week prior to each meeting.

Membership

Senior Membership is required to enable decision making in line with the functions of the Board.

Lead	Organisation
Executive Programme Sponsor	HRW CCG
Programme Lead	HRW CCG/PCU
Admin Support Officer	HRW CCG
GP clinical lead	HRW CCG
Director of Operations	TEWV
Director of Planning, Performance and Communications	TEWV
Head of Adult Services	TEWV
head of health and social care	NYCC

A wider distribution list is in place to ensure key individuals are briefed on the transformation programme.

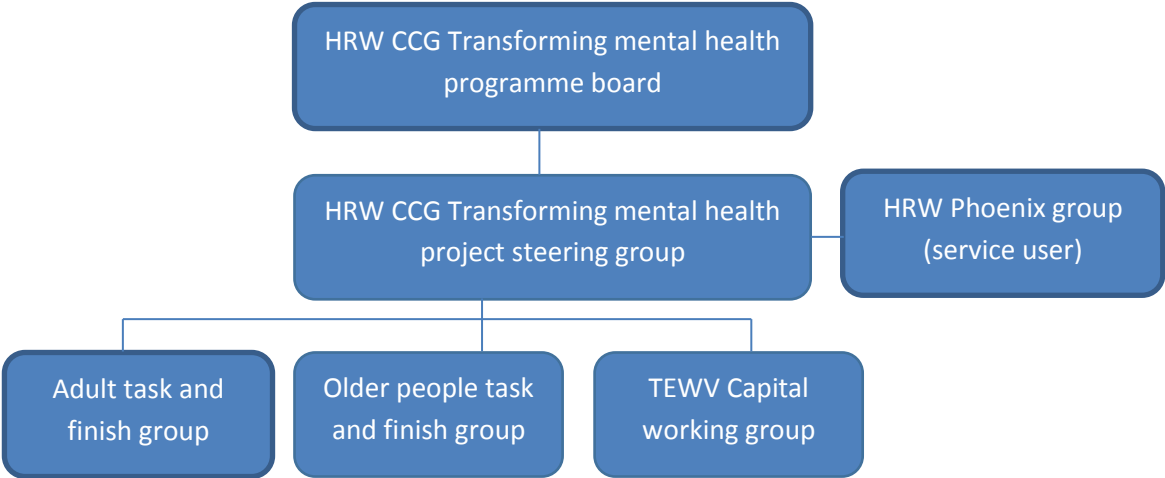
Quoracy

The Board is critical to the integrated transformation of the mental health system. All members or their nominated deputy are required to attend scheduled meetings. Where there is less than 4 people in attendance the meeting will not be held.

Accountability

The Board will be accountable for the leadership of the mental health transformation programme. In addition it will review scheme impact on performance and outcomes as exception.

Any specific contractual issues arising will be flagged to Provider/Commissioner business meetings. The Board will provide reports as necessary to HRWCCG Transformation Board and Audit and Information Governance Committee. The project governance structure is shown below:



Confidentiality

All members of the Board are expected to maintain confidentiality where appropriate.

NHS Hambleton, Richmondshire and Whitby CCG

Tees, Esk and Wear Valleys NHS
Foundation Trust

**Transforming Mental Health Services
Hambleton and Richmondshire**

Communications and engagement strategy

2016/2017

Version control

Date	Version	Change	Author
13.12.16	V1	Initial draft	Georgina Sayers
13.01.17	V2	Second draft	Georgina Sayers
17.01.17	V3	Amendments	Georgina Sayers
18.01.17	V4	Amendments (submitted to NHSE)	Georgina Sayers
23.01.17	V5	Amendments	Georgina Sayers
06.02.17	V6	Final draft	Georgina Sayers
13.02.17	V7	Final draft amends	Georgina Sayers
20.02.17	V8	Further final draft amends	Georgina Sayers
02.03.17	V9	Final draft (submitted to NHSE)	Georgina Sayers
24.04.17	V10	Further amends	Georgina Sayers
18.05.17	V11	Final amends	Georgina Sayers

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Introduction and purpose of document

This paper sets out a joint communications, engagement and consultation strategy intended to form the basis of an informed discussion around the transformation of adult and older peoples' mental health services across Hambleton and Richmondshire.

Partners involved in the joint strategy are NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG), Partnership Commissioning Unit (PCU) who procured mental health services on behalf of the CCG (up until 1 April 2017), Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) who are the mental health service provider and North Yorkshire County Council. We will also work closely with South Tees Hospitals NHS Foundation Trust (STHFT) due to the main acute services being provided within The Friarage Hospital in Northallerton.

This document provides a framework for the engagement and consultation process and includes but is not limited to:

- The aims and objectives of the strategy; including some high level key messages,
- Current legislation on the 'Duty to Involve' and the 'Equality Act 2010',
- The key principles for communication, engagement and consultation,
- Proposals for the engagement process including a clear action plan,
- The work required preparing for formal consultation and any additional resources required to deliver the strategy and plan,

There will be a period of 12 weeks for the formal consultation. Prior to this, there will be a pre-consultation period of engagement.

Background and pre-engagement

NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) is responsible for commissioning a majority of the healthcare services received by its population.

Fit 4 the Future

In 2013 the CCG published its case for change in [*Fit 4 the Future – reconfiguring older peoples' services in Hambleton and Richmondshire*](#). This outlined the CCG's vision for the development of community services in the coming years. Public and stakeholder engagement undertaken during this time demonstrated support for the case for change, with a real understanding from the public for the need to change. Key themes and messages included:

- Supporting people to stay in their own homes for as long as possible.
- More information for patients and their carers.
- Better patient transport.
- Facilitating social interaction.
- More support for carers.
- Utilising new technologies as part of the solution.

'Transforming Our Communities' consultation

A significant piece of engagement carried out by the CCG during 2016 was the 'Fit 4 the Future – Transforming Our Communities' consultation held between March and October.

In short, the CCG published a summarised version of the consultation document which was distributed to 485 contacts and locations, conducted a public survey receiving 353 responses, spoke with 493 people at 18 pre-consultation listening events and held 22 formal public consultation events attended by 353 delegates. In addition, the CCG utilised a number of existing communication channels including print and digital.

The consultation resulted in the implementation of community NHS beds known as 'step-up/down beds' within extra care housing facilities in areas of Hambleton and Richmondshire. It also meant the permanent closure of The Lambert Memorial Hospital in Thirsk and the decommissioning of some community beds on the Rutson Ward at The Friarage Hospital in Northallerton.

The full consultation strategy and report can be found on the CCG's website: www.hambletonrichmondshireandwhitbyccg.nhs.uk/transforming-our-communities

DISCOVER! engagement

Emerging themes and issues were also raised through the DISCOVER! engagement programme. DISCOVER! is an innovative engagement tool set up by the Partnership Commissioning Unit (PCU) to support the commissioning of local mental health services. DISCOVER! events were undertaken during Summer 2015 to look at mental health services in rural communities. Reports can be found on the CCG's website: www.hambletonrichmondshireandwhitbyccg.nhs.uk/mental-health

North Yorkshire Dementia Strategy development

A rich source of evidence was gathered from a consultation led by North Yorkshire County Council on the development of the Mental Health Strategy and in addition, the North

Yorkshire Dementia Strategy. More information can be found on the CCG's website: www.nypartnerships.org.uk/mentalhealthstrategy

Clinical Summit 2015

This unique event held in November 2015 brought together over 200 clinical professionals including GPs, hospital consultants, nurses, therapists and social care colleagues from across Hambleton and Richmondshire to discuss, influence and help shape how health and social care could be delivered effectively and sustainably in the future. Topics discussed included Rural Care, Urgent Care, Technology in Health and Care of the Frail Elderly.

This event helped shape communications and engagement and highlighted the importance of 'integration'. A summary report was published in December 2015 and can be found on the CCG's website: www.hambletonrichmondshireandwhitbyccg.nhs.uk/clinical-summit

About this consultation

In line with 'Fit 4 the Future' and the outcomes of previous engagement and consultation, it is now the ambition of the CCG to transform mental health services aimed at developing a modern, recovery-focused model. This will be called 'Transforming Mental Health Services' with a focus on adult and older peoples' mental health across Hambleton and Richmondshire localities.

It is widely recognised that improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation. This has an impact across all statutory and non-statutory providers and it is important therefore that services work together across the system to shift the focus from illness to wellness.

The [NHS Shared Planning Guidance](#) asked every local health and care system in England to come together to create their own ambitious local plan for accelerating the implementation of the [Five Year Forward View](#) (5YFV). These blueprints, called Sustainability and Transformation Plans (STPs), are place-based, multi-year plans built around the needs of local populations. They provide the local vehicle for strategic planning, implementation at scale and collaboration between partners. The STP which includes Hambleton and Richmondshire acknowledges that services cannot continue to be delivered in their present form. They are unable to address the key challenges of health and wellbeing, care and quality, and finance and efficiency which we are currently facing. The strategy is a 'system-wide' solution based on effective earlier intervention and prevention through to more integrated community models of care. The STP which includes Hambleton, Richmondshire and Whitby can be found here:

www.hambletonrichmondshireandwhitbyccg.nhs.uk/sustainability-and-transformation-plan

Our local population

Hambleton and Richmondshire has a predominantly rural area with a local population that is increasing and ageing, with significant in-migration from other parts of the UK in the pre-retirement and the recently retired age groups.

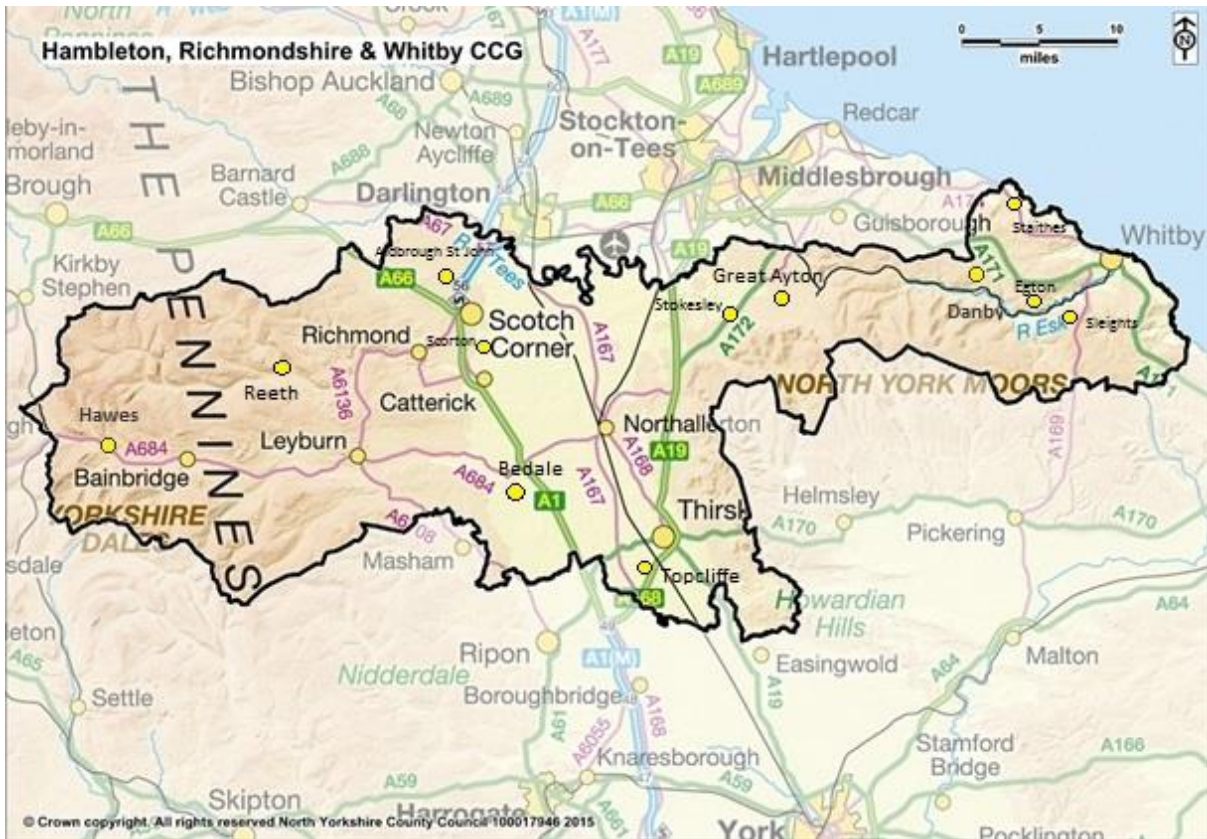


Fig 1: Map of NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group boundary with GP practices

In respect of the current provision of mental health services, most people receive their care and treatment in a community setting. Adults and older people requiring in-patient services are admitted for assessment and treatment, in the main, to The Friarage Hospital, Northallerton (wards 14 and 15). Other or specialist intensive mental health is provided in Teesside or Darlington.

The Care Quality Commission (CQC) has raised concerns about the limitations of the environment on wards 14 and 15 in The Friarage Hospital. They reported that the dormitory style wards impact on patients' privacy, dignity and safety. Reports can be found online:

The essence of mental health care is that early intervention through better education, awareness and care planning can help people to self-manage and prevent deterioration of their condition. Similarly improved support for family and carers, speedier access to support services, the use of new technologies and caring for people at home where possible all bring improved outcomes for people and help them to maintain good mental health.

In this process therefore, it is vital that services do not only consider the treatment of people already diagnosed with mental health conditions, but also consider preventative strategies aimed at the wider population, supported through Public Health services.

Please refer to the full Transforming Mental Health Services case for change document for more information.

Strengths and challenges

We have learnt from our engagement to date that **our strengths** as a health care system are:

1. Strong communities which support each other.
2. Good self-care and resilience with good informal networks.
3. Lots of projects that work well to improve care.
4. Staff that are dedicated and committed to the area.
5. Multi-professional team working.
6. Good communication with our population and a feeling of being empowered.
7. High regard for our GPs, urgent care and mental health working together.
8. Excellent care and service at The Friarage Hospital.

Some of **our challenges** identified from engagement include:

1. Perception that The Friarage Hospital will be closed.
2. Difficulties with transport.
3. Rurality of the area.
4. Poor IT and communications infrastructure which is not joined up.
5. Workforce challenges.
6. Some lack of public understanding around mental health services and services required.
7. Need for modern, evidence based services and care for patients with a mental health illness.

Key Principles

We will adhere to the following principles of good practice:

- **Open** – decision makers are accessible and ready to engage in dialogue. When information cannot be given, the reasons are explained.
- **Two-way** – there are opportunities for open and honest feedback, and people have the right to contribute their ideas and opinions about issues and decisions.
- **Timely** – information arrives at a time when it is needed, relevant to the people receiving it, and able to be interpreted in the correct context.
- **Clear** – communication should be in plain English, jargon free, easy to understand and not open to interpretation.
- **Targeted** – the right messages reach the right audiences using the most appropriate methods available and at the right time.
- **Credible** – messages have real meaning, recipients can trust their content and expect to be advised of any change in circumstances which impact on those messages.
- **Planned** – communications are planned rather than ad-hoc, and are regularly reviewed and contributed to by senior managers and staff, as appropriate.
- **Consistent** – there are no contradictions in messages given to different groups or individuals. The priority to those messages may differ, but they should never conflict.
- **Efficient** – communications and the way they are delivered are fit for purpose, cost effective, within budget and delivered on time.
- **Integrated** – internal and external communications are consistent and mutually supportive.
- **Corporate** – the messages communicated are consistent with the aims, values and objectives of NHS Hambleton, Richmondshire and Whitby CCG and Tees, Esk and Wear Valleys NHS Foundation Trust.

