BUCKINGHAMSHIRE

A joint commissioning strategy for Adult Mental Health Services 2008 - 2011

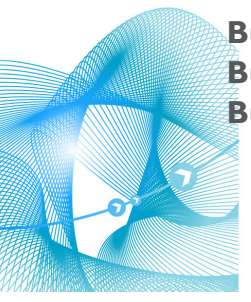
in partnership with

Buckinghamshire NHS
Primary Care Trust

Buckinghamshire County Council

Developed in partnership by:

Buckinghamshire Mental Health Partnership Board
Buckinghamshire Primary Care Trust
Buckinghamshire County Council



Contents

Executive Summary	4
Introduction	9
Our Vision	11
Background Context	15
Values and Principles	24
Previous Performance	28
Understanding Needs	39
Relating Needs to Supply	47
Financial Resources	61
Way Forward-Big Ideas	67
Strategy Implement and Review	95
Appendix 1- Glossary	96

Executive Summary

This Adult Mental Health Joint Commissioning Strategy considers the delivery of mental health services in Buckinghamshire for the period 2008 to 2011. It builds on the success of Buckinghamshire's previous strategy and takes the mental health modernisation process forward by laying out a number of key messages and commissioning priorities that will direct the delivery of services in the future.

Together, Buckinghamshire Primary Care Trust (PCT) and Buckinghamshire County Council have a joint responsibility for ensuring that adult mental health services are commissioned for the population of Buckinghamshire. In July 2006 both organisations signed a S31 Lead Commissioning Agreement and Pooled Budget for Adult Mental Health Commissioning across Buckinghamshire. As a result, the two organisations work together in a Partnership (S75 Health Act), with the 'lead commissioning responsibility' resting with the Primary Care Trust. This document sets out the joint commissioning and decommissioning intentions in relation to adult mental health for the period 2008-2011 for 'working age' adults in Buckinghamshire.

This is the second three-year integrated Adult Mental Health Joint Commissioning Strategy for Buckinghamshire building on the progress of the previous strategy. It contains the broad direction over a three-year period. One-year action plans will be produced on an annual basis to deliver implementation.

It provides a framework for the continuing direction of modernising mental health services and responds to a broad range of health and social needs, supporting Buckinghamshire to meet key national and local targets. The vision for the future of adult mental health in Buckinghamshire is one of improvement:

In Buckinghamshire we will ensure that funding is used on services that support our vision for improving mental health and well-being.

We will:-

- Prioritise better prevention services with early intervention. We will bring in more support to maintain good mental health and emotional well-being in the wider community.
- Give people more choice and a louder voice to take greater control over decisions about the way they want to live their lives and the services they need to support them to do this.
- Do more to tackle inequalities and social exclusion that leads to poor mental health and improve access to the services people may require.
- Provide more support in the community for people with long-term mental health conditions.
- Supporting people to themselves manage their condition with the right help from integrated health and social care services.
- Ensure that all delivery promotes recovery-based mental health services, helping people to realise their full potential and become active citizens within their local communities

There are a number of clear background principles for the commissioning of mental health services contained in this document. These follow the ten High Impacts, as described by the national Care Services Improvement Partnership.

Therefore, in Buckinghamshire, consideration for the commissioning of services will only occur where a service can demonstrate that it can achieve the biggest impact and maximum benefit for service users. Where the following High Impacts cannot be supported, services will not be commissioned:

- Home-based care should be treated as the norm for the delivery of mental health services.
- The flow of service users and carers across health and social care should be increased by improving access to screening and assessment.
- The variation in service user discharge processes should be managed.
- The variation in access to all mental health services should be managed.
- Unnecessary contact for service users should be avoided and contact where necessary should be in the right setting.

- The reliability of interventions designing care based on what is known to work should be increased and that service users and carers should be encouraged to inform and influence.
- A systematic approach should be applied to enable the recovery of people with long-term conditions.
- Service users flow should be improved by removing queues.
- Service user and carer flow should be optimised through the services using an integrated care pathway approach.
- Roles should be redesigned and extended in line with efficient serviced user and carer pathways to attract and retain an effective workforce.

