# Agenda

**Meeting:** **Scrutiny of Health Committee**

**Venue:** **The Grand Committee Room, County Hall, Northallerton DL7 8AD**

**Date:** **Friday 23 June 2017 at 10.00 am**

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## Business

1. Minutes of the Scrutiny of Health Committee held on 7 April 2017

   **(Pages 6 to 12)**

2. Declarations of Interest

3. Chairman's Announcements - Any correspondence, communication or other business brought forward by the direction of the Chairman of the Committee.

   (FOR INFORMATION ONLY)

4. Public Questions or Statements

| Members of the public may ask questions or make statements at this meeting if they have given notice to Daniel Harry, Principal Scrutiny Officer (*contact details below)* no later than midday on Tuesday 20 June 2017. Each speaker should limit himself/herself to 3 minutes on any item. Members of the public who have given notice will be invited to speak:-<br>• at this point in the meeting if their questions/statements relate to matters which are not otherwise on the Agenda (subject to an overall time limit of 30 minutes);<br>• when the relevant Agenda item is being considered if they wish to speak on a matter which is on the Agenda for this meeting. |
|---|

Enquiries relating to this agenda please contact Daniel Harry on 01609 533531
or e-mail daniel.harry@northyorks.gov.uk
www.northyorks.gov.uk

5. **Sustainability and Transformation Partnerships** – update on progress with planning and engagement – Janet Probert, Hambleton, Richmondshire and Whitby CCG – verbal update for the Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby STP and West Yorkshire and Harrogate STP. A paper has been provided for the Humber Coast and Vale STP.

**(Pages 13 to 21)**

6. **Transforming our Communities – mental health services** – Janet Probert and Lisa Pope, Hambleton, Richmondshire and Whitby CCG – presentation

**(Pages 22 to 197)**

7. **North Yorkshire Mental Health Strategy** – follow up to committee meeting of 2 September 2016, Kathy Clark and Kashif Ahmed - presentation

**(Pages 198 to 211)**

8. **Castleberg Hospital, Settle – update** – Sue Pitkethly and Dr. Colin Renwick, Airedale, Wharfedale and Craven CCG, Dr. Karl Mainprize and Trudy Balderson Airedale NHS Foundation Trust

**(Pages 212 to 215)**

9. **Monitoring the human health impacts of shale gas extraction** – Lincoln Sargeant, Director of Public Health, North Yorkshire County Council and Simon Padfield, Public Health England

**(Pages 216 to 231)**

10. **Joint Scrutiny with the Care and Independence Overview and Scrutiny Committee: a) health and social care workforce planning; b) integration of health, mental health and adult social care commissioning and service provision** – Daniel Harry, Scrutiny Team Leader, North Yorkshire County Council – Report

**(Pages 232 to 236)**

11. **Overview and Scrutiny at North Yorkshire County Council and committee Work Programme** – Daniel Harry, Scrutiny Team Leader, North Yorkshire County Council - Report

**(Pages 237 to 244)**

12. Other business which the Chairman agrees should be considered as a matter of urgency because of special circumstances.

Barry Khan
Assistant Chief Executive (Legal and Democratic Services)
County Hall
Northallerton

15 June 2017

**NOTES:**

(a) Members are reminded of the need to consider whether they have any interests to declare on any of the items on this agenda and, if so, of the need to explain the reason(s) why they have any interest when making a declaration.

A Democratic Services Officer or the Monitoring Officer will be pleased to advise on interest issues. Ideally their views should be sought as soon as possible and preferably prior to the day of the meeting, so that time is available to explore adequately any issues that might arise.

(b) **Emergency Procedures For Meetings**

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**Accident or Illness**
First Aid treatment can be obtained by telephoning Extension 7575.

# Scrutiny of Health Committee

1. **Membership**

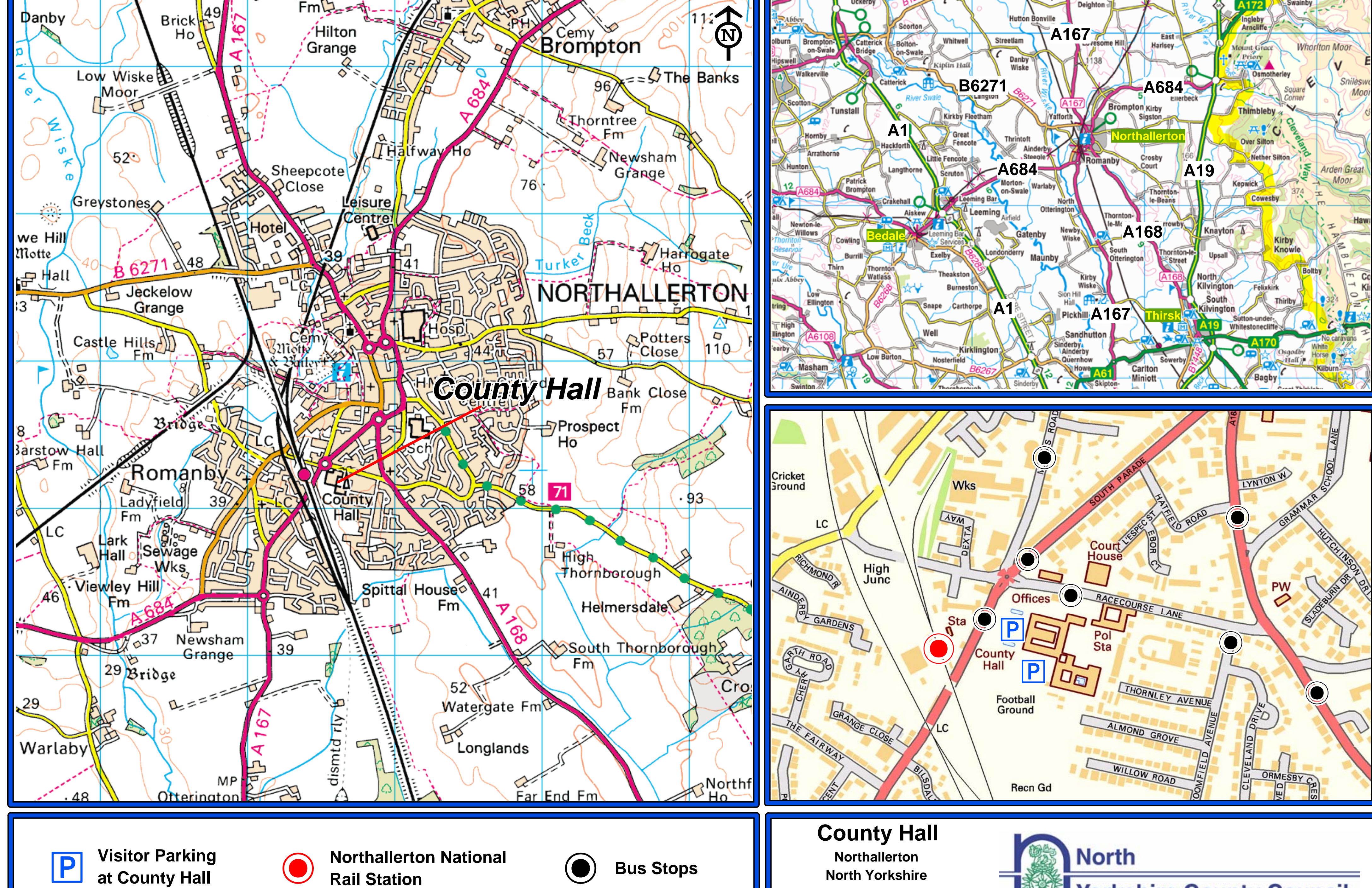
| | **County Councillors (13)** | | | |
|---|---|---|---|---|
| | *Councillors Name* | *Chairman/Vice Chairman* | *Political Group* | *Electoral Division* |
| **1** | ARNOLD, Val | | Conservative | Kirkbymoorside |
| **2** | BARRETT, Philip | | NY Independents | South Craven |
| **3** | CLARK, Jim | Chairman | Conservative | Harrogate Harlow |
| **4** | COLLING, Liz | Vice-Chairman | Labour | Falsgrave and Stepney |
| **5** | ENNIS, John | | Conservative | Harrogate Oatlands |
| **6** | HOBSON, Mel | | Conservative | Sherburn in Elmet |
| **7** | MANN, John | | Conservative | Harrogate Central |
| **8** | METCALFE, Zoe | | Conservative | Knaresborough |
| **9** | MOORHOUSE, Heather | | Conservative | Great Ayton |
| **10** | PEARSON, Chris | | Conservative | Mid Selby |
| **11** | SOLLOWAY, Andy | | Independent | Skipton West |
| **12** | SWIERS, Roberta | | Conservative | Hertford and Cayton |
| **13** | WINDASS, Robert | | Conservative | Boroughbridge |

| | **Members other than County Councillors – (7) Voting** | |
|---|---|---|
| | *Name of Member* | *Representation* |
| **1** | HARDISTY, Kevin | Hambleton DC |
| **2** | CHILVERS, Judith | Selby DC |
| **3** | GARDINER, Bob | Ryedale DC |
| **4** | MORTIMER, Jane E | Scarborough BC |
| **5** | HULL, Wendy | Craven DC |
| **6** | SEDGWICK, Karin | Richmondshire DC |
| **7** | GALLOWAY, Ian | Harrogate BC |
| | **Total Membership – (20)** | **Quorum – (4)** |

| Con | Lib Dem | NY Ind | Labour | Ind | Total |
|---|---|---|---|---|---|
| 10 | 0 | 1 | 1 | 1 | 13 |

2. **Substitute Members**

| | **Conservative** | | **NY Independents** | |
|---|---|---|---|---|
| | *Councillors Names* | | *Councillors Names* | |
| **1** | BASTIMAN, Derek | **1** | | |
| **2** | | **2** | | |
| | **Labour** | | | |
| | *Councillors Names* | | | |
| **1** | BROADBENT, Eric | | | |
| **2** | | | | |
| | | | **Substitute Members other than County Councillors** | |
| | | **1** | VACANCY | (Hambleton DC) |
| | | **2** | VACANCY | (Selby DC) |
| | | **3** | SHIELDS, Elizabeth | (Ryedale DC) |
| | | **4** | JENKINSON, Andrew | (Scarborough BC) |
| | | **5** | BROCKBANK, Linda | (Craven DC) |
| | | **6** | CAMERON, Jamie | (Richmondshire DC) |
| | | **7** | HASLAM, Paul | (Harrogate BC) |

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Northallerton
North Yorkshire
DL7 8AD

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North Yorkshire County Council

# North Yorkshire County Council
# Scrutiny of Health Committee

Minutes of the meeting held at County Hall, Northallerton on 7 April 2017.

**Present:-**

**Members:-**
County Councillor Jim Clark (in the Chair)
County Councillors: Val Arnold, Philip Barrett, David Billing, Margaret-Ann de Courcey-Bayley, Caroline Dickinson, John Ennis, Shelagh Marshall OBE, Heather Moorhouse, Chris Pearson and David Simister.

**Co-opted Members:-**
District Council Representatives:- Kevin Hardisty (Hambleton), Judith Chilvers (Selby), Jane E Mortimer (Scarborough), Wendy Hull (Craven), Jamie Cameron (Richmondshire) as substitute for Karin Sedgwick and Ian Galloway (Harrogate).

**In attendance:-**
Amanda Bloor, Chief Officer, NHS Harrogate and Rural District Clinical Commissioning Group
Chris O'Neill, Humber Coast and Vale STP Programme Director
Linsay Cunningham, Humber Coast and Vale STP Communications and Engagement
Janet Probert, Chief Operating Officer, Hambleton, Richmondshire and Whitby CCG
Lisa Pope, Deputy Chief Operating Officer, Hambleton, Richmondshire and Whitby CCG
Liz Herring, Head of Service Adult Mental Health and Substance Misuse North Yorkshire, Tees Esk and Wear Valleys NHS Foundation Trust.

County Councillor Clare Wood, Chair of the North Yorkshire Health and Wellbeing Board

**County Council Officers:-**
Daniel Harry, Scrutiny Team Leader

Apologies for absence were received from: County Councillor John Clark, District Councillor Karin Sedgwick (Richmondshire) and County Council officer Amanda Reynolds, Assistant Director for Integration, Health and Adult Services.

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**Copies of all documents considered are in the Minute Book**

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**148. Minutes**

**Resolved**

That the Minutes of the meeting held on 27 January 2017 be taken as read and be confirmed and signed by the Chairman as a correct record.

**149. Any Declarations of Interest**

There were no declarations of interest to note.

**150. Chairman's Announcements**

The Chairman provided the Committee with an update relating to the following matters:-

**Mid Cycle Briefing – 3 March 2017**

Cllr Jim Clark confirmed that the following were discussed at the Mid Cycle Briefing:

- The outcome of the initial consultation on a new mental health hospital for the Vale of York and the progress being made with the development of an outline business case that will go to the Governing Body meeting on 4 May 2017.
- The redevelopment of the Whitby Hospital and the continuous and ongoing engagement with public and stakeholders. The aim is to start building work in Autumn 2017.
- The extended scrutiny of 'End of life care in North Yorkshire' and the presentation of the final report to the North Yorkshire Health and Wellbeing Board on 17 March 2017.
- The work being undertaken by North Yorkshire County Council Public Health and Public Health England to monitor the potential human health impacts of shale extraction at Kirby Misperton.

These items were noted by the Committee Members.

**Castleberg Hospital in Settle**

Daniel Harry, Scrutiny Team Leader, gave an update on the recent temporary closure of the Castelberg Hospital in Settle.

Daniel Harry stated that Sue Pitkethly, Chief Operating Officer at Airedale Wharfedale and Craven CCG, had recently confirmed that the Castleberg Hospital in Settle was going to be closed on a temporary basis due to serious concerns about the safety of the building. In recent weeks there have been sewerage leaks in the building, power cuts, no heating, no hot water and fire alarms failing.

There are typically between 5 and 10 in-patients who tend to be older people who are there for a period of recuperation. The plan is to transfer patients to the Airedale Hospital site on a temporary basis, whilst the NHS estates determine what can be done repair the building and return it to safe use.

Daniel Harry confirmed that Airedale, Wharfedale and Craven CCG had spoken to North Yorkshire County Council Health and Adult Services and that there may be opportunities to use some social care beds locally, as opposed to transferring patients to Airedale Hospital.

Cllr Jim Clark raised his concern that Castleberg Hospital was in danger of going the same way as the Lambert Hospital in Thirsk, which closed temporarily and then never re-opened.

There followed a discussion, with the key points summarised as below:

Cllr Shelagh Marshall OBE raised her concerns about the distances people will have to travel now that the hospital has been closed.

Cllr Philip Barrett expressed concern that the Scrutiny of Health Committee had been circumvented. Also, that the Castleberg Hospital served an area much larger than Settle and so any resettlement arrangements would need to take this into account.

Cllr Wendy Hull acknowledged the concerns raised by the temporary closure of the Castleberg Hospital but noted that there were alternative models of delivery for integrated health and social care that could be delivered. She also stated that any support of North Yorkshire County Council in the resettlement of existing and future patients would be appreciated.

Cllr Health Moorhouse stated her disappointment with the Foundation Trust and their lack of early engagement with patients and key stakeholders over the problems experienced with the running of the hospital.

**Resolved –**

a) That senior representatives from the Airedale, Wharfedale and Craven CCG and Airedale NHS Foundation Trust attend the next meeting of the Committee to explain what led to the temporary closure of the Castleberg hospital site and what the plans there are for future provision of that service.

**151. Public Questions or Statements**

There were no statements or questions from members of the public.

**152. Sustainability and Transformation Plans**

Considered –

The report of Amanda Bloor, Chief Officer, NHS Harrogate and Rural District Clinical Commissioning Group, Janet Probert, Chief Officer, NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group and Chris O'Neill, Humber Coast and Vale STP Programme Director on the current position on the development of the STP plans and also the outcome of the refresh of the NHS Five Year Forward View and the revised NHS England guidance for STPs.

Amanda Bloor introduced this item, providing an update on progress being made with the development of the three Sustainability and Transformation Partnerships that cover North Yorkshire. She emphasised that the focus remained upon the provision of integrated and responsive care in the community, with specialist care offered in regional centres where this made clinical sense.

Amanda Boor stated that primary care, the first point of contact with health services in the community, included a wide range of agencies and organisations and was not just about GPs. The integration of primary care services in 'hubs' across the county offered real opportunities for sustainable and local care.

In reference to the Harrogate and Craven element of the West Yorkshire and Harrogate STP, Amanda Bloor made the following points:

- Current STP plan is well aligned to the priorities in the recently released NHS England 'Next Steps on the NHS Five Year Forward View'
- Awaiting confirmation of transformation funding to support the development of cancer diagnosis and A&E services
- Workforce issues are steadily being addressed
- Anticipated that there will be additional funding to support diabetes prevention, screening and treatment
- A joint committee of health commissioners across the STP has been established.

In reference to the North Yorkshire element of the Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby STP, Janet Probert made the following points:

- Both physical and mental health services are being reviewed in parallel
- Greater use of primary care services is being looked at to help reduce hospital admissions, such as more testing in the community at GP practices
- Focus upon the best quality service and where it makes best sense to provide it
- More use of early diagnosis and treatment
- Expansion of the ‘step-up and step-down’ system of beds in the community
- Stronger links with care homes and nursing care homes, looking at ways to support the providers and promote a resilient and stable market of care across more rural areas.

In reference to the North Yorkshire element of the Humber Coast and Vale STP, Chris O’Neill made the following points:

- The plans that were published in October 2016 were just the starting point
- The planning for changes to health services was initially thought to have been needed to meet a need a number of years in the future. It is apparent that the need is now, which leaves less time to plan
- The priority is the same for Humber Coast and Vale as for the other STPs covering North Yorkshire, being to develop integrated services that are local with a smaller number of centralised specialist services provided where there is a strong business case to support it
- The development of an integrated system of hospital services, primary care and social care based in Scarborough and Ryedale is a model that could be applied elsewhere
- There are also developments in the Vale of York and the creation of an Accountable Care System.

Cllr Jim Clark re-iterated the concerns that had previously been raised by the Committee regarding the STP process, specifically:

- The apparent lack of meaningful engagement with non-NHS services
- That the increasing demand upon social care services will impact upon NHS services, placing the achievement of identified NHS savings in doubt
- The shortage of necessary capital funding to enable service transformation
- The impact of any NHS-led service re-configuration upon travel distances and times
- The risk posed to local health and social care, community-based funding and services in the county by the need to support acute care and increase capacity in large, urban population centres elsewhere
- That short term workforce shortages are driving reconfiguration and not patient need.

There followed a general discussion on the development of the STPs.

Cllr David Billing raised concerns about the ability of the NHS to successfully undertake large procurement exercises, particularly in the wake of a number of failed procurements nationally.

In response, Chris O’Neill stated that a NHS England assurance process had been introduced that helped to ensure that any procurement was robust and not open to challenge.

Cllr Wendy Hull noted that there needed to be a full and open discussion with the public about the provision of health care services and when it was appropriate for services to remain local and when it was appropriate for them to be centralised.

Janet Probert agreed and stated that the challenge for the NHS was articulate the evidence in a way that was easy to understand and not to resort to jargon or technical explanations.

Cllr Chris Pearson queried what role community pharmacies had to play in the delivery of primary care, particularly as the Scrutiny of Health Committee had recently heard that central government funding was being reduced and that this may lead to mergers and/or closures of community pharmacies in the longer term.

Amanda Bloor stated that a broad range of allied health professionals had a role to play in the development of integrated and local community care services that took the pressure off GPs and Hospitals.

Cllr Philip Barrett suggested that greater use could be made of GP practices, where there was capacity to do so. He questioned, however, whether there was a willingness amongst GPs to change how they work.

Cllr Jane Mortimer asked where the necessary capital funding would come from the develop the necessary hospital and community infrastructure.

In response, Janet Probert stated that some capital could be generated by partial or complete sales of existing sites, such as in the case for the redevelopment of the Whitby Hospital. In terms of the national STP capital funding pot, each area would have to make a bid for funding and that an award would be made on the strength of the business case.

Cllr Heather Moorhouse suggested that the whole approach to the Accident and Emergency service provision in the county needed to be re-thought.

In summing up, Cllr Jim Clark noted that the messages given out by NHS England were often confused and that further engagement was needed with the public to make it clear what services there were and which were most appropriate for different conditions at different points in time. Otherwise, people would continue to go to their GP or Accident and Emergency, when they did not need to.

Daniel Harry confirmed that both a copy of the presentation and the paper by Chris O'Neill on the Humber Coast and Vale STP would be circulated to Committee Members by email after the meeting.

**Resolved –**

a) Thank Amanda Bloor, Janet Probert and Chris O'Neill for attending

b) That an update on the development of the STPs and any outline programme for formal public consultation be brought to a future meeting of the Committee.

**153. Transforming our Communities – Mental Health Services**

Considered –

The report of Janet Probert, Chief Operating Officer, Hambleton, Richmondshire and Whitby CCG, Lisa Pope, Deputy Chief Operating Officer, Hambleton, Richmondshire and Whitby CCG and Liz Herring, Head of Service Adult Mental Health and Substance Misuse North Yorkshire, Tees Esk and Wear Valleys NHS Foundation

Trust providing the context and background to a proposed re-configuration of adult and older peoples' mental health services in Hambleton, Richmondshire and Whitby.

Janet Probert gave an overview of the pre-engagement work that had been undertaken and people's priorities, as summarised below:

- keep care close to home
- end mixed sex units
- maintain high levels of privacy and dignity
- improve crisis care
- make sure that the right care is in place at the right time
- focus upon home-based care rather than hospitals
- treat people as a whole person and not just as a diagnosis
- treat physical ill health at the same time as mental ill health.

Lisa Pope highlighted that over time the minimum requirements and standards for mental health services had risen as had the expectations of the Care Quality Commission (CQC). In many cases, the existing service provision was not future proof and in some cases insufficient to meet the regulatory standards. It was noted that the CQC had previously raised concerns about the mental health units at the Friarage Hospital in Northallerton.

Janet Probert emphasised that NHS England was promoting collaborative approaches across physical and mental health care services.

Cllr James Cameron noted that there remained a significant social stigma around mental ill health and this prevented people from seeking treatment at the early stages.

Liz Herring stated that Tees Esk and Wear Valleys NHS Foundation Trust is working with North Yorkshire County Council on ways in which people can be encouraged to come forward and seek help at the early onset of mental ill health.

Janet Probert referred to the 'Time to Change' campaign which is aimed at ending mental health stigma. A link will be circulated.

Daniel Harry confirmed that a copy of the presentation would be circulated to Committee Members by email after the meeting.

**Resolved –**

a) Thank Janet Probert and Lisa Pope for attending

b) That a further report on the proposed next steps for the process of service reconfiguration and consultation on proposals be brought to this committee at the meeting on 23 June 2017.

**154. Work Programme**

Considered –

The report of the Scrutiny Team Leader, North Yorkshire County Council, highlighting the role of the Scrutiny of Health Committee and reviewing the work programme, taking into account current areas of involvement and decisions taken in respect of earlier agenda items.

**Resolved –**

a) That the Work Programme be noted.

**155. Chairman's closing comments**

Cllr Jim Clark noted that this was the last meeting of the North Yorkshire Scrutiny of Health Committee before the May local government elections. He passed on his best wishes to all those people who were standing for re-election and also to those that had decided to stand down and move onto other things. In particular, he thanked Cllrs Shelagh Marshall OBE, Clare Wood and David Simister for their support over the past years.

In response, committee members expressed their thanks to Cllr Jim Clark for all of his work as the Chair of the Committee and wished him well for the future.

The meeting concluded at 12:00

DH

**North Yorkshire Scrutiny of Health Committee**
**Update on the Humber Coast and Vale Sustainability and Transformation Partnership (STP)**
**23 June 2017**

Note – this report is in addition to the verbal update being provided on the Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby STP and the West Yorkshire and Harrogate STP that is on the agenda.

**Background**

Since April 2016, leaders from health and care organisations across the region, together with our vibrant voluntary sector, have been working together to establish the Humber, Coast and Vale Sustainability and Transformation Partnership (STP). It is a partnership of nearly 30 different organisations including NHS Trusts, Social Enterprise Companies, Local Councils and Health Commissioners covering a wide area with a diverse mix of rural, urban and sub-urban communities (see appendix A).

An overarching vision and draft set of proposals were submitted to NHS England in October 2016. This set out the shared vision for our local health and care system of enabling everyone in our area to ***start well, live well and age well***.

To achieve the vision we are working hard to create a health and care system that ***supports everyone's health and wellbeing and that is there to help when people need it.*** Our proposed future system will begin with people and be built around their needs rather than being built around organisations, processes or pathways. It will focus on promoting better health wherever possible by connecting people, places and services and delivering genuinely integrated care. We want to become a health improving system rather than an ill-health treating system.

**Delivering our vision – our programmes**

We are working with all the partner organisations on a complex programme of change. Our plan is sub-divided into 11 interdependent areas of work: six place-based plans and five cross-cutting workstreams, details of which are set out in appendix B.

In each of our six CCG areas we are developing place-based plans, which identify the needs of local people and communities and plan future services to meet those health and care needs. Our local plans focus on ***prevention*** (keeping people well), ***supported self-care*** (helping people to manage their health conditions at or close to home) and ***integrated commissioning and provision*** of local health and care services (so that services are joined up and flexible enough to meet different people's needs). Improving and joining up care outside of hospital settings is central to delivering the changes that are required in our health and care system.

In addition to place-based plans, we have established a number of programmes to plan changes on a regional (i.e. STP-wide) basis looking at hospital-based services, cancer and mental health provision. These programmes will be supported by a number of other projects (enablers) to help us get the basics right, including digital technology, estates, communications and engagement and workforce and organisational development.

The programmes are currently developing a series of proposals and a timeline for implementation. Each programme will have its own communications and engagement plan to ensure the public and other stakeholders are involved in the development of plans and that plans are communicated effectively.

**Our Finances**
At the time of initial submission of the draft partnership strategy in October 2016, a significant amount of work was carried out to model current and future demand on our health and social care system against the level of funding available both now and in the future. In our submission we predicted that by 2020/21 there will be a gap of around £420 million between the amount of money available and cost of delivering services in the way that we are currently delivering them.

This prediction was based on cost of delivering services on current models and expected future demand. It also assumed the Humber, Coast and Vale system would remain within its spending limits (known as the system "control total") this year. However, a number of organisations within the partnership have seen their financial position deteriorate in year. Therefore we need to work together to address the pressing financial challenges of today as well as working together on longer term plans to improve the overall effectiveness of local health and care provision. Work is underway at present to refresh the financial models within our programmes to reflect the current system position.

**Communications and Engagement**
We have developed a comprehensive communications and engagement strategy for the Humber, Coast and Vale STP that is intended to increase awareness, understanding, enthusiasm and engagement across a very wide range of stakeholders. Public and professional support is crucial to the achievement of our objectives, so the implementation of our communications and engagement strategy will be a priority for the STP over the coming months.

**Role of scrutiny**
Much of the work of the STP will be undertaken in each of our six 'places' (CCG areas). Humber Coast and Vale STP leaders and the relevant partnership organisations will continue to consult and engage with individual local authority Health Scrutiny Committees on matters relating to place-based plans. Place-based plans are largely coterminous with local authority boundaries and will focus on delivering integrated commissioning (Local Authority and CCG) and integrated provision (across health and social care, across primary and community care) of services in each area. We welcome the continued input from elected members in this work, including through the scrutiny process.

Where STP programmes propose changes over a wider area, local authority scrutiny committees may wish to meet together and/or form a joint committee. It would be for members to determine the process and timeline for this in line with existing political processes.

**Role of Healthwatch**
Healthwatch continue to provide constructive feedback and critique throughout. This builds on the baseline report produced in July 2016, which helped to shape the initial STP submission, in October 2016. Healthwatch is represented on the STP Strategic

Partnership Board via a named representative – Sian Balsom of Healthwatch York. Locally, Healthwatch North Yorkshire has contributed to the planning and delivery of STP engagement via the partnership communications and engagement network and through its role on the Vale of York Accountable Care Partnership Board. Engagement and involvement in relation to local place-based plans across North Yorkshire is being led by engagement teams from the two CCGs and York Foundation Trust and collaborative working with local Healthwatch will continue.

**Involving lay members and non-executive directors in the STP**
The publication of the Five Year Forward View Next Steps document on the 31st March 2017 reaffirmed the requirement for STPs to engage lay members from CCG governing bodies and non-executive directors from NHS Trusts in ensuring the partnership makes best use of the skills, experience and knowledge this group of individuals brings.

In the HCV, the NEDs and lay members have agreed to establish a regular forum to advise the STP programmes and plans, carry out a skills audit of lay members and non-executives from across the organisations to make sure we are utilising all the skills and experience we have collectively.

**Staff side forum**
The STP has established a Staff Side Forum and the first meeting with the representatives was held on 16 May 2017. It has been agreed to meet with the forum on regular basis to provide updates on the programme of work and pick up issues relating to the HCV STP raised by the staff side representatives.