Aims and objectives of this strategy

The overarching aims and objectives of this strategy are:

- To ensure that appropriate mechanisms are in place so that the public, key stakeholders and partners feel engaged and informed throughout the process so they can influence the future model.
- To contribute to shaping public, and health services' staff, expectations of mental health services across Hambleton and Richmondshire.
- To provide a framework by which the CCG and TEWV, who are both involved in the consultation are able to deliver consistent messages through a coordinated approach to communications and engagement activity.
- To maintain credibility by being open, honest and transparent throughout the process.
- To monitor and gauge public and stakeholder perception throughout the process and respond appropriately.
- To be clear about what people can and cannot influence throughout the engagement and consultation phases.
- To achieve engagement that is meaningful and proportionate, building on existing intelligence and feedback such as previous engagement/consultation activities, complaints, compliments etc.
- To provide information and context about the proposals in clear and appropriate formats that is accessible and relevant to target audiences.
- To give opportunities to respond through a formal consultation process.
- To maintain trust between the NHS and the public that action is being taken to ensure high quality NHS services in their local area.
- To raise awareness and understanding of why it is important that HRW CCG and TEWV has a plan to deliver sustainable and viable mental health services closer to home in the future.

Legislation – our statutory requirements

Any reconfiguration of services requires a robust and comprehensive engagement and consultation process. NHS organisations are required to ensure that local people, stakeholder and partners are informed, involved and have an opportunity to influence any change.

1. This document is guided and influenced by the “Six Principles for Engaging People and Communities; definitions, evaluation and measurement”. The principles are: Care and support is person-centered; personalised, coordinated and empowering.
2. Services are created in partnership with citizens and communities.
3. Focus in on equality and narrowing inequality.
4. Carers are identified, supported and involved.
5. Voluntary community and social enterprise, and housing sectors are involved as key partners and enablers.
6. Volunteering and social action are key enablers.

At the heart of the principles is the assertion in the [NHS Five Year Forward View](#) that ‘a new relationship with patients and communities’ is key to closing the three gaps identified by the NHS Five Year Forward View: health and wellbeing, quality of care and treatment, finance and efficiency.

These principles require the NHS to ensure that there is a move away from paternalistic, fragmented health and social care services and that the focus is on supporting people better to manage their health and wellbeing. It is for NHS organisations to ensure that the focus is

on ensuring people have as much choice, voice, control and support as they want in decisions that involved their health and care. Growing evidence shows that involvement is the key to improving outcomes and improving the experience of care.

Creating services in partnership with the public and communities and using a co-design approach to design services means working with all sectors of the community including voluntary, community and social enterprise sectors along with patient participation groups, carers and other agencies.

The document supports the need to focus on equality and ensuring that includes all the groups protected under the Equality Act 2010, as well as people who are less likely to use services and those who have the lowest health outcomes. Identifying and supporting carers and ensuring they are involved in this part of the process.

Key messages

It is our ambition to support people to live fulfilling and meaningful lives in their community, irrespective of symptoms or diagnosis of mental illness (a recovery-focused approach)

We aim to achieve this by:

- Providing more recovery-focused services in the community, closer to patients' homes.
- Making sure patients and their carers get the treatment and support they need, when they need it (any time, day or night).
- Supporting access to specialist assessment and treatments such as inpatient care, when required.
- Providing evidence-based treatment in the most appropriate care setting.
- Ensuring mental health services and general practitioners (GPs) continue to work closely together to provide local services for local people.
- Delivering inpatient and community services in high quality, fit-for-purpose buildings.

The proposed key messages are:

- The CCG has already carried out significant engagement and consulted on older peoples' community services where mental health provision was highlighted by the public as an area to address.
- The public tell us that they want to see more services being provided at home or as close to home as possible.
- The ways in which mental health care can be delivered are changing and evolving. More people are now able to receive the mental health care and treatment they need at home and hospital admission is becoming the exception rather than the norm.
- Because of national challenges facing the NHS and local authorities it is important that we use resources effectively and efficiently. We must achieve the best outcomes for our patients within the available budget.
- The CQC have recommended actions with regards to privacy and dignity for patients in wards 14 and 15 at The Friarage Hospital in Northallerton.
- We need to review the type of services that are available in community settings and those that are delivered in hospital. We also need to look at integrating some

services and providing others so that more can be delivered locally, close to where people live.

Stakeholders

For the purpose of this strategy, the definition of stakeholders is anyone who will be affected (either positively or negatively) by a proposed change to adult and older peoples' mental health services locally, those who have an opinion on the proposed changes and those who could influence other stakeholders.

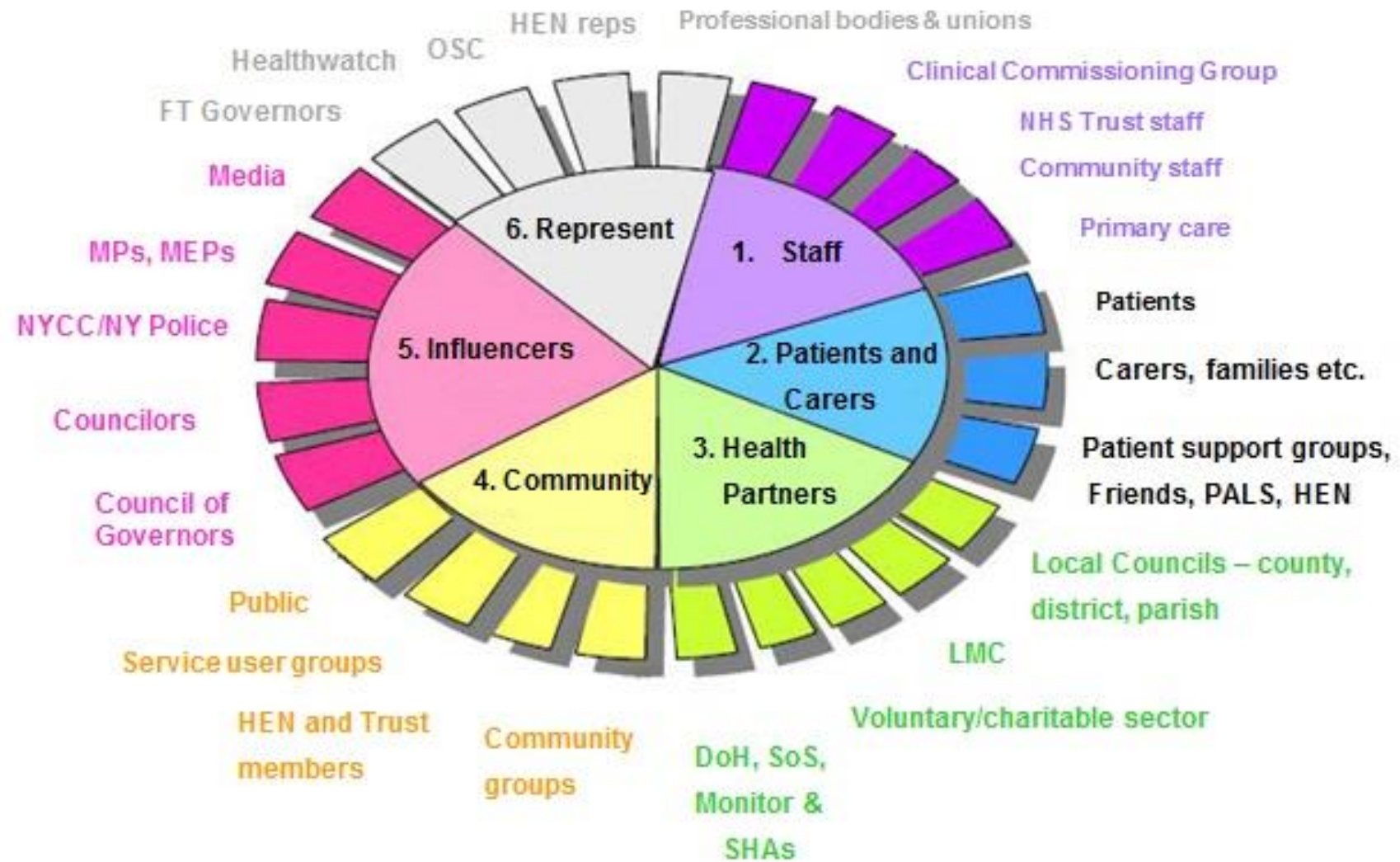
There are a wide range of stakeholders who will have varying degrees of interest in and influence on the acute care services agenda.

Broadly, those stakeholders fall into the following categories:

- Service users and their carers
- Internal (CCG and Trust staff)
- NHS partners (including GPs, LMCs and other CCGs) and local authority directors
- Non-NHS partners including North Yorkshire Police and the North Yorkshire Police and Crime Commissioner
- The local community (to include community and voluntary groups outlined in Appendix 4)
- Political audiences
- Governance and regulators
- Under-represented groups

Please refer to Appendix 4 for further detail on stakeholders.

Stakeholder segmentation



Communication and engagement process

The three phased plan to build a better future was approved by the HRW Transformation Board, which is made up of the following members:

- NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG)
- South Tees Hospitals NHS Foundation Trust (STHFT)
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
- York Hospitals NHS Foundation Trust (YHFT)
- County Durham and Darlington NHS Foundation Trust (CDDFT)
- Harrogate and District NHS Foundation Trust (HDFT)
- Humber NHS Foundation Trust (HFT)
- Yorkshire Ambulance Service NHS Trust (YAS)
- Hambleton District Council (HDC)
- Richmondshire District Council (RDC)
- Scarborough Borough Council (SBC)
- North Yorkshire County Council (NYCC), through the Joint Health and Wellbeing Board (JHWB) and the Scrutiny of Health Committee.
- Heartbeat Alliance - GP Federation
- Community and voluntary sector organisations
- NHS England Area Team – North Yorkshire and Humber

Engagement process

Pre-engagement relating to this programme or work began in 2013 and has been outlined from pages 5 to 7.

The Transforming Mental Health Services consultation will take a three-phased approach as outlined below.

Phase one: pre-consultation engagement/ listening (January 2017 - May 2017)

This pre-consultation engagement (or listening) phase will involve:

- the in-depth gathering of views and suggestions from, patients and carers.
- the view of clinicians and other professionals in relation to current mental health provision across Hambleton and Richmondshire.
- the public in developing the options criteria to assess potential health services scenarios to go forward for modelling and then as potential options for consultation.
- reviewing the ways in which those people, and the wider general public, think adult and older peoples' mental health services can be improved or changed.
- revisiting existing staff, patient and public views based on previous consultation feedback (including customer feedback, complaints, suggestions and previous surveys).

Key questions during engagement will include:

1. What can your local NHS do to care for more people with mental health problems in the community?
2. How can we improve the standard of care for those who are in crisis?
3. What can we do to reduce the need for hospital admission and to keep the length of stay to a minimum?

Phase two: Reporting and options development (May 2017 - June 2017)

This important phase is an opportunity to review feedback, respond to queries and review reoccurring themes from the pre-consultation engagement.

This information will help inform the formal consultation options. These options will be informed by staff, service user and general public feedback alongside clinical evidence and will be shared for formal consultation.

A period of purdah began 20 March 2017 until 4 May 2017 for local elections. This period was extended until 8 June 2017 due to the sudden announcement of the 2017 General Election. During purdah, information about the consultation is unable to be released publically – however engagement is able to continue.

Phase three: Formal consultation (June 2017 - September 2017)

Following the pre-consultation engagement, there will be a formal consultation period of a minimum of 12 weeks. The consultation will provide:

- proposed consultation options developed by the CCG and TEWV informed by clinical evidence and pre-consultation engagement (published after purdah ends)
- patients, the public and stakeholders with the opportunity to comment on and choose between the consultation options developed from the pre-consultation phase.
- the chance to build on learning from the engagement phase.
- the opportunity for the CCG and TEWV to identify hard to reach groups from the equality impact assessment.

A full consultation document which outlines the case for change and questions will be distributed widely across Hambleton and Richmondshire, available online and upon request. A summary version will be made available more widely and in accessible formats.

There will be a range of mechanisms and activities to gather feedback and views including:

- Opportunities for formal and informal discussion in appropriate and accessible locations.
- Presentations to a wide range of groups and audiences (pro-active and upon request).
- Staff briefings and meetings.
- Information in prime community and health settings.
- Information on relevant websites.
- Media relations.
- Posters in a range of community venues throughout the including health settings, libraries, District Council reception areas etc.
- Information distributed and shared through other publications and information points.
- Feedback forms and questionnaires.
- Social media.

Purdah and elections

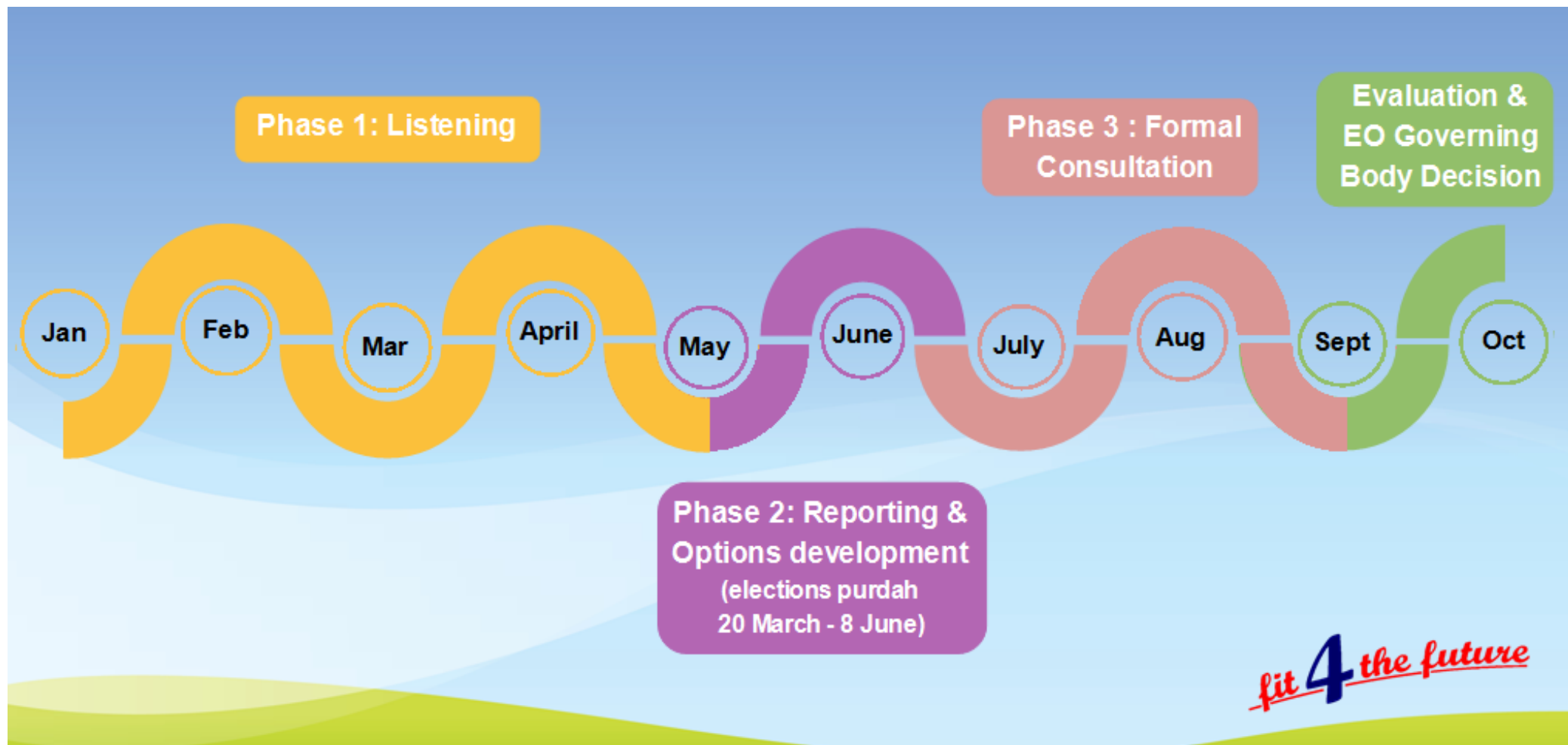
This strategy acknowledges two separate elections (local and national) taking place within the timeframe of the pre-consultation engagement phase. The consultation will abide by national guidelines for periods of purdah (the pre-election period).