Commissioning Messages

- The mental health agenda is broadening out towards inclusion and well-being and moving away from a focus on mental health specific policy targeted at specialist mental health services. There is a whole system responsibility to take this forward.
- Severe and enduring mental illness should be seen as part of the Long-Term Conditions agenda.
- This requires all parts of the health system and social care to co-ordinate services to tackle health and social inequalities through effective case management. For mental health services this needs to be through the Care Programme Approach.
- Promoting mental well-being and long-term condition management require the utilisation of different commissioning mechanisms.
- Mental health services need to have a focus on the outcomes being achieved for people and not solely on inputs and outputs.
- It is the intention to include service users whenever appropriate in being involved at both a strategic and individual care planning level.
- It is recognised that, for the majority of service users, the focus will be on being involved in the development and implementation of their own individual care plan.

This integrated commissioning strategy has to address:-

- Improvements in health and social care performance indicators which impact on the Primary Care Trust, Local Authority and Mental Health Trust performance.

- Service modernisation will need to be directly linked to improved performance against identified national and local priority areas and targets.
- It is the role of commissioners and the Mental Health Joint Management Group to monitor delivery against this strategy.

Commissioning Priorities

- Adult Mental Health Joint Commissioning will operate a transparent process for working with provider partners. This will include clarity around commissioning, contracting, monitoring and reviewing arrangements, and the promotion of stability in the provider market.
- Whilst provider integration between health and social care has taken place at a structural level with the S75 provider agreement there are still issues around the delivery of integrated services at a practical level. These issues must be addressed to ensure that resources are effectively targeted.
- Further attention will be paid to strengthen the commissioning relationship between Buckinghamshire Primary Care Trust and Buckinghamshire County Council to make best use of the pooled commissioning arrangement.
- During the lifetime of this commissioning strategy it will be critical that we further extend capacity within primary care by supporting people with mild and moderate mental health difficulties to retain, or move back into, paid work.
- Where appropriate we will promote the use of individualised budgets.
- Services to support and address the significant health inequalities of people with a severe and enduring mental illness will be a key priority of this strategy.
- Representations will be made to the Buckinghamshire Local Strategic Partnership to ensure that mental health has a significant profile within the prevention agenda in the Local Area Agreement.
- Proper integration of all counselling and therapy services will be achieved through the development of the Improving Access to Psychological Therapies Service.
- The delivery of effective alternatives to admission services will underpin the modernisation of inpatient services in accordance with the decisions made as an outcome of the 'Putting People First' consultation. Buckinghamshire PCT will actively work with the

provider mental health trust to support, progress and implement Foundation Trust status.

- To ensure that the outcome of the consultation in respect of inpatient services is delivered and that Buckinghamshire PCT and the provider mental health trust progress the build of the mental health unit on the Manor House site in Aylesbury.
- An integrated prison mental health in-reach service will be developed to cover all three custodial sites in Buckinghamshire.
- Wherever possible services will be delivered as close to people as possible. Those placed in out of county residential care and nursing placements will be reviewed to ensure we are supporting people to move on and that we are getting value for money.
- We will review the provision of home support to ensure that we use the new Supporting People funded floating support services as part of a pathway to provide accommodation and support for people with mental health difficulties and that access arrangements are clear and streamlined.
- The modernisation of Group Homes and the Home Options project will need to continue to deliver more appropriate accommodation.
- There will be a full and systematic review of all adult mental health day services with the intention of having in place day services that meet the needs of service users and promote independence, provide equity in availability across the county, and promote stability in the provider market.
- In order to maintain current performance we will consider how we will continue to meet the needs of carers.
- A satisfactory workforce will need to be reviewed and commissioned, taking into account the changes in roles of Approved Social Workers and the implementation of the Approved Mental Health Professional role.
- During the timescale of this document the County Council will lead a review of the Out of Hours Emergency Duty Team. This will involve some development tasks being carried out by Mental Health Commissioning.
- Wherever possible we will encourage the involvement of service users at strategic planning, service review and development. Commissioners will actively work with the Mental Health Partnership Board and individual care planning levels.