**Building Health Partnerships Programme – 2017/18**
The Humber Coast and Vale STP has successfully won a bid for support from the Building Health Partnerships (BHP) programme for 2017/18. The programme provides funded support to enable STPs to engage with voluntary and community sector partners in their area as well as the general public to help improve local health and wellbeing. The BHP programme is jointly funded by NHS England and the Big Lottery Fund and delivered in partnership by Social Enterprise UK (SEUK) and the Institute for Voluntary Action Research (IVAR). The programme will run from April 2017 to June 2018.

Through Building Health Partnerships we would like to bring together health organisations and people who are experts in delivering community development projects (often on very small scale) to think differently about how to improve the health and wellbeing of our local communities. In particular, we are interested in the role the arts can play in helping us to think differently about improving health in our local populations. The programme will enable us to think more creatively and work together to solve a specific challenge in our health system together.

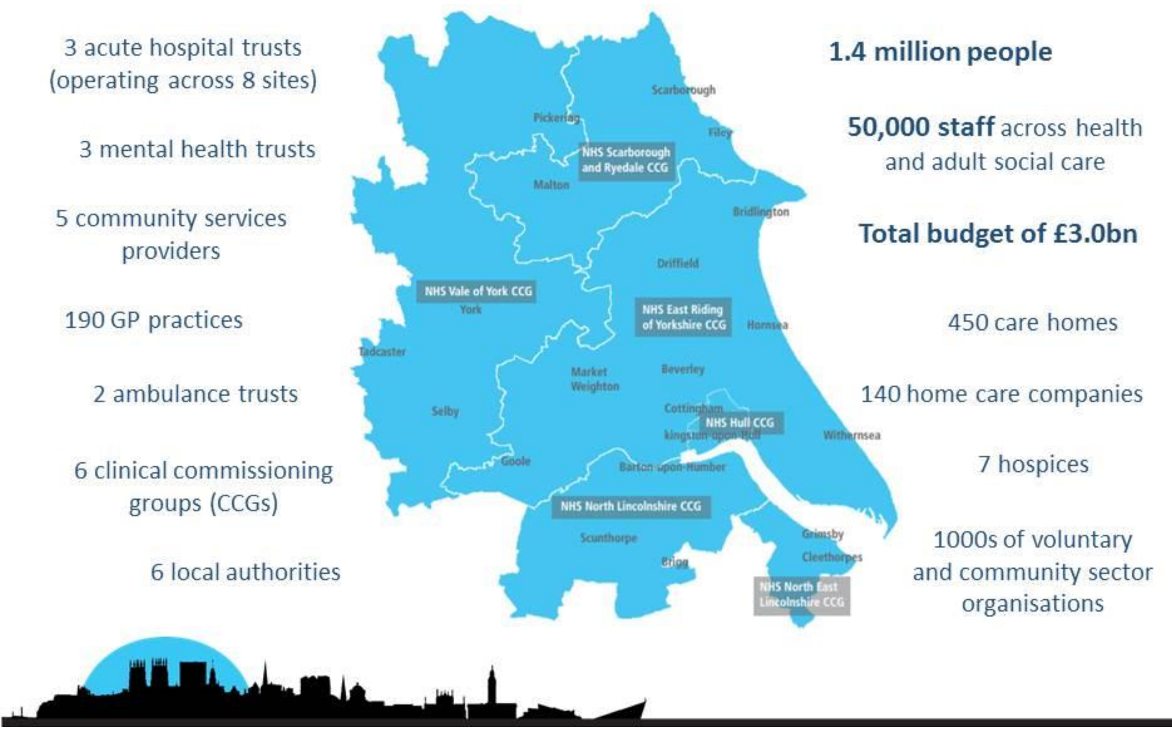
The steering group met together at the end of May and are now working together to plan the first major stakeholder event in early September. Further details will be available on the Humber, Coast and Vale STP website in due course.

**Next steps**
Work will continue in each of the programmes to develop detailed delivery plans. These documents will set out a clear timetable for proposed changes as well as a

detailed communications and engagement plan that will explain how and when patients, the public and other stakeholders can get involved in development of the STP programmes.

## Appendix A – Humber, Coast and Vale Partnership

# Health and care in Humber, Coast and Vale



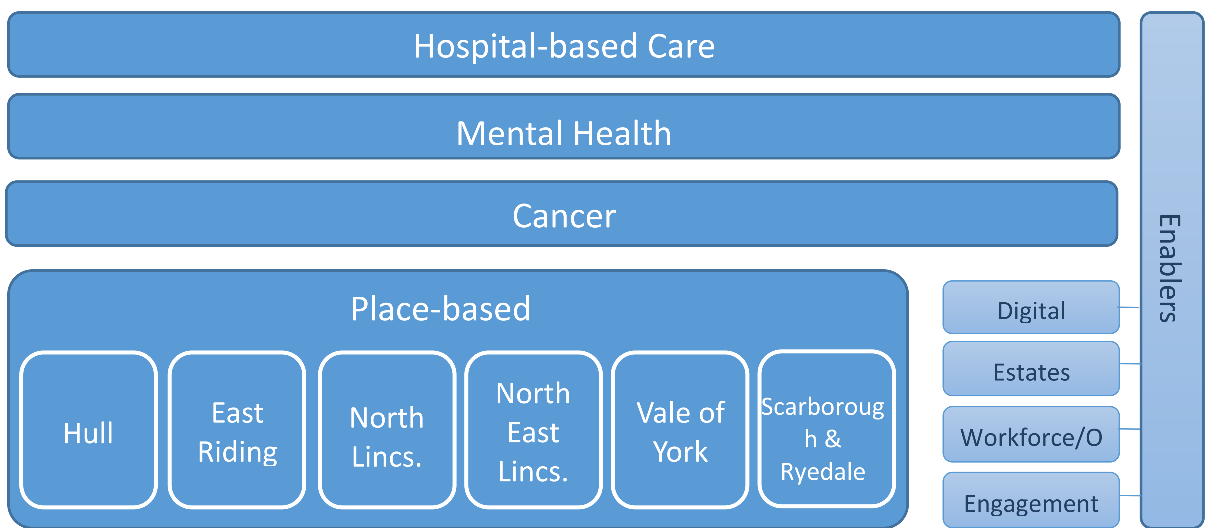

The Humber, Coast and Vale Sustainability and Transformation Partnership (STP) is a collaboration of nearly 30 different organisations across a geographical footprint of more than 1500 square miles taking in cities, market towns and remote rural and coastal communities. Together we form the complex system that is responsible for planning, paying for and providing health and care services within the area known as Humber, Coast and Vale. We serve a population of 1.4 million people, around 23% of whom live in the most deprived areas of England.

The Humber, Coast and Vale STP Partnership Board is made up of NHS Commissioners, Providers and Local Authorities. These are:

- East Riding of Yorkshire CCG
- Hull CCG
- North Lincolnshire CCG
- North East Lincolnshire CCG
- Scarborough and Ryedale CCG
- Vale of York CCG
- Northern Lincolnshire and Goole NHS Foundation Trust
- Hull and East Yorkshire Hospitals NHS Trust
- York Teaching Hospitals NHS Foundation Trust
- Humber NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Foundation Trust

- City Health Care Partnerships CIC
- Navigo
- Focus
- Care Plus Group
- Yorkshire Ambulance Service NHS Trust
- East Midlands Ambulance Service NHS Trust
- City of York Council
- East Riding of Yorkshire Council
- Hull City Council
- North Lincolnshire Council
- North East Lincolnshire Council
- North Yorkshire County Council

## Appendix B – Humber, Coast and Vale Partnership Programmes




# Place-based Plans

**Integrated Commissioning**

- Collaboration with Local Authorities
- Aligned budgets
- Commissioning for outcomes and population health management

**Integrated Provision**

- Improved access to GPs and other primary care
- Increased range of out of hospital services
- Improved access and ease of use – joined-up care

**Prevention, Self Care and Staying Well**

- Prevention at scale
- Healthy communities
- Healthy workplaces
- Supported self care

**Wider Determinants**

- Housing
- Employment
- Education

**Better Use of IT and Public Estate**

- Shared electronic records
- New ways to access and provide services
- Shared use of accommodation

# Hospital-based Care

### Overall Hospital Configuration

- Elective services
- Emergency medical services
- Emergency surgical services
- Paediatric services
- Shift of services to non-hospital settings

### Sustainable Specialised Services

- Clinical networks for Cancer, Major Trauma, Vascular and Critical Care
- Service reviews: Rehabilitation , Neonatal Intensive Care, specialised Paediatrics and Orthopaedics

### Maternity Care

- Improve local maternity systems to reduce stillbirth and neonatal death rates and improve perinatal mental health

### Clinical Support Services

- Radiology
- Pathology
- Pharmacy

### Shared Non-Clinical Services

- Standardise what we do and share functions to provide better and more efficient services

2

# Cancer

### Increased Awareness and Early Diagnosis

- Improving lifestyle choices and raising awareness
- Screening and active case finding
- Diagnosing vague symptoms
- qFIT for symptomatic patients

### Smarter Use of Diagnostics

- Diagnostic capacity and demand – system review
- Networked model of Radiology and Pathology
- Developing the diagnostic workforce

### Optimal Treatment

- Standardised and optimised pathway for lung cancer
- High value pathway reviews – Prostate, Colorectal and Breast
- Chemotherapy services review

### Consistent Cancer Recovery

- Personalised cancer follow up
- Better support for people after treatment

3

# Mental Health

### Support on Recovery Journey

- Treatment in the community to become default option
- Addressing existing gaps in onward placements and services

### Address Health Inequalities

- Invest in evidence based practice, informed by lived experience to commission services designed to achieve comparable outcomes for all

### Avoid Unnecessary Hospital Stays

- Develop more non-clinical services
- Ensure that we have 24/7 intensive home based alternatives to admission and effective 24/7 urgent & emergency liaison mental health services for all ages

### Prevention Under 5s

- Focus on bonding and attachment delivered through health visitors, schools & parenting support

### Provide Services Which Maintain Independence

- Address the independence of those with dementia

### Consider Physical Health

- Propose new pathways and prescribing guidelines which address the known potential impact of some mental health medications on physical health

# Enabling the Change to Happen

To address shortages of staff we will expand clinical training and develop new roles. We are already developing two training programmes:

- Support Staff at scale
- Advanced Practice at scale.

**Transformed Workforce**

We will use the buildings we have to support delivery of our priorities.

We will make best use of **all** public estate in our areas to enable the provision of joined-up care.

**Estate Strategy**

We will make that all of our plans are shaped through engagement with our stakeholders including:

- Public
- Patients
- Staff
- Other stakeholders

**Communication and Engagement**

We will utilise technology to:

- Give patients access to more information to help manage their own health;
- Create a single electronic care record so patients should only be asked things once.

**IT Strategy**

**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.

AUTHOR: Lisa Pope, Deputy Chief Operating Officer, Hambleton, Richmondshire and Whitby Clinical Commissioning Group.

DATE: Wednesday June 14th 2017.

# Hambleton and Richmondshire:

# Transforming Mental Health Services

Consultation Document

14 June 2017

**Co Authors**:

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- Dr Liz Herring, Head of Adult Mental Health services, Tees, Esk & Wear Valleys NHS Foundation Trust

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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 prevalence[1] 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 |
|---|
| **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.<br><br>**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.<br><br>**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.<br><br>**Commissioners:** The organisations that have responsibility for buying health services on behalf of the population of the area work for.<br><br>**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.<br><br>**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.<br><br>**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 of family member if they needed that kind of treatment.<br><br>**Functional (MHSOP):** Older people with a decreased mental function which is not due to a medical or physical condition. |

| 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.<br><br>**IAPT (also known as 'Talking Therapies'):** IAPT stands for "Increasing Access to Psychological Therapies".<br><br>**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.<br><br>**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.<br><br>**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.**<br><br>**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.<br><br>**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.<br><br>**Monitor:** the independent economic regulator for NHS Foundation Trusts.<br><br>**Multi-agency:** this means that more than one provider of services is involved in a decision or a process.<br><br>**Multi-disciplinary:** this means that more than one type of professional is involved – for example: psychiatrists, psychologists, occupational therapists, behavioural therapists, |

| Description |
| --- |
| nurses, pharmacists all working together in a Multi-Disciplinary Team (MDT).<br><br>**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.<br><br>**National Strategic Executive Information System (STEIS):** a new Department of Health system for collecting weekly management information from the NHS.<br><br>**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.<br><br>**NHS England – Area Teams:** The teams with NHS England responsible for commissioning specialised services and monitoring our performance against our specialist services contracts.<br><br>**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.<br><br>**NHS Staff Survey:** an annual survey of staffs' experience of working within NHS Trusts.<br><br>**Organic (MHSOP):** Older people with a decreased mental function which is due to a medical or physical condition. This includes dementia-related conditions.<br><br>**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.<br><br>**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.<br><br>**PPI:** Patient and Public Involvement.<br><br>**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.<br><br>**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.<br><br>**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.<br><br>**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.<br><br>**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.<br><br>**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.<br><br>**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.<br><br>**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 |

| Description |
| --- |
| health assessment. This procedure is contained within Section 136 of the Mental Health Act.<br><br>**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.<br><br>**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.<br><br>**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).<br><br>**Trust-wide:** This means across the whole geographical area served by the TEWV’s 3 Localities.<br><br>**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 majority[2] 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:

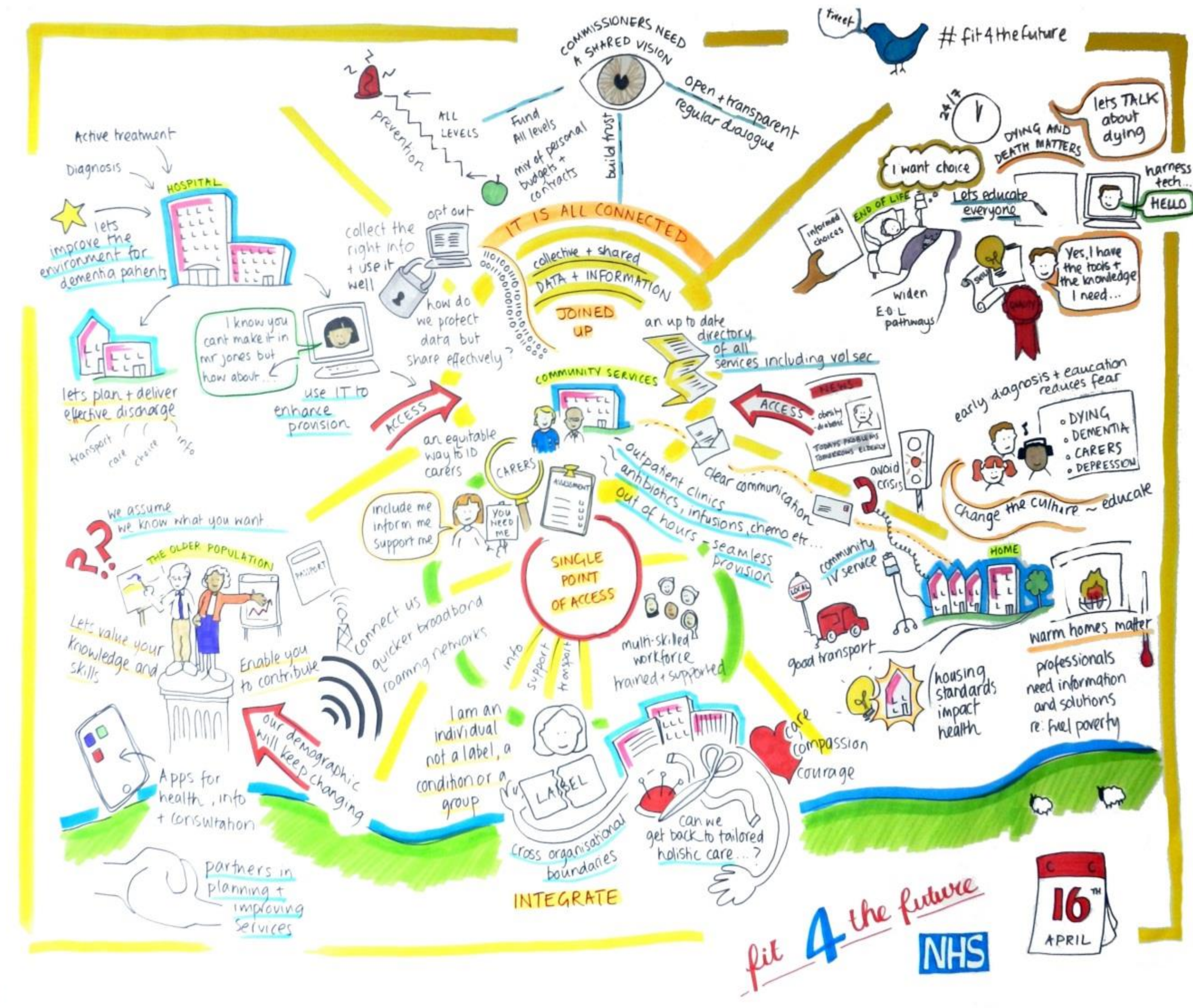


**Figure 1: HRW CCG: Fit 4 the Future vision**

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 | *DISCOVER!* 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, *DISCOVER!,* 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**

| 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 Year 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 to[3]:

- 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 Fund[4] 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

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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.

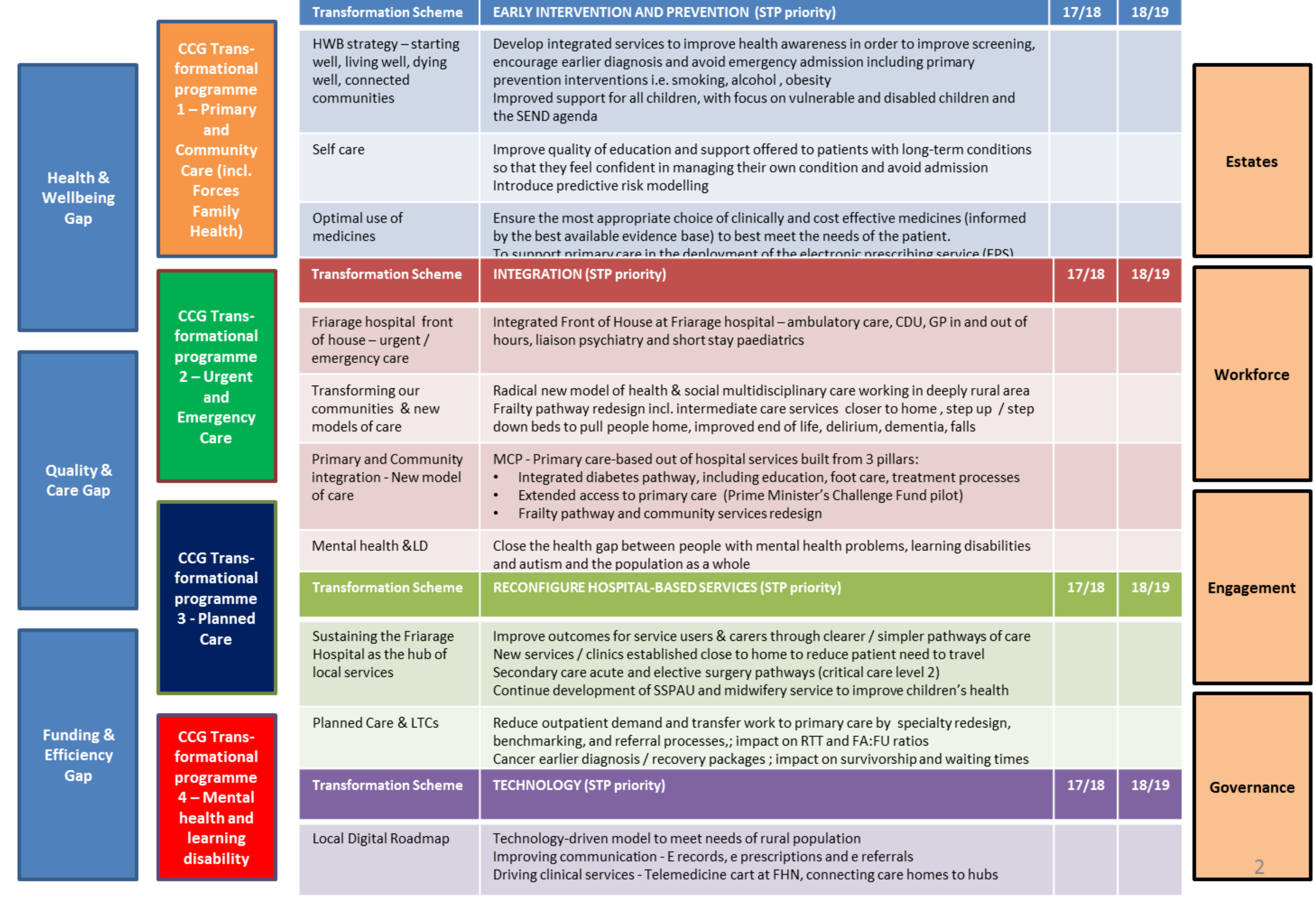


**Figure 2: CCG strategic plan on a page**

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## 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.

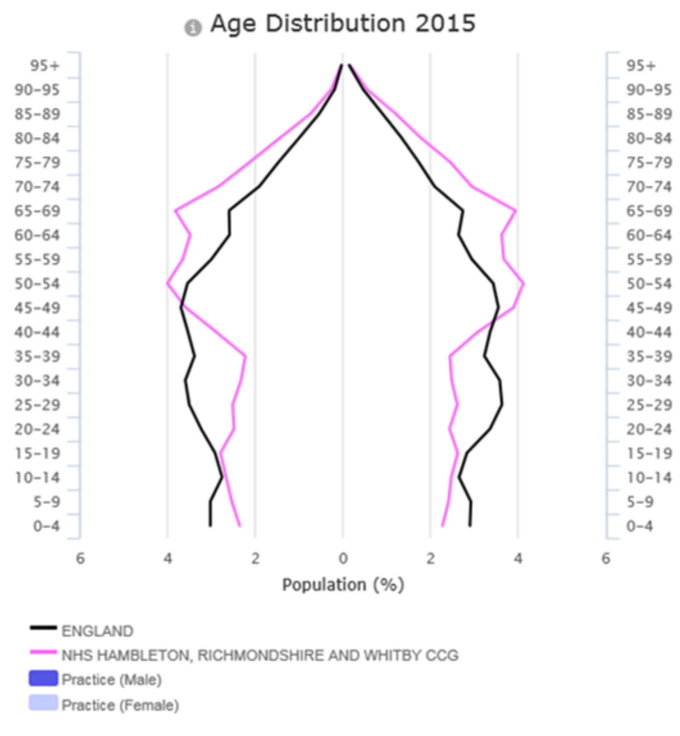



**Figure 3: CCG Age Distribution**

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<br>Mayford House, Northallerton |
| **Stokesley Integrated Locality Team** | Stokesley Health Centre<br>Great Ayton |
| **Bedale Integrated Locality Teams** | Glebe House Surgery |
| **Thirsk Integrated Locality Team** | Lambert Medical Practice<br>Thirsk Health Centre<br>Topcliffe Surgery |
| **Catterick Integrated Locality Team** | Catterick Village Health Centre<br>Colburn Medical Centre<br>Harewood Medical Centre |
| **Richmond Integrated Locality Team** | Aldbrough St John |

| Team | GP Practice Cluster |
|---|---|
| | Quakers Lane<br>Scorton Medical Centre<br>Friary Medical Centre |
| **Dales Integrated Locality Team** | Leyburn Practice<br>Dales Medical Practice<br>Aysgarth Practice<br>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.

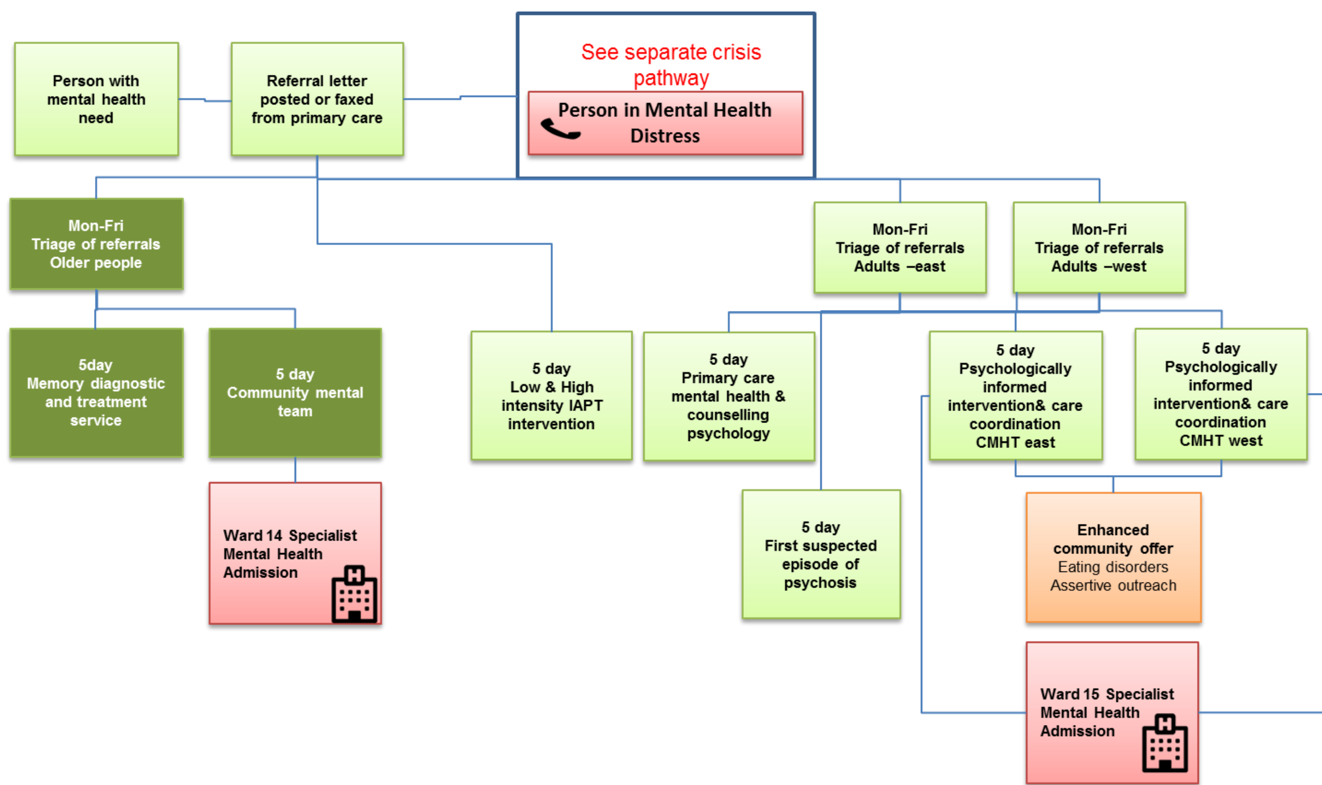



**Figure 4: Current out of hospital secondary care mental health provision**

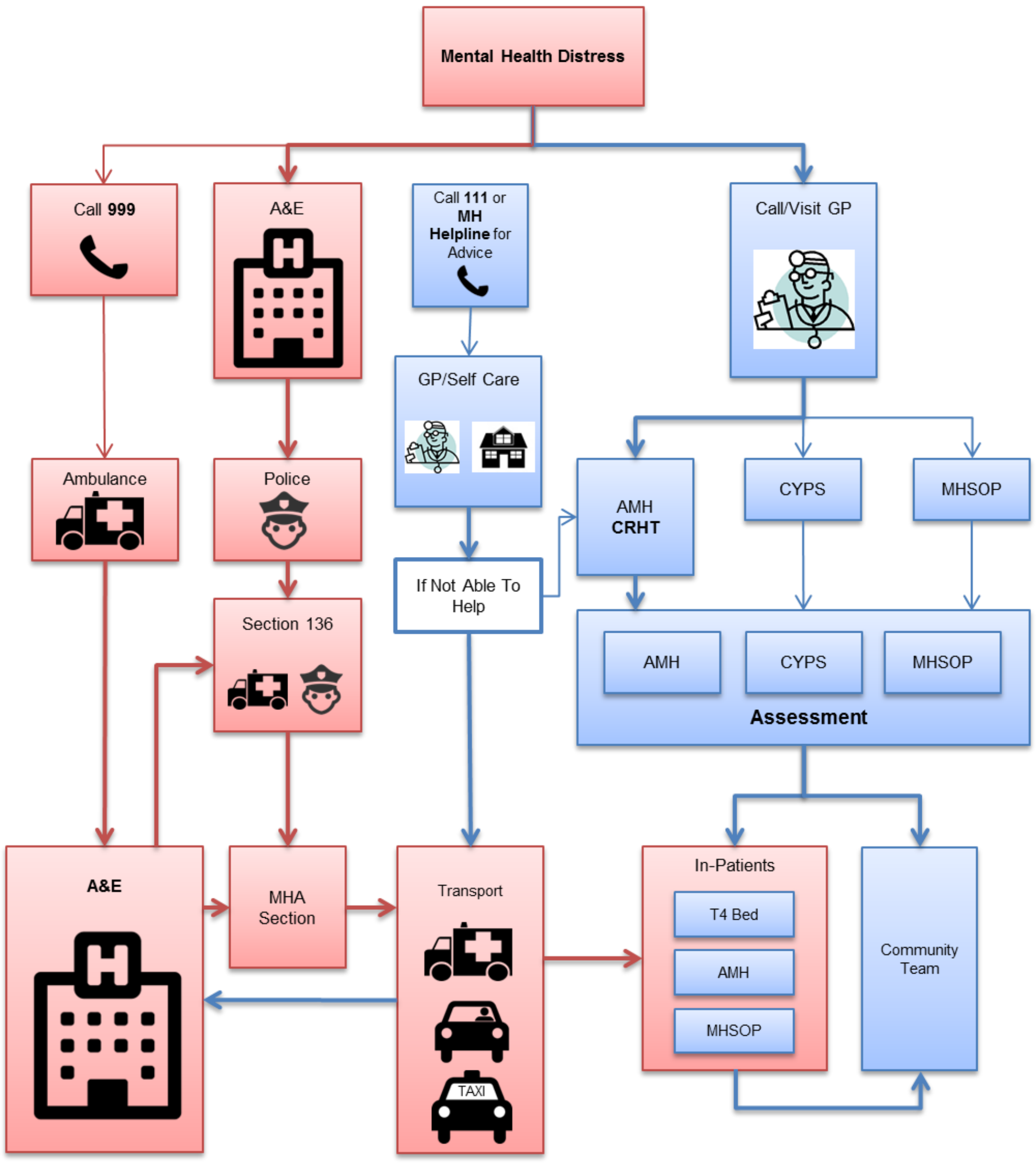



**Figure 5: Current crisis response pathway**

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**<br><br>18 to 65 years | **Older persons**<br><br>65years<br><br>Functional and organic mental disorders |
|---|---|
| Operates 5 days a week offering:<br><br>• Daily triage of referrals.<br>• Assessment by primary mental health care and community teams.<br>• Lead referral point for people with first suspected episode of psychosis (EIP) - 14-65years.<br>• NICE approved interventions for early psychosis presentations.<br>• Additional capacity to support those with long-term mental health.<br>• 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.<br>• Armed forces and veterans have access to a dedicated resource based with the Military campus.<br>• Psychologically informed interventions.<br>• Physical health management. | Operates 5 days a week offering<br><br>• Daily triage of referrals.<br>• Assessment and treatment by community teams.<br>• Community memory diagnostic and treatment service.<br>• Physical health management.<br>• 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