Post consultation

Once the outcome of the consultation process has been decided feedback will be provided to all key stakeholders using agreed channels. Opportunities for communication can be found under 'Methodology'.

A more detailed communications and engagement action plan can be found from page 21 of this document.

Engagement and consultation timeline:



Methodology

We want to involve as many people as possible in our consultation and intend on using a variety of approaches to provide people with the opportunity to have their say. We aim to utilise a number of opportunities and to:

- Publish a full consultation document (electronic and hard copy).
- Publish a consultation summary document (electronic, hard copy and easy read).
- Brief North Yorkshire County Council (NYCC) Scrutiny of Health Committee prior to and during the consultation.
- Hold a number of pre-consultation listening events to help shape the options included in the consultation.
- Hold public consultation events across the CCG footprint.
- Utilise existing CCG, Trust and community events.
- Meet with consultant physicians at The Friarage Hospital to discuss the proposals.
- Attend a number of NHS staff briefings.
- Attend a number of meetings with local groups such as the Phoenix Group and the Friends of the Friarage.
- Circulate stakeholder briefings (to include MPs, councillors and Health Engagement Network members).
- Present to representatives of NYCC and Hambleton/ Richmondshire District Scrutiny Committees.
- Produce a short video describing the purpose of the consultation (dependent on need and cost).
- Conduct a survey, both online and in paper form.
- Present the consultation to the Council of Members (representing each of the 22 GP Practices).
- Involve local GPs through email correspondence and regular locality meetings.
- Produce and distribute posters advertising consultation events.
- Launch a dedicated webpage (on the CCG website with links from the Trust website).
- Issue proactive media releases and statements where appropriate.
- Respond to media enquiries, direct public/ stakeholder enquiries and MP letters.
- Post a number of dedicated tweets using #TransformingMentalHealthServices
- Post a number of Facebook posts.
- Include features in public and GP newsletters.
- Develop a set of frequently asked questions (FAQs) made available online and in hard copy.
- Utilise existing 'feedback' email address: hrwccg.feedback@nhs.net

It is important to acknowledge the challenges around the rurality of the patch. We will therefore organise face-to-face events or meetings in accessible locations right across Hambleton and Richmondshire ensuring we are inclusive.

Materials required:

- Full consultation document (PDF and hard copies).
- Summary consultation documents (PDF and hard copies).
- Easy-read consultation summary documents (PDF and hard copies).
- Presentation slides.
- Survey/questionnaire – online and hard copies.
- FAQ document – living document produced in house as required.
- Other evidence or case for change documents – produced in house as required.
- Dedicated webpage to host information, FAQ, link to online survey – hosted on CCG website.
- Feedback form/mechanisms including social media.

Sharing information

As part of this work we will consider the best ways to engage with protected groups and those who are sometimes overlooked.

The population of Hambleton, Richmondshire and Whitby is predominantly of white British ethnic origin (97%) with only a very small percentage of the population (3%) representing other ethnic groups (Reference 2011 Census).

Information will be made available in formats that are relevant and accessible to the public and patients where appropriate, including easy read. Hard copy surveys and documents will be made available to those without access to a computer or who are otherwise able to access electronic. They will be placed in accessible locations within the community including The Friarage Hospital, the Friary Hospital, GP surgeries, pharmacies, libraries and community centres.

Information will also be made available via online, digital and social media channels to facilitate discussion and feedback amongst stakeholders who are more likely to engage via these channels. This will also assist with the challenges around our rurality.

Engagement will be supported by existing patient and service user groups. We therefore acknowledge the importance of effectively capturing and evidencing feedback. A template to capture appropriate information will be circulated.

Previous engagement and consultation

Pre-engagement

Listening and consultation events held across Hambleton and Richmondshire during the 2016 'Transforming Our Communities' consultation on community services are listed below. Overall, 885 members of the public attended these events:

Date	Venue	Location
22/03/2016	Thirsk School	Thirsk
30/03/2016	Golden Fleece	Thirsk
31/03/2016	Thirsk & Sowerby Town Hall	Thirsk
04/04/2016	Thirsk Market Place	Thirsk
07/04/2016	Thirsk Auction Mart	Thirsk
12/04/2016	Osmotherley Coffee Morning	Osmotherley
12/04/2016	Thirsk Auction Mart	Thirsk
13/04/2016	Northallerton Market Place	Northallerton
14/04/2016	Sandhutton & Breckenbrough	Thirsk
20/04/2016	East Thirsk Community Hall	Thirsk
09/05/2016	Golden Lion Hotel	Northallerton
10/05/2016	Friarage 'Hub'	Northallerton
13/05/2016	Stokesley Market Stand	Stokesley

Date	Venue	Location
16/05/2016	Thirsk Market Stand	Thirsk
17/05/2016	Bedale Market Stand	Bedale
20/05/2016	Leyburn Market Stand	Leyburn
23/05/2016	Hawes GP practice	Hawes
26/06/2016	Thirsk Truck Gathering	Thirsk
07/07/2016	Thirsk Library	Thirsk
10/07/2016	Northallerton Carnival	Northallerton
12/07/2016	Coffee Morning, Osmotherley	Osmotherley
16/07/2016	Sowerby Summer Fete	Sowerby
21/07/2016	Thirsk Library	Thirsk
23/07/2016	Emergency Services Show	Richmond
25/07/2016	Thirsk Market	Thirsk
27/07/2016	Borrowby Show	Thirsk
02/08/2016	Lambert Medical Centre	Thirsk
03/08/2016	Northallerton Market	Northallerton
04/08/2016	Civic Centre	Northallerton
04/08/2016	Civic Centre	Northallerton
06/08/2016	Osmotherley Show	Osmotherley

Date	Venue	Location
10/08/2016	Danby Show	Whitby
11/08/2016	Thirsk Health Centre	Thirsk
16/08/2016	Glebe House Bedale Surgery	Bedale
18/08/2016	Meadowfields Extra Care Housing	Thirsk
22/08/2016	Thirsk Garden Centre	Thirsk
24/08/2016	Egton Horse & Agricultural Show	Whitby
30/08/2016	Friarage Entrance	Northallerton
01/09/2016	Thirsk Library	Thirsk
05/09/2016	Topcliffe Surgery	Thirsk
05/09/2016	Topcliffe Surgery	Thirsk
07/09/2016	Muker Show	Dales
08/09/2016	Civic Centre	Northallerton
08/09/2016	Civic Centre	Northallerton
12/09/2016	Stokesley Health Centre	Stokesley
15/09/2016	Thirsk Leisure Centre	Thirsk
19/09/2016	The Friary Surgery	Richmond
20/09/2016	Friarage Entrance	Northallerton
21/09/2016	Thirsk Health Centre	Thirsk

Date	Venue	Location
26/09/2016	Great Ayton HC	Richmond
27/09/2016	Meadowfields Extra Care Housing	Thirsk

A full consultation outcome report can be found on the CCG's website: www.hambletonrichmondshireandwhitbyccg.nhs.uk/transforming-our-communities

Other previous engagement has been outlined from pages 5 to 7. The outcomes of these can be found on the CCG's website.

Engagement already undertaken during 2016 prior to pre-consultation engagement with a focus on mental health prior includes:

Date	Audience	Location
08/02/2016	Consultants and managers	The Friarage Hospital
05/07/2016	Consultants and managers	The Friarage Hospital
13/07/2016	Consultants and managers	The Friarage Hospital
09/08/2016	Service users and carers	The Friarage Hospital
10/08/2016	Consultants and managers	The Friarage Hospital
05/10/2016	TEWV and NYCC staff	The Friarage Hospital
10/10/2016	Service user/carer/staff/charity/voluntary sector/general public	Richmond Cricket Club
09/11/2016	TEWV and NYCC staff	The Friarage Hospital
11/11/2016	Service users/carers/staff	The Friarage Hospital

07/12/2016	TEWV and NYCC staff	The Friarage Hospital
07/12/2016	TEWV and NYCC staff	The Friarage Hospital
13/12/2016	Service users/carers/staff	The Friarage Hospital
15/12/2016	Consultants and managers	The Friarage Hospital

Communications and engagement action plan

NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (CCG) key players and spokespeople:

Janet Probert – Chief Officer (JP)

Dr Charles Parker – local GP and Clinical Chair (CP)

Dr George Campbell – local GP and Governing Body member (GCa)

Dr Mark Hodgson – local GP and Governing Body member (MH)

Gill Collinson – Chief Nurse (GC)

Dr Richard James – CCG GP Lead for Mental Health (RJ)

Beverley Hunter – Head of Mental Health, Partnership Commissioning Unit (BH) (*until 1 April 2017*)

Lisa Pope – Deputy Chief Operating Officer (LP)

Abi Barron – Head of Strategy/Community Care (AB)

Georgina Sayers – Communications and Engagement Manager (GS)

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) key players and spokespeople:

Mr Colin Martin – Chief Executive (CM)

Dr Nick Land – Medical Director (NL)

Adele Coulthard – Director of Operations, North Yorkshire (AC)

Dr Liz Herring – Head of Adult Mental Health Services, North Yorkshire (LH)

Mark Spencer – Locality Manager for Adult Mental Health (MP)

Cath Crawford – Locality Manager for Older Persons' Mental Health (CC)

Julie Jones – Head of Communications (JJ)

Phase one – pre-consultation engagement (listening phase)

Audience	Mechanism	Attended/actions by	Proposed/ completed date
NHS England	Attend formal meeting to discuss consultation process	JP/BH/LP	17.01.17
OSC	Attend formal meeting to discuss and present on consultation proposals	JP/BH/LP	27.01.17
CCG/PCU staff TEWV staff STHFT staff Governing Bodies HEN Reps	Briefings circulated	GS/JJ	27.02.17
MPs NY Scrutiny Committee Councillors	JP to brief via email/ telephone/meeting prior to circulation of briefing: <ul style="list-style-type: none">• Rishi Sunak MP• Kevin Hollinrake MP• Health Overview and Scrutiny Committee (OSC) Cllr Clark / Daniel Harry	JP/LP	27.02.17

Audience	Mechanism	Attended/actions by	Proposed/ completed date
Clinical stakeholders	Briefing circulated to clinical stakeholders including: <ul style="list-style-type: none"> • LMC • GPs • Pharmacies • Dentists • TEWV adult and MHSOP inpatient and community staff • NHS partner organisations including other CCGs (if clinical) Include dates, venues and timings and public and clinical/stakeholder engagement events.	GS/JJ	27.02.17
Wider stakeholders	Briefing circulated to wider stakeholders including: <ul style="list-style-type: none"> • County and Local Councillors • Parish Councillors • Voluntary sector organisations • Non NHS partner organisations • PPGs • Health Engagement Network members • Trust governors • Trust members • Service users and carer groups • North Yorkshire Police • HealthWatch Include dates, venues and timings and public/stakeholder engagement events.	GS/JJ	27.02.17
Wider public	Create dedicated website page Create posters and circulate	GS/JJ	27.02.17
Media	Reactive statement prepared (prior to NHS England checkpoint 2 visit)	GS/JJ	27.02.17

Audience	Mechanism	Attended/actions by	Proposed/ completed date
CCG Governing Body	Briefing on the engagement and consultation process	LP	23.03.17
NY Scrutiny Committee	Briefing on the engagement and consultation process	JP/LP/LH	07.04.17
All stakeholders	Briefing inviting to open engagement sessions <ul style="list-style-type: none"> • 10 May, Northallerton • 11 May, Richmond 	GS/JJ	18.04.17
Service users/public	Media release inviting to open engagement sessions <ul style="list-style-type: none"> • 10 May, Northallerton • 11 May, Richmond 	GS/JJ	19.04.17
End of pre-consultation engagement			12.05.17
Phase 2 – purdah and engagement analysis/formulation of consultation options			15.05.17

Pre-consultation engagement for Transforming Mental Health Services (January – May 2017)

Date	Audience	Location
04/01/2017	TEWV and NYCC staff/service users	The Friarage Hospital
01/02/2017	TEWV and NYCC staff	The Friarage Hospital
21/01/2017	TEWV and NYCC staff	The Friarage Hospital
01/03/2017	TEWV, Darlington, Durham, Tees NYCC staff/service users	The Friarage Hospital
03/03/2017	Service users	Leyburn
07/03/2017	Service users/public	Bedale
08/03/2017	Carers	The Friarage Hospital
15/03/2017	Service users	The Friarage Hospital
27/03/2017	Service users/staff	Leyburn
05/04/2017	TEWV and NYCC staff	The Friarage Hospital
06/04/2017	Service users/carers	Northallerton
10/04/2017	Service users/public/carers	Romanby
08/05/2017	Service users/carers	Catterick
09/05/2017	Staff	Northallerton
10/05/2017	Service users/staff	Northallerton
11/05/2017	Service users/carers/staff/public	Northallerton
12/05/2017	Service users/carers/staff/public	Northallerton

In total, the following activity took place during pre-consultation engagement:

Type	Description	Numbers engaged	Comments captured
Events	Face-to-face engagement	481	537
Direct	Via capture form (post or email)	n/a	212
Direct	Via email (hrwccg.feedback@nhs.net)	n/a	46
	Total	481	795

More detail on the pre-consultation engagement including key themes will be made available in the final consultation report.

Phase three – announcing options and formal consultation (purdah until 4 May for local elections and 8 June for general election)

Audience	Mechanism	Attended/actions by	Proposed/ completed date
CCG Governing Body	Briefing on the engagement and consultation process (no consultation options due to purdah)	LP	25.05.17
TEWV staff	Staff briefing event on draft options	LH/JJ	08.06.17
End of purdah			09.06.17
NHS England	Circulate briefing with draft options	JP/BH/LP	09.06.17
NY Scrutiny Committee	Circulate briefing with draft options	JP/BH/LP	09.06.17
CCG staff TEWV staff STHFT staff Governing Bodies HEN Reps	Briefings circulated to include draft options, event details and next steps	GS/JJ	12.06.17
MPs NY Scrutiny Committee Councillors	JP to brief via telephone/meeting/email to include draft consultation options, event details and next steps (dependent upon election results)	JP/LP	12.06.17
Clinical stakeholders	Briefings circulated to include draft options, event details and next steps: <ul style="list-style-type: none"> • GPs • Pharmacies • Dentists • TEWV adult and MHSOP inpatient and community staff 	GS/JJ	12.06.17

Audience	Mechanism	Attended/actions by	Proposed/ completed date
	<ul style="list-style-type: none"> NHS partner organisations including other CCGs (if clinical) 		
Wider stakeholders	<p>Briefings circulated to include draft options, event details and next steps:</p> <ul style="list-style-type: none"> County and Local Councillors Parish Councillors Voluntary sector organisations Non NHS partner organisations PPGs Health Engagement Network members Trust governors Trust members Service users and carer groups North Yorkshire Police HealthWatch 	GS/JJ	13.06.17
Media contacts	Reactive statement for draft options pending formal approval	GS/JJ	13.06.17
CCG Governing Body (closed)	Approval of final consultation options	LP	22.06.17
NY Scrutiny Committee	Formal approval of consultation options	JP/LP/LH	23.06.17
All stakeholders	Updated briefing announcing outcome of scrutiny and confirming formal consultation	GS/JJ	23.06.17
Media contacts	<p>Media release to Hambleton & Richmondshire media contacts to include draft options, event details and next steps (subject to scrutiny approval)</p> <p>Offer interviews with senior CCG/PCU/TEWV representatives.</p>	GS/JJ	23.06.17
Wider public	<p>Update website page</p> <p>Post on social media channels</p> <p>Include information in relevant newsletters</p> <p>Update posters and circulate</p>	GS/JJ	23.06.17

Audience	Mechanism	Attended/actions by	Proposed/ completed date
	Update video and circulate Update FAQs		
Start of formal consultation (if approved)			26.06.17

Consultation event/meeting opportunities (from 9am 26 June – 5pm 15 September 2017)

Date	Time	Location	Location	Status
Tuesday 27 June 2017	2pm – 4.30pm	CCG AGM and marketplace event, Richmond Town Hall, Richmond	Richmond	Confirmed

Opportunities to be confirmed:

The aim is to provide at least one face-to-face consultation opportunity each week throughout the 12 week period.