Introduction

This section of the strategy:

- ***Introduces the relationship between Buckinghamshire Primary Care Trust and Buckinghamshire County Council***
- ***Gives a definition of the commissioning strategy and its scope***

Buckinghamshire Primary Care Trust and Buckinghamshire County Council have a joint responsibility for ensuring that adult mental health services are commissioned for the population of Buckinghamshire. In July 2006 both organisations signed a S31 Lead Commissioning Agreement and Pooled Budget for Adult Mental Health Commissioning across Buckinghamshire. As a result, the two organisations work together in a Partnership (S75 Health Act), with the 'lead commissioning responsibility' resting with the Primary Care Trust. This document sets out the joint commissioning and decommissioning intentions in relation to adult mental health for the period 2008-2011 for 'working age' adults in Buckinghamshire.

This is the second three-year integrated Adult Mental Health Joint Commissioning Strategy for Buckinghamshire building on the progress of the previous strategy. It contains the broad direction over a three-year period. One-year action plans will be produced on an annual basis to deliver implementation.

It provides a framework for the continuing direction of modernising mental health services and responds to a broad continuum of health and social needs, supporting Buckinghamshire to meet key national and local targets.

What is a Commissioning Strategy?

A commissioning strategy is a formal statement of plans for securing, specifying and monitoring services to meet peoples' needs at a strategic level. It applies to services provided by the NHS and Local Authority, other public agencies and the private and voluntary sectors.

This commissioning strategy is a plan which will:-

- Effect change in the overall configuration of adult mental health services to meet the needs of the adult population of Buckinghamshire.
- Ensure service change is commissioner led, based on evidence of what works best.
- Provide a statement of commitment about the way in which the commissioning agencies intend to purchase services for the population in the future.

The scope of this Commissioning Strategy

The Adult Mental Health Commissioning Strategy considers four tiers reflecting the Standards within the Mental Health National Service Framework and the service user pathway.

- **Tier One - Promotion and Prevention.**
- **Tier Two - Primary Care.**
- **Tier Three -Specialist mental health care (secondary health care and social care).**
- **Tier Four - Tertiary Services.**

It should be noted that tier four is not covered in this document in detail as the commissioning responsibility sits with the Locality Specialised Commissioning Group led by South Central Strategic Health Authority.

Our Vision

This section of the strategy:

- ***Describes the broad vision for mental health services in the future***
- ***Considers the evidence base for service improvements***

'because Every Adults Matters' (bEAM) is the strategic framework for the development of Adult Social Care Services in Buckinghamshire.

It is the County Council's delivery vehicle to support the implementation of the White Paper 'Our Health, Our Care, Our Say'. 'bEAM' is a progressive approach to the provision of services to the whole community bringing a shared philosophy to planning, commissioning and the provision of services to the County Council and its partners. This document sets out how the bEAM vision is delivered in Buckinghamshire over the next three years for people with a mental health difficulty.

In Buckinghamshire we will ensure that funding is used on services that support our vision for improving mental health and well-being by:

- **Applying the minimum intervention necessary**

By prioritising better prevention services with early intervention we will bring in more support to maintain good mental health and emotional well-being in the wider community.

- **Achieving Independence and Control**

Give people more choice and a louder voice to take greater control over decisions about the way they want to live their lives and the services they need to support them to do this.

- **Promoting well-being**

Do more to tackle inequalities and social exclusion that lead to poor mental health and improve access to the services people may require.