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

| | Direct Contacts | | | |
|---|---|---|---|---|
| MHSOP | F2F | Telephone | Total | Full Year |
| 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 |
| **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**

<table>
<tr><th>Working Age Adult<br><br>16 to 65 years functional and organic</th><th>Acute hospital liaison<br><br>16 and above acute liaison</th></tr>
<tr><td>Operates 7days a week offering:<br><br>• Consultant - led<br>• 4 hour response to people in crisis 24/7 for people aged 16-65years<br>• Gatekeeping assessment prior to admission to adult bed<br>• Lead service for the assessment under Section 136 of the Mental Health Act.<br>• Benefits of integration with social care staff and appropriate mental health practitioner (AMHP).<br>• 7 day service to provide Intensive home support<br>• Health based-place of safety (Section 136 suite)</td><td>Operates 7 days a week offering<br><br>• 1hour crisis response to Emergency department (8am-8pm)<br>• Inpatient liaison within 72hours of referral</td></tr>
<tr><td colspan="2">• Joint consultant and junior doctor on call</td></tr>
</table>

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:

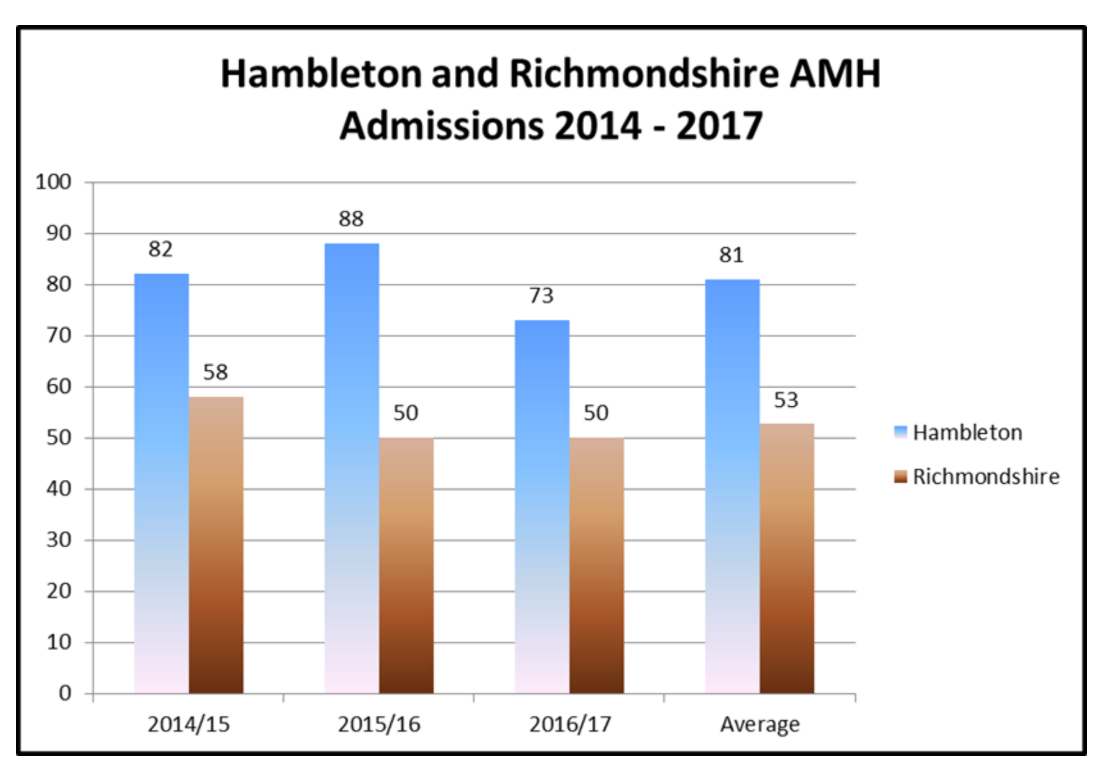
- 1wte consultant
- 1wte team manager
- 13.41wte crisis clinicians
- 1.1wte admin and secretarial support

**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:



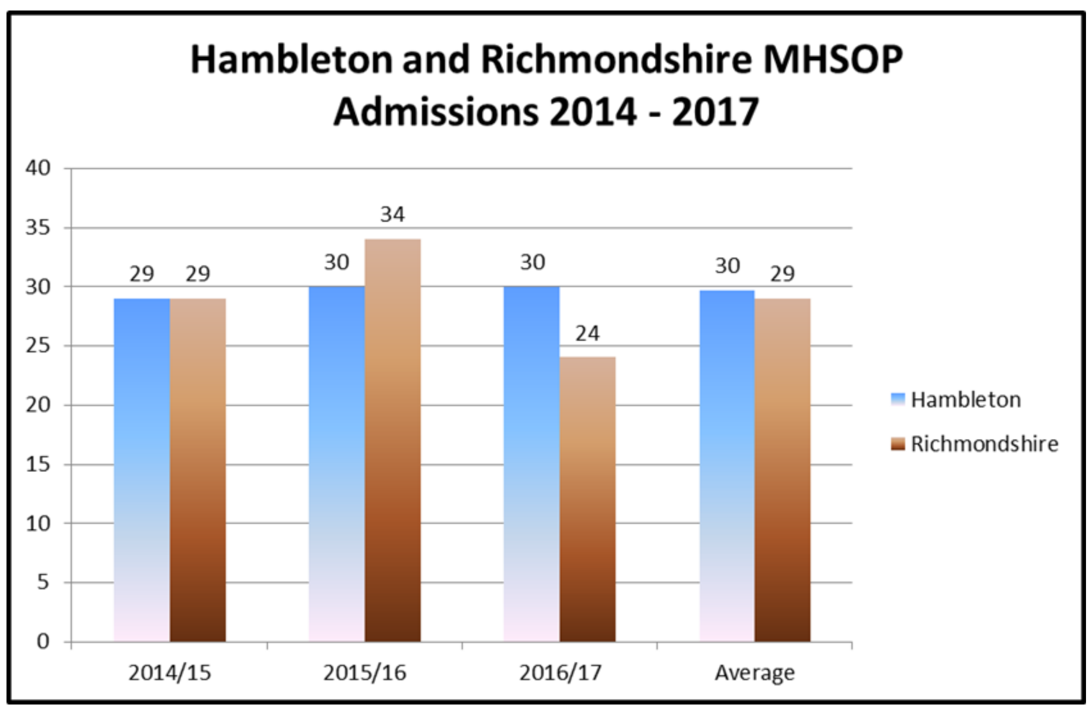
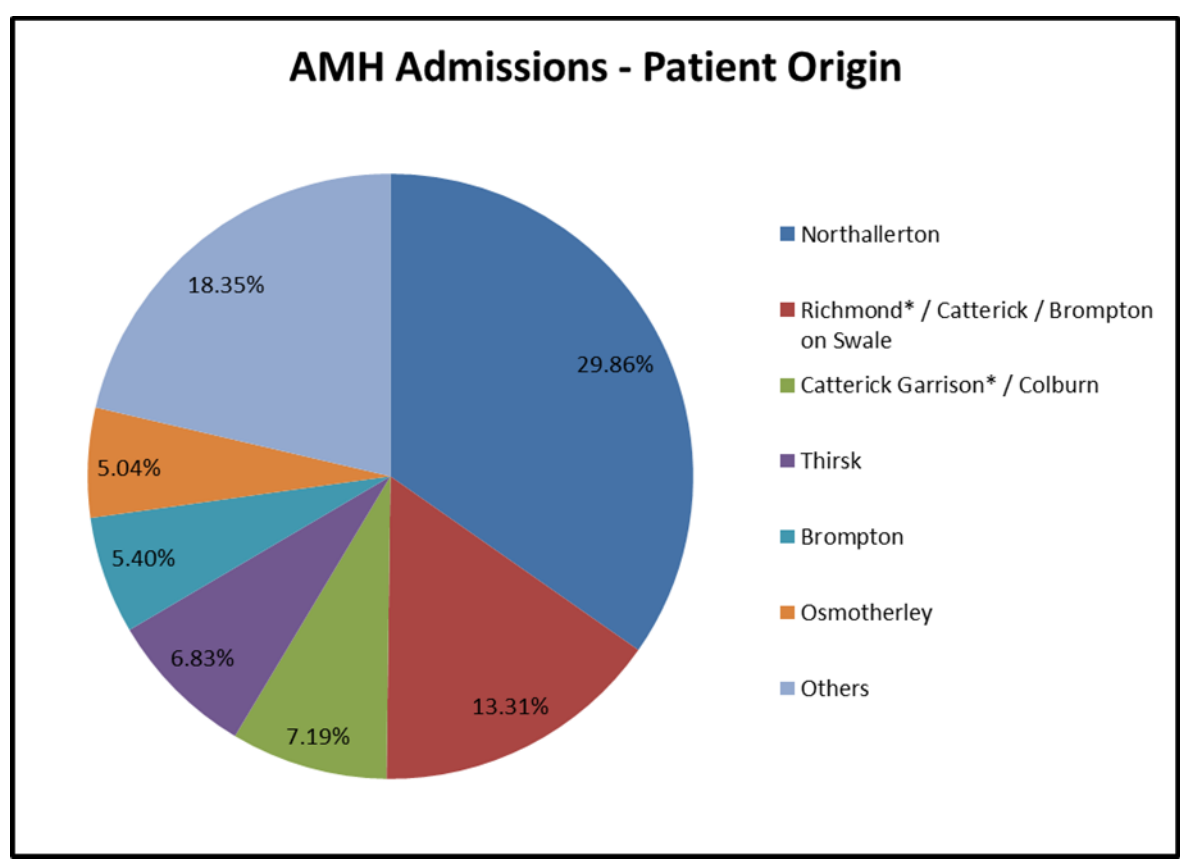




**Figure 6: Number of patients admitted**

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



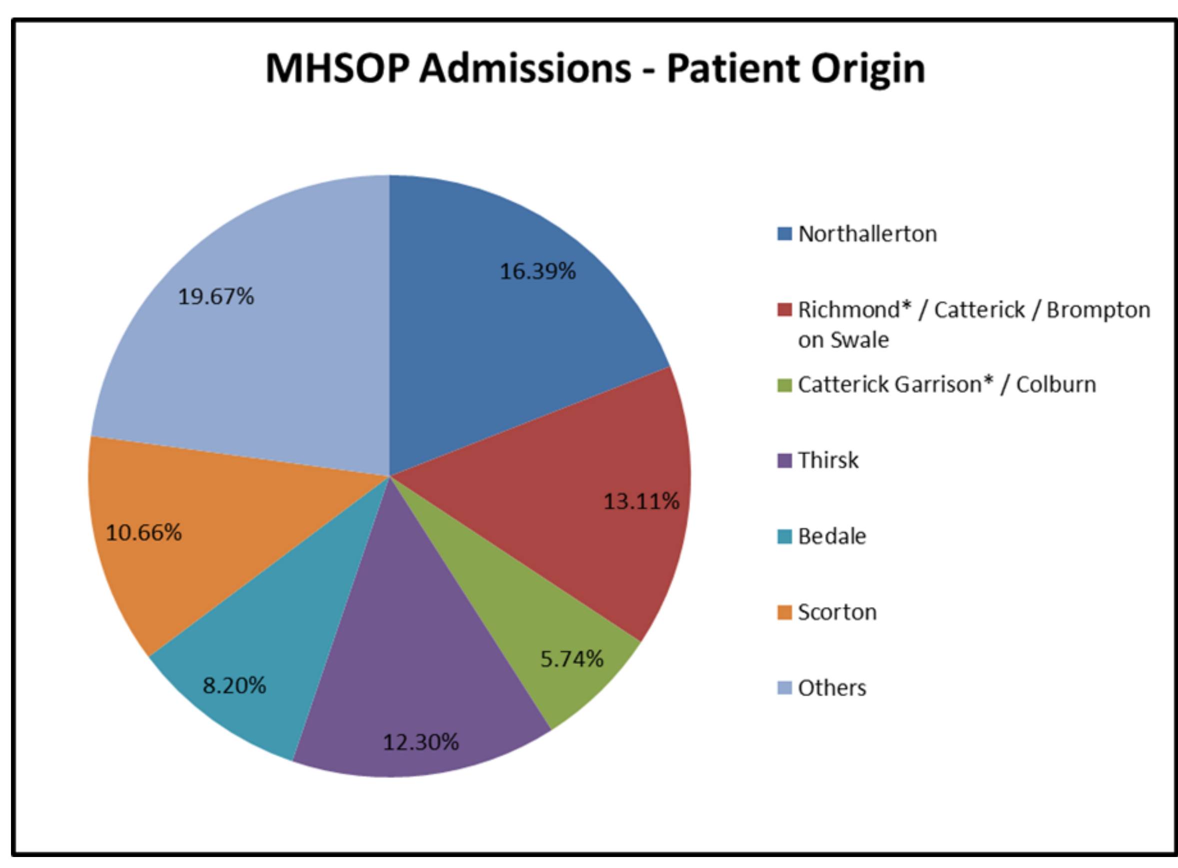
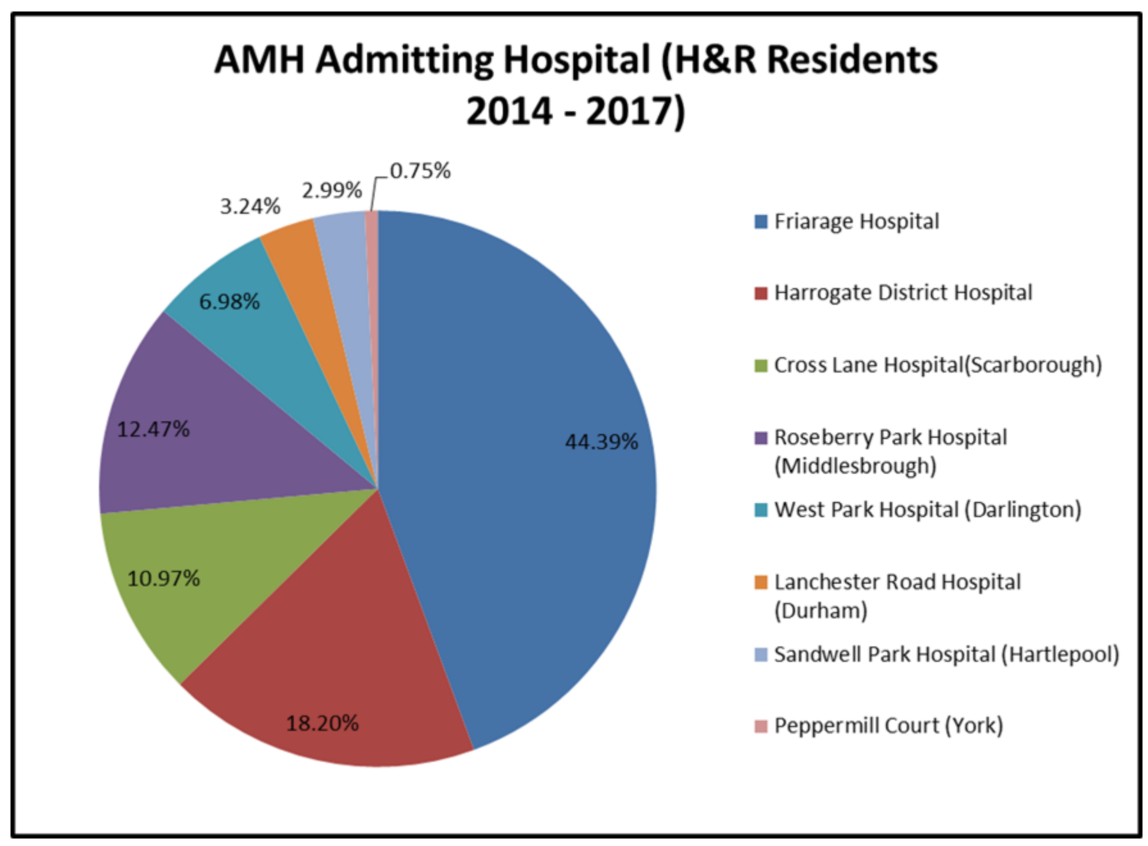




**Figure 7: Admitted patient origins**

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:



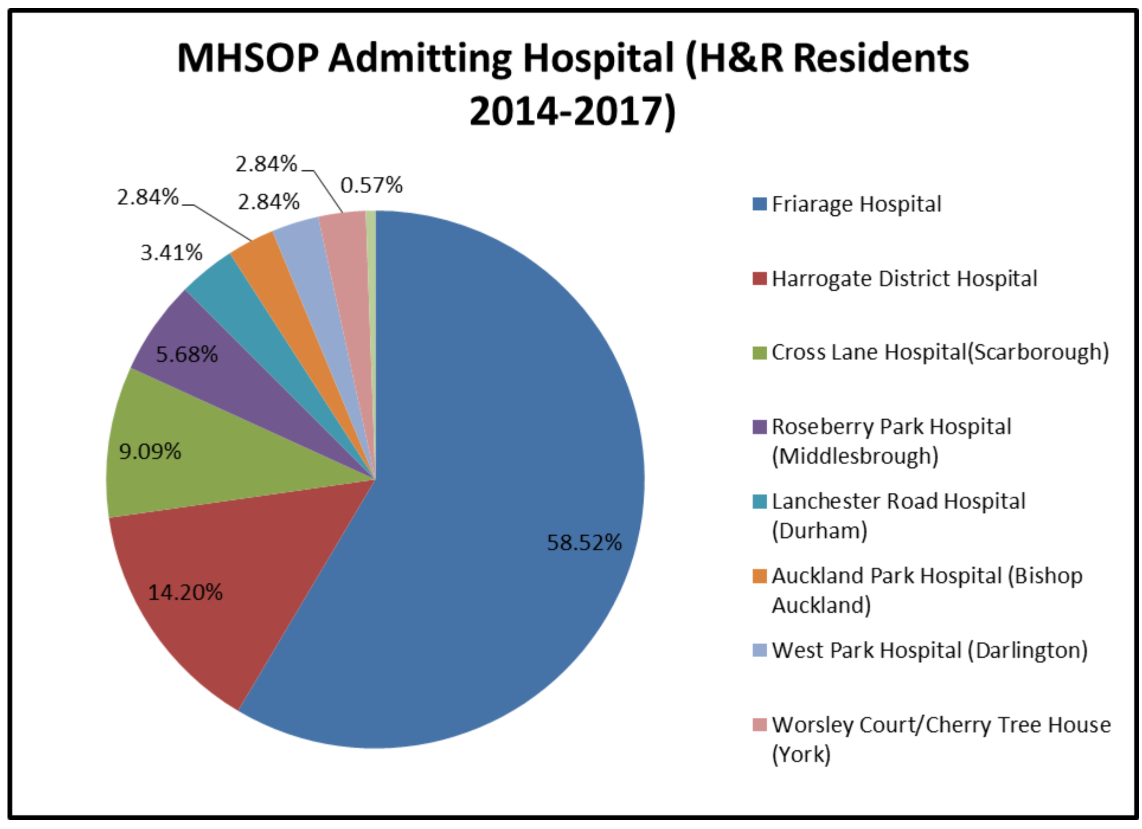
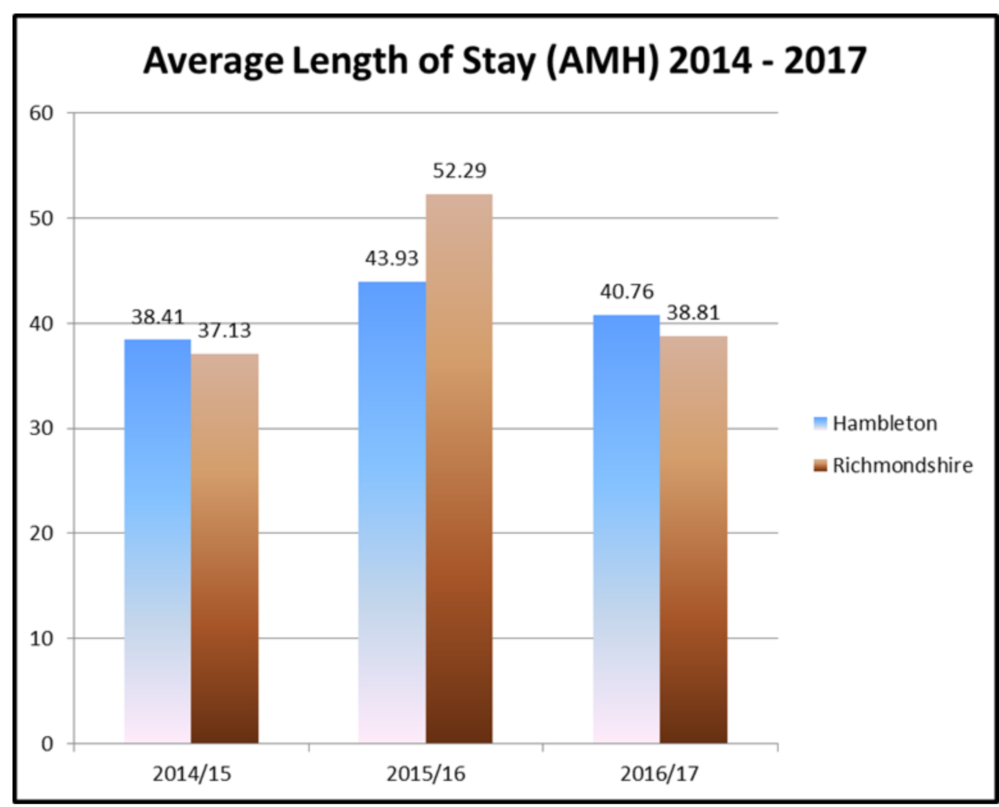




**Figure 8: Location of current admission**

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:



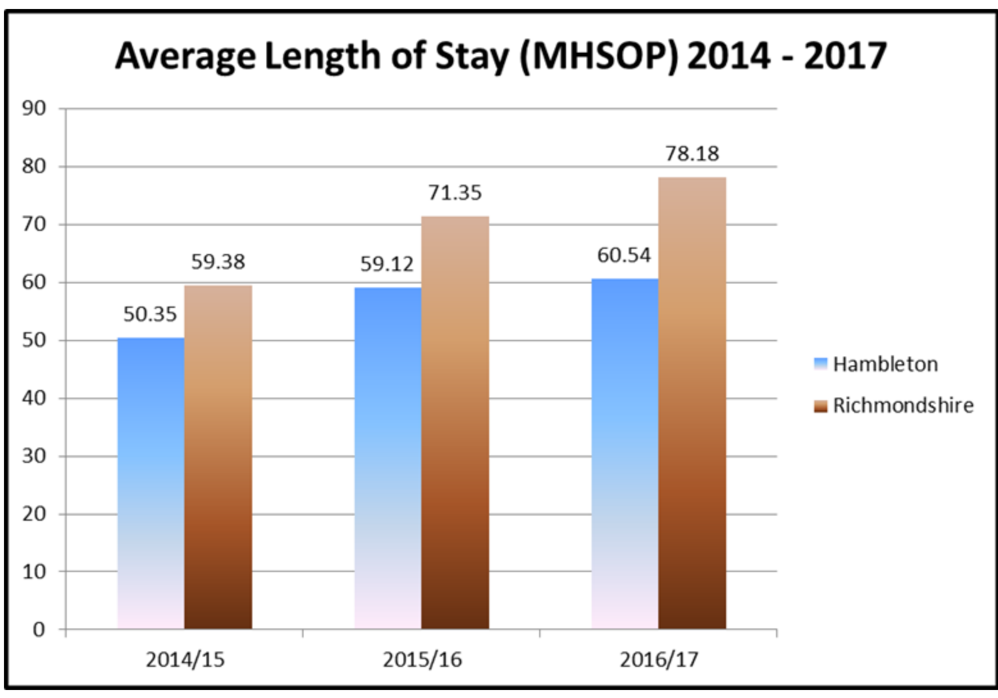




**Figure 9: Length of stay**

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**

<table>
<tr><th>Working Age Adult<br><br>18 to 65 years</th><th>Older persons<br><br>65years<br><br>Functional and organic mental disorders</th></tr>
<tr><td>Operates 7 days a week 24hours a day<ul><li>Consultant-led</li><li>12 Beds – mixed sex accommodated</li><li>Junior doctor rotation</li></ul></td><td>Operates 7 days a week<ul><li>Consultant-led</li><li>10 Beds – functional organic mixed sex accommodated</li><li>Junior doctor rotation</li></ul></td></tr>
<tr><td colspan="2"><ul><li>Joint consultant and junior doctor on call</li><li>Specialist psychiatric intensive care (PICU) – Darlington and Teesside</li><li>Open rehabilitation beds – Orchards, Ripon</li><li>MHSOP access to Complex Care/Challenging behaviour inpatients from Springwood Malton</li><li>Locked rehabilitations – individually funded</li></ul></td></tr>
</table>

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 11months. 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 sign-post 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, compromising 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 dementia[6] 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.

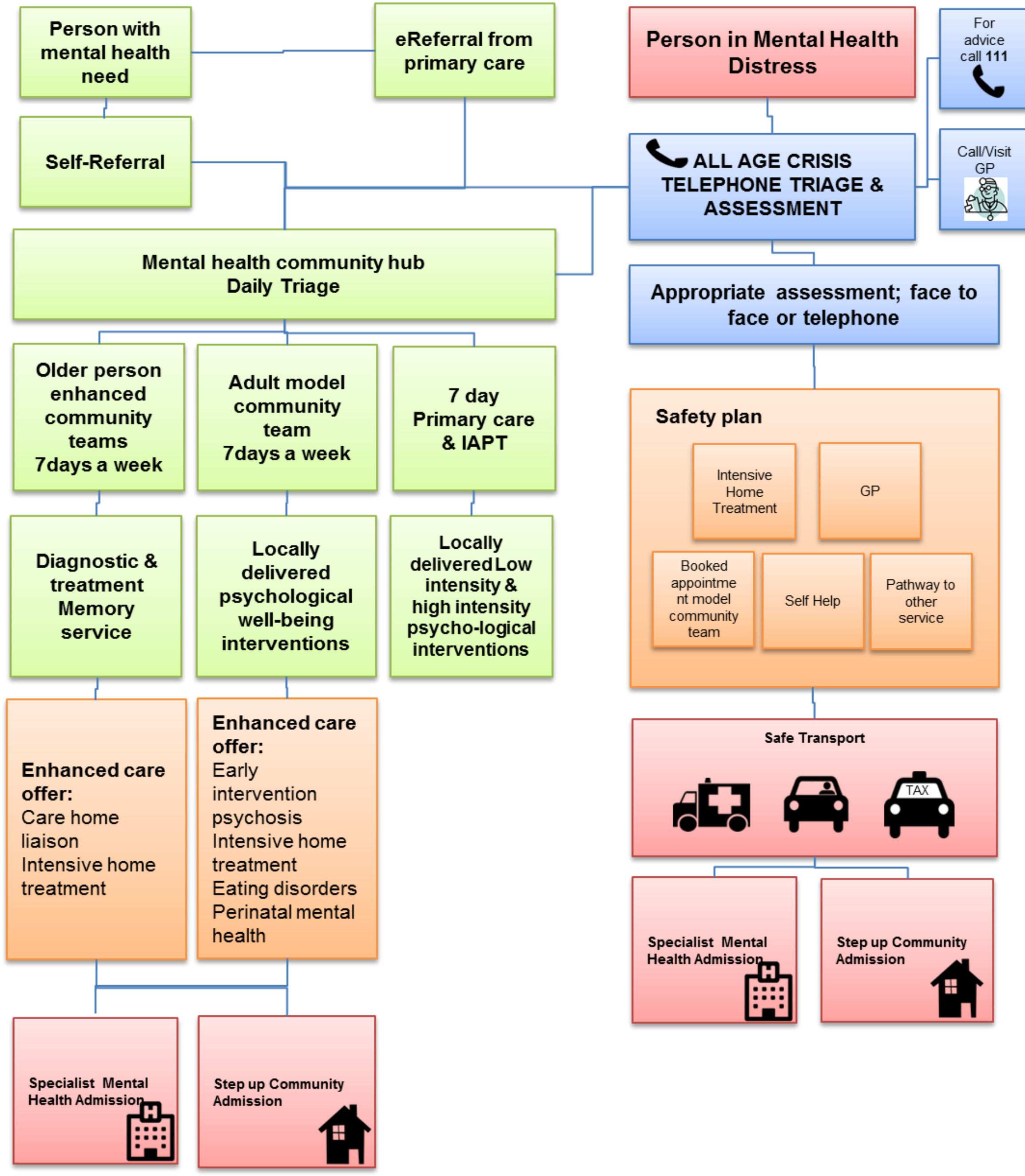



**Figure 10: Alternative mental health model**

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 Richmondshire[7] 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.