The dates, times, venues and groups are to be confirmed and will be made available to the public via the media, website, newsletter and posters.

Agricultural shows	Libraries	Community groups
<ul style="list-style-type: none"> • Osmotherley • Wensleydale • Kildale • Borrowby • Reeth • Borrowby • Moorcock • Muker 	<ul style="list-style-type: none"> • Thirsk • Northallerton • Stokesley • Bedale • Catterick • Leyburn • Colburn • Hawes 	<ul style="list-style-type: none"> • Age UK Northallerton • Alzheimer's Society • Broadacres • Dementia Collaborative • Leyburn Bipolar Group • MENCAP • Mental Health Forum • Mental Health Support • Mind • Northdale • Over 50s Forum • Phoenix Group • Rethink Mental Health • Rural Action Yorkshire • Sporting Memories
Market stalls	GP practices	Other

Agricultural shows	Libraries	Community groups
<ul style="list-style-type: none"> • Northallerton • Thirsk • Stokesley • Leyburn • Hawes • Richmond 	<ul style="list-style-type: none"> • Catterick and Colburn Medical Group, Catterick • Central Dales Practice, Hawes • Doctor's Lane Surgery, Aldbrough St John • Glebe House Surgery, Bedale • Great Ayton Health Centre, Great Ayton • Harewood Medical Practice, Catterick Garrison • Lambert Medical Centre, Thirsk • Leyburn Medical Practice, Leyburn • Mayford House Surgery, Northallerton • Mowbray House Surgery, Northallerton • Quakers Lane Surgery, Richmond • Reeth Medical Centre, Reeth • Scorton Medical Centre, Scorton • Stokesley Health Centre, Stokesley • The Doctors' Surgery, Thirsk • The Friary Surgery, Richmond • Topcliffe Surgery, Topcliffe 	<ul style="list-style-type: none"> • Friarage Hospital • Healthwatch North Yorkshire • WIs • Rotary clubs

A list of community groups can be found in Appendix 5.

Reporting, evaluation and post-decision communications – to be confirmed

Audience	Mechanism	Attended/actions by	Proposed/ completed date
End of formal consultation			15.09.17
NHS England	Attend formal meeting to present results of consultation	JP/BH/LP	TBC Sept 17
TEVV staff briefing	Staff briefing event with end of consultation update (pending approval)	LH/JJ	18.09.17

Audience	Mechanism	Attended/actions by	Proposed/ completed date
Media contacts	Reactive statement for results of consultation (pending approval)	GS/JJ	18.09.17
NY Scrutiny Committee	Update on the formal consultation	JP/LP	22.09.17
CCG Governing Body	Update on the formal consultation	LP	28.09.17
CCG Governing Body (extraordinary meeting)	Final decision and agreement of implementation (subject to approval)	LP	26.10.17
NY Scrutiny Committee	Final outcome report briefing	JP/LP	03.11.17
TEWV staff briefing	Staff briefing event with decision and next steps	LH/JJ	18.09.17
CCG staff TEWV staff STHFT staff Governing Bodies HEN Reps	Briefings circulated with decision and next steps	GS/JJ	19.09.17
MPs NY Scrutiny Committee Councillors	JP to brief via telephone/meeting/email to include draft consultation options, event details and next steps (dependent upon election results)	JP/LP	19.09.17
Clinical stakeholders	Briefings circulated to include draft options, event details and next steps: <ul style="list-style-type: none"> • GPs • Pharmacies • Dentists • TEWV adult and MHSOP inpatient and community staff • NHS partner organisations including other CCGs (if clinical) 	GS/JJ	19.09.17

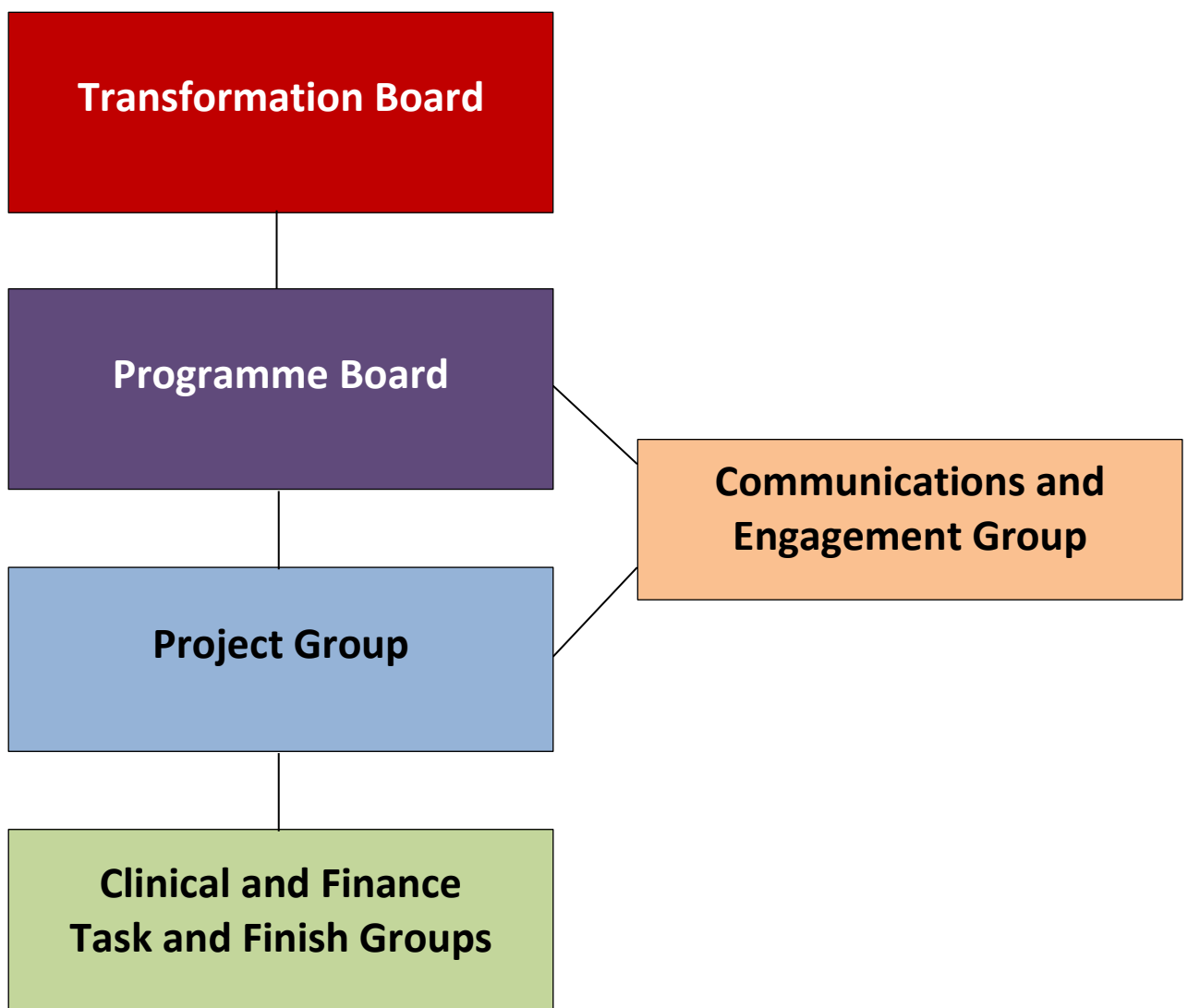
Audience	Mechanism	Attended/actions by	Proposed/ completed date
Wider stakeholders	Briefings circulated to include draft options, event details and next steps: <ul style="list-style-type: none"> • County and Local Councillors • Parish Councillors • Voluntary sector organisations • Non NHS partner organisations • PPGs • Health Engagement Network members • Trust governors • Trust members • Service users and carer groups • North Yorkshire Police • Healthwatch 	GS/JJ	20.09.17

Management and responsibilities

A communications and engagement working group comprising of representatives from CCG and Tees, Esk and Wear Valleys NHS Foundation Trust and reporting to the programme board will oversee the practical implementation of plans relating to this plan. The following resources will be in place to manage this communications and engagement process:

Communications and engagement planning	CCG / TEWV
Production of reports and consultation document	CCG / PCU / TEWV
Implementing the consultation plan	CCG / PCU / TEWV
Presenting to NYCC Scrutiny of Health	CCG / TEWV
Presenting to Community Transformation Board	CCG / TEWV
Management of Comms and all enquiries	CCG
Decision following consultation	CCG Governing Body
Dissemination of decision	CCG / TEWV

Governance structure



Budget

The CCG will:

- ensure any activity is relevant, cost-effective and, where possible, reusable;
- use in-house resources and only out-source after seeking competitive quotations;
- utilise pre-organised meetings and events to save staff expenses and venue costs;
- use joint messages and resources with partners where possible.

In order to reach as many people as possible, the CCG may need to make some investment. Projected communications and engagement costings are:

Item	Estimated cost (£)
Printed materials	£3,000
Events	£1,000
Videos	£2,000
Advertorials	£1,000
Other	£100
Total	£7,100

Risk and mitigation

Risk and risk mitigation will be managed by the programme board and escalation to the CCG weekly Strategic Management Team meetings. Risks will be placed on the CCG corporate risk register.

Reporting and feedback

Representatives from the CCG and TEVV will re-group on a monthly (or weekly as the consultation develops) basis to review:

- progress against the agreed timelines.
- the action log.
- the risk register.
- the effectiveness of the communications and engagement strategy.
- effectiveness in line with the wider programme strategy.

A communications and engagement working group will liaise on a weekly basis, reporting to the programme board on a monthly basis.

Evaluation and monitoring

This communications and engagement strategy will be formally evaluated at four stages of the process:

- At the end of the phase one pre-consultation engagement.
- At the end of phase two consultation.

- In the middle of phase three consultation.
- At the end of phase three consultation.

The CCG will log all communications and engagement activity (including materials circulated, feedback, survey responses and number of event delegates) and regularly analyse to ensure the methods, tools and techniques remain appropriate.

Weekly teleconferences dedicated to communications and engagement will take place throughout the engagement and consultation. Members of other organisations (including other CCGs where appropriate) will be invited to join as the consultation develops.

Note: This is a working document subject to different information being added or amended as the consultation develops.

Appendix 1: Legislation

The process for involving people requires a clear action plan and audit trail, including evidence of how the public have influenced decisions at every stage of the process and the mechanisms used.

Section 242 of the NHS Act 2006 sets out the statutory requirement for NHS organisations to involve and consult patients and the public in:

- The planning and provision of services.
- The development and consideration of proposals for changes in the way services are provided.
- Decisions to be made by NHS organisations that affect the operation of services.

Section 244 of the NHS Act 2006 requires NHS organisations to consult relevant Overview and Scrutiny Committees (OSC) on any proposals for a substantial development of the health service in the area of the Local Authority, or a substantial variation in the provision of services.

Section 2a of the NHS Constitution gives the following right to patients:

“You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.”

In addition the Secretary of State for Health has outlined four tests for service change:

Support from GP Commissioners	Engagement with GPs, particularly with practices whose patients might be significantly affected by proposed service changes
Clear clinical evidence base	The strength of the clinical evidence to be reviewed, along with support from senior clinicians from services where changes are proposed, against clinical best practice and current and future needs of patients
Strengthened patient and public engagement	Ensure that the public, patients, staff, Healthwatch and Health Overview and Scrutiny Committees are engaged and consulted on the proposed changes
Supporting patient choice	Central principle underpinning service reconfigurations is that patients should have access to the right treatment, at the right place and the right time. There should be a strong case for the quality of proposed service and improvements in the patient experience

Appendix 2: The Gunning Principles

Before 1985 there was little consideration given to consultations until a landmark case of Regina v London Borough of Brent ex parte Gunning. This case sparked the need for change in the process of consultations when Stephen Sedley QC proposed a set of principles that were then adopted by the presiding judge. These principles, known as Gunning or Sedley, were later confirmed by the Court of Appeal in 2001 (Coughlan case) and are now applicable to all public consultations that take place in the UK.

The principles are:

- **Consultation must take place when proposals are still at a formative stage**
Consultation should be at a stage when the results of the consultation can influence the decision-making (and Gunning 4).
- **Sufficient reasons must be put forward for the proposals to allow for 'intelligent consideration'**
A preferred option may be included and this must be made obvious to those being consulted. Information and reasons for the proposals must be made available to allow for consultees to understand why they are being consulted as well as all the options available and what these mean. Equality Impact Assessment to be completed and sit alongside the consultation document.
- **Adequate time must be given for consideration and response**
There is no set timeframe recommended but reasonable steps must be taken to ensure that those consulted are aware of the exercise and are given sufficient time to respond.
- **The outcome of the consultation must be conscientiously taken into account**
Decision-makers must be able to show they have taken the outcome of the consultation into account – they should be able to demonstrate good reasons and evidence for their decision. This does not mean that the decision-makers have to agree with the majority response, but they should be able to set out why the majority view was not followed.

Appendix 3: Best practice and managing risk

This strategy takes account of NHS England good practice guidance - Transforming Participation in Health and Care - 'The NHS Belongs to us all' by:

- Engaging communities with influence and control e.g. working with CVS and Healthwatch.
- Engaging the public in the planning and delivery of service change e.g. engage early and build on insights.
- Providing good quality information.
- Providing a range of opportunities for participation.
- Working with patients and the public from the initial planning stages.

In summary, any reconfiguration of services requires a robust and comprehensive engagement and consultation process. The risk of not following these procedures could result in a Judicial Review. A number of public bodies across the UK have been taken to Judicial Review and deemed to have acted unlawfully in the Public Sector Equality Duty – usually linked to the four Gunning Principles.

As well as documented evidence of GP support, the case for change will need to:

- State clearly the benefits for patients, quality and finance.
- Demonstrate that the clinical case conforms to national best practice.
- Be aligned to commissioners' strategic plans.
- Be aligned with the recommendations of *Healthy Ambitions*.
- Have clear details of option appraisals.
- Provide an analysis of macro impact.
- Be aligned with QIPP work streams.

The Independent Reconfiguration Panel (IRP), whose role is to advise ministers on controversial reconfigurations, recommends that those considering proposals for significant health service changes should:

- Make sure the needs of patients and the quality of patient care are central to the proposal.
- Consider the role of flexible working in the proposals – this may involve developing new approaches to working and redesigning roles.
- Assess the effect of the proposal on other services in the area.
- Give early consideration to transport and site access issues.
- Allow time for public engagement and a discussion phase before the formal consultation – people want to understand the issues, so involving them early on will help when it comes to the formal stage.
- Obtain independent validation of the responses to the consultation.

The IRP has also identified a range of common themes:

- Inadequate community and stakeholder engagement in the early stages of planning change
- The clinical case has not been convincingly described or promoted
- Clinical integration across sites and a broader vision of integration into the whole community has been weak

- Proposals that emphasis what cannot be done and underplay the benefits of change and plans for additional services
- Important content missing from the reconfiguration plans and limited methods of conveying them
- Health agencies caught on the back foot about the three issues most likely to excite local opinion - money, transport and emergency care.
- Inadequate attention given to responses during and after the consultation.

Consultations should influence final proposals and it is important to be able to show that they have. Clearly, not all these recommendations will be applicable to all engagement and consultation exercises, but the basic principles of early involvement, and being able to demonstrate that responses have influenced the final outcome, are.

Commissioners and providers should also consider how their engagement and consultation activity impacts upon a wide range of service users including those protected groups identified within the Equality Act.