- **Ensuring timely access to services for those people who are eligible and safeguarding the most vulnerable**

Provide more support in the community for people with long-term mental health conditions. Supporting people to manage their condition themselves with the right help from integrated health and social care services and ensuring that all delivery promotes recovery based mental health services; helping people to realise their full potential and become active citizens within their local communities

Preventative services that support people to maintain their independence are central to the vision. This strategy incorporates preventative services at every level of service provision whether that is low-level services for people with mild and moderate mental health difficulties, through to services for those with the most complex needs. The commissioning priorities in this document all have a preventative focus.

Evidence base for service improvements in mental health

In Buckinghamshire we will ensure that all commissioned services support improved outcomes for individuals. These outcomes embedded in the White Paper 'Our Health, Our Care, Our Say' are set out below. We believe that if we are providing the right services then people will tell us that:-

'I am as healthy as I can be'- Improved health and emotional well-being

People living longer and with better physical, mental and emotional health. More people living healthier lifestyles.

'I am able to live a fulfilled life'- Improved quality of life

Better access to ordinary housing, transport, leisure, information, life long learning and support that promotes well-being. More people living in a cohesive community with a good environment and little crime.

'I can participate as a full and equal member of my community'- Making a positive contribution

People living, working, learning and taking part in community life as equal members. More people involved in planning and decision making about the direction of services. More people reporting a positive experience of using services and increased support and recognition for carers.

'I have the same life chances as other adults'- Exercise of choice and control

People with mental illness with a Person-Centred Plan, determining for themselves where they live, how they are supported and how they spend their day. Reliable information and advice available in accessible formats. More people accessing equipment and assistive technology and fair and equitable complaints systems. More people getting Direct Payments and Individualised Budgets.

'I have an equal chance to live free from avoidable harm, fear, discrimination and prejudice': Freedom from discrimination and harassment

Action is taken against maltreatment, neglect and exploitation, including hate crime. More people report reduced discrimination, harassment and abuse. Opportunities to build and sustain valued relationships and raise a family.

'I am financially stable and have as much control as possible over my money': Economic well-being

More people have access to financial information, welfare benefits and employment opportunities.

'I feel valued by others': Maintaining personal dignity

More people experience secure, stable and good quality care. People experience privacy in all settings – home, residential care and hospital – and appropriate levels of confidentiality. People feel they are treated with respect and listened to, have a sense of self-worth and are valued by others.

In addition to the delivery of the outcomes set out above we will ensure that all commissioned services support the delivery of the ten High Impact Changes (www.csip.org.uk). Decommissioning decisions will be made where services cannot demonstrate that they achieve the biggest impact and maximum benefit for service users.

We will expect the benefit to be based upon the following

High Impact 1	Treat home based care as the norm for the delivery of mental health services
High Impact 2	Improve flow of service users and carers across health and social care by improving access to screening and assessment
High Impact 3	Manage variation in service user discharge processes
High Impact 4	Manage variation in access to all mental health services
High Impact 5	Avoid unnecessary contact for service users and provide necessary contact in the right setting
High Impact 6	Increase the reliability of interventions, designing care based on what is known to work and which service users and carers inform and influence
High Impact 7	Apply systematic approach to enable the recovery of people with long term conditions
High Impact 8	Improve service users flow by removing queues
High Impact 9	Optimise service user and carer flow through the services using integrated care-pathway approach
High Impact 10	Redesign and extend roles in line with efficient services, user and carer pathways to attract and retain an effective workforce

Background Context

This section of the strategy:

- ***Describes the national drivers for change***
- ***Describes the local drivers for change***

National Drivers for Change

In Buckinghamshire we will ensure that the provision of mental health services and the way we commission mental health services supports the local implementation of national policy.

Our challenge over the lifetime of this strategy is to not only deliver on the mental health specific requirements but more critically to ensure that mental health is central to the delivery of the mainstream health and social care agenda. This will require a joined-up approach across all agencies. The Primary Care Trust and Local Authority have a key role in driving this forward.

National Mental Health Policy Context

National Service Framework (NSF)

- A 10-year national strategy to improve adult mental services for people against seven standards. These include a focus on improved mental health promotion, specialist primary care mental health services, specialist secondary mental health services, services for carers and suicide prevention
- Health and social care organisations have been monitored against their local delivery of the NSF through the Autumn Assessment and key service deliverables have formed a major part of the organisational star rating of PCTs and Mental Health Trusts.