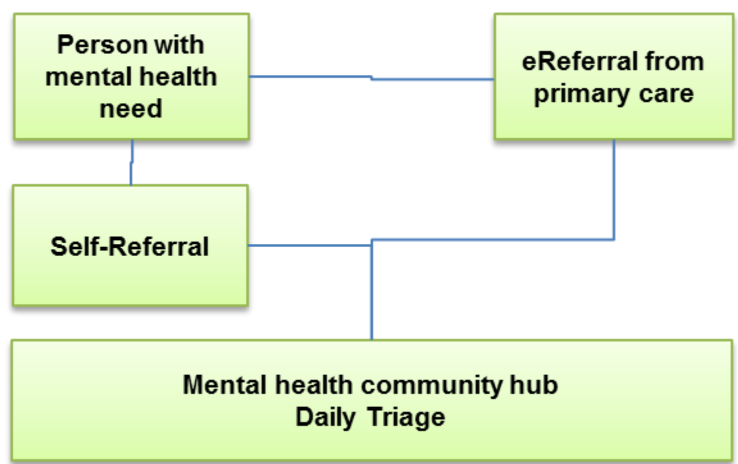



**Figure 11: Triage and access to community services**

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.

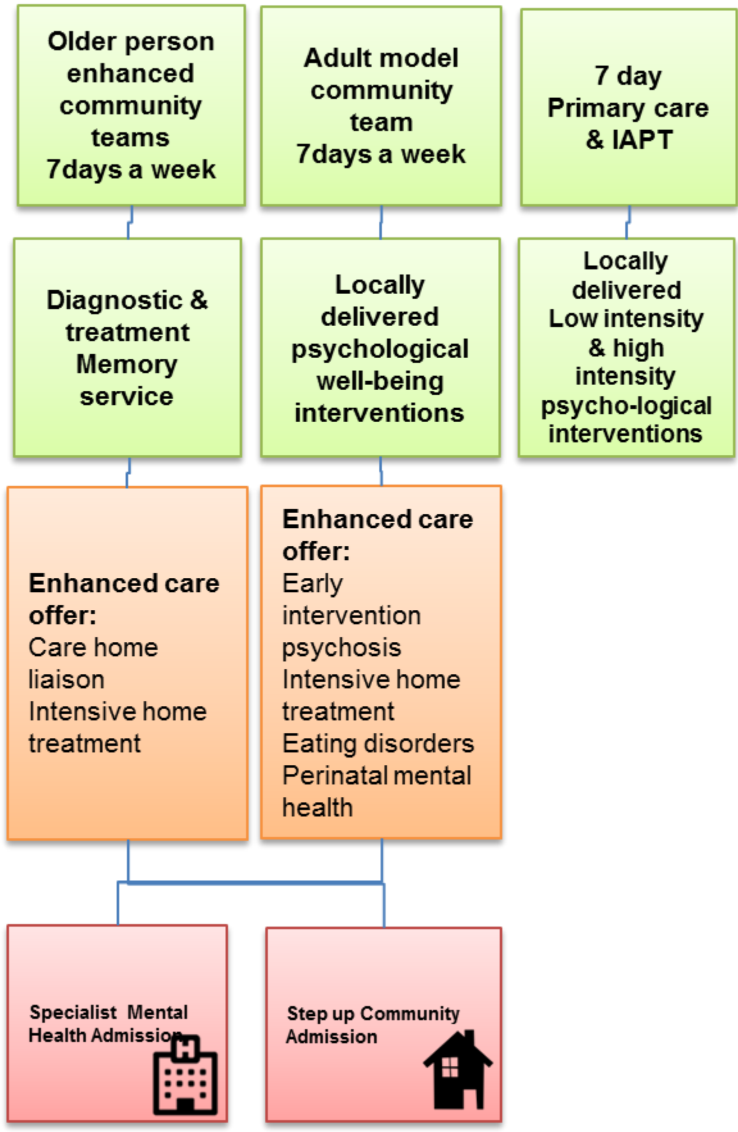



**Figure 12: Enhanced community services**

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 persons 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. *Triaging 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.

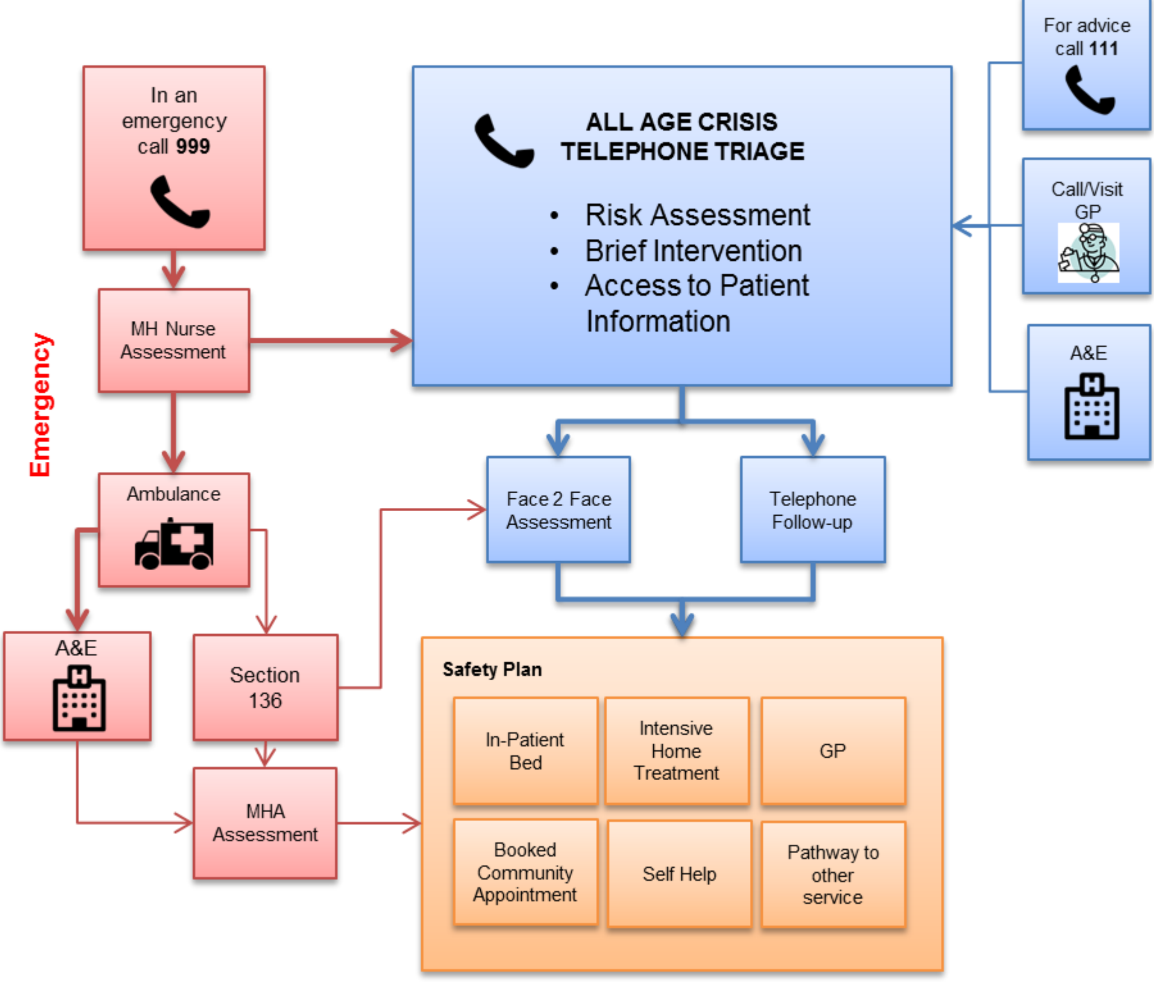



**Figure 13: All age crisis service model**

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 if 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 form 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 en-suite 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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**<br><br>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.<br><br>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.<br><br>Memory services will be able to consistently provide a diagnosis and access to relevant treatment within 4 weeks of referral.<br><br>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.<br><br>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.<br><br>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.<br><br>Older people, especially with organic needs, will benefit from dedicated care home liaison to reduce the need for them to be admitted to hospital.<br><br>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.<br><br>Increased workforce opportunities for support staff and specialist roles, assisting with staff recruitment and retention.<br><br>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.<br><br>**Disadvantages**<br><br>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.<br><br>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.<br><br>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.<br><br>**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** | 2013<br>- Launch of Fit 4 the Future with a number of local focus groups to scope a vision for Hambleton and Richmondshire and Whitby.<br>- Vision documents shared with members of the public and used as a further discussion document to seek further views<br>2014<br>- Stakeholder and patient engagement to develop an understanding of strengths and weaknesses and explore opportunities, forming a direction of travel for community services<br>- 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<br>2015<br>- Testing the direction of travel with members of the public and local stakeholders<br>- Launch of the Dales Project to undertake detailed scoping with clinical teams with a view to piloting new models of care<br>- Clinical summit attended by over 200 stakeholders<br>2016<br>- 'Transforming our Communities' consultation<br>2017<br>- 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 |
|---|---|
| **and prospective need for patient choice** | - care closer to home is achieved whilst also commissioning safe and sustainable services which are fit for the future.<br>- 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<br>- Development of an integrated locality team to ensure that patients are better supported in the community reducing the requirement for admission into hospital |
| **Clear clinical evidence base** | 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. |
| **Support for proposals from clinical commissioners** | 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. |

## 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.

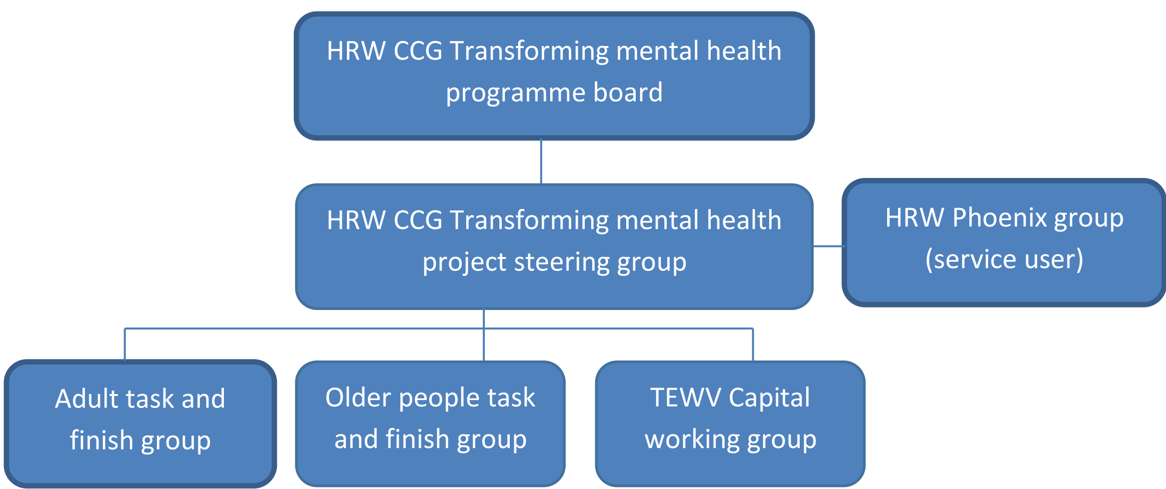
**Quoracy**

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.

**Appendix 2: Communication and engagement strategy**

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.

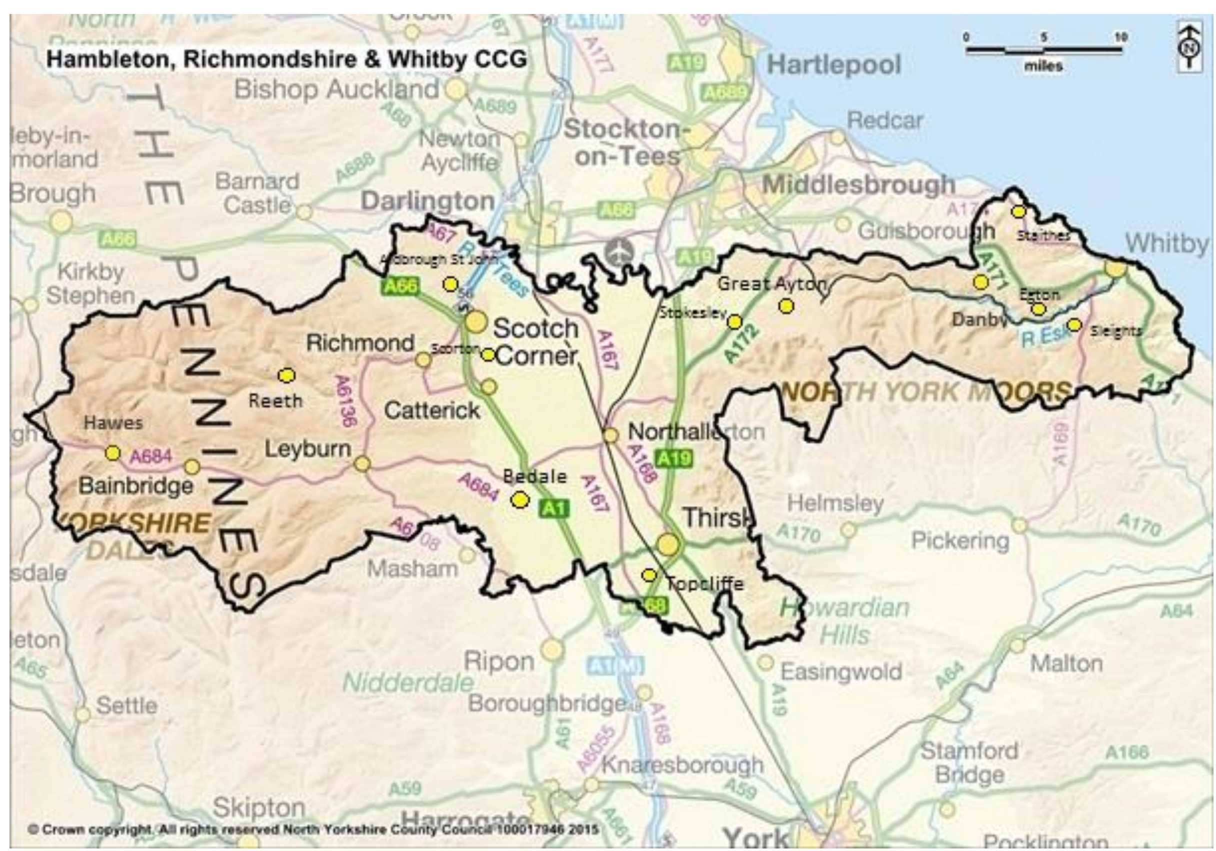



**Fig 1: Map of NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group boundary with GP practices**

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.

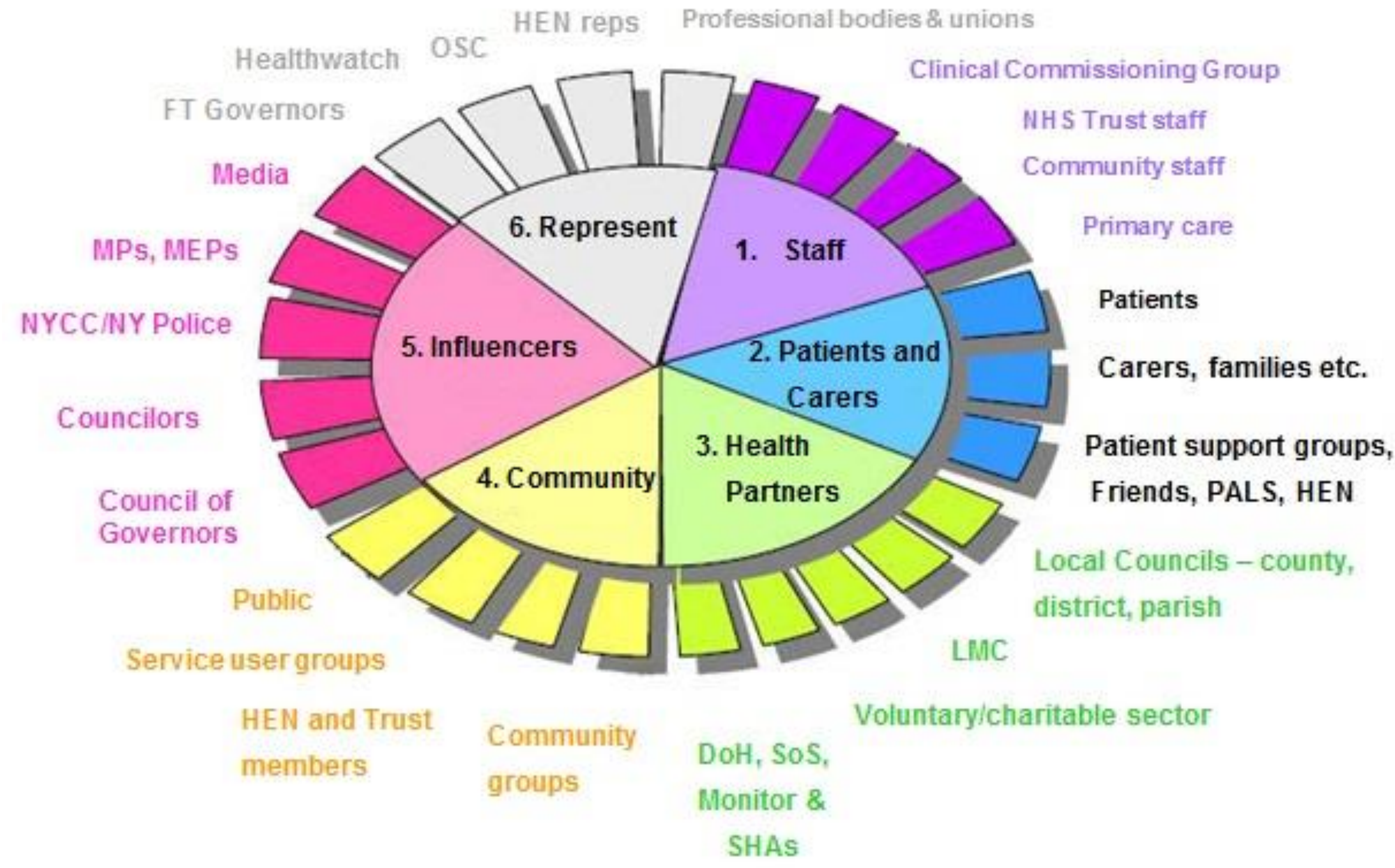
There are a wide range of stakeholders who will have varying degrees of interest in and influence on the acute care services agenda.

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 relatable to this programme or work begin 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

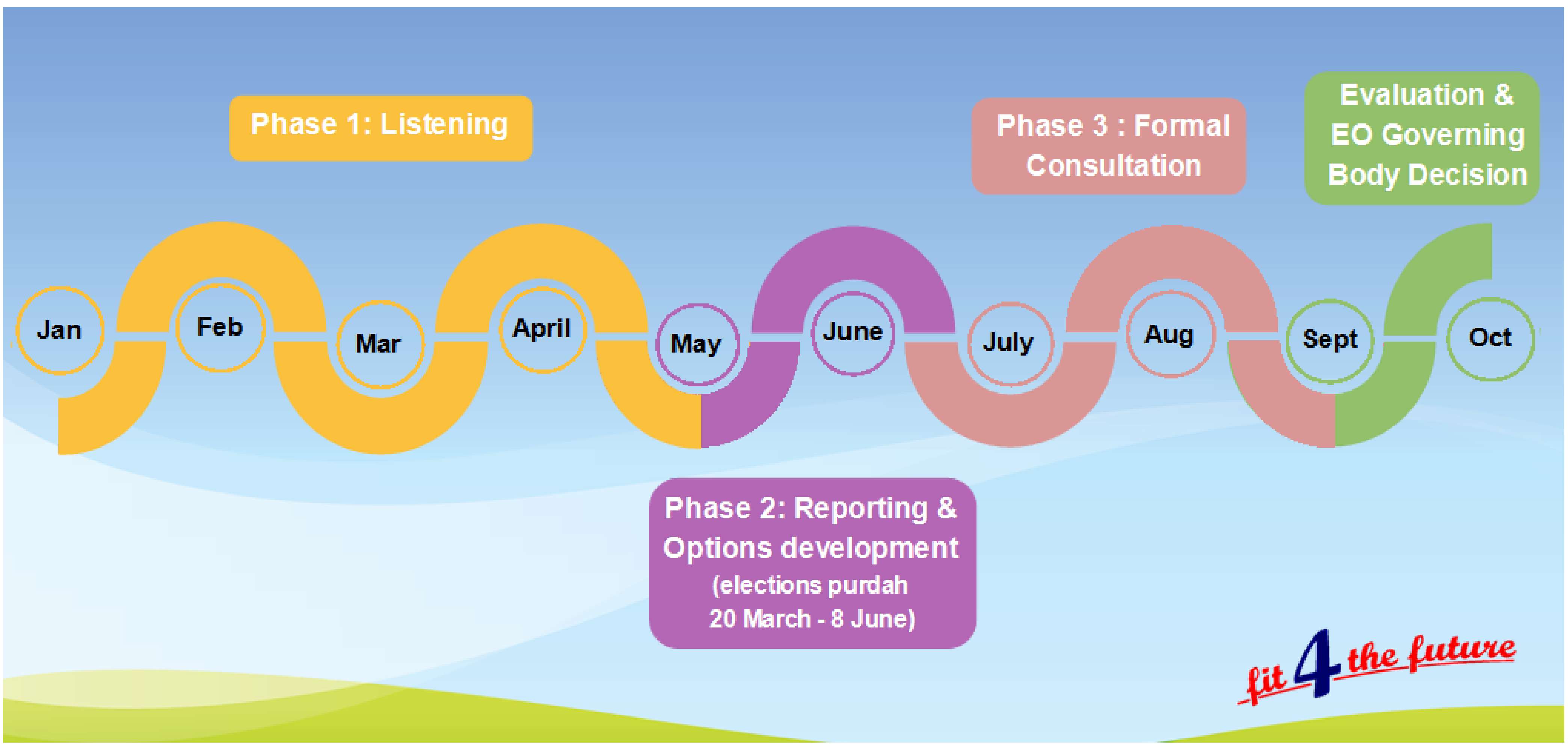
This strategy acknowledges two separate elections (local and national) taking place within the timeframe of the pre-consultation engagement phase. The consultation will abide by national guidelines for periods of purdah (the pre-election period).

## 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<br>TEWV staff<br>STHFT staff<br>Governing Bodies<br>HEN Reps | Briefings circulated | GS/JJ | 27.02.17 |
| MPs<br>NY Scrutiny Committee<br>Councillors | JP to brief via email/ telephone/meeting prior to circulation of briefing:<br>• Rishi Sunak MP<br>• Kevin Hollinrake MP<br>• 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:<br><br>• LMC<br>• GPs<br>• Pharmacies<br>• Dentists<br>• TEWV adult and MHSOP inpatient and community staff<br>• NHS partner organisations including other CCGs (if clinical)<br><br>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:<br><br>• County and Local Councillors<br>• Parish Councillors<br>• Voluntary sector organisations<br>• Non NHS partner organisations<br>• PPGs<br>• Health Engagement Network members<br>• Trust governors<br>• Trust members<br>• Service users and carer groups<br>• North Yorkshire Police<br>• HealthWatch<br><br>Include dates, venues and timings and public/stakeholder engagement events. | GS/JJ | 27.02.17 |
| Wider public | Create dedicated website page<br><br>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<br>• 10 May, Northallerton<br>• 11 May, Richmond | GS/JJ | 18.04.17 |
| Service users/public | Media release inviting to open engagement sessions<br>• 10 May, Northallerton<br>• 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<br>TEWV staff<br>STHFT staff<br>Governing Bodies<br>HEN Reps | Briefings circulated to include draft options, event details and next steps | GS/JJ | 12.06.17 |
| MPs<br>NY Scrutiny Committee<br>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:<br>• GPs<br>• Pharmacies<br>• Dentists<br>• TEWV adult and MHSOP inpatient and community staff | GS/JJ | 12.06.17 |

| Audience | Mechanism | Attended/actions by | Proposed/ completed date |
|---|---|---|---|
| | • NHS partner organisations including other CCGs (if clinical) | | |
| Wider stakeholders | Briefings circulated to include draft options, event details and next steps:<br><br>• County and Local Councillors<br>• Parish Councillors<br>• Voluntary sector organisations<br>• Non NHS partner organisations<br>• PPGs<br>• Health Engagement Network members<br>• Trust governors<br>• Trust members<br>• Service users and carer groups<br>• North Yorkshire Police<br>• 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 | Media release to Hambleton & Richmondshire media contacts to include draft options, event details and next steps **(subject to scrutiny approval)**<br><br>Offer interviews with senior CCG/PCU/TEWV representatives. | GS/JJ | 23.06.17 |
| Wider public | Update website page<br><br>Post on social media channels<br><br>Include information in relevant newsletters<br><br>Update posters and circulate | GS/JJ | 23.06.17 |

| Audience | Mechanism | Attended/actions by | Proposed/ completed date |
|---|---|---|---|
| | Update video and circulate<br><br>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 |
|---|---|---|
| • Osmotherley<br>• Wensleydale<br>• Kildale<br>• Borrowby<br>• Reeth<br>• Borrowby<br>• Moorcock<br>• Muker | • Thirsk<br>• Northallerton<br>• Stokesley<br>• Bedale<br>• Catterick<br>• Leyburn<br>• Colburn<br>• Hawes | • Age UK Northallerton<br>• Alzheimer's Society<br>• Broadacres<br>• Dementia Collaborative<br>• Leyburn Bipolar Group<br>• MENCAP<br>• Mental Health Forum<br>• Mental Health Support<br>• Mind<br>• Northdale<br>• Over 50s Forum<br>• Phoenix Group<br>• Rethink Mental Health<br>• Rural Action Yorkshire<br>• Sporting Memories |
| **Market stalls** | **GP practices** | **Other** |

| Agricultural shows | Libraries | Community groups |
|---|---|---|
| • Northallerton<br>• Thirsk<br>• Stokesley<br>• Leyburn<br>• Hawes<br>• Richmond | • Catterick and Colburn Medical Group, Catterick<br>• Central Dales Practice, Hawes<br>• Doctor's Lane Surgery, Aldbrough St John<br>• Glebe House Surgery, Bedale<br>• Great Ayton Health Centre, Great Ayton<br>• Harewood Medical Practice, Catterick Garrison<br>• Lambert Medical Centre, Thirsk<br>• Leyburn Medical Practice, Leyburn<br>• Mayford House Surgery, Northallerton<br>• Mowbray House Surgery, Northallerton<br>• Quakers Lane Surgery, Richmond<br>• Reeth Medical Centre, Reeth<br>• Scorton Medical Centre, Scorton<br>• Stokesley Health Centre, Stokesley<br>• The Doctors' Surgery, Thirsk<br>• The Friary Surgery, Richmond<br>• Topcliffe Surgery, Topcliffe | • Friarage Hospital<br>• Healthwatch North Yorkshire<br>• WIs<br>• 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 |
| TEWV 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<br><br>TEWV staff<br><br>STHFT staff<br><br>Governing Bodies<br><br>HEN Reps | Briefings circulated with decision and next steps | GS/JJ | 19.09.17 |
| MPs<br><br>NY Scrutiny Committee<br><br>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:<br><br>• GPs<br>• Pharmacies<br>• Dentists<br>• TEWV adult and MHSOP inpatient and community staff<br>• NHS partner organisations including other CCGs (if clinical) | GS/JJ | 19.09.17 |