Appendix 4: Key stakeholder plan

Stakeholder Group	Stakeholder	Stakeholder Prioritisation Category	Communication Method(s)
Internal	CCG Governing body	Key Player	Face to face meetings
Internal	CCG Staff	Key Player	Face to face meetings and briefings
Internal	GPs	Key Player	Face to face meetings and briefings
Internal	Staff-side representatives	Active Engagement and Consultation	Face to face meetings/briefings
Internal	Staff affected by changes	Active Engagement and Consultation	Team and individual briefings/meetings with line managers/ Q&As/ existing internal comms channels
Internal	FT Governors	Active Engagement and Consultation	Meetings / briefings
Patients & Public (charities)	Charitable organisations and highly interested groups	Active Engagement and Consultation	Face to face meetings and briefings/engagement events and activities
Patients & Public	General public	Keep Informed Engage and Consult	Public meetings/ media releases/ website/information stands/ posters/info distributed at prime settings/consultation and engagement documents

Stakeholder Group	Stakeholder	Stakeholder Prioritisation Category	Communication Method(s)
Patients & Public	Affected service user groups	Active Engagement and Consultation	Meetings with identified service user groups/ engagement events/ consultation events
Patients & Public	GP Patient Participation Groups	Keep Informed and engaged via practices	Meetings/briefings
Patients & Public	Healthwatch	Active Engagement and Consultation	Meetings and presentations/ongoing briefings and updates/ consultation and engagement documents
Patients & Public	Protected groups, voluntary and community groups, third sector	Active Engagement and Consultation	Meetings with identified groups/ engagement events/ consultation events
Patients & Public	Health Engagement Network	Active Engagement and Consultation	Briefings
Political Audiences	Local MPs	Key Player	Regular briefings/letters/ meetings
Political Audiences	Local Councillors	Active Engagement and Consultation	Regular correspondence updating on progress /OSC/engagement and consultation documents
Political Audiences	Overview and Scrutiny Committees	Key Player	Meetings & presentations/ regular briefings

Stakeholder Group	Stakeholder	Stakeholder Prioritisation Category	Communication Method(s)
Media	Local and regional media	Keep Informed	Pro-active and re-active press releases and statements/ interviews / briefings/ paid-for advertorials and supplements
Partners	North Yorkshire County Council	Key player	Briefings as required/ engagement and consultation documents
Partners	Local Medical Committee	Active Engagement and Consultation	Meetings & presentations/ regular briefings
Partners	North Yorkshire Police & Commissioner	Active Engagement and Consultation	Meetings & presentations/ regular briefings
GPs	GPs	Active Engagement and Consultation	Meetings & presentations at clinical council/ regular briefings
LMC	Local Medical Committee	Active Engagement and Consultation	Meetings & presentations/ regular briefings
Governance & regulators	NHS England	Keep Informed	Briefings via regional office
Governance & regulators	Overview and Scrutiny Committee	Key Player	Regular Briefings/ Consultation Documents
Governance & regulators	Local health and Wellbeing Board	Key Player	Meetings/briefings

Appendix 5: Local voluntary sector groups/organisations

ABLE Day Centre (Broadacres)
Advice Partnership (SENDIASS)
Age UK Northallerton
Alzheimer's Society, Richmond (main office)
Alzheimer's Society
Breathing Space
British Red Cross
Broadacres
Carers Resource
Catterick Garrison
Cllr Karin Sedgwick
Chopsticks North Yorkshire
Citizen's Advice Bureau H&R
Council for Voluntary Services
Cygnnet Healthcare
Dementia Collaborative (& Avalon Group)
Farming and community network
Friarage Breast Cancer Care Group
Friends of the Friarage
Foundation
Hambleton and Richmondshire Carers Centre
Hambleton and Richmondshire Citizens Advice
Hambleton churches
Hambleton Community Action
Healthwatch North Yorkshire

Healthwatch North Yorkshire
Help for Heroes
Herriot Hospice Homecare
Holy Rood House
Housing Care 21
Ivy workshops
Jobcentre Plus (Northallerton)
Jobcentre Plus (Richmond)
Just the Job Environmental Enterprises
Keyring
Kirk House activity group (Age UK)
Leyburn Bipolar Group
Lifeline Project
MENCAP
Making Space
Mental Health Forum
Mental Health Matters
Mental Health Support Hambleton and Richmondshire
Mind (Darlington)
National Farmers Union
NCT Hambleton
Northallerton & District Voluntary Service Association
Northallerton Library and Customer Services Centre (Mobile Library Services)
Northdale
North Yorkshire Advocacy
North Yorkshire Forum
North Yorkshire Horizons

North Yorkshire PACT
North Yorkshire Police and Crime Commissioner
Over 50s Forum
Parents 4 Parents
Partnership Coordinator Healthwatch North Yorkshire
Phoenix Group
Restore Project
Rethink Mental Health
Richmondshire Community Action
Richmondshire Community Action
Richmondshire Housing Forum
Rural Action Yorkshire
Samaritans of Northallerton and the Dales
Sporting Memories
Stokesley & District Community Care Association
Stronger communities - NYCC
Thirsk Community Care
Thirteen Group
Wilf Ward Trust
Work Craft Company
Yatton House
YMCA
Yorkshire & Humber Alzheimer's Society
Yorkshire Humberside & Lincolnshire circles of support & accountability
Yorkshire MESMAC

Transforming Mental Health Services

Hambleton and Richmondshire

Pre-consultation engagement Events summary report

Wednesday 10 May, Northallerton
Thursday 11 May, Richmond



Foreword

On Wednesday 10 and Thursday 11 May 2017, NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (CCG) held joint engagement events with the main local provider of mental health services, Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV).

These events formed the final part of the pre-consultation engagement under 'Fit 4 the Future, Transforming Mental Health Services'. The CCG and TEWV have attended a number of targeted groups and sessions across Hambleton and Richmondshire with staff, service users and carers since January 2017.

We're building on learning from DISCOVER! , engagement from the North Yorkshire Dementia strategy and the 'Fit 4 the Future, Transforming Our Communities' consultation, where a majority of people said they wanted services at home or as close to home as possible.

Currently, adults and older people requiring in-patient services are admitted in the main into The Friarage Hospital in Northallerton. Other or specialist intensive mental health is provided in Teesside or Darlington.

It's our ambition to support people to live fulfilling and meaningful lives in their own communities, no matter what their symptoms or diagnosis is – that includes mental health.

We've therefore been asking for views on how we can support more people at home and improve the standard of care for those experiencing a mental health crisis.

Staff, service users, carers and residents of Hambleton and Richmondshire were invited to attend two open pre-consultation engagement events from 4pm – 6pm in May 2017.

This report gives a summary of both events and identifies key themes which will help inform the development of formal consultation options. A full consultation document will include details of all engagement taken place since January 2017.

More information on the consultation can be found on the CCG's website:

www.hambletonrichmondshireandwhitbyccg.nhs.uk/transforming-mental-health-services

Sincere thanks to all who attended these events or took part in the engagement. We hope you enjoy the read.

Janet Probert
Chief Officer

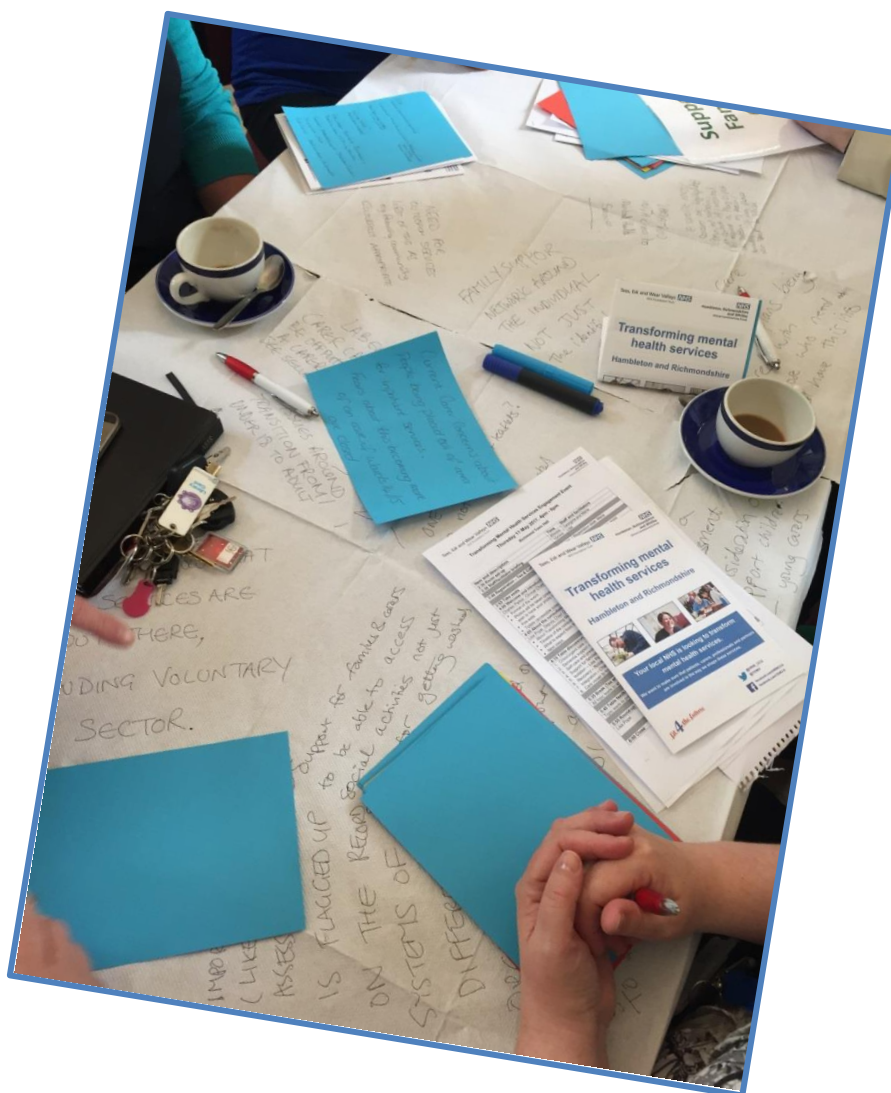
NHS Hambleton, Richmondshire and
Whitby Clinical Commissioning Group

Adele Coulthard
Director of Operations, North Yorkshire
Tees, Esk and Wear Valleys NHS
Foundation Trust

Event format

Both events took place 4pm until 6pm. The format of the sessions was as follows:

1. Welcome
2. About the consultation (presentation enclosed)
3. Break-out sessions with table top discussions with themes:
 - Care closer to home
 - Crisis/urgent care
 - Dementia
 - Integration
 - Isolation
 - Self-care and prevention
 - Support for families/carers
 - Recovery
4. Write-up and key themes presented from each table



Event attendees

Facilitators included representatives from the CCG, TEWV and North Yorkshire County Council. A service user put themselves forward to facilitate the 'Recovery' table at the Northallerton event.

The total number of delegates attending each event (not including CCG or TEWV representatives) were as follows:

- Wednesday 10 May, Northallerton – 42
- Thursday 11 May, Richmond – 22



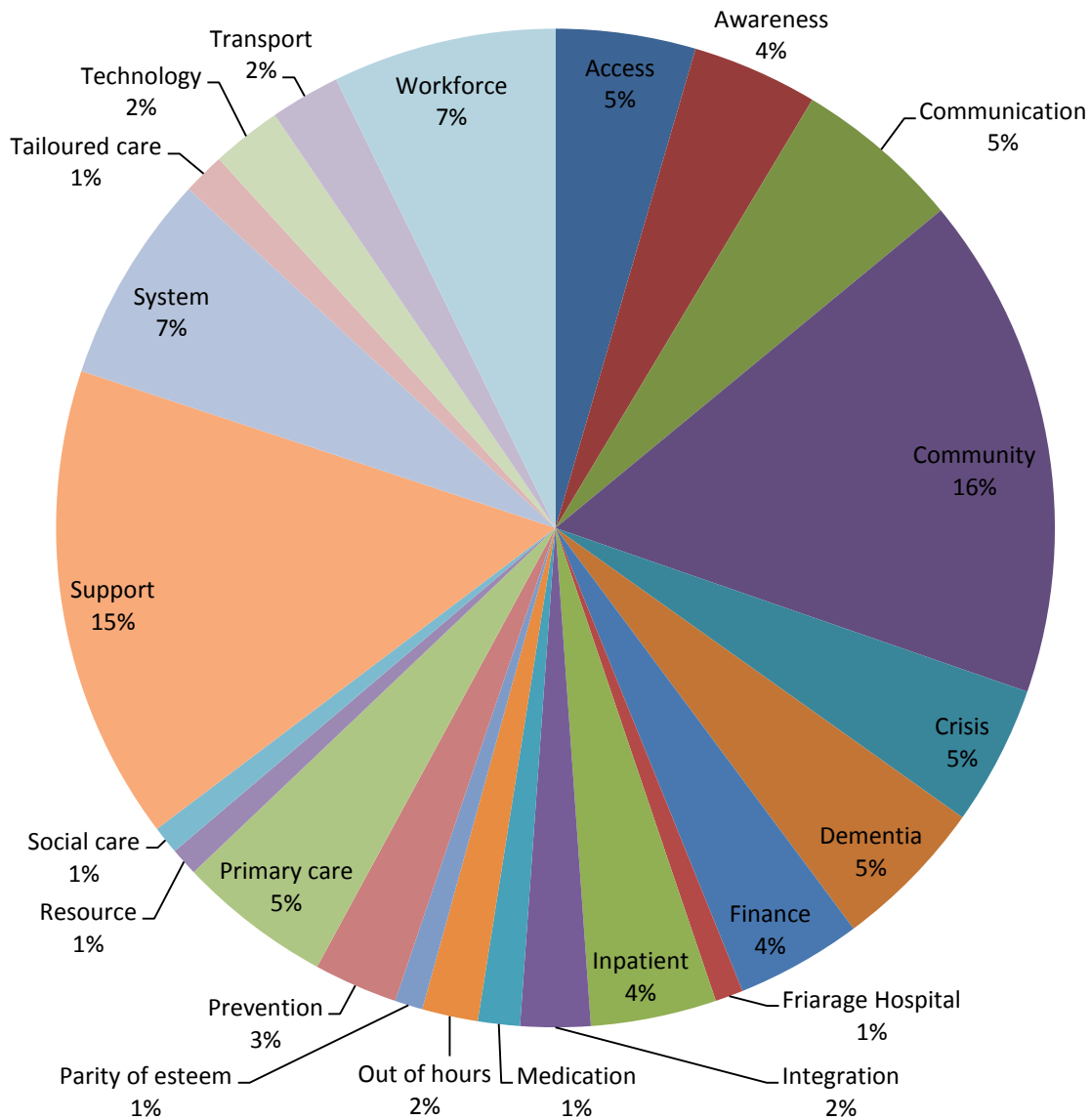
Key themes from each event

The top four themes captured from the Northallerton event were as follows:

1. **Community**
2. **Support**
3. **System**
4. **Workforce**

Further themes have been identified and are captured in the chart below:

Northallerton event

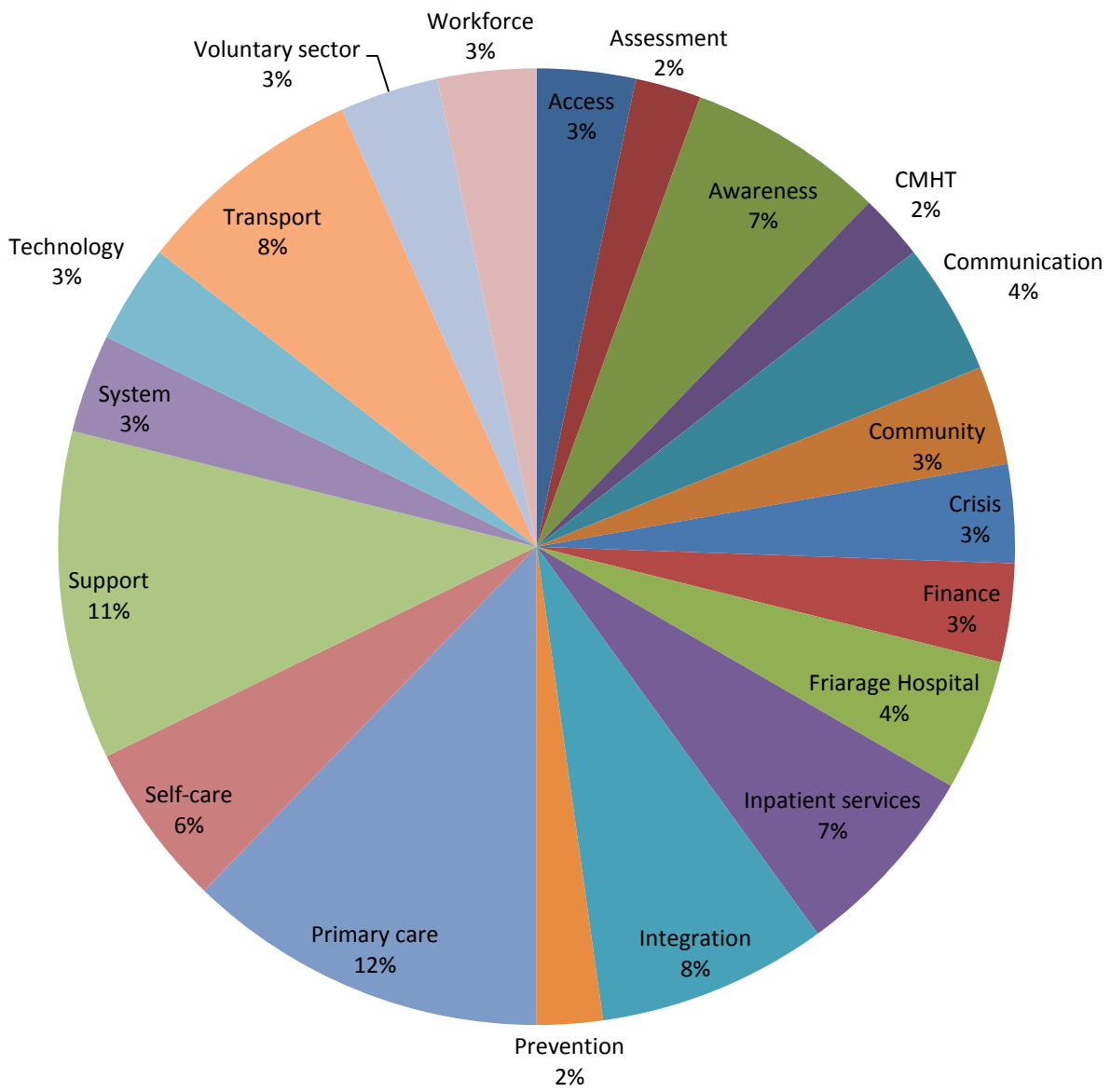


The top four themes captured from the Richmond event were as follows:

1. **Primary care**
2. **Support**
3. **Integration**
4. **Transport**

Further themes have been identified and are captured in the chart below:

Richmond event



Sample comments from each table

Care closer to home

Facilitators: Lisa Pope (CCG) and Dr Mark Hodgson (CCG)

- Want to be closer to home but some just want to be in the best place
- Build up care closer to home (using local networks) so crisis occurs less
- Awareness of community services and support available
- Need more support in the community like community psychiatric nursing and support for carers
- Peer support groups are needed - many 'sitting' services don't do personal care
- Transport can be an issue
- Effective integrated team / multi agency meetings involving 3rd sector
- Peer support groups are needed - many 'sitting' services don't do personal care
- Patients meeting lots of different staff so they are "confused" and "confounded"

Crisis/urgent care

Facilitators: Mark Spencer (TEWV)

- Crisis - someone or somewhere in the middle of the night, telephone help line, sympathetic ear, not clinical, can offer practical support
- Crisis services for dementia
- Crisis team not really a crisis team, it is a telephoning answering machine service in both York and Friarage
- Access to 136 suite
- 1 hour response to crisis referrals - is there more money?

Dementia

Facilitators: Cath Crawford (TEWV)

- Dementia awareness required in the community e.g. pools, shops, any community facilities that may be used
- Discharge to assess - hospital is not the right place to be assessed
- GPs not recording that people are carers. Hambleton carers association sent carer forms to GPs and practice managers rang eventually to ask why the forms were being sent to GPs
- More day care in different places to keep people in society
- People with learning disabilities and dementia - are they sufficiently identified and supported?
- Education for children in schools to raise awareness of dementia
- What happens after diagnosis - what do GPs, practices do to support the person – e.g. communicating with carer?

- Are staffing levels considered in light of increasing older population and increasing residential developments? People are already working at capacity
- What is in place for carers who have reached the end of their tether?
- Identifying dementia early is complicated by non-mental health and non-older people clinicians being less aware of dementia symptoms
- Avoiding hospital admissions when person with dementias carer is in crisis
- Discharge to assess patient discharged to get financial assessment and look at support
- Dementia awareness for all local amenities
- Patients end up with unused medication building up at home
- Services for younger people diagnosed with dementia - lacking at present

Integration

Facilitators: Julie Jones (TEWV) and Neil Bowden (NYCC)

- Peripatetic services within communities - police, health and social care, members of the public
- Communication so services know what community service are available
- Health and social care inequalities – is there more work to do with partners to address this e.g. should there be a premium for providers that can demonstrate how they've addressed this?
- Integrate with police. People are being passed around the system because they didn't fit specific criteria
- Integration in children's services are really important – and pressures on young people in today's society
- If there's not enough social care then this impacts on healthcare
- Staff are frustrated by lack of integration in older people's services
- For GPs to have invites to mental health forum for increased awareness
- More collaborative working between first level (primary care) and charity/organisation in order that people with mental health difficulties are aware of options
- Referral by GP to be made for people not under CMHT
- Third sector to be involved, role as first one options
- Integration between health services that crossover county boundaries but have that shared service

Isolation

Facilitators: Linda Lloyd (CCG) and Georgina Sayers (CCG)

- Weekends are hard
- Lack of transport
- Coordination of services, join up the dots
- Use what already exists
- Somewhere in the middle of the night - telephone helpline
- More information about existing services
- Care closer to home for as long as it takes (not just 6 weeks)
- Consistent staffing - look after them so they can continue to look after us

- More outreach support workers - funding for mileage
- Improved communication including GPs about existing services - sign posting
- Buddy system
- Transport difficult due to rurality
- More social networks in the evening and weekends - reduce isolation and loneliness
- Pop up coffee shops open late into the evening and train staff in MHFA
- Records - don't seem to follow the patient or perhaps not fast enough (Isolation)
- Some patients are isolated by choice - they don't know what is available
- Transport to clinics and groups
- Challenge of technology
- Use of technical jargon
- Some issues with technology and signal
- Better transition between services
- Assistance with transport
- Issues around visiting relatives in hospital - if they don't drive and are unable to use public transport it can be costly to visit relative (carer paying £80 for a taxi once a week is an example). If they didn't visit relative, relative may become more unwell
- Family members very far away - I use Whatsapp to talk with my daughter
- Skype consultations are good but not necessarily for all patients. It depends on the condition
- Cutting bus service - out of hours is an issue
- Having a bus pass is helpful

Self-care and prevention

Facilitators: Janet Probert (CCG) and Dr Charles Parker (CCG)

- Early intervention and prevention
- Social media - negative influence
- Training for GPs
- Stigma
- Parents - wider detriment of wealth impacting on parenting
- Horizons service
- Being open: talking about issues to support older aging well beforehand
- Supportive living
- Waiting for IAPT
- Training services
- Occupational support
- Political influence and lobbying
- Networks
- Keep us well
- Start early - build resistance - 0-5 young mums schools and investment
- Localism
- Minimum health spend
- Self-presentation
- Whole person

- Not mental v physical health
- Language/Acronyms
- Offer more carer support at earlier stage (e.g.: Primary care) - not just carers - assessment and leaflets - but a "listening ear" and short term 1-2-1 support. This could prevent carer or service user becoming more unwell and needing secondary care
- A need for guidance, education and information on how to best support someone or info on diagnosis
- One person to help not loads of leaflets?

Support for families/carers

Facilitators: Georgina Sayers (CCG) and Cath Crawford (TEWV)

- Don't know who to talk to about concerns who to access
- Crisis issues - how to deal with it
- Discussions with family friends about future wishes - advanced decision making essential
- End of life planning
- Recommend wills to be made for any illness but particularly where memory issues/dementia/capacity and issues
- Lack of information for neighbours regarding what to do
- Neighbourhood networks are often great but needs to be supported by GPs and outreach into the community
- Workforce development for staff, health, social care, community, shops about dementia
- Frightening for people to know what to do when presented with peoples change/behaviour/dementia
- Socialisation/inclusivity - reduce avoid stress, anxiety or depression. Often named by carers of people linking with dementia at diagnosis when actually eventually diagnosed as dementia
- Advanced care planning
- Making decisions before the crisis occurs
- Talking to younger people in the family to ensure they know what your wishes are
- People would like to have consistent and adequate care at home, how to achieve this within budget constraints
- Highlight opportunities for community group, clarity about what help is possible
- Better working with other services and health & social care
- Skilling up staff in regular groups so people with dementia can feel comfortable accessing them
- Avoid too many moves
- Help carers in family
- Impact on your carers, need more help, should be social care
- Access to correct advice and information
- Living well services - telephone number for support to help coordination
- More information for patients and families around
- Interested in contact centre / support for families & parents within TEWV NHS FT
- Need assessments on carers
- NYCC offer a support line service

- "Living Well" engagement by NYCC
- Some carers are not carers - they are just family and friends "doing their job"
- I turn to family and friends and attend groups in Bedale and Northallerton
- Added pressure from multiple family members with mental health conditions - often falls to one family member
- More "family work/therapy" resource needed
- Relying on neighbours - when they move they can't support
- Join up the support groups more
- Support system is no longer there - older people are wary about the future
- As you get older the more support you need
- Carers supporting carers and family members - they provide company

Recovery

Facilitators: Jess Williams (service user) Dr Richard James (CCG)

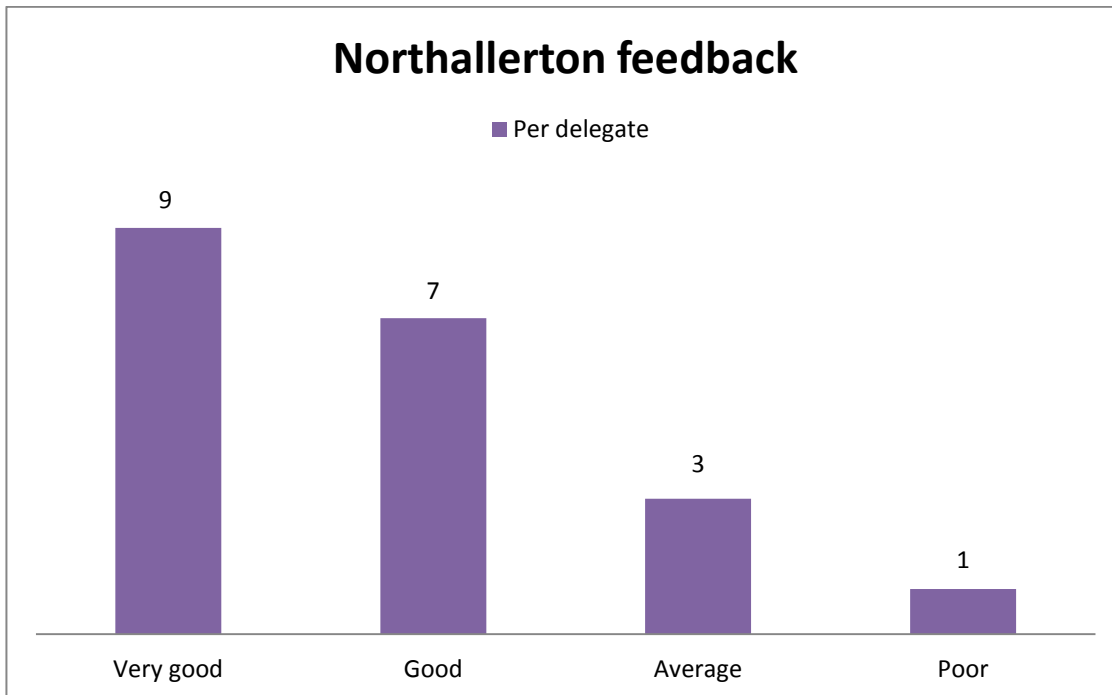
- Mental and physical health are interconnected need to be soon as such
- Why couldn't psychiatrists /psychologists
- Learning a way of coping and hoping not a cure
- Transport is an important issue for family and carers
- Point of contract IAPT needs to be more available
- How long is a piece of string - different for everyone
- Will there be enough staff put into the local community
- Support which is going, encouragement
- Different things at different times
- Focus resources in the community
- Team well informed about mental health issues and 3rd sector organisations
- Better to have a team and support at home /in community to prevent a crisis
- Need a key worker plan/CPN (Health worker, midwife, Police, 136 etc.) to provide info
- Access to 3rd sector - meet others, pace to stay away from home
- Not at hospital if at all possible
- Challenge people about how services are provided - clarity, pro-actively in service
- Communication of what is out there
- Communication
- Flexible, tailored, to the individual
- More services are seen in the community - more open to a more centralised specialist service
- Issue more complex than just distance - culture
- Transition services
- Clarity of diagnosis
- Challenging stigma
- Supported employment
- Exercise
- Walks
- Reading
- Positive Risk Taking

- Health carers, remove plank flow one's own tune

Event feedback

10 May – Northallerton

Out of the 20 comments received, the event was rated as below:



Positive comments included:

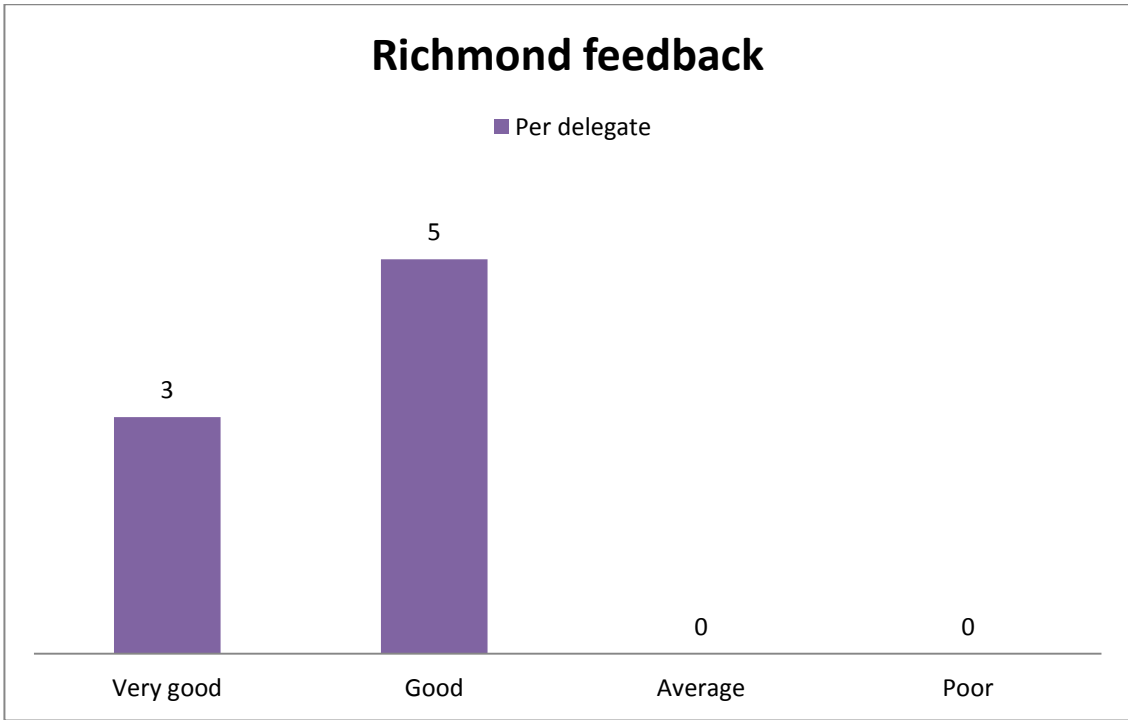
"Well-structured table discussion and brainstorming"

Learning identified included:

"Please ensure that GP surgeries advertise these meetings - nothing was noted in my surgery notice board as recently as Monday this week"

11 May – Richmond

Out of the 8 comments received, the event was rated as below:



Positive comments included:

“A very good idea, need to have more of these meetings”

Learning identified included:

“The coffee!”