NSF Five Years On 2005

- A re-cast for the final five years of the NSF. As we move towards 2010 there will not be a focus on new developments within specialist mental health services but will be bringing mental health into the wider health and social care policy agenda.
- The priorities for the final five years are choice, social inclusion, care of long-term conditions, dual diagnosis and improved access to services in a primary care setting.
- Performance assessment framework for mental health over the final five years of the delivery of the NSF will reflect this shift in focus.

Mental Health and Social Exclusion Report 2004

- Adults with mental health problems are the most disadvantaged and socially excluded group in society.
- This forms the Local Authority's agenda for mental health services, addressing the areas that were silent in the National Service Framework.
- It is everyone's agenda to address the barriers that lead to social exclusion
- There is a 27-point national action plan, the responsibility for the delivery of which sits with the Director of Social Services locally.
- The Layard Report published in 2005 by the Prime Minster's Policy Unit identified that 'mental health is the biggest social problem of our country' as it affects people with mild and moderate mental health problems.
- This led to the establishment of Pathways to Work pilots to provide psychological therapy support for people on incapacity benefit to enable them to return to work.

The Future of Mental Health: a Vision for 2015

- By 2015 mental well-being will be a concern of all public services.
- There will still be people who live with debilitating mental health conditions, but the focus of public services will be on mental well-being rather than mental ill-health.
- The balance of power will no longer be so much with the system, but instead there will be more of an equal partnership between services and the individuals who have used or even choose them.

Mainstream Health and Social Care Policy Context

The Joint Strategic Needs Assessment (JNSA) came from the Social Care Green Paper 'Independence, Well-being and Choice'. It was reinforced in the Health White Paper,' Our Health. Our Care, Our Say'. The Local Government and Involvement Act 2007 specify that LA and PCT produce a JSNA for the health and well-being of the local community.

JSNAs are seen as an essential and statutory requirement to effective commissioning as outlined in the recent Commissioning Framework for Health and Well-being. It is a key means by which the PCTs and the LA will describe the future health, care and well-being needs for local populations both in preparation for the new LAAs and to inform commissioning strategies.

'Choosing Health' White Paper (DH 2004)

- Acknowledges the key role of mental health promotion "because mental well-being is crucial to good physical health and making healthy choices".
- States stress is the commonest reported cause of sickness absence and a major cause of incapacity.
- Reconfirms the need to focus on suicide prevention. This is a key performance indicator for mental health trusts.

'Our Health, Our Care, Our Say' White Paper (DH 2006)

- Sets a new direction for health and social care community service systems
- Focuses on providing services closer to peoples homes or work places
- Requires health and social care services to integrate to meet peoples needs at different stages of their lives. For mental health this means integrated specialist and primary care services
- Helping people to help themselves and involving people in shaping local services.

Change Up: 2002

- This is the cross-Government framework on capacity building and infrastructure in the Voluntary and Community Sector.
- The role of the voluntary sector is pivotal in the delivery of mental

health services as the 'third sector', hence implementation of the Change Up framework will be required.

'A New Deal for Welfare – Empowering People to Work' (DWP, 2006)

- Aims to end benefit dependency and deprivation.
- 'Roll out Pathways to Work by 2008' aimed to get people with mental health problems on incapacity benefit into paid employment.
- Target to reduce the number of people on incapacity benefit by one million.

'Transforming Social Care' (DH, 2008)

- The Local Authority Circular sets out information to support the transformation of social care.
- It describes the vision and expectation for development of a personalised approach to the delivery of adult social care over the next three years.

The Centrality of Commissioning to Drive Improvement

Commissioning competence for the first time is now formally being assessed. Across both health and social care there is an increased emphasis on the role of effective commissioning to drive improvement and change.