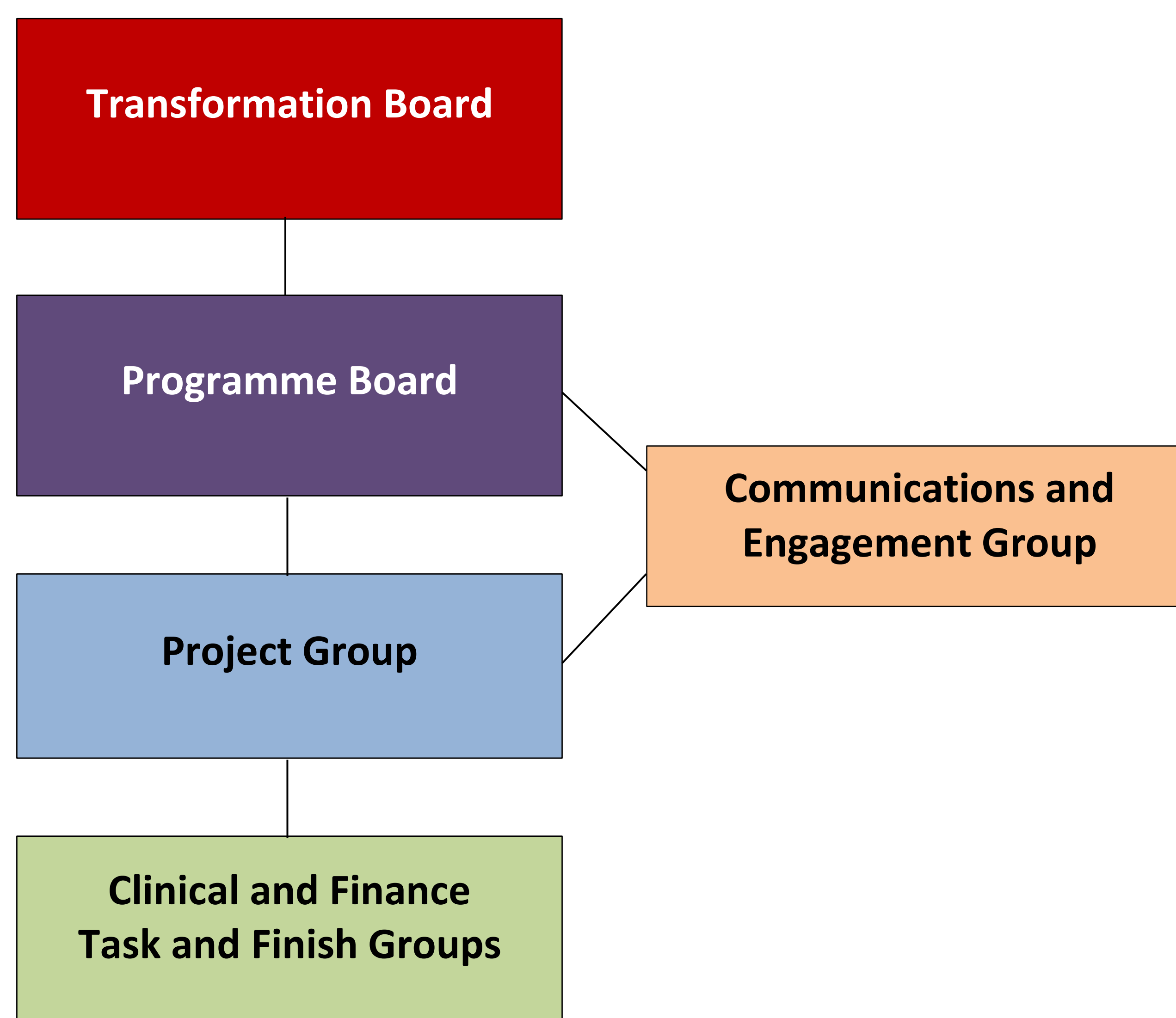
| Audience | Mechanism | Attended/actions by | Proposed/ completed date |
|---|---|---|---|
| Wider stakeholders | Briefings circulated to include draft options, event details and next steps:<br>• County and Local Councillors<br>• Parish Councillors<br>• Voluntary sector organisations<br>• Non NHS partner organisations<br>• PPGs<br>• Health Engagement Network members<br>• Trust governors<br>• Trust members<br>• Service users and carer groups<br>• North Yorkshire Police<br>• 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 TEWV 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 |
| Cygnet 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 |

Appendix 3: Public engagement sessions

# Transforming Mental Health Services

## Hambleton and Richmondshire

## Pre-consultation engagement

# Events summary report

**Wednesday 10 May, Northallerton**

**Thursday 11 May, Richmond**

@HRW_CCG

@TEWV

facebook.com/HRWCCG

facebook.com/TEWV.ft

# 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.

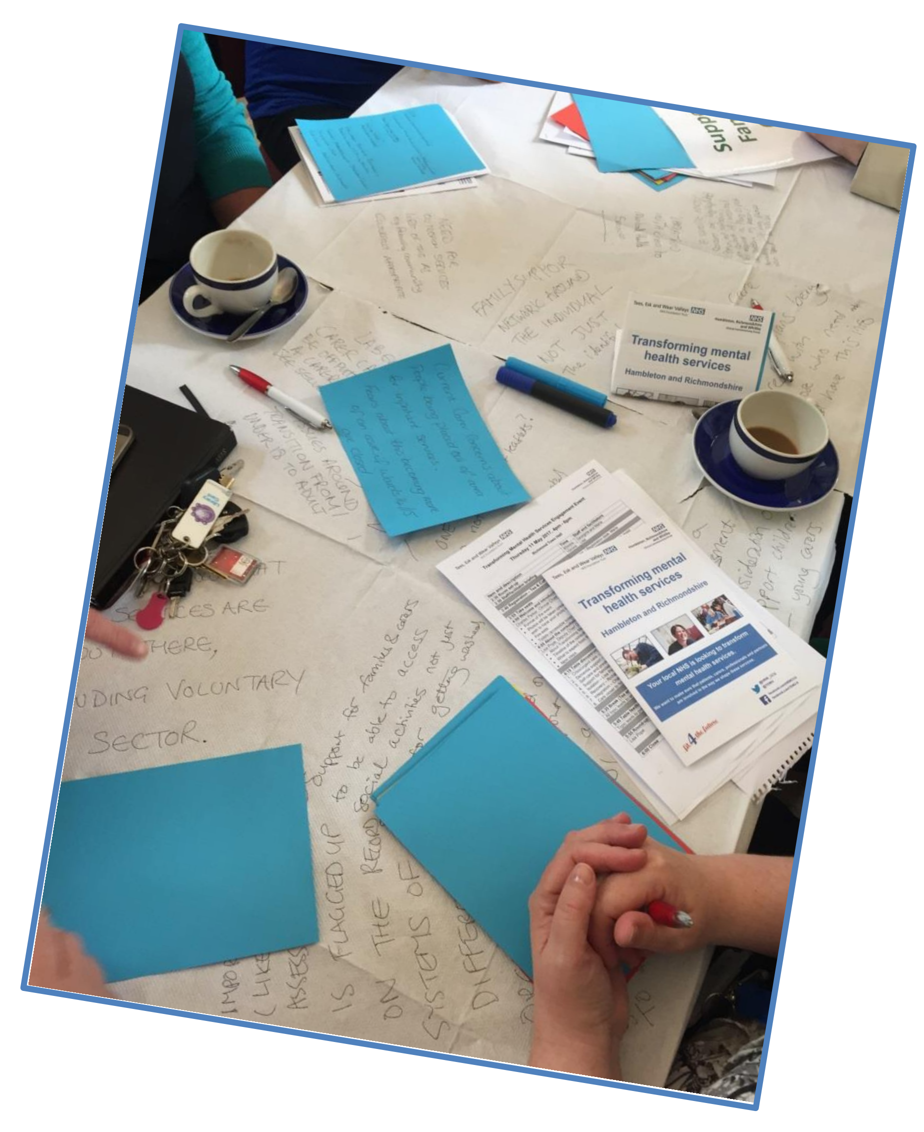
**Janet Probert**
**Chief Officer**
NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group

**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:

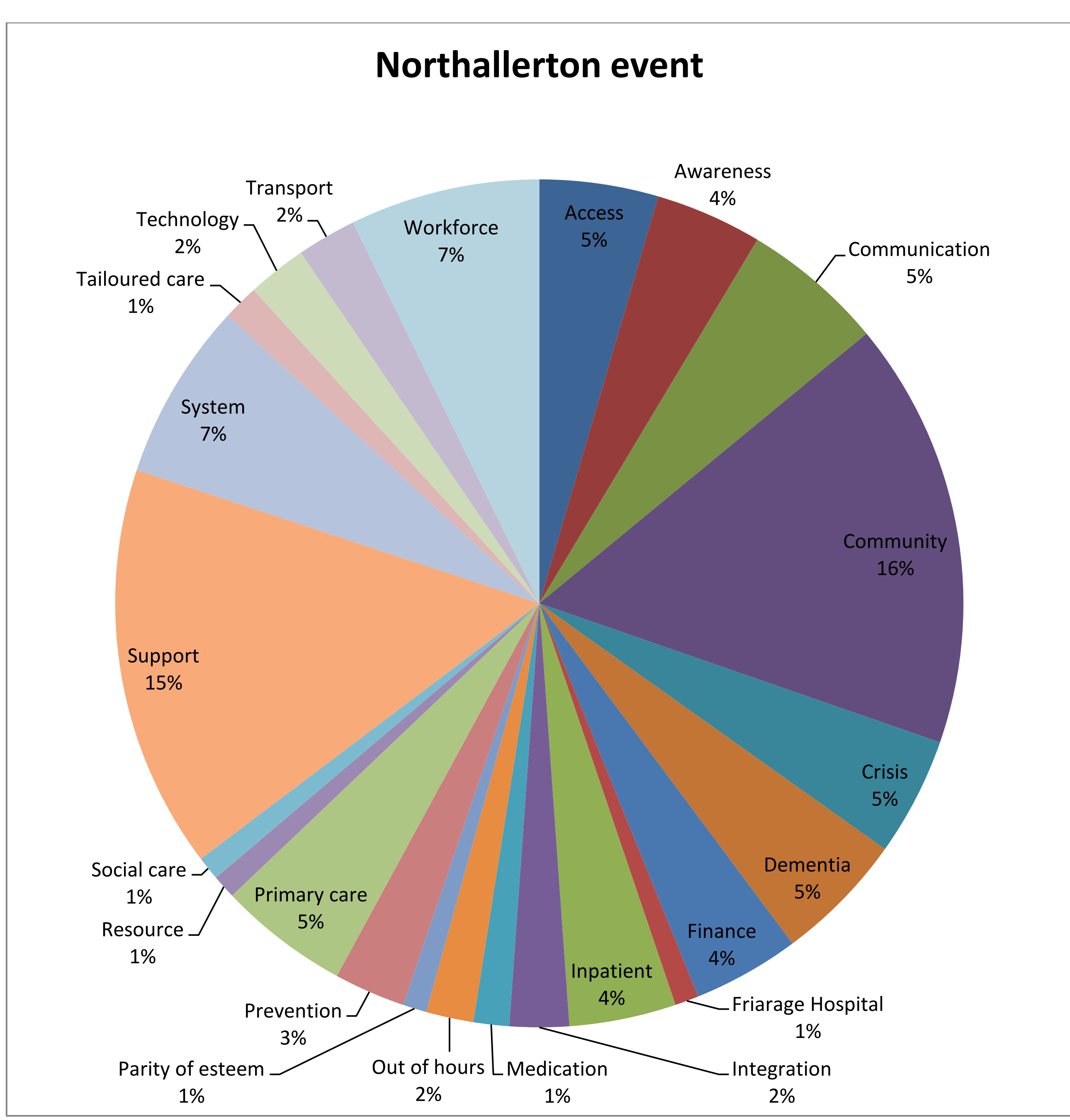
- Wednesday 10 May, Northallerton – 42
- Thursday 11 May, Richmond – 22

## 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**

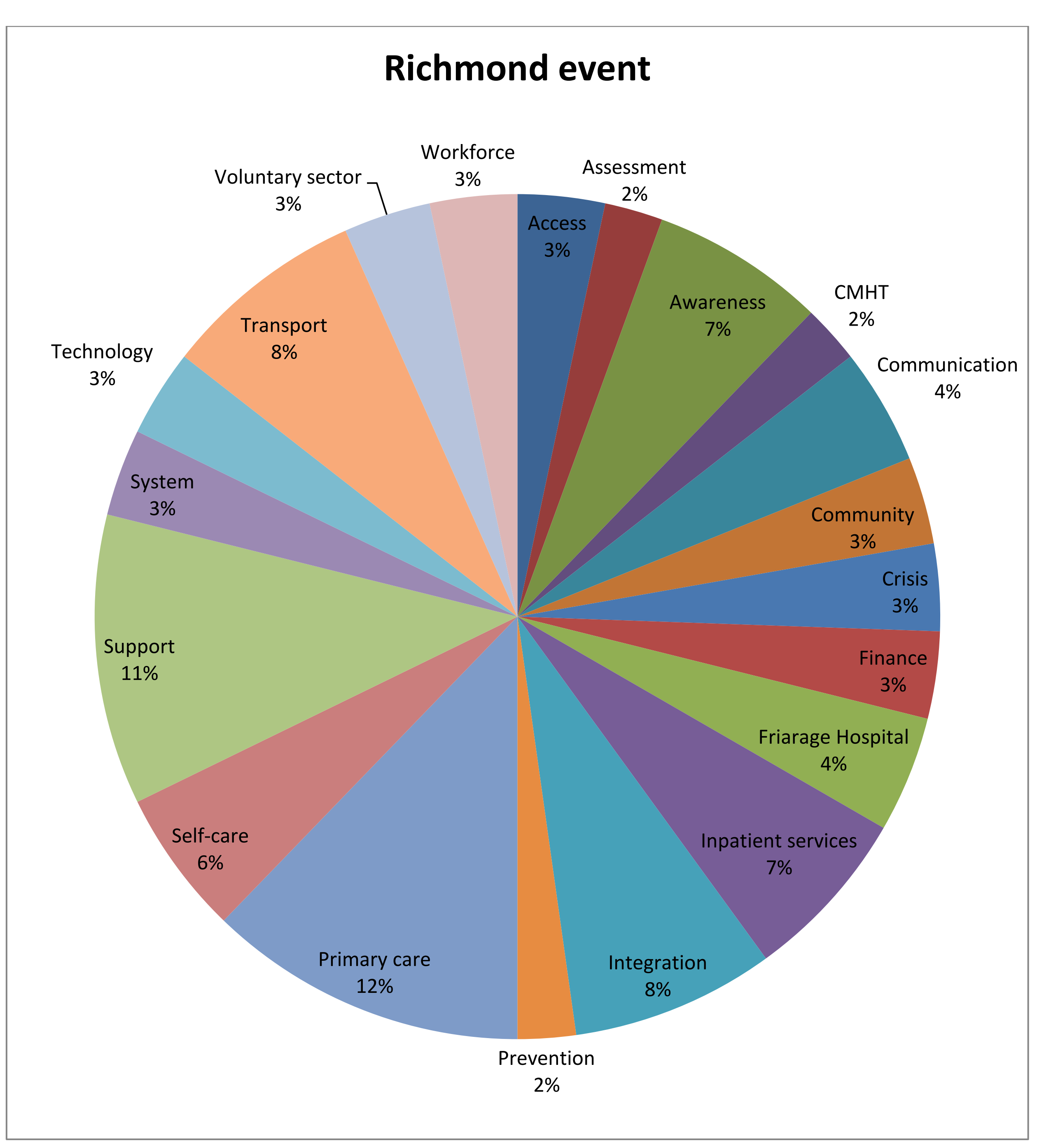
Further themes have been identified and are captured in the chart below:




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
Access 3%
Assessment 2%
Awareness 7%
CMHT 2%
Communication 4%
Community 3%
Crisis 3%
Finance 3%
Friarage Hospital 4%
Inpatient services 7%
Integration 8%
Prevention 2%
Primary care 12%
Self-care 6%
Support 11%
System 3%
Technology 3%
Transport 8%
Voluntary sector 3%
Workforce 3%

## 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)**

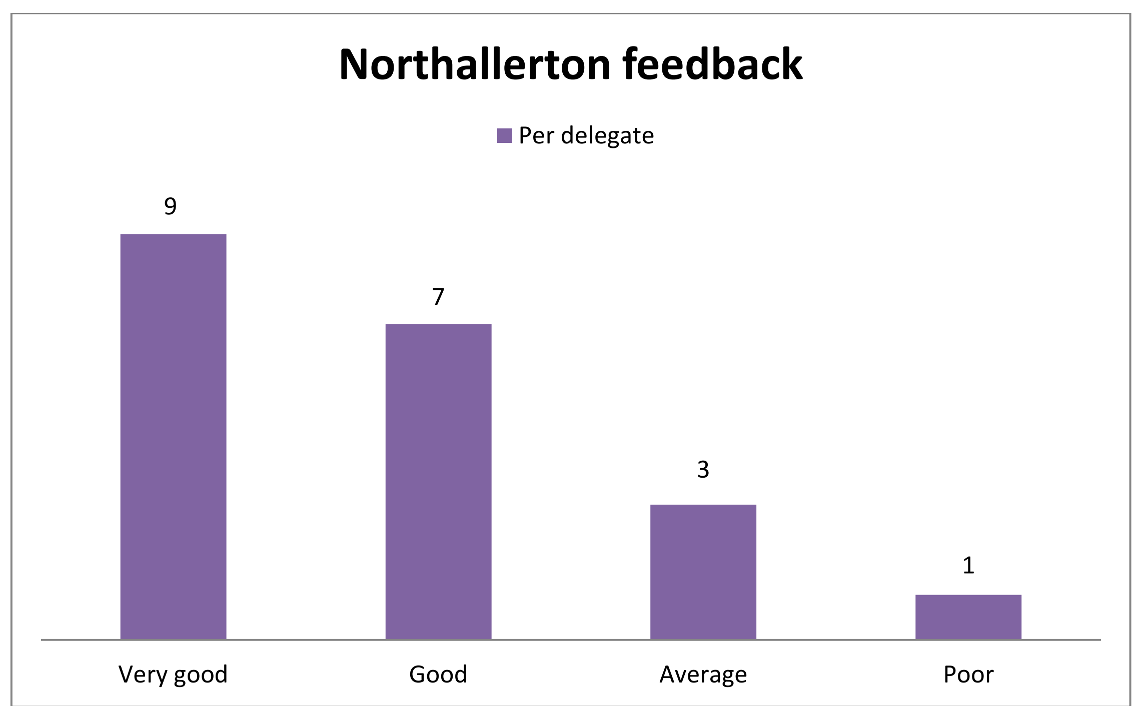
- Mental and physical health are interconnected need to be soon as such
- Why couldn't psychiatrists /psychologists
- Learning a way of coping and hoping not a cure
- Transport is an important issue for family and carers
- Point of contract IAPT needs to be more available
- How long is a piece of string - 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

<u>10 May – Northallerton</u>

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




**Positive comments included:**

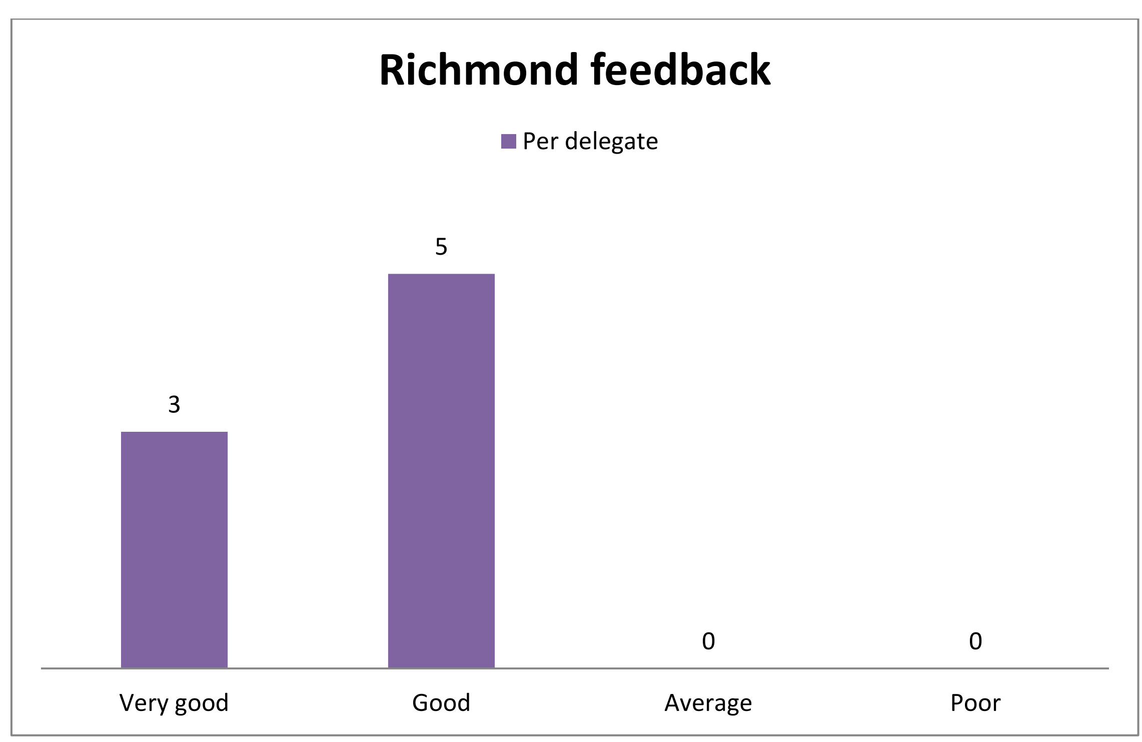
*"Well-structured table discussion and brainstorming"*

**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"*

<u>11 May – Richmond</u>

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 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 | Beds | Current State WTE | £ | Future State | Beds | Future State 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 | WTE (Current State) | £ (Current State) | Future State | Beds | WTE (Future State) | £ (Future State) |
|---|---|---|---|---|---|---|---|
| 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.

Appendix 6: Equality Impact Assessment

| **1. EQUALITY IMPACT ASSESSMENT**<br>**Please refer to equality and sustainability impact assessment guidance and local profiling data before completing** | |
|---|---|
| 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<br>Service Improvement Manager<br>Hambleton, Richmondshire and Whitby Clinical Commissioning Group |
| What are the aims and intended effects of this policy, project of function? | This project aims to transform key elements of mental health provision by:<br>• 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<br>• Providing assessment and treatment to patients and carer support when they need it, whatever time of day or night<br>• Supporting access to specialist assessment and treatments such as inpatient care, when required<br>• Providing evidence-based treatment in the most appropriate care setting<br>• Retaining our local identity to ensure we can continue to work closely with general practice<br>• Delivering services in high quality fit for purpose buildings across inpatient and community services.<br><br>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 |

| | |
|---|---|
| | health services.<br><br>The plans will be delivered through an overarching work programme for Mental Health as articulated at Appendix 1. |
| Please list any other policies that are related to or referred to as part of this analysis: | 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.<br>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.<br><br>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. |

| Who does this policy, project or function affect?: | Employees | X | Service Users | X | Members of the Public | X | Other (List below) | |
|---|---|---|---|---|---|---|---|---|

| 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:<br>**Ethnic Origin** **Number of People** **Percentage of population** |

| **White** | **146965** | **97.3%** |
|---|---|---|
| English/Welsh/Scottish/Northern Irish/British | 144052 | 95.4% |
| Gypsy or Irish Traveller | 151 | 0.1% |
| Irish | 523 | 0.3% |
| Other White | 2239 | 1.5% |
| **Mixed/multiple ethnic group** | **1155** | **0.8%** |
| Other Mixed | 313 | 0.2% |
| White and Asian | 390 | 0.3% |
| White and Black African | 125 | 0.1% |
| White and Black Caribbean | 327 | 0.2% |
| **Asian/Asian British** | **1931** | **1.3%** |
| Bangladeshi | 61 | 0.0% |
| Chinese | 227 | 0.2% |
| Indian | 287 | 0.2% |
| Other Asian | 1191 | 0.8% |
| Pakistani | 165 | 0.1% |
| **Black/African/Caribbean/Black British** | **681** | **0.5%** |
| African | 337 | 0.2% |
| Caribbean | 125 | 0.1% |
| Other Black | 219 | 0.1% |
| **Other ethnic group** | **297** | **0.2%** |
| Any other ethnic group | 230 | 0.2% |
| Arab | 67 | 0.0% |
| **Grand Total** | **151029** | **100.0%** |

Age:

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.
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

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:

- 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

| | |
|---|---|
| | • Reliance on public transport is significantly higher in this group3. This has an impact on accessibility of services for this group |
| Sexual Orientation: | 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. |
| Disabled People: | 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.<br>There are numerous health inequalities associated with learning disabilities (see www.northyorks.gov.uk/CHttpHandler.ashx?id=19174&p=0 )<br>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. |
| Gender: | See table below. 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.<br>The gender breakdowns for Hambleton, Richmond and Whitby and projections (Office of National Statistics). |

| | **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** |

| | |
|---|---|
| Transgender People: | 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.<br>The Gender Identity Research and Education Society (GIRES) suggests that across the UK:<br>• 1% of employees and service users may be experiencing some degree of gender variance.<br>• At some point, about 0.2% may undergo transition (i.e. gender reassignment).<br>• 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.<br><br>More than one in three people who are described by the Equality Act 2010 definition of gender reassignment have attempted suicide.<br>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. |
| Pregnancy & Maternity: | 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).<br>Conception rate per 1000 for 15 – 17 year olds was at 21.6 (Health Profile 2015)<br>1274 deliveries were completed in 2015-16 across the locality.<br><br>It is recognised that targeted services are required for women during and post pregnancy. |
| Marital Status: | 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. |

| Religion & Belief: | | | 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. |
|---|---|---|---|
| | 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.<br>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.<br>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 |

| | |
|---|---|
| | stakeholders and the wider public in relation to the proposed model. |
| Promoting Inclusivity: How does the policy, project or function contribute towards our aims of eliminating discrimination & promoting equality and diversity within our organisation | This project aims to promote equality of services by:<br>• Reducing inequity of services across the localities of Hambleton and Richmondshire<br>• Reduce the financial and emotional strain currently faced by many communities required to travel excessive distances to receive community inpatient are. |

## 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**<br>(Men and Women) | X | | | |
| **Race**<br>(All Racial Groups) | X | | | |
| **Disability**<br>(Mental and Physical | X | | | |
| **Religion or Belief** | X | | | |
| **Sexual Orientation**<br>(Heterosexual, Homosexual and Bisexual) | X | | | |
| **Pregnancy and Maternity** | X | | | |
| **Transgender** | X | | | |
| **Marital Status** | X | | | |

| | | | | |
|---|---|---|---|---|
| **Age** | | X | | 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:<br><br>Graph 1: Distribution of population and tariff based acute hospital spend by age band<br><br>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 *et al* 2007; Lafont *et al* 2011). |

## 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: |
| 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. | | | | |
| | | | | |
| | | | | |
| | | | | |

## 7. FINDINGS

| Analysis Rating: | Red | Red/Amber | Amber | Green |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ | X |

| Rating | Notes | Actions | Wording for Policy/Project/Function |
|---|---|---|---|
| Red<br><br>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**<br>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<br><br>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**<br>a) List the justification of the discrimination and source the evidence (i.e. clinical need as advised by NICE)<br>b) Consider if there are any potential actions which could reduce the risk of discrimination.<br>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.<br>[***Insert the nature and justification of the discrimination, plus any actions which could help reduce the risk***] |
| Amber<br><br>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**<br>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) |

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

| 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)<br><br>Negative (N) | Risk score CxL | Comments to support assessment |
|---|---|---|---|---|---|---|
| **Quality** | **Duty of Quality** | Could the proposal impact adversely on any of the following:<br>a) Compliance with NHS constitution<br>b) Partnerships<br>c) Safeguarding children or adults | No | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | **Equality** | Could the proposal impact on any of the following protected characteristics and our duty to comply with?<br><br>1. Age<br>2. Disability<br>3. Race<br>4. Religion or belief<br>5. Sex<br>6. Sexual orientation<br>7. Gender re-assignment<br>8. Pregnancy and maternity<br>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.<br><br>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.