Where delegates learnt about these events:

CCG email/letter	8
Community groups	5
Facebook	3
Meeting	1
Newspaper	2
Poster	2
TEWV email	2
Website	1
Word of mouth	3
Work	1

Conclusion and next steps

The public have given us a very clear view that they feel strongly about the future of mental health services in Hambleton and Richmondshire. The output and intelligence we have been

able to gather from our pre-consultation engagement work has shown us that the public agree that the current arrangements are not fit for purpose and that the current service specification does not provide equitable access for all patients across the patch by virtue of geography.

We therefore now have a clear direction from the public that we need to do something differently. We will assess all of the data we have collated in more detail in order to complete a draft consultation document which will be presented to the NYCC Scrutiny of Health Committee on June 23rd where we will ask them for formal permission to begin consultation. If we receive permission to consult at that meeting a formal 12 week consultation period will begin on June 26th 2017.

Appendix 4: Indicative costed options

OPTION 1							
Remain at Friarage Hospital with Current Bed Base - DO NOTHING							
Current State	Current State			Future State	Future State		
	Beds	WTE	£		Beds	WTE	£
Ward 14 MHSOP (4,3 roster)	10	20.88	738,358	Ward 14 MHSOP (4,3 roster)	10	20.88	738,358
Ward 15 AMH (4,3 roster)	12	23.18	836,201	Ward 15 AMH (4,3 roster)	12	23.18	836,201
Friarage Hospital IP SLA			668,316	Friarage Hospital IP SLA			668,316
Inpatient Sub Total	22	44.06	2,242,875	Inpatient Sub Total	22	44.06	2,242,875
Friarage Hospital CMHT SLA			323,000	Friarage Hospital CMHT SLA			323,000
Gibraltar House EFM Costs			102,533	Gibraltar House EFM Costs			102,533
H&R AMH Community Team		27.52	1,153,553	H&R AMH Community Team		27.52	1,153,553
H&R MHSOP Community Team		21.58	878,307	H&R MHSOP Community Team		21.58	878,307
Community Sub Total		49.10	2,457,393	Community Sub Total		49.10	2,457,393
CRES 2.2%			- 104,000	CRES 2.2%			- 104,000
Current Services Cost		93.16	4,596,268	Future Services Cost		93.16	4,596,268
(Surplus)/Deficit							0
Assumptions							
CRES at 2.2%, £104,000							
FINANCIAL ADVANTAGES & DISADVANTAGES OF OPTION 1							
Advantage				Disadvantage			
Minimum Disruption				Not fit for purpose accommodation			
				South Tees FT expressed for TEWV to move from the hospital			
				Current South Tees FT SLA expensive			

OPTION 2 & OPTION 3

No Bed base at the Friarage Hospital - Beds provided elsewhere in the Trust

Current State	Beds	Current State		Future State	Beds	Future State	
		WTE	£			WTE	£
Ward 14 MHSOP (4,3 roster)	10	20.88	738,358	MHSOP - Functional	5		642,400
Ward 15 AMH (4,3 roster)	12	23.18	836,201	MHSOP - Organic	2		260,000
Friarage Hospital IP SLA			668,316	AMH	8		868,700
Inpatient Sub Total	22	44.06	2,242,875	Inpatient Sub Total	15		1,771,100
Friarage Hospital CMHT SLA			323,000				
Gibraltar House EFM Costs			102,533				
H&R AMH Community Team		27.52	1,153,553	H&R AMH Community Team	27.52		1,153,553
				H&R AMH Enhanced Service	4.90		238,898
					32.42		1,392,451
H&R MHSOP Community Team		21.58	878,307	H&R MHSOP Community Team	21.58		878,307
				H&R MHSOP Enhanced Service	6.82		308,410
					28.40		1,186,717
				New Build Community Overheads incl EFM			350,000
Community Sub Total		49.10	2,457,393	Community Sub Total	60.82		2,929,168
CRES 2.2%			- 104,000	CRES 2.2%			- 104,000
Current Services Cost		93.16	4,596,268	Future Services Cost	60.82		4,596,268
(Surplus)/Deficit							0

Assumptions

*capital investment of £5m for new build facility at the Friarage Site for Community Services

*increased investment in community services, leading to a 20% reduction in Length of Stay and 50% reduction admissions

*beds provided at Roseberry Park, West Park or Auckland Park Trust Hospitals

CRES at 2.2%, £104,000

FINANCIAL ADVANTAGES & DISADVANTAGES OF OPTION 2 & 3

Advantage	Disadvantage
Maximisation of current usage of Trust beds and accommodation	Capital investment of £5m required
Fit for purpose accommodation for inpatients	
Fit for purpose new community building and infrastructure	
Pooled Resource	
Not an isolated unit, and support from other wards accessible	

Appendix 5 Role Descriptions

Adult services

Community mental health teams (CMHT)

- Team Manager – responsible for the day to day management of the team. Duties include; allocating referrals, supervising staff, investigating complaints, monitoring performance, reporting performance and providing leadership.
- Consultant Psychiatrist – responsible for all aspects of medical care that is delivered to patients. Also key leader of the team and supports/leads decision making for patients on all aspects of care. They are responsible for the training of junior doctors and play a key role in the development of the wider team.
- Junior Doctor – works under the supervision of a consultant. They are able to prescribe medications and have the majority of their contact with patients in clinics.
- Advanced Practitioner – a qualified mental health professional who has undertaken extra training in a therapy or approach (master's level). This person is responsible for the clinical leadership of the team, and some operational support to the manager. They are considered to have “advanced skills” and will deliver the advanced intervention to the more complex cases, as well as supervising staff in the delivery of their interventions.
- Care Coordinator – the back bone of secondary mental health teams. These are qualified professionals who are responsible for the coordination of multiple agencies involved in the care for all the patients on their caseloads, as well as delivering needs based intervention.
- Clinical Psychologist – none medical doctors. Highly trained and skilled. Responsible for the delivery of therapy to individuals and in groups. They lead on the psychological formulations for all patients in the team and have a key role in leadership and service development.
- Health Care Assistant – works under the supervision of a qualified professional. They are responsible for the delivery of interventions prescribed by a qualified member of staff.

Primary Care Team

- Team Manager – same as above
- Primary Care Practitioner – responsible for the assessment of and brief intervention in mild to moderate mental health problems.
- Counsellor – provides counselling for mild to moderate mental health problems.

Older people services

CMHT

- Team Manager – responsible for the operational day to day management and leadership of the team. Duties include; supervising staff, monitoring and improving performance, budget management, responding to complaints, and incidents.
- Consultant Psychiatrist – responsible for all aspects of medical care that is delivered to patients. Also key leader of the team and supports/leads decision making for patients on all aspects of care. They are responsible for the training of junior doctors.
- Junior Doctor – works under the supervision of a consultant. They are able to prescribe medications and have the majority of their contact with patients in clinics and on wards.
- Advanced Practitioner – a qualified mental health professional who has undertaken extra training in a therapy or approach (master's level). This person is responsible for the clinical leadership of the team, caseload supervision and some operational support to the manager. They are considered to have “advanced skills” and will deliver the advanced intervention to the more complex cases, as well as supervising staff in the delivery of their interventions.
- Care Coordinator – registered health professionals who are responsible for the coordination of care for the patients on their caseload. This usually involves liaising with multiple agencies, as well as delivering needs based interventions.
- Clinical Psychologist – specialise in working with older people, with highly developed skills to deliver psychological therapies, neuropsychological assessment and interventions. As well as supporting the multidisciplinary team in working therapeutically with patients.
- Health Care Assistant – deliver a range of interventions prescribed by, and under the supervision of, a registered health or social care professional.
- Occupational Therapist – develop and implement occupational therapy treatment plans and provide advice to service users with mental health conditions and complex needs to enable them to maintain or restore or adapt their abilities to manage necessary activities of daily living.
- Physiotherapist - specialist mental health physiotherapists work with people who have complex enduring mental health problems, to optimise physical and mental health to empower people to achieve their potential and promote recovery.

<h2 style="margin: 0;">1. EQUALITY IMPACT ASSESSMENT</h2> <p style="margin: 0; font-size: small;">Please refer to equality and sustainability impact assessment guidance and local profiling data before completing</p>	
Policy/Project/Function:	Hambleton and Richmondshire: Transforming mental health services
Date of Analysis:	March 2017
This Equality Impact Analysis was completed by: (Name & Department)	Gemma Umpleby Service Improvement Manager Hambleton, Richmondshire and Whitby Clinical Commissioning Group
What are the aims and intended effects of this policy, project or function?	<p>This project aims to transform key elements of mental health provision by:</p> <ul style="list-style-type: none"> • Investing in the provision of a recovery orientated approach in the community close to patients' homes; so that the majority of people receive their care in the community • Providing assessment and treatment to patients and carer support when they need it, whatever time of day or night • Supporting access to specialist assessment and treatments such as inpatient care, when required • Providing evidence-based treatment in the most appropriate care setting • Retaining our local identity to ensure we can continue to work closely with general practice • Delivering services in high quality fit for purpose buildings across inpatient and community services. <p>To achieve the programme objectives it is recognised that effective action is needed to eliminate the stigma that can contribute to poor mental health. Stigma can lead to people suffering in silence, and can affect their ability to recover. There is considerable evidence that some protected groups are at higher risk of developing mental health problems, have lower wellbeing and may have reduced access to, a different experience of, and outcome from a range of mental</p>

	<p>health services.</p> <p>The plans will be delivered through an overarching work programme for Mental Health as articulated at Appendix 1.</p>
Please list any other policies that are related to or referred to as part of this analysis:	<p>This project forms part of our over-arching programme of work to continue to strengthen the community system across Hambleton, Richmondshire and Whitby so it has the capability and capacity to provide local integrated health and social care, built around the patient, organised around their local GP practice, as close to home as possible. This builds on two years of engaging with the population of Hambleton, Richmondshire and Whitby as part of the CCG Fit 4 the Future Transformation Strategy. Through which local community primary and secondary care clinicians and our public expressed that care at home or as close to home as possible should be central to any future developments.</p> <p>This assessment has been informed by 'NO HEALTH WITHOUT MENTAL HEALTH: A cross-Government mental health outcomes strategy for people of all ages, Analysis of the Impact on Equality (AIE)' published in by The Department of Health in February 2011.</p>

Who does this policy, project or function affect?:	Employees <input checked="" type="checkbox"/>	Service Users <input checked="" type="checkbox"/>	Members of the Public <input checked="" type="checkbox"/>	Other (List below) <input type="checkbox"/>
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2. EQUALITY IMPACT ANALYSIS: SCREENING

Protected Characteristic (Please refer to supporting pack for full definitions):	Positive Impact	Negative Impact	No Impact	Evidence of Impact
Race:			X	
Age:	X			The project specifically presents options as to how the CCG proposes to address the issues faced by an increasing ageing population.
Sexual Orientation:			X	

Disabled People:			X	
Gender:			X	
Transgender People:			X	
Pregnancy & Maternity:			X	
Marital Status:			X	
Religion & Belief:			X	

ADDITIONAL SCREENING DUE TO LOCAL AREA

Characteristic	Positive Impact	Negative Impact	No Impact	Evidence of Impact
Rurality:	X			This project specifically aims to address the challenges faced by our population accessing services and information in relation to both the diagnosis and treatment of mental health conditions. It also aims to address the role of transport in delivering equitable and accessible services.
Finance:			X	

3. LOCAL PROFILE DATA

Local Profile/Demography of the Groups affected (population figures)

General	See further detail provided at https://www.hambletonrichmondshireandwhitbyccg.nhs.uk/equality-and-diversity		
Race:	The 2011 Census states that our profile is as follows:		
	Ethnic Origin	Number of People	Percentage of population

	<p>White 146965 97.3%</p> <p>English/Welsh/Scottish/Northern 144052 95.4%</p> <p>Irish/British</p> <p>Gypsy or Irish Traveller 151 0.1%</p> <p>Irish 523 0.3%</p> <p>Other White 2239 1.5%</p> <p>Mixed/multiple ethnic group 1155 0.8%</p> <p>Other Mixed 313 0.2%</p> <p>White and Asian 390 0.3%</p> <p>White and Black African 125 0.1%</p> <p>White and Black Caribbean 327 0.2%</p> <p>Asian/Asian British 1931 1.3%</p> <p>Bangladeshi 61 0.0%</p> <p>Chinese 227 0.2%</p> <p>Indian 287 0.2%</p> <p>Other Asian 1191 0.8%</p> <p>Pakistani 165 0.1%</p> <p>Black/African/Caribbean/Black British 681 0.5%</p> <p>African 337 0.2%</p> <p>Caribbean 125 0.1%</p> <p>Other Black 219 0.1%</p> <p>Other ethnic group 297 0.2%</p> <p>Any other ethnic group 230 0.2%</p> <p>Arab 67 0.0%</p> <p>Grand Total 151029 100.0%</p>
Age:	<p>Older people (65+); this is one of the most significant groups in terms of size of population and service need, compared to other groups who share protected characteristics.</p> <p>This project recognises the importance of mental health promotion and mental ill health prevention in older people. Hambleton, Richmondshire and Whitby CCG has a higher than national average population of over 65's with 32938 of individuals, (21%) in this population group*1</p> <p>Older people generally have greater health needs than young people, especially with regards to long term conditions so they tend to access health services more as they age:</p> <ul style="list-style-type: none"> • 1 in 3 people over 65 will die with a form of dementia. • Isolation was regarded as one of the key concerns, based on engagement input in to the JSNA which particularly affects older people

	<ul style="list-style-type: none"> Reliance on public transport is significantly higher in this group³. This has an impact on accessibility of services for this group 																				
Sexual Orientation:	<p>More research and better data analysis is needed to determine the incidence of poor mental health among lesbian, gay and bisexual people, both male and female. The 2011 Census states that there are 742 people in a registered same-sex civil partnership or cohabiting (same-sex) in Hambleton, Richmondshire and Whitby CCG area (0.49% of the resident population compared to NHS Harrogate and Rural District 0.61%, NHS Scarborough and Ryedale 0.60%, NHS Vale of York 0.65%). Stonewall estimates that 5 - 7% of the national population are lesbian, gay or bisexual communities.</p>																				
Disabled People:	<p>Disability does not necessarily equate to ill health, however disabled people are more at risk of ill health and there is a belief that people with learning disabilities have worse levels of health care intervention than other disability groups. This means that people with disabilities are likely to be disproportionately affected by commissioning decisions relating to all health services. People with mental health problems meet the criteria for being disabled under the legislation. Health promotion and preventative services have a statutory duty to address the needs of people with mental health problems. The project recognises that a number of individuals with other disabilities e.g. learning disability have higher rates of mental health problems.</p> <p>There are numerous health inequalities associated with learning disabilities (see www.northyorks.gov.uk/CHttpHandler.ashx?id=19174&p=0)</p> <p>In summary, people with learning disabilities have poorer health than their non-disabled peers, differences in health status that are, to a large extent, avoidable. Mortality rates for this group are higher than other groups. People with learning disabilities not associated with any other condition (such as Down's syndrome) average age of death is 65, compared to age 80 in the general population.</p>																				
Gender:	<table border="1"> <thead> <tr> <th></th> <th>2015</th> <th>2016</th> <th>%Change from Previous year</th> <th>2017</th> </tr> </thead> <tbody> <tr> <td>Females</td> <td>75240</td> <td>75372</td> <td>0.18%</td> <td>75499</td> </tr> <tr> <td>Males</td> <td>78620</td> <td>78735</td> <td>0.15%</td> <td>78870</td> </tr> <tr> <td>Total</td> <td>153860</td> <td>154108</td> <td>0.16%</td> <td>154370</td> </tr> </tbody> </table> <p>Rates of mental health problems are generally higher in boys compared to girls (Hunt R, Fish J (2008) Prescription for Change, Stonewall). They are also exposed to different experiences, for example, rates of sexual abuse. Men and women also have different rates of mental health problems. The different pattern of mental health problems across the sexes is explicitly recognised in the strategy. The delivery of new services provides the opportunity to deliver a number of different health promotion and prevention approaches across all ages.</p> <p>The gender breakdowns for Hambleton, Richmond and Whitby and projections (Office of National Statistics).</p>		2015	2016	%Change from Previous year	2017	Females	75240	75372	0.18%	75499	Males	78620	78735	0.15%	78870	Total	153860	154108	0.16%	154370
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Total	153860	154108	0.16%	154370																	