- For the NHS, these changes are being driven through the policy of 'Commissioning a Patient Led NHS'.
- For social care, the new Social Care outcomes framework has commissioning as one of the seven areas of focus.
- For health and social care commissioning, competence will be assessed against Joint Commissioning and Contracting frameworks to underpin 'Our Health, Our Care, Our Say'.

New commissioning mechanisms are being established and a competent commissioning system will need to demonstrate use of these. The commissioning mechanisms are:-

Practice Based Commissioning

- PCT retains the strategic commissioning responsibility.
- Practices are given an indicative budget for commissioning services on behalf of the PCT for their practice population based on an agreed set of priorities with the PCT.
- Practices have the opportunity to develop alternative services to secondary care within primary care utilising a range of providers including the private and voluntary sector. This is the contestability test.
- Practice Based Commissioning will be effective when there are real alternatives in the market place.
- In Buckinghamshire localities of practices have formed. Practice sign up is significant but not universal.
- Early Practice Based Commissioning priorities will focus efforts on general acute services as opposed to mental health.

Payment by Results

- A tariff (price) for specific healthcare activity is paid by the PCT to health care providers. This is determined nationally.
- Payment by results complements practice based commissioning as it enables a unit cost calculation to develop the indicative practice level budgets for practice based commissioning.
- For mental health, payment by results is not operational. A national target date for the introduction of payment by results for mental health is 2008.
- Work is underway nationally to consider what Payment by Results will mean for mental health.

Foundation Trusts

During 2008, all provider NHS Trusts will become Foundation Trusts. This affects the commissioning / provider relationship for the following reasons:-

- Foundation Trusts are able to borrow money and invest money without some of the current restrictions.

- Foundation Trusts require that the service level agreement with commissioners is a legally binding contract for a three-year period. This differs from the previous arrangement of a one-year service level agreement which has no legal status.
- Foundation Trusts have greater flexibility to commission the voluntary and private sector directly to provide services on their behalf.
- Local Authorities, through integrated services, will need to have robust governance structures in place with provider Trusts for service provision and with health commissioners to manage demand and cost.
- Provision for greater accountability at a local level through revised governance arrangements.

Individual Budgets

- Changes the way in which social care packages are costed and managed through providing an individual budget from which services are commissioned.
- Power shifts from the Council to the individual to manage the social care market with the support of effective information, advice and brokerage systems.
- Individualised budgets can include other streams of funding including supporting people, independent living fund, and access to work, in addition to social care budgets.

Health Act Flexibilities (referred to as Section 75 partnership agreements)

- Enable health and Local Authorities to delegate responsibility to either party.
- The three flexibilities of integrated provision, pooled budgets, lead commissioning can be used on their own or in combination to integrate services.
- The flexibilities enable the establishment of clear governance arrangements for integration underpinned through a legally binding agreement.
- Health and social care will be monitored on their use of Health Act flexibilities.

Local Area Agreements

- Provide the opportunity to set out whole system targets to support improvements in health and well-being.
- Representations will be made to the Buckinghamshire Local Strategic Partnership to ensure that mental health has a significant profile within the prevention agenda in the Local Area Agreement.
- Representation will be made to the Buckinghamshire Local Strategic Partnership to ensure that mental health has a significant profile within the new LAA agreement to be established in 2008.

Local Drivers for Change

The following are some of the key factors and challenges that need to be addressed in looking at future mental health provision in Buckinghamshire:

Partnership arrangements

The Health Act 2000 (now incorporated into the Health Act 2006) created a number of Health Act flexibilities that enabled health authorities and social care authorities to delegate roles, functions and tasks to each other. In Buckinghamshire Mental Health Services we have signed agreements at:

(i) ***A commissioning level***

The PCT has taken on the role of lead commissioner for health and social care and the role of pooled budget manager with responsibility for managing the lead funds for health care and for social care and the pooled fund for health and social care. The governance arrangements provide for accountability through a joint management group in which senior managers represent both authorities in equal numbers with accountability to their respective organisations. The Pooled Budget Manager on behalf of the Joint Managing Group provides an annual report on its work to the respective Boards, MH Partnership Board and the Adult Commissioners Board.