# Hope Control and Choice; North Yorkshire Mental Health Strategy: Key Achievements…

Kashif Ahmed
Health & Adult Service
Commissionig
NYCC

## Providers of Mental Health Services in North Yorkshire from October 2015

### Services provided by North Yorkshire County Council

| Team | Service |
| --- | --- |
| Adult Social Care | • Commissioning, funding and contracts for social care support such as day time activities, support groups<br>• Approved Mental Health Practitioners, and Mental Health Act assessments and reports<br>• Care Act Assessments and personal budgets<br>• Short term Recovery Workers<br>• Community Support Officers<br>• Supported Employment service |
| Children and Young People's Services | • Commissioning, planning and service provision for children and young people's education and support<br>• Early years support<br>• Education services,<br>• Looked after children,<br>• Support for disabled children and their families,<br>• Youth justice |
| Public Health | • Surveillance and assessment of the population's health and wellbeing<br>• Assessing the evidence of effectiveness of health and healthcare interventions, programmes and services<br>• Policy and strategy development and implementation<br>• Strategic leadership and collaborative working for health<br>• Public Health Intelligence<br>• Commissioning, funding and contracts for Health Improvement services – including public mental health, suicide prevention, stop smoking; drugs and alcohol; lifestyle and weight management |

### Services provided by NHS Organisations

| Organisation | Service |
| --- | --- |
| Clinical Commissioning Groups (see map):<br>• Hambleton, Richmondshire and Whitby<br>• Harrogate and Rural District<br>• Scarborough and Ryedale<br>• Vale of York<br>• Airedale, Wharfedale and Craven<br>• Cumbria | • Commissioning community and secondary mental and physical health services<br>• Provision of primary health services |
| Community and secondary Mental health services:<br>• Tees Esk Wear Valley NHS Trust (for Hambleton Richmondshire and Whitby, Harrogate and Rural District, Scarborough and Ryedale and Vale of York )<br>• Bradford District Care Trust for Craven | • Talking therapies, early intervention, crisis intervention, community health teams, in-patient beds for all ages<br>• Child and Adolescent Mental Health Services<br>• Psychiatric liaison in-reach to acute hospitals |
| Acute And Community Health Trusts:<br>• South Tees<br>• York and Scarborough<br>• Harrogate<br>• Airedale | • Acute health services |
| NHS England | Specialised services including:<br>• Secure and forensic series<br>• Tier 4 services for Child and Adolescent Mental health and Personality Disorders<br>• Gender Identity<br>• Services for those with serious perinatal problems;<br>• Eating disorders<br>• Services for the deaf |

# Key Achievements: 2016/17

| Service Areas | What we have done: | Achievements / Expected benefits |
|---|---|---|
| Public Health: | Public health have awarded grants to organisation across the county to roll out of instructor training around Mental Health First Aid (MHFA) and Assist training which is part of suicide prevention strategy. | ➢ 7 new MHFA trainers in North Yorkshire<br>➢ 10 new ASIST trainers in North Yorkshire<br>➢ 6 ASIST courses delivered (83 participants)<br>➢ 5 MHFA courses delivered (108 participants (total = 191)<br>➢ Overall aim is that MHFA/ASIST training will be delivered to 700 individuals across the county |
| Public Health | In May 2017, the public health team commissioned an organisation to develop an evidence based campaign to promote mental health promotion techniques including the 'Five Ways to Wellbeing'. | |

# Key Achievements: 2016/17

| Service Areas | What we have done: | Achievements / Expected benefits |
|---|---|---|
| Children & Young People | The School Mental Health and Wellbeing Service is now in place and being delivered by Compass REACH. The service aims to provide support to schools to develop a whole school approach to positive mental health by delivering tiered training to school staff and key partners, followed up by expert professional consultation, coaching and mentoring to education staff on the use of brief interventions and targeted group work. | Commissioned a **schools Wellbeing Worker project** to cover all of North Yorkshire. The project will improve early identification and improve access. |
| Children & Young People | Eating disorder offer (FiM funded), delivered by CAMHS service.<br><br>Initiated to reshape specialist education provision for SEMH<br><br>A DfE strategic plan for specialist education provision & improved outcomes for children with SEMH difficulties | - will bring access and waiting times in line with national expectations.<br>- To build a support team around schools that can prevent exclusion and improve outcomes for children and young people with SEMH difficulties. |

# Key Achievements: 2016/17

| Service Areas | What we have done: | Achievements / Expected benefits |
|---|---|---|
| Health – CCG<br><br>Improving Access to Talking Therapies | Work on developing IAPT (Increasing Access to Psychological Therapies) services,<br><br>Harrogate CCG were successful in bidding for national monies (300K) to implement an IAPT service dedicated to persons with Long term conditions.<br><br>Harrogate have also been nominated for a national awarded following the introduction of IAPT working in the maternity department at Harrogate Hospital. | All three North Yorkshire CCGs saw an increased performance in IAPT during 2016/17. All CCGs met the prevalence, 6 and 18 week targets. Hambleton, Richmondshire and Whitby CCG and Harrogate CCG met the national recovery target and Scarborough saw their recovery rate increase from the outset of 2016/17. |

# Key Achievements: 2016/17

| Service Areas | What we have done: | Achievements / Expected benefits |
|---|---|---|
| Health – CCG<br><br>Crisis Care Concordat | - TEWV has secured funding through the Tier 4 vanguard with an on-going commitment to support the delivery of crisis response and intensive home treatment for children and young people in North Yorkshire and York.<br>- Vale of York Clinical Commissioning Group have successfully bid to receive funding of £498K from NHS England to bolster liaison mental health services so that they can deliver prompt access to care 24/7.<br>- North Yorkshire Police has awarded £9.5K to the Major Incident Response Team to develop further capacity and capability in MHFA and ASIST.<br>- CCC group is looking at136 information sharing between partners, availability of Section 12 doctors, AMPs and issues relating transport. | **Access to support before crisis point** - making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.<br>**Urgent and emergency access to crisis care** - making sure that a mental health crisis is treated with the same urgency as a physical health emergency.<br>**Quality of treatment and care when in crisis** - making sure that people are treated with dignity and respect, in a therapeutic environment.<br>**Recovering and staying well** - preventing future crises by making sure people are referred to appropriate services. |

# Key Achievements: 2016/17

| Service Areas | What we have done: | Achievements / expected benefits |
|---|---|---|
| Social Care<br><br>Innovation Fund | The fourth round of Innovation Fund has awarded grants for delivery of 9 early intervention and prevention projects, including 6 which are specifically targeted towards mental health. | Projects will be evaluated later this year on the following outcomes:<br>- Reduction in social isolation/loneliness<br>- Increase participation of physical activity<br>- Increase reporting of wellbeing & independence |
| Social Care<br><br>Mental Health Review | Social Care offer is part of the integrated delivery arrangement with health. A strategic review of HAS mental health services will begin in July 2017.<br>This will include HAS in-house services and commissioned services | - The aim is to ensure there is a NY distinct social care mental health offer which meets local needs and is based on prevention and recovery. |

# Craven Mental Health Locality Plan

# Craven Virtual Map: Current distribution of services

KEY

- VCS
- Substance Misuse
- Older People's CMHT
- Inpatient
- IAPT
- Friends of AGH (Vol Trans)
- Early Intervention Phycosis
- Carers Resource
- County Boundary
- District Boundary

Appendix 1: Strategic priorities, strategic outcomes, strategic commitments and enabling priorities

| Our strategic priorities | | |
|---|---|---|
| Our wellbeing | Our mental and physical health | Care when we need it |
| We will build resilience, promote mental wellbeing and deliver early intervention to enable our population to increase control over their mental health and wellbeing and improve their quality of life and mental health outcomes. | Mental health and wellbeing is of equal importance with physical health. We will develop and deliver care that meets these needs through the integration of mental and physical health and care. | When people experience mental ill health we will ensure they can access high quality, evidence based care that meets their needs in a timely manner, provides seamless transitions and care navigation. |

Strategic outcomes

**People in Bradford district and Craven will:**

be supported to recognise and value the importance of their mental wellbeing and take early action to maintain their mental health through improved prevention, awareness and understanding;

enjoy environments at work, home and in other settings that promote good mental health and improved wellbeing;

experience seamless care and have their physical and mental health needs met through services that are integrated and easily accessible;

reach their maximum potential through services which are recovery focused, high quality and personalised and which promote independence;

expect support to be commissioned and delivered in a way which leads to increases in efficiency and enables transformation of care through reinvestment.

# Hope Control and Choice: North Yorkshire Mental Health Strategy

## The outcomes we want to see within the three priority areas

**(1) Resilience:** individuals, families and communities with the right skills, respect and support

- 1.1 Support for family, friends and carers embedded in all services
- 1.2 Better public understanding and acceptance of mental health issues
- 1.3 Greater Investment in prevention and early intervention for children and adults
- 1.4 More services and activities led by communities themselves
- 1.5 Reduced impact of rural isolation on mental health
- 1.6 Better partnership working, especially with the voluntary and independent sectors

**(2) Responsiveness:** better services designed in partnership with the people who use them

- 2.1 Timely diagnoses for all conditions, especially dementia
- 2.2 Better services for those experiencing a mental health crisis
- 2.3 Greater access to talking therapies
- 2.4 Better transitions between services, eg children to adults
- 2.5 Better services for vulnerable groups, eg students, military families, veterans, those detained under the Act etc
- 2.6 Better services for those with mental health and substance misuse needs
- 2.7 Better Ad[illegible] Services

**(3) Reaching out:** recognising the full extent of people's needs

- 3.1 Better understanding of the links with physical health, leading to dual diagnoses
- 3.2 Improved support for people with mental health needs to gain/maintain employment
- 3.3 Improved support for people with mental health needs to gain/maintain housing
- 3.4 More volunteering and other activities to promote wellbeing
- 3.5 Safeguarding fully embedded in all partners' practices

# Craven Mental Health Locality Plan 2016/17

| Locality Priorities | What we will do |
|---|---|
| 1. Improving access to Talking Therapies | - Improve access for priority groups; older people, people with Long Term Conditions<br>- Improve recovery rate |
| 2. Public Mental Health Programme | - Ensure the work relating to Mental Health First Aid, Assist Training and Anti-stigma Campaign benefit Craven |
| 3. Public Health Budgets (PHBs) | - Review the take up of PHBs from a Craven perspective |
| 4. Better Integration between physical & mental health services | - Commissioning of Psychiatry Liaison service within general hospitals.<br>- Explore other opportunities |
| 5. Explore the use of technology | - Explore the feasibility of assistive technology and tele-health within mental health services |
| 6. Social Care Mental Health Offer | - Health & Adult Service to undertake a strategic review of current services |
| 7. Crisis Care Concordat (CCC) | - Review current arrangements for Craven |

# Craven Mental Health Locality Plan 2016/17

| Locality Priorities | What we will do |
|---|---|
| 8. Dual diagnosis (mental health and substance misuse): ensure access for people in Craven | - Review current arrangements for people with dual diagnosis |
| 9. Issues of Rurality & Transport | - Map current provision across Craven on a visual<br>- Map services that are available for Craven but are provided locally |
| 10. Engagement and participation of people with lived experience and Carers | - Invite people with lived experience to locality group meetings<br>- Invite voluntary sector rep to locality meetings<br>- Ensure Craven mental health and wellbeing Forum is engaged on service developments |
| 11. Children & Young People | - Ensure a cohesive early intervention offer Schools wellbeing project to be rolled out |
| 12. Advocacy Services | - Review current arrangements across Children and Adults |
| 13. Transition between CYP and Adults services | - Review current arrangements |

# Next Steps:

- Seek feedback from Craven Mental Health & Wellbeing Forum and other service user groups (July 2017).
- Craven Locality Group will continue to meet and support the implementation of the locality plan.
- Invite people with lived experience of mental health and voluntary sector rep to the locality group.
- Further develop the Craven virtual Map of services.

North Yorkshire County Council

**Airedale, Wharfedale and Craven Clinical Commissioning Group**

## NORTH YORKSHIRE HEALTH OVERVIEW COMMITTEE 23rd June 2017

## CASTLEBERG COMMUNITY HOSPITAL

**Background:**

**April 2017:** Estate issues resulting in patient safety concerns were raised by Airedale NHS Foundation Trust (ANHSFT), the provider of services at Castleberg Community Hospital. Following discussions with commissioners and with the approval of their Trust Board the facility was temporarily closed on 13 April 2017.

As the provider of services ANHSFT ultimately maintains responsibility for patient and staff safety. A robust risk assessment was undertaken prompted by a number of adverse incident reports relating to the infrastructure at the Castleberg site and two narrowly avoided evacuations of the inpatient beds during prolonged power failures. The valiant efforts of staff to maintain safe patient care during difficult circumstances was noted; however the impact of the increasing incidents was also impacting on staff morale.

Interim arrangements have been put in place during the temporary closure to support patients to be cared for at home or, working in close partnership with North Yorkshire County Council, to undertake a period of rehabilitation in a Local Authority Care Home in Gargrave. Where necessary, patients can be admitted to the Intermediate care ward at ANHSFT.

Ward staff from Castleberg have been redeployed into existing community nursing and intermediate care teams within the Craven locality, creating additional capacity, to enable the provision of more enhanced packages of care in community settings, including end of life care.

The CCG has a statutory duty to carry out public consultation to determine the future of the hospital.

The CCG as the responsible commissioner has, with partners, considered the need for public consultation, and how this can be undertaken. AWC CCG will lead the consultation on behalf of Morecambe Bay Clinical Commissioning Group for the Bentham population, in collaboration with ANHSFT and NHS Property Services.

The intended approach is to undertake early engagement to ensure the background leading to the decision to close temporarily is within the public domain and the cost and benefits of the options being consulted on are shared and can be scrutinised. This will inform the consultation and the options to be considered.

**Consultation:**

Three immediate options which the CCG Executive team has considered are set out in this document. Through discussion with stakeholders there will be opportunity to determine any additional alternatives during the pre-consultation activities.

Any options we put to the public for consultation should be realistic and affordable and the public response be taken into account when making future decisions.

The options to be considered are:

1. Keep Castleberg Community Hospital open.
2. Close Castleberg Community Hospital and provide care at home or in a community setting; for example in collaboration with North Yorkshire County Council in terms of integration.
3. Build/utilise an alternative facility.

We recognise that the pre-consultation activities may identify other options to take into account.

**Approach to consultation:**

Healthwatch has set out five steps to ensure local people have their say:

1. Set out the case for change so people understand the current situation and why things may need to be done differently.

2. Involve people from the start in coming up with potential solutions.

3. Understand who in your community will be affected by your proposals and find out what they think.

4. Give people enough time to consider your plans and provide feedback.

5. Explain how you have used people's feedback, the difference it made to the plans and how the impact of the changes will be monitored.

A critical component is early involvement of people in coming up with potential solutions. This will be undertaken during pre-consultation and with support from Healthwatch North Yorkshire.

The period leading up to pre-consultation will allow time for appraisal of the three options identified, for the pre-consultation activities to be organised and materials to be prepared and publicised. If any options subsequently prove to be unviable it is recommended that the reasons for excluding any option should be included in the consultation material.

Information and data will back up the options appraisal; this will include a summary of bed occupancy and utilisation rates and include patterns of admission from registered practices and an indication of individuals' home locations, which will inform the optimum base for any re-provision.

Following pre-consultation the options appraisal will be further developed if necessary to help inform the consultation options.

The outcome of the public consultation will be taken into account during CCG decision making and the future provision of care with a suitable estates solution.

**High level timeline**

- Tuesday 20th June: Deadline for information and data.
- By early July: Finalise options informed by the information and data, including NHS Property Services' economic review and prepare pre-consultation material.
- 17th July: Pre-consultation engagement to take place for 3 weeks.
- 7th August: Review outputs of engagement and take into account when finalising criteria and consultation material 4 weeks.
- 4th September: 12 week consultation period to begin.
- 4th December: Consultation to conclude.
- Early December: Appraise consultation outputs and prepare recommendation/s.
- 8th December: CCG Clinical Executive Group to review and approve recommendation.
- 9th January: The CCG Governing Body Committee in Common approves the decision recommended by the Clinical Executive Group.

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

**Monitoring the human health impacts of shale gas extraction**

Lincoln Sargeant, Director of Public Health, North Yorkshire County Council and
Simon Padfield, Public Health England

## 1 Purpose of the Report

1.1 This paper provides an update to the Scrutiny of Health Committee on progress to monitor human health impacts from shale gas extraction at Kirby Misperton and follows on from the previous proposal dated 3rd March 2017. Data presented here shows baseline health data at small area level around the site.

## 2 Background

2.1 The most useful and reliable information in relation to the potential risks to human health will come from environmental monitoring data. Environmental monitoring, required as part of the environmental permit conditions as well as the baseline monitoring will provide direct evidence to determine the potential for any exposure of the local population to emissions from the site. Information regarding the baseline environmental monitoring is publically available through the website for the British Geological Survey here: http://www.bgs.ac.uk/research/groundwater/shaleGas/monitoring/yorkshire.html

## 3 Surveillance of local health data

3.1 Purpose of the surveillance:
Concerns have been about the potential health effects of shale gas extraction at Kirby Misperton. An assessment of the currently available evidence indicates that the potential risks to public health from exposure to the emissions associated with shale gas extraction will be low if the operations are properly run and regulated. Where potential risks have been identified in the literature, these were typically the result of operational failure and poor regulatory framework. In light of the regulatory approach in the UK, and experience from similar industries, it is expected that well managed exploration sites will only make a small contribution to local concentrations of pollutants.

3.2 Baseline health data used:
The data shown here (Figures 1 to 14) is drawn from existing sources of routinely collected health information. These sources have been selected as they are able to provide a reliable baseline for data comparison. The baseline data shows rates for 5 year time periods.

3.3 Health indicators and data sources shown here:

- Hospital admission rates for cancer, respiratory disease and cardiovascular disease *(Source: Hospital Episode Statistics)*

- Deaths rates from cancer, respiratory disease and cardiovascular disease *(Source: Office of National Statistics)*
- Rate of low birth weight babies *(Source: Office of National Statistics)*

3.4 Data comparison:
The data is presented at Lower Super Output Area (LSOA). LSOAs are a geography of small areas covering the whole country, which are used to collect and publish small area statistics. Each LSOA covers roughly 650 households and 1,500 individuals. The area 5km around the site covers six LSOA areas and these are labelled here as areas E01027774; E01027776; E01027800; E01027801; E01027793 and E01027794. Four areas for comparison have also been included. These LSOA areas are labelled E01027557; E01027562; E01027742; E01027753. These four areas lie within national parks boundaries and do not have PEDL licences available therefore will represent populations that will not be close to any shale gas extraction sites (Appendix 1).

3.5 Quality and Timeliness of data:
The data used is derived from routinely collected sources. As such, the data should be of good quality. Nevertheless, all data relies on the reliability of those individuals and organisations collecting and recording the data. For example, variation in disease recording between hospitals may account for changes in diagnosis or admission rates. This is particularly true when analysing statistics involving only a small number of residents.

3.6 Important considerations in interpretation of data and terms used
3.6.1 Small area statistics:
Due to the relatively low numbers of residents who live near the drilling site, the data collected will concern only small numbers of individuals, and the admission rates and death rates from these conditions is likely to be very low. Drawing reliable conclusions from these numbers may therefore be difficult. In this report, graphs are used to show differences in health data between areas. Although the height of the columns on the graphs may look different, statistics experts can judge if two values are truly different by comparing what are called "confidence intervals" (sometimes known as error bars) of the numbers. Rates of admissions and deaths will naturally vary in small areas from one year to the next. The use of 5 years' worth of data for the baseline here helps to reduce some of the differences that would be seen if just one years' worth of data was considered. These confidence intervals are represented on the graphs in this report like this:

3.6.2 Assessment of exposure:
Whilst environmental and meteorological monitoring will be undertaken and provide the best available indication of the potential for exposure to the population in the area, it will be challenging to accurately assess to what extent a specific individual living in the area has been exposed to any potential pollutants produced by the site. However, well managed

and regulated exploration sites are expected to only make a small contribution to local concentrations of pollutants.

3.6.3 Cause and effect relationship

Linking a possible environmental exposure to a health outcome is also complex. Many diseases have several potential causes, and therefore identifying the impact of an exposure on a background of other contributing factors (such as genetics, smoking status, alcohol intake, etc.) is difficult. Furthermore, the potential emissions from shale gas extraction are not necessarily unique to that activity (e.g. vehicle or industrial emissions) therefore some individuals may already be exposed to these pollutants.

## 4 Summary

The baseline health data shows that there is variation in disease and death rates between the small geographical areas shown here and prior to any shale gas extraction activity at Kirby Misperton. This is expected due to the small underlying populations being considered and it is not possible to interpret these differences further. The small geographic areas include six areas close to the site and four areas within North Yorkshire but at considerable distance away from the site to allow comparison between broadly similar populations of North Yorkshire residents.

## Cardiovascular disease

Figure 1: Admission rate for cardiovascular disease (DSR per 100,000 population), 2011/12 to 2015/16

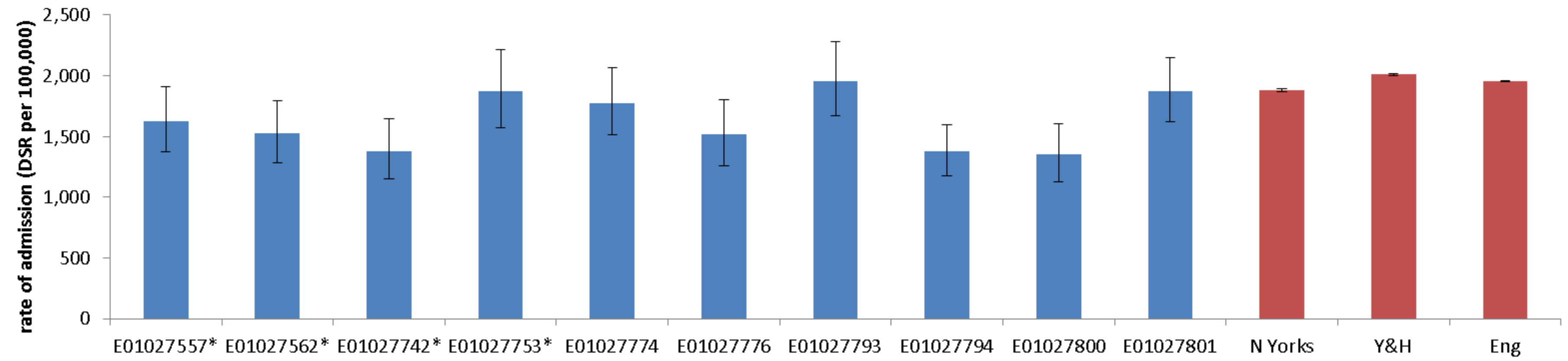
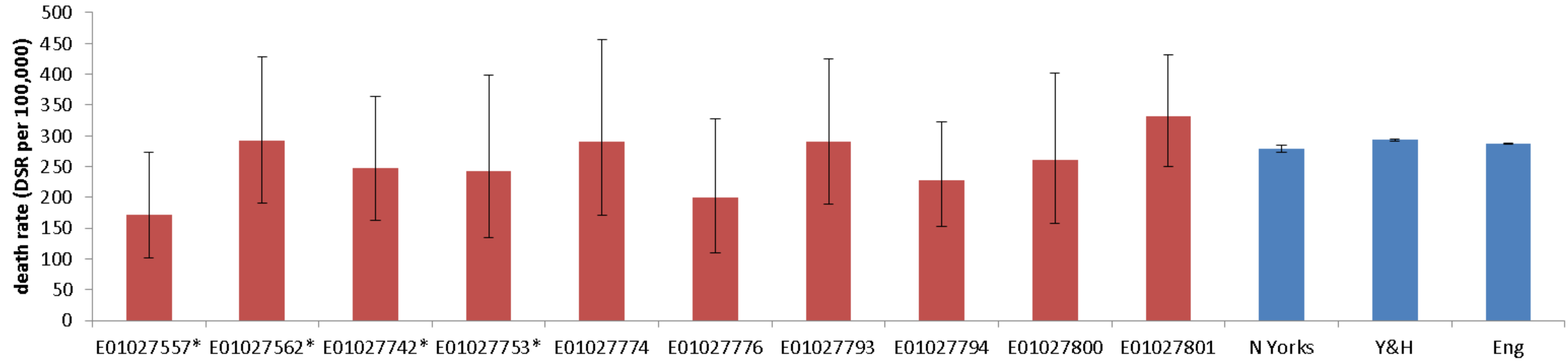



Figure 2: Death rate for cardiovascular disease (DSR per 100,000 population) 2011 to 2015




All bars shown with confidence intervals for the data; *indicates comparison LSOA area
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Figure 3: Map of cardiovascular disease admission rate by LSOA (DSR per 100,000) 2011/12 to 2015/16

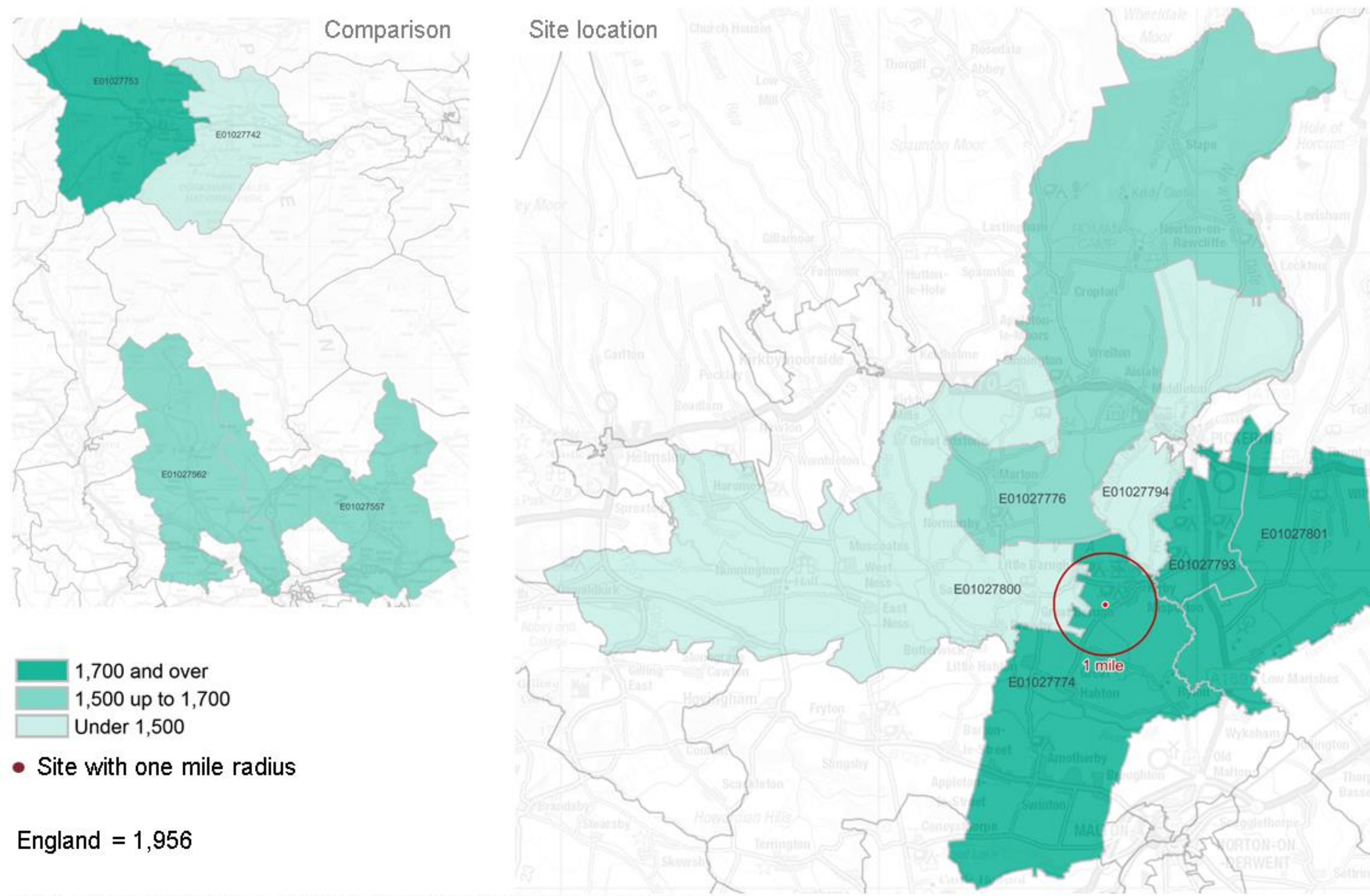


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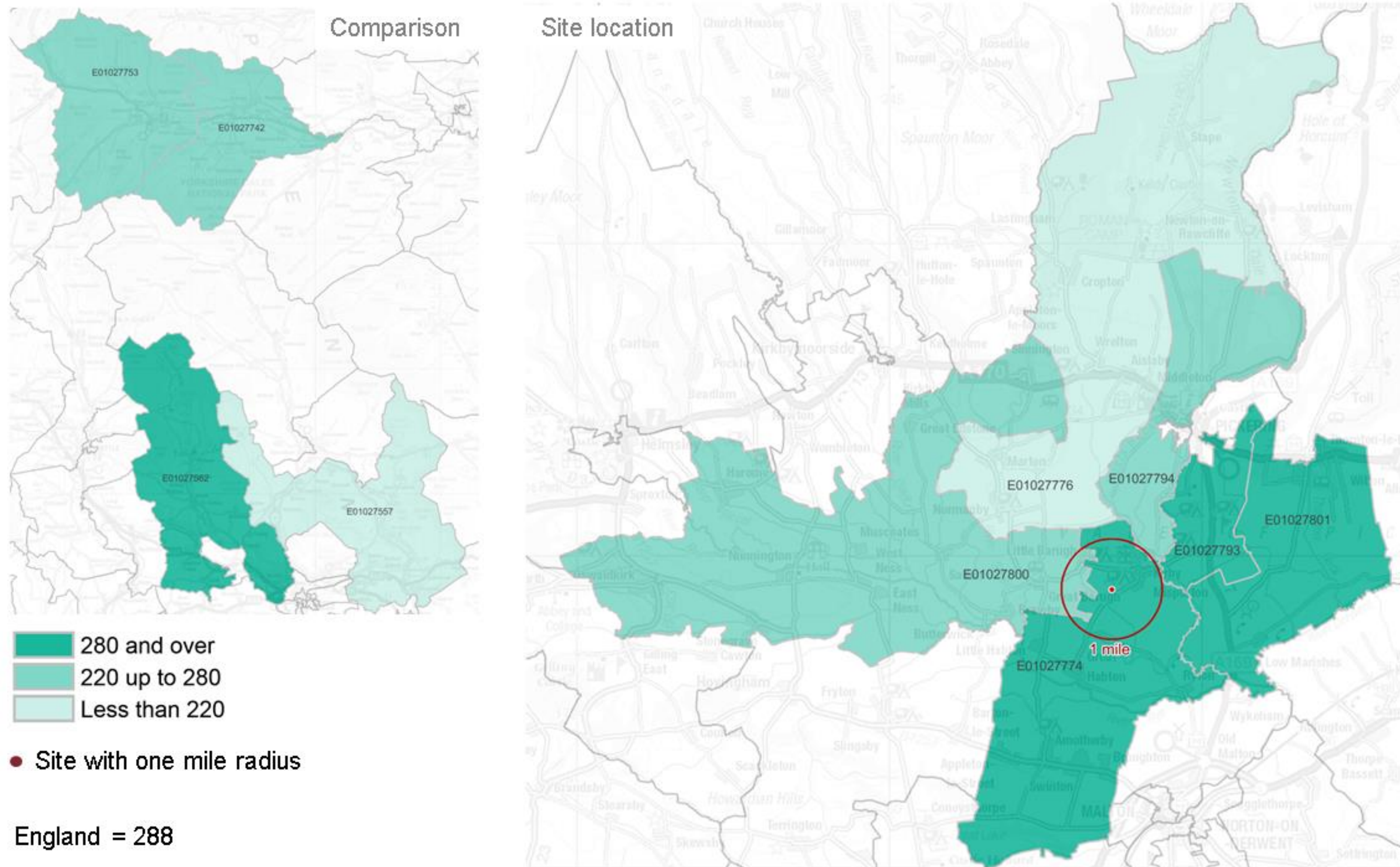
Figure 4: Map of cardiovascular death rate by LSOA (DSR per 100,000) 2011 to 2015