Transgender People:	<p>Someone who proposes to, starts to follow a process (transition), or has completed the process, to change his or her gender is protected under this characteristic. The person does not have to be under medical supervision to be protected.</p> <p>The Gender Identity Research and Education Society (GIRES) suggests that across the UK:</p> <ul style="list-style-type: none"> • 1% of employees and service users may be experiencing some degree of gender variance. • At some point, about 0.2% may undergo transition (i.e. gender reassignment). • Around 0.025% have so far sought medical help and about 0.015% have probably undergone transition. In any year 0.003% may start transition. <p>More than one in three people who are described by the Equality Act 2010 definition of gender reassignment have attempted suicide.</p> <p>A key objective of this programme is to recognise that services must deliver a truly personalised approach that identifies the needs of each individual will ensure that there is a comprehensive understanding of the mental health needs of all people including transgender people. This will ensure they have access to prevention and health promotion services.</p>
Pregnancy & Maternity:	<p>Conception rate per 1000 for 15 – 17 year olds was 13.8 at Quarter 3 2013. This is below the rate for England (22.2) and Yorkshire and Humberside (24.2).</p> <p>Conception rate per 1000 for 15 – 17 year olds was at 21.6 (Health Profile 2015)</p> <p>1274 deliveries were completed in 2015-16 across the locality.</p> <p>It is recognised that targeted services are required for women during and post pregnancy.</p>
Marital Status:	<p>Evidence suggests being married is associated with better mental health (Scott K M et al (2009), Gender and the relationship between marital status and the first onset of mood, anxiety and substance use disorders, Psychological Medicine, Cambridge University Press 26 November 2009). There is less evidence on the benefits of being in a civil partnership; however, there is evidence that being in a good supportive relationship is beneficial for mental health.</p>

Religion & Belief:			<p>This programme of change recognises that to improve outcomes for all people it will be necessary to incorporate religion and belief into the assessment of all individuals. Evidence suggests that having religious or other beliefs can be associated with better mental health, although this is not directly addressed in the programme.</p>
	Christian	70.23%	
	No religion	20.47%	
	Religion not stated	6.91%	
	Hindu	0.40%	
	Buddhist	0.36%	
	Other religion	0.29%	
	Muslim	0.28%	
	Jewish	0.05%	
	Sikh	0.01%	

4. LOCAL ACTIVITY

Local Profile/Demography of the Groups affected (population figures)

List any Consultation (e.g. with employees, service users, Unions or members of the public that has taken place in the development or implementation of this policy, project or function

The impact assessment identifies no negative impact on a specific protected group. This assessment will be reviewed and revised following a period of public consultation.

All options developed to date have been formed through a period of extensive public engagement and pre-consultation listening events completed to inform the overarching 'Transforming our Communities Programme' as part of our 'Fit for the Future' campaign.

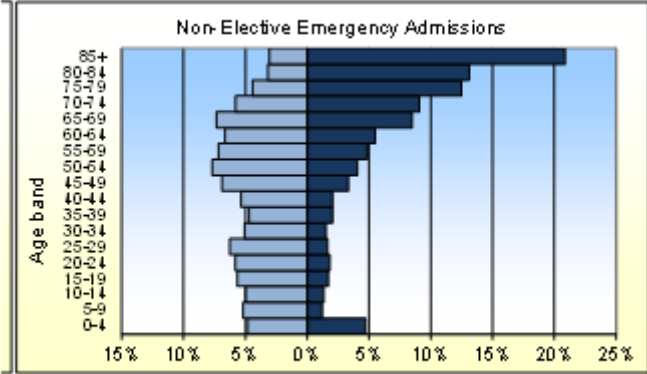
A Communications and Engagement Plan Phase outlines the required actions for NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) to communicate and engage (where appropriate) with

Promoting Inclusivity: How does the policy, project or function contribute towards our aims of eliminating discrimination & promoting equality and diversity within our organisation	<p>stakeholders and the wider public in relation to the proposed model.</p> <p>This project aims to promote equality of services by:</p> <ul style="list-style-type: none"> • Reducing inequity of services across the localities of Hambleton and Richmondshire • Reduce the financial and emotional strain currently faced by many communities required to travel excessive distances to receive community inpatient care.
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5. EQUALITY IMPACT ANALYSIS: ASSESSMENT TEST

What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by The Equality Act 2010?

Protected Characteristic	No Impact	Positive Impact	Negative Impact	Evidence of Impact and, if available, justification where a Genuine Determining Reason exists
Gender (Men and Women)	X			
Race (All Racial Groups)	X			
Disability (Mental and Physical)	X			
Religion or Belief	X			
Sexual Orientation (Heterosexual, Homosexual and Bisexual)	X			
Pregnancy and Maternity	X			
Transgender	X			
Marital Status	X			

<p>Age</p>		<p>X</p>	<p>Our population is increasing. Population estimates from mid-2015-16 to mid-2020-21 show an increased population of +0.89% of which +10.13% are over 65+ (forecast by the Office for National Statistics 2016). We know that over 65+ are more likely to attend hospital, especially as an emergency admission:</p> <p>Graph 1: Distribution of population and tariff based acute hospital spend by age band</p>  <p>An emergency admission to hospital is a disruptive and unsettling experience, particularly for older people, exposing them to new clinical and psychological risks and increasing their dependency (Glasby 2003; Hoogerduijn <i>et al</i> 2007; Lafont <i>et al</i> 2011).</p>
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6. ACTION PLAN

As a result of performing this analysis, what actions are proposed to remove or reduce any risks of adverse outcomes identifies on employees, service users or other people who share characteristics protected by The Equality Act 2010.

Identified Risk:	Recommended Actions:	Responsible Lead:	Completion Date:	Review Date:
<p>There are not any identified risks specifically associated with the protected characteristics. All risks associated with the impact of the service change will be review as part of continuous risk monitoring throughout project implementation.</p>				

7. FINDINGS

Analysis Rating:	Red <input type="checkbox"/>	Red/Amber <input type="checkbox"/>	Amber <input type="checkbox"/>	Green <input checked="" type="checkbox"/>
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Rating	Notes	Actions	Wording for Policy/Project/Function
Red Stop and remove the policy	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share Protected Characteristics. It is recommended that use of the policy be suspended until further work or analysis is performed.	Remove the policy Complete the Action Plan on the previous page to identify the areas of discrimination, and the work or actions that need to be undertaken to minimise the risk of discrimination	No wording needed as policy is being removed.
Red/Amber Continue the policy	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share Protected Characteristics. However a genuine determining factor may exist that could legitimise or justify the use of this policy, and further professional advice should be taken.	The Policy can be published with the EIA a) List the justification of the discrimination and source the evidence (i.e. clinical need as advised by NICE) b) Consider if there are any potential actions which could reduce the risk of discrimination. c) Another EIA must be completed if the policy is changed, reviewed, or if further discrimination is identified at a later date.	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share Protected Characteristics. However a genuine determining reason exists which justifies the use of this policy and further professional advice. <i>[Insert the nature and justification of the discrimination, plus any actions which could help reduce the risk]</i>
Amber Adjust the policy	As a result of performing the analysis, it is evident that a risk of discrimination (as described above)	The Policy can be published with the EIA The policy can still be published but the	As a result of performing the analysis, it is evident that a risk of discrimination (as described above)

	<p>exists and this risk may be removed or reduced by implementing the actions detailed within the Action Plan section of this document.</p>	<p>Action Plan must be monitored to ensure that work is being carried out to remove or reduce the discrimination.</p> <p>Any changes identified and made to the service/policy/strategy etc. should be included in the policy.</p> <p>Another EIA must be completed if the policy is changed, reviewed, or if further discrimination is identified at a later date.</p>	<p>exists and this risk may be removed or reduced by implementing the actions detailed within the <i>Action Planning</i> section of this document.</p> <p><i>[Insert what the discrimination is and what work will be carried out to reduce/eliminate the risk]</i></p>
<p>Green</p> <p>No major change</p>	<p>As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share <i>Protected Characteristics</i> and no further actions are recommended at this stage.</p>	<p>The policy can be published with the EIA</p> <p>Another EIA must be completed if the policy is changed, reviewed or if any discrimination is identified at a later date</p>	<p>As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share <i>Protected Characteristics</i> and no further actions are recommended at this stage.</p>

QUALITY AND SAFETY COMMITTEE SIGN OFF

Name/Position	Dr Jon James
Date:	22 May 2017
Signature:	

SUSTAINABILITY IMPACT ASSESSMENT

Staff preparing a Policy/ Board Report / Committee Report / Service Plan / Project are required to complete a Sustainability Impact Assessment. Sustainability is one of the CCG's key priorities and the CCG has made a corporate commitment to address the environmental effects of activities across CCG services. The purpose of this Sustainability Impact Assessment is to record any positive or negative impacts that this activity is likely to have on each of the CCG's Sustainability Themes. For assistance with completing the Sustainability Impact Assessment, please refer to the equality and sustainability impact assessment guidance.

Policy / Report / Service Plan / Project Title:				
Theme (Potential impacts of the activity)	Positive Impact	Negative Impact	No specific impact	What will the impact be? If the impact is negative, how can it be mitigated? (action)
Reduce Carbon Emission from buildings by 12.5% by 2010-11 then 30% by 2020			X	
New builds and refurbishments over £2million (capital costs) comply with BREEAM Healthcare requirements.			X	
Reduce the risk of pollution and avoid any breaches in legislation.			X	
Goods and services are procured more sustainability.			X	
Reduce carbon emissions from road vehicles.			X	
Reduce water consumption by 25% by 2020.			X	
Ensure legal compliance with waste legislation.			X	
Reduce the amount of waste produced by 5% by 2010 and by 25% by 2020			X	
Increase the amount of waste being recycled to 40%.			X	
Sustainability training and communications for employees.			X	
Partnership working with local groups and organisations to support sustainable development.			X	
Financial aspects of sustainable development are considered in line with policy requirements and commitments.			X	

Appendix 7: Quality Impact Assessment

Mental Health Service Transformation

The Yes/No cell should be colour-coded red, amber or green to indicate negative (Red) , partly negative (Amber) or no negative impact (green) from the decision on this field

DRAFTING NOTE: carefully complete the colour coding - where one criterion might be green due to a 'yes', another area might be red due to a 'yes'. All cells in the template version are answered yes/no with what would be the 'red' rated answer - change those to green where quality is not impacted

Clinical - Quality Impact Assessment	Fundamental	Key Features to be demonstrated in plans	Yes / No	positive (P) Negative (N)	Risk score CxL	Comments to support assessment
Quality	Duty of Quality	Could the proposal impact adversely on any of the following: a) Compliance with NHS constitution b) Partnerships c) Safeguarding children or adults	No			

Equality	Could the proposal impact on any of the following protected characteristics and our duty to comply with? 1. Age 2. Disability 3. Race 4. Religion or belief 5. Sex 6. Sexual orientation 7. Gender re-assignment 8. Pregnancy and maternity 9. Marriage and civil partnership	No			
	Will this impact on equality of access to NHS services?	No			
	IF YES TO THE ABOVE: Complete an Equality Impact Assessment (EIA)				Equality Impact Assessment has been completed due to the associations between the protected characteristics and diagnosis of mental health conditions.
Safety	Will this impact on the provider organisation's duty to protect children, young people and adults?	No			
	Will it impact on patient safety?	Position to be clarified			Expected impact is positive way. Individuals will be supported earlier in the community and for discharge from hospital and inadvertently mitigate against a number of Hospital stay associated conditions.

		Will it impact on preventable harm?	Position to be clarified			As above. Earlier discharge and rehabilitation services would prevent development of complications associated with hospital admission and immobility.
		Will it maximise reliability of safety systems?	Position to be clarified			Secure patients continue to be admitted to the appropriate setting.
		Will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?	Yes			Individuals will be in receipt of health care in a different environment, although beds located outside of acute hospital will present lower risk of contracting HCAI.
		Will it impact on clinical workforce capability, care and skills?	Yes			Professionals will need to work collaboratively and may need to upskill and multiskilling in order to deliver this service.
		Will this impact adversely against the recommendations of key national reports in to patient safety, particularly protecting vulnerable patients - the Francis, Berwick and Winterbourne View Reports?	No			The service is provided by NHS organisations and should be monitored for these outcomes and reports are available in the same way as they are for all other services.
Experience	Patient Experience	Will this likely have an impact on self-reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)	Position to be clarified			Expected impact positive
		Will it impact on patient choice?	Position to be clarified			Expected impact positive
		Will this affect patient satisfaction?	Position to be clarified			Expected impact positive

		Does it support the compassionate and personalised care agenda?	Yes			Expected impact positive
Effectiveness	Clinical Effectiveness and Outcomes	Will it impact on implementation of evidence based practice?	Position to be clarified			Proposals based on clinical best practice evidence
		Will it impact on clinical leadership?	Yes			Will require revised model of workforce and extended peripatetic capacity
		Will it impact on patient's length of stay?	Yes			Expected impact positive
		Will it reduce/impact on variations in care? (e.g. readmission rates)	Yes			Expected impact positive
		Will it impact on the way in which care is delivered in the most clinically and cost effective way?	Yes			Expected impact positive
		Will it impact on potential improvements in care pathway(s)?	Yes			Modelling being developed through existing pathway review & improvement
		Will this impact on the groups of people in the CCG's area that have a worse outcomes and experience of care and the CCG's plans to close the gap?	Yes			Expected outcome positive
		Will this impact on the parity of esteem agenda, including reducing the impact of mental health issues on life expectancy?	Yes			Expected outcome positive

NHS Outcomes Framework	Could the proposal impact positively or negatively on the delivery of the five domains:	Will it impact on preventing people from dying prematurely?	Yes		Potentially -as better managed morbidity improves mortality rates in the longer term. Mental Health services will work as part of the Integrated Care Team.
		Will it impact on enhancing quality of life for people with long term conditions?	Yes		
		Will it impact on helping people recover from episodes of ill health or following injury?	Yes		Expected outcome positive
		Will it impact on ensuring people have a positive experience of care?	Position to be clarified		Expected positive impact - care closer to home
		Will it impact on treating and caring for people in a safe environment and protecting them from avoidable harm?	Position to be clarified		Expected outcome positive

Governance: Completed by Lisa Pope Date: 070317. Will be reviewed at QSC Date April 2017 finalised by Gill Collinson date April 2017

Appendix 8: Privacy Impact Assessment

A Privacy Impact Assessment will be completed during the next phase of project implementation to ensure there is no collection, storage, access, use or dissemination of identifiable personal information that is not both needed and permitted. This will further be reviewed once Standard Operating procedures are in place for service referrals and delivery.