(ii) ***A provider level***

The Mental Health Trust operates secondary and specialist health and social care services through a fully pooled budget.

The governance arrangements provide for the Chief Operating Officer of OBMH as Pooled Budget Manager to account through a Joint Management Group for achieving the objectives of the pool and delivery of the Mental Health (MH) commissioning priorities assigned to the Trust.

The first of these agreements was made under section 31 of the 2000 Act and the second under section 75 of the 2006 Act which by then had replaced it without change to the content of the legislation.

Buckinghamshire Community Strategy 2005 – 2008

The Local Government Act 2000 places a duty on County and District Councils for Buckinghamshire to prepare 'community strategies', for promoting or improving the economic, social and environmental well-being of their areas, and contributing to the achievement of sustainable development in the UK. Developed by the Local Strategic Partnership, the Buckinghamshire Community Strategy 2005-2008 provides the framework for joint action by the public, private and voluntary organisations in the county. It has an ambitious and long-term vision for Buckinghamshire. The priorities for action are set against the following seven themes for improvement:-

- **Quality of Life for Older People.**
- **Safe Communities.**
- **Cohesive Communities.**
- **Healthy Communities.**
- **Prosperous Communities.**
- **Accessible Communities and Transport.**
- **Superb Environment.**

The new Local Area Agreement for Buckinghamshire is the core delivery plan for the strategy, setting out in detail how each partner will contribute to it. The LAA is not the only way the Community Strategy will be achieved, but it is the core element. Whilst mental illness is not referred to directly in the Community Strategy for 2005-2008 two of the key themes have a direct impact on the quality of life of people with

mental health difficulties. The priorities set against Healthy Communities and Prosperous Communities include a focus on lifestyle and physical health. Given the clear connection between poor life circumstances and mental health, this theme has relevance to improving the lifestyle and physical health of people with a severe and enduring mental illness and ameliorating the impact of poor physical health on mental well-being.

Strategic Direction for Health Services in Buckinghamshire

Buckinghamshire Primary Care Trust's strategic vision for health services is to ensure that people receive the 'right care, in the right place at the right time'. Central to delivering this is to continue to shift the balance of provision from secondary care to primary and community services and promoting choice for the service user.

Over the next three years, there will be a greater use of the independent and third sector to provide health care services, as all services will be subject to the test of contestability. GP practises through practice-based commissioning will be encouraged to develop more services in primary care settings, whilst secondary care providers will have greater opportunities to attract patients from outside of their traditional geographical boundaries. The direction is one of a commissioning led NHS, with informed patients exercising choice in partnership with their local GP.

Values and principles

This section of the strategy:

- ***The core values and principles***
- ***The importance of Service User involvement***

Core Values behind this strategy

This Commissioning Strategy promotes:

- The commissioning of services that help maintain the independence of individuals.
- The provision of services that are well planned and integrated.
- Making the most effective use of available resources to meet the needs of a diverse community.
- Services of high quality and delivered by a well-trained workforce.
- The provision of services with an emphasis on recovery and preventing problems.
- The promotion of community-based services wherever possible.
- The importance of organisations working in partnership with each other in service delivery.

The success of mental health services can be assessed against the following outcomes for the Buckinghamshire population:

- Improved health.
- Improved quality of life.
- Making a positive contribution.
- Exercise of choice and control.
- Freedom from discrimination or harassment.
- Economic well-being.
- Personal dignity.

The Importance of Service User and Carer Involvement

Service Users and Carers are 'experts by experience'. Their perspectives are not only essential to the planning and delivery of their own care and support, but are also required in all aspects of mental health service planning, development, delivery and evaluation of services. The implementation of successful service user and carer involvement is identified as a clear policy imperative in the NHS Plan and the NSF.

This strategy is committed to the meaningful and effective involvement of users and carers across all tiers of this document.