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**Respiratory disease**

Figure 5: Admission rate for respiratory disease (DSR per 100,000 population), 2011/12 to 2015/16

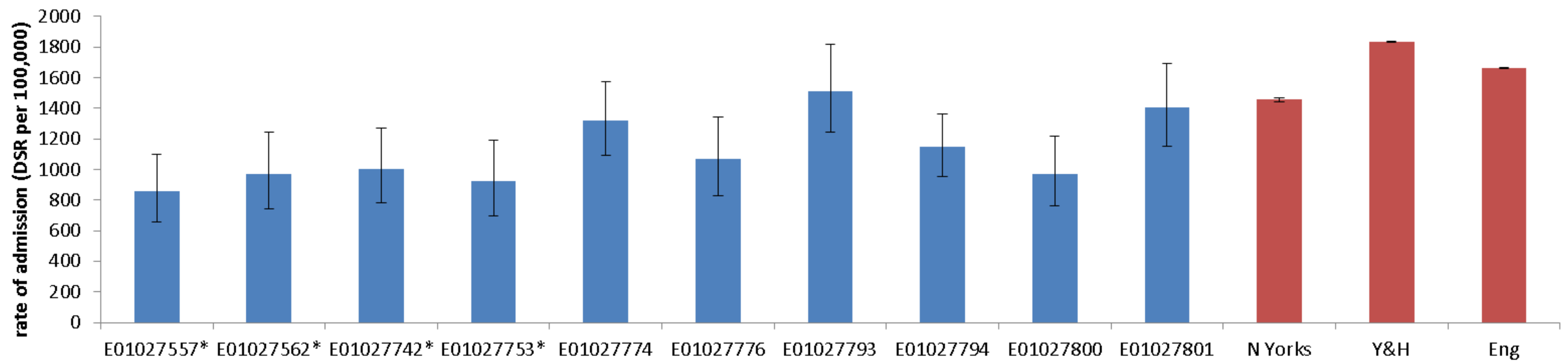
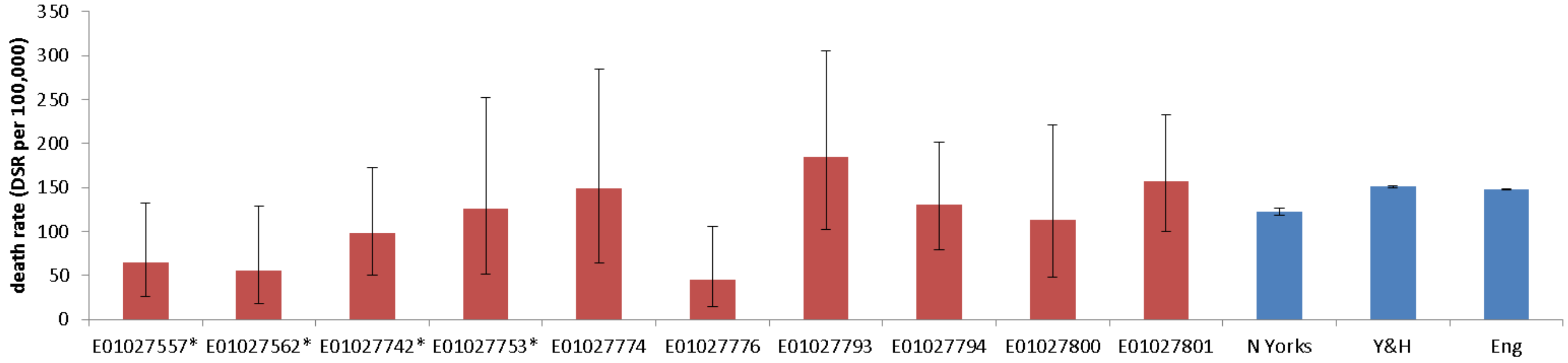



Figure 6: Death rate for respiratory disease (DSR per 100,000 population) 2011 to 2015




All bars shown with confidence intervals for the data; *indicates comparison LSOA area

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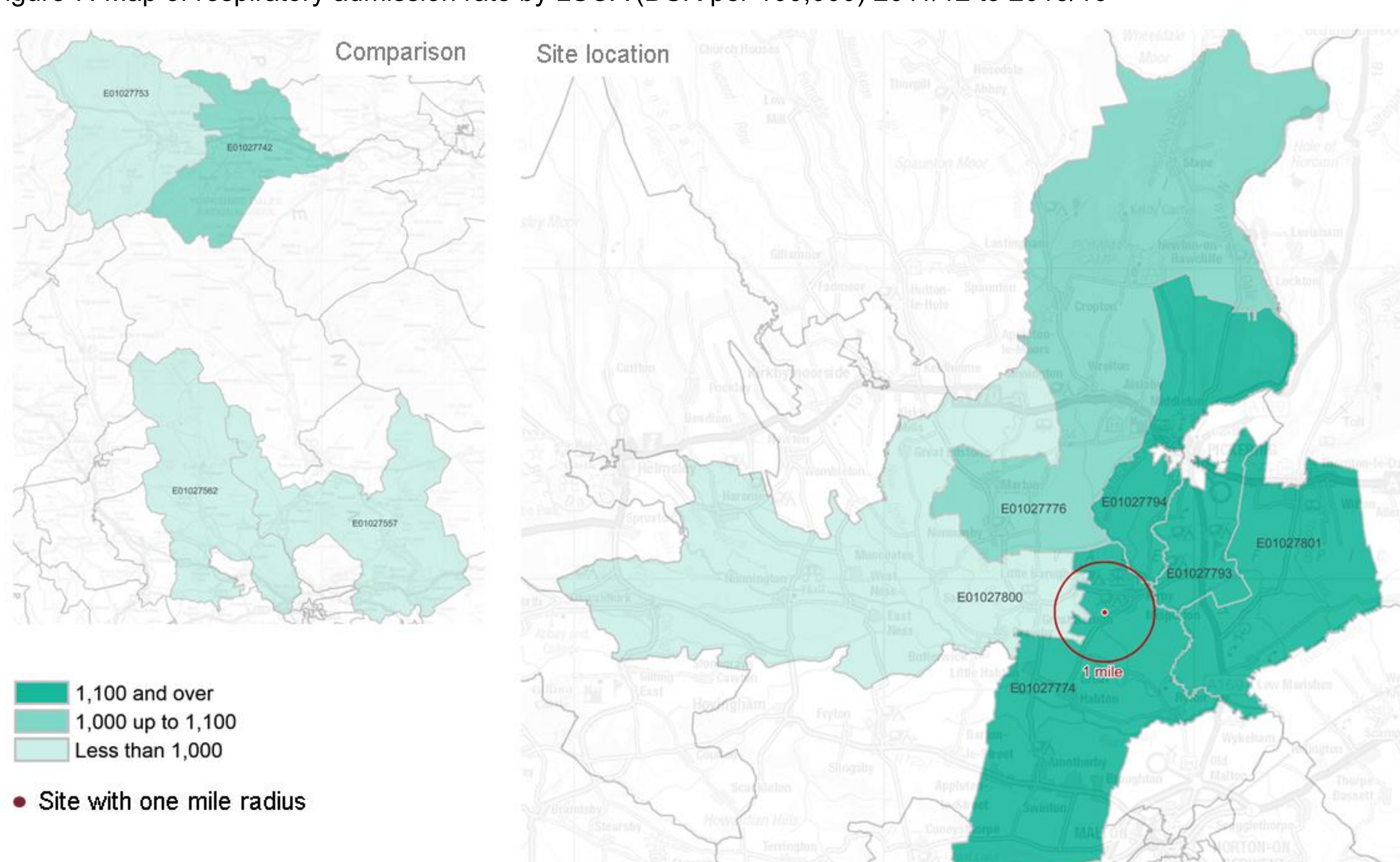
Figure 7: Map of respiratory admission rate by LSOA (DSR per 100,000) 2011/12 to 2015/16




England = 1,664


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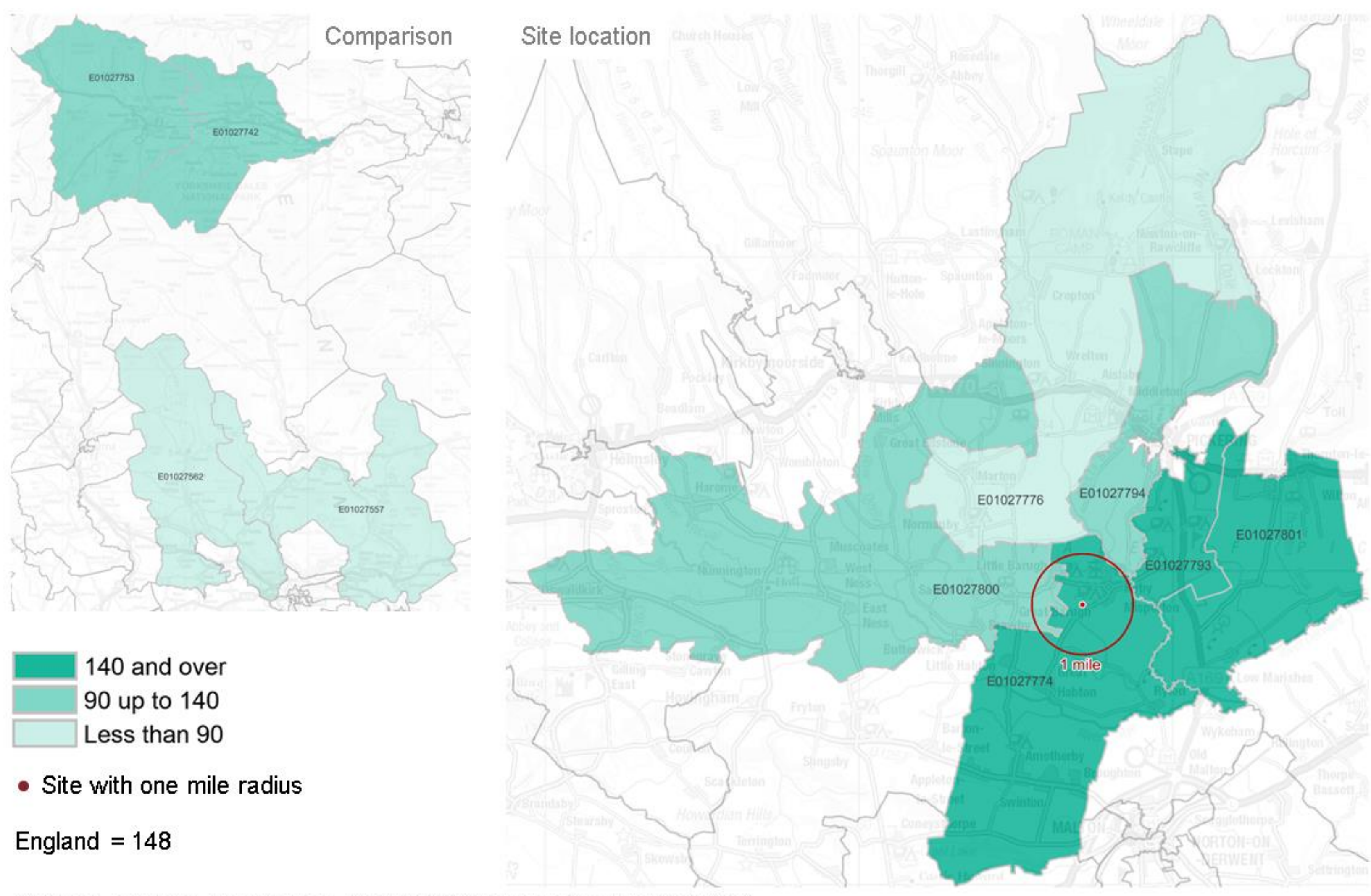
Figure 8: Map of respiratory death rate by LSOA (DSR per 100,000) 2011 to 2015

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## Cancer

Figure 9: Admission rate for cancer (DSR per 100,000 population), 2011/12 to 2015/16

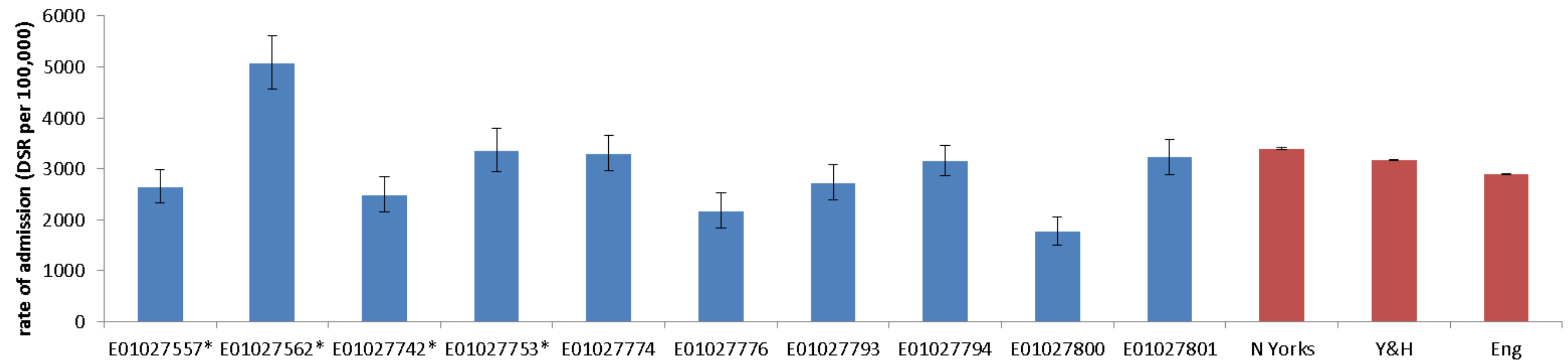
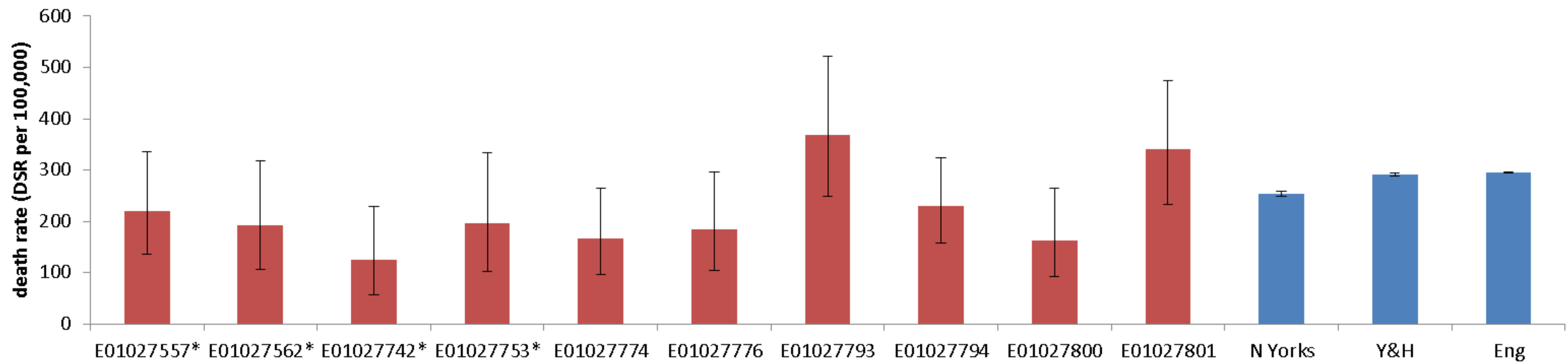



Figure 10: Death rate for cancer (DSR per 100,000 population) 2011 to 2015




All bars shown with confidence intervals for the data; *indicates comparison LSOA area

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Figure 11: Map of cancer admission rate by LSOA (DSR per 100,000) 2011/12 to 2015/16

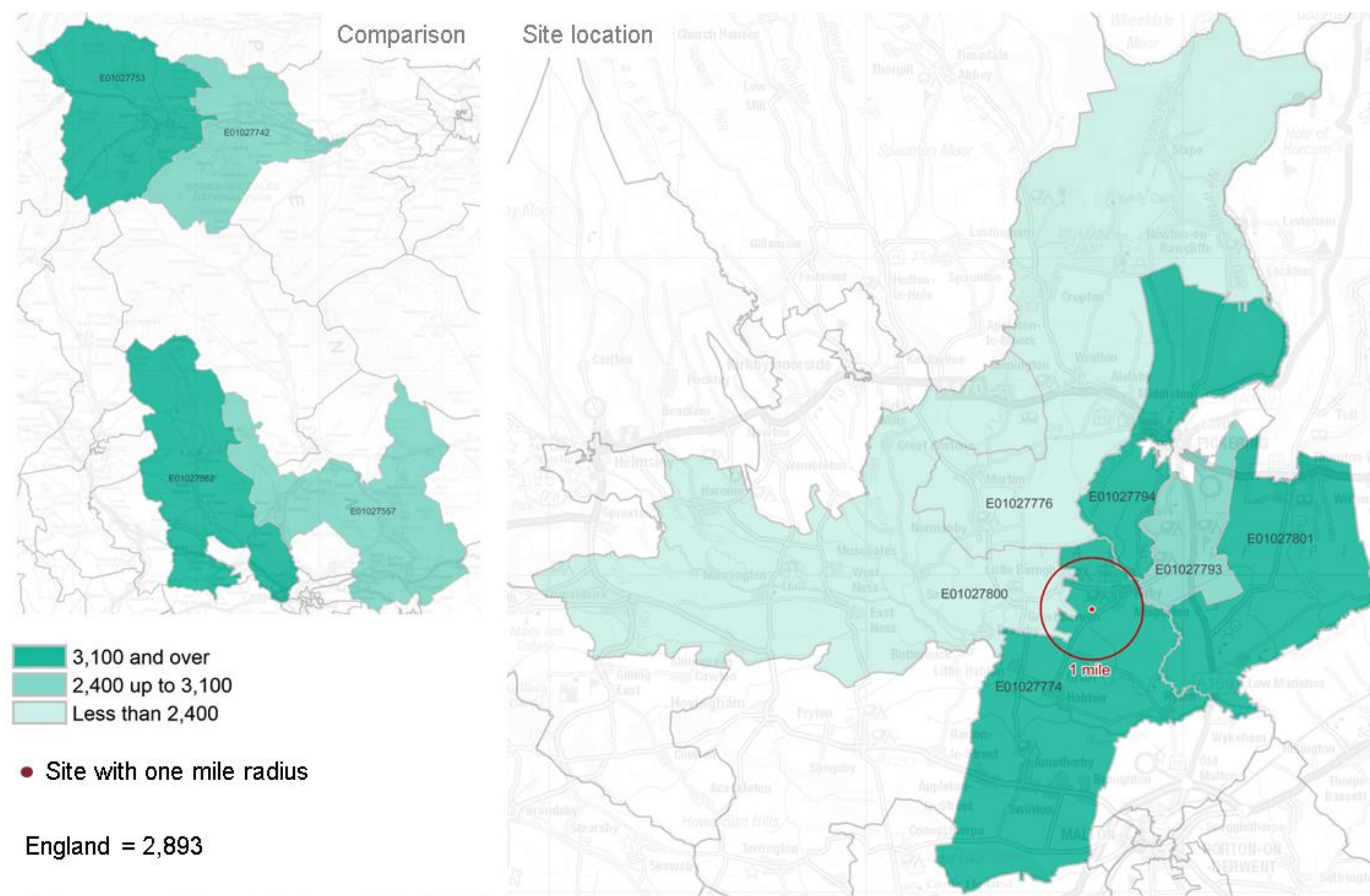


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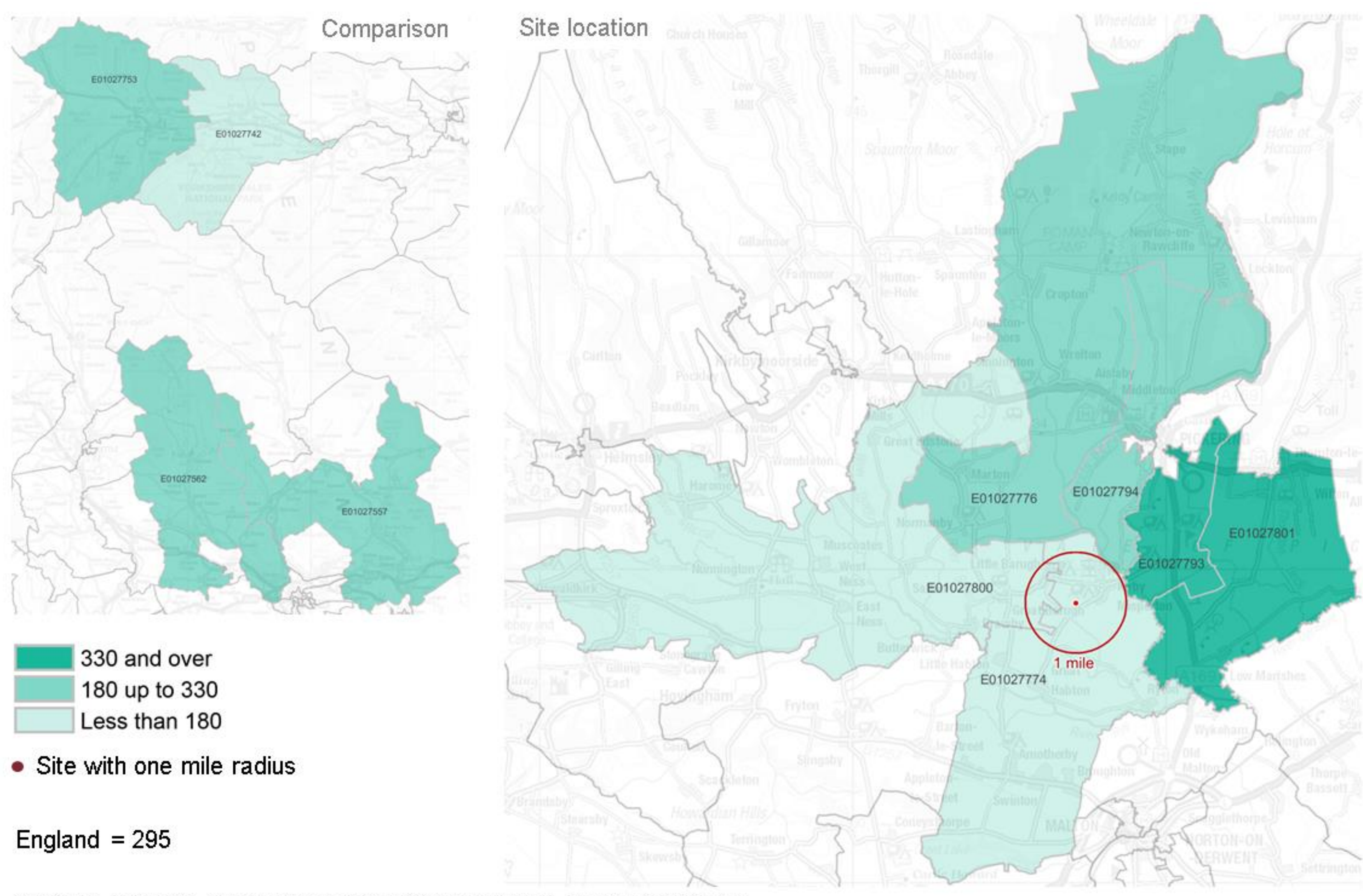
Figure 12: Map of cancer death rate by LSOA (DSR per 100,000) 2011 to 2015

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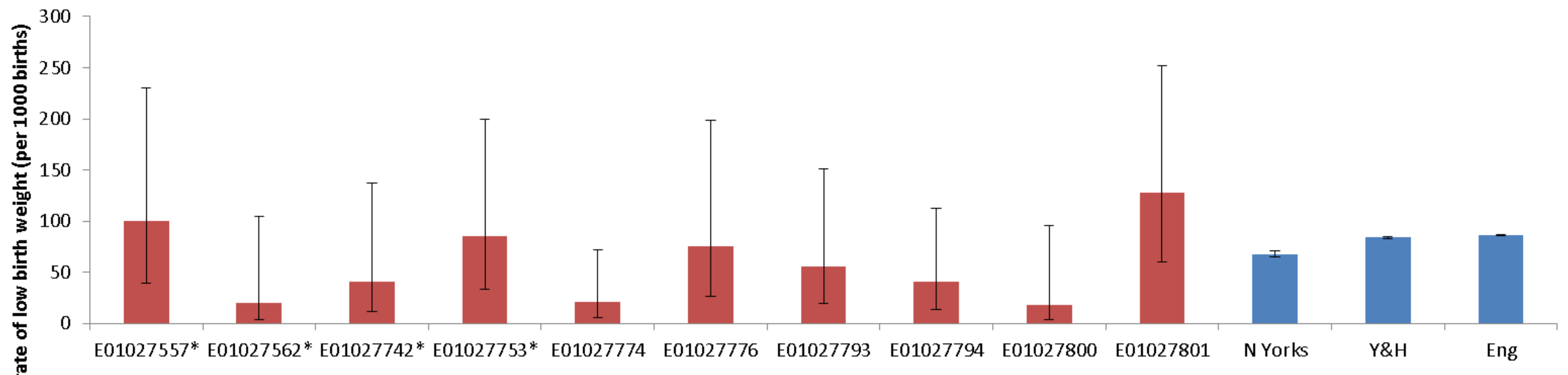
**Birth weight**

Figure 13: Rate of low birth weight (rate per 1000 births), 2011 to 2015




All bars shown with confidence intervals for the data; *indicates comparison LSOA area

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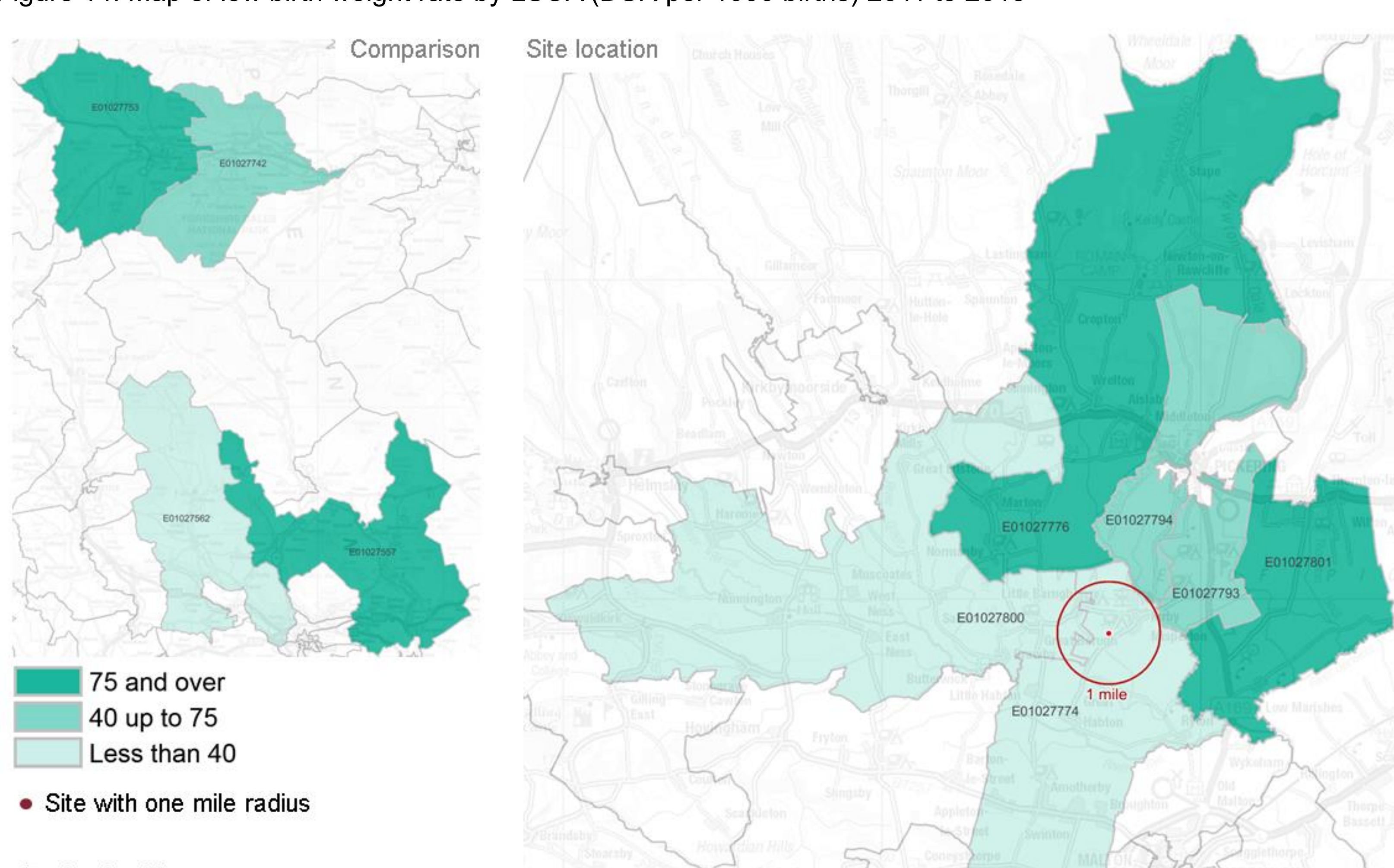
Figure 14: Map of low birth weight rate by LSOA (DSR per 1000 births) 2011 to 2015




England = 86

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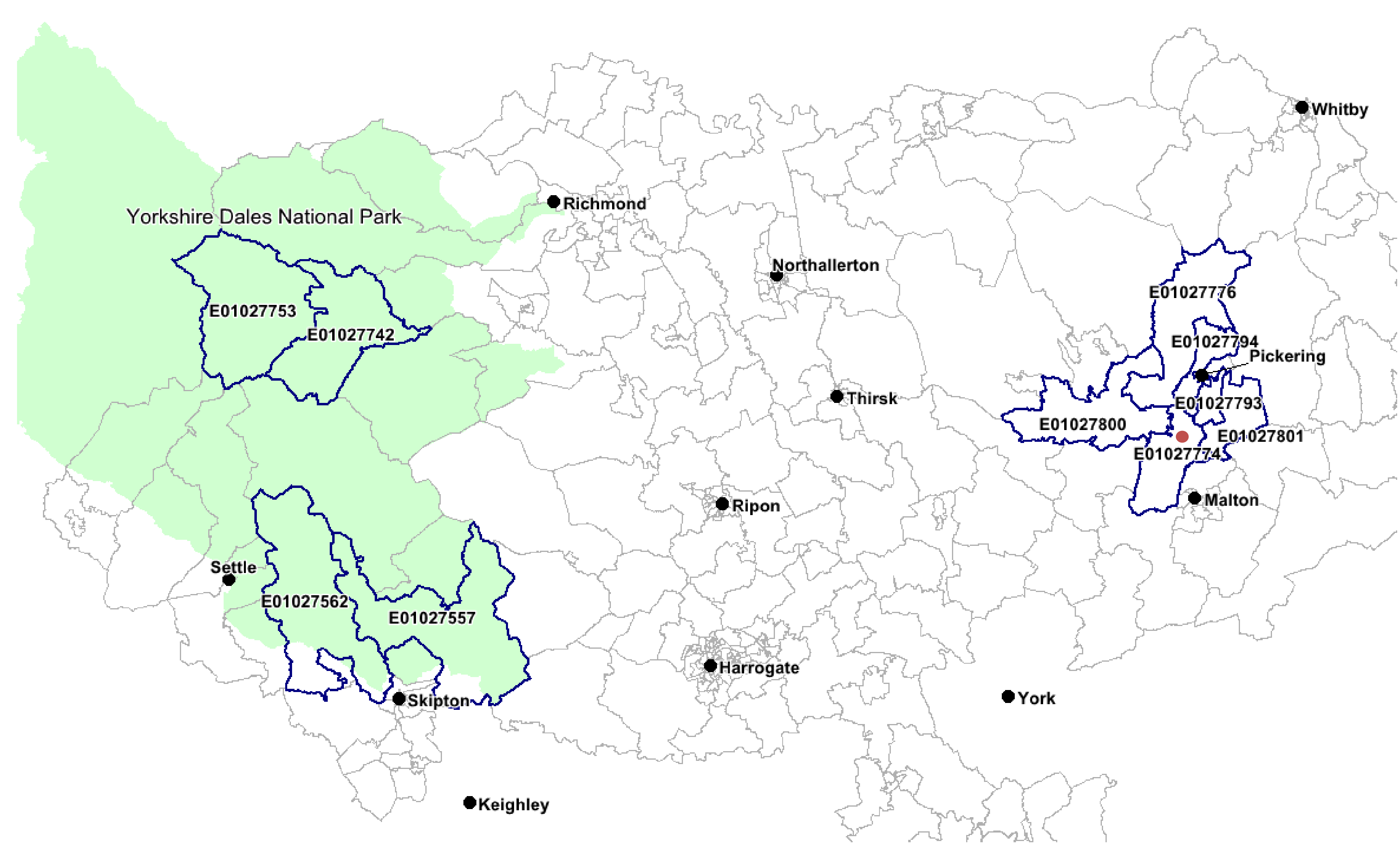
**Appendix 1: location of LSOA areas around the Kirby Misperton site and comparison LSOA areas**



**Appendix 2: Other terms used and definitions**

DSR (Direct Standardised Rate): this is a rate that is calculated to allow data for different areas to be compared. It would not be appropriate to compare death rates for cardiovascular disease, for example, for two areas – one with a high proportion of very elderly residents and one with a high proportion of young families and children. Using a DSR adjusts for any differences that would otherwise be expected due to the age structure of a population.

Rate of low birth weight: All births (live and still births) with a recorded birth weight under 2500g as a percentage of all live births with stated birth weight.

Admission rate for Cancer: All hospital admissions with a primary cause of cancer (DSR per 100,000 population)

Admission rate for Respiratory disease: All admissions with a primary cause of respiratory disease including admissions for asthma and chronic obstructive airways disease (DSR per 100,000 population).

Admission rate for Cardiovascular disease: All admissions with a primary cause of cardiovascular disease including admissions for heart attacks and strokes (DSR per 100,000 population).

Death rate for Cancer: All deaths with an underlying cause for cancer (DSR per 100,000 population)

Death rate for Respiratory disease: All deaths with an underlying cause for respiratory disease including deaths from asthma and chronic obstructive airways disease (DSR per 100,000 population)

Death rate for Cardiovascular disease: All deaths with an underlying cause for cardiovascular disease including deaths from heart attacks and strokes (DSR per 100,000 population).

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

## Proposed Joint Scrutiny with the Care and Independence Overview and Scrutiny Committee: a) health and social care workforce planning; b) integration of health, mental health and adult social care commissioning and service provision

| Health and social care workforce planning |
| --- |

**Background**
A recurrent theme that has arisen from the scrutiny of health and social care over the past 12 months has been one of shortages of health, mental health and social care staff.

Some of the concerns that have been raised are as follows:

- A large number of GPs are expected to retire in the next 5 years. These are not being replaced by newly qualified GPs, leading to shortages in GPs particularly in rural practices
- There are shortages of consultants in hospital settings, particularly in smaller hospitals that tend to serve rural areas and which have a large catchment area
- There are shortages in social care staff, which is affecting the ability of social care providers to offer a comprehensive service
- There are shortages in community-based health and social care staff, which is affecting the ability of commissioners to develop out-of hospital services
- There are shortages in out of hours nursing (the District Nurse Service is not provided on a 24/7 basis in North Yorkshire), which can generate demand for more specialist and costly hospital based services
- Individual health services are being re-designed to compensate for or mitigate the existing workforce pressures with the potential for significant unintended consequences.

Some of the questions that have been raised include:

- What workforce planning is underway?
- How does it fit with strategic commissioning planning?
- Is it system wide?
- How do we address the short term and immediate workforce shortages whilst planning for the medium and long term?
- How well-equipped is the workforce to meet future health and social care needs?
- Are there variations in recruitment and retention across North Yorkshire and surrounding areas?
- How are work patterns changing and how does this impact upon the availability of workers?
- What is the impact of the UK leaving the EU?
- What impact will technology have, particularly in diagnosis and consultation?
- Is there a role for volunteers?

**Objective**
The objective of this piece of scrutiny work is to engage with a broad range of commissioners, service providers, patients and the public to better understand the causes of workforce shortages, what the short term and long term impacts are, what actions are being taken to mitigate them and how successful these actions are or likely to be.

**Methodology**
The approach taken is likely to be joint scrutiny by the Scrutiny of Health Committee and the Care and Independence Overview and Scrutiny Committee over a 3 month period.

Subject to agreement by both committees, the project will be overseen by a sub-group of the committees (4 members from each committee). The project will be supported by Ray Busby and Daniel Harry, from the Overview and Scrutiny Team.

The approach taken is likely to include:

- Desktop research into national guidance, policy and best practice
- Written reports and presentations to the sub-group
- Expert witnesses
- Consultation with stakeholders, carers and patients.

It is envisaged that the sub-group will meet three times during the course of the project. Terms of Reference will be drafted for the sub-group.

**Work plan**
The following work programme is draft and intended to give an impression of the likely timeframe and level of resourcing required for the project. It has yet to be agreed by the committees or the proposed sub-group.

| Date | Action | Comment |
|---|---|---|
| Care and Independence OSC – 29 June 2017<br>Scrutiny of Health Committee – 23 June 2017 | Work plan taken to committee | Agree TOR, sub-group nominations/membership and arrangements for Chairing |
| wc 17 July 2017 | First meeting of the sub-group | Evidence gathering |
| wc 14 August 2017 | Second meeting of the sub-group | Evidence gathering |
| wc 11 September 2017 | Third and final meeting of the sub-group | Drawing conclusions and developing recommendations |
| wc 9 October 2017 | Final report and recommendations to sub-group | Circulated by email for comment |
| Care and Independence OSC MCB – 9 November 2017 | Final report and recommendations taken to committee – delegated to MCB | |

| Scrutiny of Health MCB – 3 November 2017 | | |
|---|---|---|
| 24 November 2017 | Final report and recommendations taken to the North Yorkshire Health and Wellbeing Board | |
| 5 December 2017 | Final report and recommendations taken to Executive | |

**Key stakeholders and expert witnesses**
Outlined below is an initial list of people who may be able to contribute to
- NYCC Health and Adult Services – Louise Wallace et al TBC
- NYCC HR and OD – Justine Brooksbank
- HRW CCG – Janet Probert
- S&R CCG – Simon Cox
- H&RD CCG – Amanda Bloor
- VoY CCG – Phil Mettam
- AWC CCG – Helen Hirst
- Harrogate and District NHS Foundation Trust – Dr Ros Tolcher
- South Tees Hospital NHS Trust – Siobhan McArdle
- York Teaching Hospital NHS Foundation Trust – Pat Crowley/Mike Proctor
- Airedale NHS Foundation Trust – Bridget Fletcher
- Yorkshire Ambulance Service – Vince Larvin
- Tees Esk and Wear Valleys NHS Foundation Trust – Adele Coulthard
- North Yorkshire Provider Forum - TBC
- Local Medical Committee - TBC
- Local Pharmaceutical Committee – Jack Davies
- Healthwatch North Yorkshire - TBC
- Complaints and Advocacy North Yorkshire – TBC.

**Recommendation**

That Members review the proposal and make suggestions for any amendments. Subject to agreement of any proposed amendments, that 4 members of the committee are nominated to take part in the joint sub-group of the Scrutiny of Health Committee and the Care and Independence Committee.

## Integration of health, mental health and adult social care commissioning and service provision

**Background**

A recurrent theme that has arisen from the scrutiny of health and social care over the past 12 months has been one of there being a pressing need to integrate health, mental health and social care services. Whilst there is a general acceptance at a national and local level that the integration of services is a good thing which will lead to improvements in service delivery, many aspects of what integration means remain unclear.

Some of the areas where greater clarification is sought are as follows:

- What is the level of ambition for the integration of health, mental health and social care services in North Yorkshire?
- What services are likely to be included?
- How will the workforce have to change and will they be able to?
- What are the benefits to services users and patients?
- What are the system wide financial benefits?
- What are the risks and how will these be mitigated?
- Is there a preferred model for or approach to integration locally?
- Will there be variations in approaches across services and geographies?
- Is the formal integration of services too time consuming, cumbersome and bureaucratic? Is greater collaboration and coordination of service planning and delivery quicker, easier and more flexible?

The context for integration is one of reducing budgets, increasing demand and workforce shortages. Integration is often perceived to be the solution to these problems, when there may be other ways to tackle these pressures.

The assumption is that the current focus is upon integrating services and enhancing service delivery, rather than integrating structures and organisations.

The King's Fund (2011) 'Integrating health and social care - where next?' identified a number of factors that are helpful to integration and which my hinder integration, as summarised below:

| **Helpful factors** | **Hindering factors** |
|---|---|
| Friendly relationships | Performance regimes |
| Leadership | Financial pressures |
| Commitment from the top | Organisational complexity |
| Joint strategy | Changing leadership |
| Joint vision | Financial complexity |
| Co-terminosity | Culture |
| Additional funding | Commissioning |
| Patient and user focus | National policies |
| Frontline staff commitment | Local history |
| Joint commissioning | Data and information technology |
| Central guidance | Planning |
| Joint appointments | Workforce |
| History of success. | |

Some of all of these factors may provide a helpful framework for the scrutiny.

**Objective**
The objective of this piece of scrutiny work is to engage with a broad range of commissioners, service providers, patients and the public to better understand what is meant by ‘integration’ in North Yorkshire. In particular, what integrated services are currently delivered, what services are planned and what the impact of these services has or will be upon patient/service user outcomes.

**Methodology**
The approach taken is likely to be a select committee involving both the Scrutiny of Health Committee and the Care and Independence Overview and Scrutiny Committee. It is envisaged that the select committee will have one session, running from 10am to 3.30pm, during which they will hear evidence and then form conclusions and recommendations.

The select committee will be supported by Ray Busby and Daniel Harry.

The approach taken is likely to include:

- Desktop research into national guidance, policy and best practice
- Written reports and presentations
- Expert witnesses
- Consultation with stakeholders, carers and patients.

**Timing**
Further work is required to determine when this piece of scrutiny could start. This is, in part, due to the complexity of the issues and the need to focus in on some clearly defined lines of enquiry.

**Recommendation**

That Members agree that this is a topic that would benefit from joint scrutiny with the Care and Independence Overview and Scrutiny Committee. Also, that work continues to identify a small number of clearly defined lines of enquiry.

Daniel Harry
Scrutiny Team Leader
North Yorkshire County Council
13 June 2017

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

## Overview and Scrutiny at North Yorkshire County Council

**Purpose of Report**
The purpose of this report is to provide Members of the Scrutiny of Health Committee with a summary of how overview and scrutiny is undertaken at the Council, the way in which subjects for scrutiny are identified, why it is important and what role committee Members have to play.

This report provides Members with details of some of the specific responsibilities and powers relating to this committee and also a copy of the committee work programme for review and comment.

### Overview and Scrutiny
The Local Government Act 2000 first introduced the requirement for every local authority to include provision for at least one scrutiny committee. Under this Act and associated legislation, scrutiny can make recommendations to the executive and other local bodies. The committees also have the power to question Cabinet members, Council officers and representatives of other organisations, such as health and community safety agencies. The committees can also investigate any issue which affects the local area or its residents.

For more detail on the roles and responsibilities of the overview and scrutiny committees have, please refer to the North Yorkshire County Council Constitution – http://www.northyorks.gov.uk/article/24041/The-council-constitution

### Why it is important
Overview and scrutiny provides an important check and balance, helping to ensure that the decisions made by the executive reflect the needs of local people, are financially robust and are in keeping with the strategic priorities and responsive to the operational demands of the Council.

Where overview and scrutiny is not active, engaged and inquisitive, then there is a risk that some strategic and operational issues could be overlooked and opportunities for early intervention and action missed. Examples of where this has occurred in other local authorities, albeit at the extreme, include: child sexual exploitation in Rotherham MBC; poor care and high mortality rates at Mid Staffordshire NHS Foundation Trust; and governance failings in Tower Hamlets LBC.

### How it contributes to the Council's outcomes
In addition to being an important check and balance and providing early warning, scrutiny aims to contribute to the Council's corporate outcomes in many other ways, including:

- Enabling Councillors to become directly involved in the development of: policy and strategy; consultation and public engagement planning; and the performance management of the Council

- Keeping Councillors and the public informed of key issues, priorities and initiatives
- Enabling direct engagement with the people of North Yorkshire
- Acting as a critical friend and providing Cabinet Members and senior officers with a non-partisan forum in which to test out ideas, approaches and gain feedback and suggestions
- Providing a structure, through the call-in process, for scrutinising specific decisions of the Executive
- Scrutinising issues of public concern beyond the remit of the Council.

**The overview and scrutiny committees**
There are five thematic overview and scrutiny committees, each of which meet in public four times a year, as below:

- Transport, Economy and Environment – focussed upon transport and communications infrastructure, supporting business and helping people develop their skills, sustainable development, climate change, countryside management, waste management, environmental conservation and cultural issues

- Corporate and Partnerships - the Council's corporate organisation and structure, resource allocation, asset management, procurement policy, people strategy, equality and diversity, performance management, communications, partnership working, community development and engagement and community safety (as the designated Crime and Disorder Committee).

- Young People – focussed upon the interests of young people, including education, care and protection and family support

- Care and Independence – focussed upon the needs of vulnerable adults and older people and people whose independence needs to be supported by intervention from the public or voluntary sector

- Health - focussed upon the planning, provision and operation of health services in the County with the aim of acting as a lever to improve the health of local people and ensuring that the needs of the local people are considered as an integral part of the delivery and development of health services.

Overview and scrutiny functions are also supported through the following bodies:

- Scrutiny Board – this is made up of the Chairs of the five thematic overview and scrutiny committees and enables work to be co-ordinated, opportunities for joint scrutiny to be identified, and committee Chairs to act as critical friends.

- Police and Crime Panel - which scrutinises the Police and Crime Commissioner. There is also a Complaints Sub-Committee which meets on an ad hoc basis.

- Looked After Children's Members Group – this is not a formal committee but acts as an informal advisory group to the Executive Portfolio Holder for Children's and Young Peoples Services. The group performs a role consistent with statutory guidance for local authorities to promote the health and well-being of looked-after children.

**Mid Cycle Briefings**
In addition to formal meetings of the committees, there is also a system of Mid Cycle Briefings. A Mid Cycle Briefing enables the Chair, Vice Chair and Spokespersons for each committee to meet in private four times a year to: discuss the work of the committee; identify areas for in-depth scrutiny; and have an early discussion with commissioners and providers about topics that may be confidential or under development.

**Different approaches to overview and scrutiny**
In addition to formal committee meetings and Mid Cycle Briefings, there are a number of approaches that overview and scrutiny can take, including:

- Task and finish groups – these are informal, time-limited bodies comprised of councillors that are established by the committee to undertake a discrete piece of scrutiny work and then report back their findings and recommendations.

- In-depth scrutiny review – this is when the committee undertakes a prolonged and detailed piece of work, which includes: desktop research; expert witnesses, typically commissioners and providers; service/site visits; and engagement with service users. This approach combines formal committee meetings and the use of a sub-group.

- Select Committee – where an overview and scrutiny committee works as a whole committee to address a particular issue. Typically, this would involve a one-off meeting lasting a day where a range of expert witnesses are invited to attend and give evidence. The committee members then analyse the evidence given and make recommendations for improvements.

- Call-in – this is when non-executive members of the Council can have decisions of the Executive considered by a scrutiny committee.

- Joint scrutiny – this is when there is an issue that is directly relevant to more than one overview and scrutiny committee and so a collaborative approach is taken. This can be internal or external. External joint scrutiny is often undertaken by the Scrutiny of Health Committee.

**Role of committee members**
All the members of an overview and scrutiny committee have a key role to play in ensuring that Council and other public sector services are delivered effectively, efficiently and that they achieve good outcomes for local people. The things that committee members can do, include:

- Contributing to the development of the committee’s work programme, providing constructive challenge and suggesting topics for inclusion
- Actively engaging with all stages of the scrutiny process, including any additional groups or meetings that are setup outside of the scheduled, formal meetings of the committee
- Developing constructive relationships with other members of the committee, the relevant portfolio holders and service leads
- Working apolitically as a committee, with a strong focus upon service improvement and outcomes

- Receiving the data, information and analysis that is presented in an impartial manner
- Assessing the data, information and analysis presented to the committee and testing the conclusions that are drawn
- Contributing to the development of recommendations, based on the committee's deliberations, which are specific, realistic and relevant.

**Scrutiny of Health Committee**
The Scrutiny of Health Committee has a responsibility to review any matter relating to the planning, provision and operation of health services in the County. This includes:

- being consulted on the reconfiguration of healthcare and public health services locally
- contributing to the Department of Health's Quality Accounts initiative and the Care Quality Commission's process of registering NHS trusts
- carrying out detailed examination into a particular healthcare/public health service.

The Scrutiny of Health Committee's powers include:

- reviewing and scrutinising any matter relating to the planning, provision and operation of health services in the local authority's area
- requiring NHS bodies to provide information within 28 days to and attend (through officers) before meetings of the committee to answer questions necessary for the discharge of health scrutiny functions
- making reports and recommendations to local NHS bodies and to the local authority on any health matters that they scrutinise
- requiring NHS bodies to respond within a fixed timescale to the health scrutiny reports or recommendations
- requiring NHS bodies to consult health scrutiny on proposals for substantial developments or variations to the local health service
- referring contested proposals to the Secretary of State for Health.

In addition to the County Councillors on the committee, there are also District Councillors. This helps ensure that there is as full as possible a consideration of health issues in a two-tier area.

**Work programme**
The topics for overview and scrutiny are identified by the committee Chairs, Vice-Chairs, Spokespersons and Members, advised by the relevant overview and scrutiny officer, using some of the following sources of information:

- Performance data, information and analysis, in particular when it has been benchmarked against similar local authorities
- Inspection reports, such as those produced by the Care Quality Commission or OFSTED
- National research findings
- National policy changes
- National and local consultations and public engagement events
- County Council Plan

- County Council budget and delivery against savings proposals and targets
- Agendas for Executive
- Local issues raised by elected members, members of the public or highlighted in the media
- Local networks and partnerships.

Where an initial area of interest or line of inquiry is identified, further information is gathered to ascertain whether this is a valid area for scrutiny that will add value and not duplicate work that is already underway.

On every agenda for formal meetings of the overview and scrutiny committees, there is an item on the committee work programme. This provides Members with an opportunity to reflect on the issues that have been identified and assure themselves that they are appropriate for the committee.

The work programme for this committee is in Appendix 1.

**Further information**
Further information on Overview and Scrutiny is available on the North Yorkshire County Council website - http://www.northyorks.gov.uk/article/23665/Scrutiny

The overview and scrutiny officer supporting the work of this committee is:

Daniel Harry, Scrutiny Team Leader
E: daniel.harry@northyorks.gov.uk
T: 01609 533531.

Committee papers are available from the North Yorkshire County Council website as follows - http://democracy.northyorks.gov.uk/

**Recommendation**

That Members review the Committee's work programme, taking into account issues highlighted in this report, the outcome of discussions on previous agenda items and any other developments taking place across the County.

Daniel Harry
Scrutiny Team Leader
Tel: (01609) 533531
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8 June 2017

Appendix 1

**NORTH YORKSHIRE COUNTY COUNCIL**
**Scrutiny of Health Committee – Work Programme/Areas of Involvement – 2017 and 2018**

(Note: Shading denotes period of on-going involvement/monitoring but without confirmed dates for items to the committee;
✓ = Confirmed agenda item)

| | 7 Apr | 23 Jun | 22 Sep | 15 Dec | 16 Mar | |
|---|---|---|---|---|---|---|
| **Strategic Developments** | | | | | | |
| 1. Implications on health and care services of Sustainability and Transformational Plans across North Yorkshire | ✓ | ✓ | ✓ | ✓ | ✓ | Verbal update by the STP lead officers at the 23 June 2017 committee meeting, in response to issues raised at 7 April 2017 meeting. |
| 2. NY Mental Health Strategy | | ✓ | | | | Follow up at 23 June 2017, particularly with regard to issues raised at 2 September 2016 meeting. |
| 3. Funding of Community Pharmacies | | | ✓ | | | Follow up to 27 January 2017 committee meeting – watching brief and Public Health impact monitoring. |
| 4. Health and social care workforce planning | | ✓ | | | | Proposal for joint scrutiny - review of work underway to address shortages of skilled, trained and experienced health and social care staff in the county. |
| 5. Suicide prevention and reduction | | | | | | Report to 3 November 2017 MCB. Follow up to audit in July 2016. |
| **Local Service Developments** | | | | | | |
| 6. Hambleton, Richmondshire & Whitby CCG: Hambleton and Richmondshire - "Fit 4 the Future", including developments at the Lambert Hospital, Thirsk | | | ✓ | | | Follow up on use of Lambert and continuity of care at 23 June 2017 committee. |
| 7. Hambleton, Richmondshire & Whitby CCG: Transforming our Communities – mental health services. | ✓ | ✓ | | | | Report on the early findings of the programme of public engagement/consultation and proposed next steps for the process of service reconfiguration. |
| 8. Hambleton, Richmondshire & Whitby CCG – future plans for Whitby Hospital | | | ✓ | | | Follow up to discussions at 3 March 2017 MCB. Update at MCB on 28 July 2017. |
| 9. Integrated prevention, community care and support in Scarborough and Ryedale | | | ✓ | | | 28 July 2017 MCB<br>22 September 2017 Committee. |

| | 7 Apr | 23 Jun | 22 Sep | 15 Dec | 16 Mar | |
|---|---|---|---|---|---|---|
| 10. Mental Health Service in York/Selby area and Bootham Hospital | | | | | | 28 July 2017 MCB – progress with business case and commencement of building. |
| 11. District Nurse Service – opening times, coverage, challenges - TBC | | | | | | 28 July 2017 MCB – initial discussion TBC |
| 12. Castleberg Hospital, Settle – update | | ✓ | | | | Formal report to committee on why the temporary closure was necessary and what plans there are for the future delivery of the service. |
| 13. James Cook, Darlington Memorial and Friarage –Siobhan McArdle and Janet Probert | | | | | | 28 July 2017 MCB |
| **Public Health Developments** | | | ✓ | | | |
| 14. Development of base-line data and an on-going monitoring system on the impact of Fracking. | | ✓ | | | | Lincoln Sargeant and Simon Padfield PHE. |
| 15. Dentistry provision in North Yorkshire - TBC | | | ✓ | | | Lincoln Sargeant to follow up and ascertain whether there are issues relating to access to services, especially on an emergency basis |
| 16. Pharmaceutical Needs Assessment for North Yorkshire | | | | ✓ | ✓ | |
| **In-depth Project** | | | | | | |
| 17. Dying well and End of Life Care | | | ✓ | | | Report to Health and Wellbeing Board on 17 March 2017. Follow up September. |

Other areas to be explored:

- Supporting people living with one or more long term condition
- Online medical advice and prescriptions
- Integration of health and social care – progress to date, principles and outcomes
- Health and social care services in Craven

**Meeting dates 2017/18**

| Meeting | | | | |
|---|---|---|---|---|
| Agenda Briefing | 20 June 2017<br>10.30am | 19 September 2017<br>10.30am | 12 December 2017<br>10.30am | 13 March 2018<br>10.30am |
| Scrutiny of Health Committee | 23 June 2017<br>10.00am | 22 September 2017<br>10.00am | 15 December 2017<br>10.00am | 16 March 2018<br>10.00am |
| Mid Cycle Briefing | 28 July 2017<br>10.30am | 3 November 2017<br>10.30am | 26 January 2018<br>10.30am | 27 April 2018<br>10.30am |