Whilst the successful delivery of modernisation set out in this document will provide a framework to improve service users and carers experience of mental health services, more is required to ensure that service users and carers are equal partners both in terms of decisions that are made about their own care and the development of services at a strategic level.

Service User and Carer Involvement - a strategic approach

The achievement of effective involvement requires the development of structures and processes to ensure that the principles of partnership are embedded within this document. This strategy will support the development of a structure which will ensure the delivery of several key outcomes:-

- Involvement in planning decisions to ensure that services, systems and structures meet the needs of users and carers.
- Involvement in service developments.
- Participation in service review and audit.
- Representation in the overall governance agenda.
- Contribution to, and influence of, the education, training and research and development agenda.
- Involvement in staff recruitment, induction and training.
- Increasing the numbers of service users and carers in paid employment.

This strategy is committed to overcoming the barriers which prevent meaningful participation and will ensure that:-

- A structural framework is developed to ensure that the outcomes identified above are achieved and services commissioned to ensure that this takes place.

- That service users and carers will be supported in their involvement through appropriate training, expenses, induction and access to administrative resources.
- Carers and service users will receive the information and support they require to carry out their role effectively.
- Carer and service user representation will also include the needs and interests of minority groups.

Service User and Carer Involvement - a care planning approach

Service Users and Carers as well as being involved in the planning, design and development of services also need to be partners in the planning and delivery of their own care and support. A number of national policy directives will be implemented over the lifetime of this strategy which will have a significant impact on how we commission services.

Delivering choice cannot simply be bolted on to existing services, it requires fundamental changes to the way those services work and investment in support systems to enable people to make informed choices about their care. As commissioners we will have to demonstrate how people have more choice over their own care. A number of mechanisms are already available to people to help support the delivery of these objectives, some are already being implemented, others will be adopted throughout the life of this document. The commissioners are committed to the following:-

- Both carers' and service users' rights are established through an assessment of their needs.
- That all people with mental illness who are subject to enhanced CPA will be eligible for independent support and advice at the time of assessment and review.
- All carers of people with a severe and enduring mental illness, where a person is either on enhanced CPA or has a Community Care Assessment, will be eligible for an assessment of their needs. (The Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000/ Standard 6 of the MHNSF, Carers Equal Opportunities Act 2004).
- That all carers of people on enhanced CPA will receive independent advice and support at the point of assessment, the gateway into services. This will support the Implementation of the Carers Equal Opportunities Act 2004.

- All service users and carers will receive a signed and agreed copy of their support plans, stating clearly their needs, who the partners to the agreement are and who will take responsibility for particular elements of the service response, a detailed Crisis Plan, and an Advance Directive.
- Those service users who are compulsorily detained under the Mental Health Act 1983 will be able to access independent support and advice at the point of review and access Mental Health Act Tribunals.

Mental Health Partnership Board

The Mental Health Partnership Board (MHPB) is Buckinghamshire's main mental health forum taking on the responsibility, as a Local Implementation Team, for considering the implementation of the Mental Health National Service Framework. Its purpose includes:

- Informing the strategic direction for mental health services for Buckinghamshire in response to need and local and national policy through the development of a Mental Health Strategy to inform the commissioning and provision of mental health services.
- Providing effective leadership and direction to the mental health community of Buckinghamshire.
- Ensuring that mental health services are effectively planned, delivered and reviewed at both a local and county level.
- Ensuring that best use is made of available resources.
- Championing the inclusion of service users and carers to ensure that services are locally accessible and responsive.
- Championing the broader mental health agenda across statutory partners and through the community of Buckinghamshire through local community planning arrangements.
- Overseeing the implementation of the Mental Health National Service Framework through acting as the Buckinghamshire Local Implementation Team.
- Ensuring that local arrangements are in place to support the smooth and effective transition between children's, adults and older adults mental health services and that there are effective protocols and joint working arrangements in place with other services where appropriate.

Previous Performance in Buckinghamshire

This section of the strategy:

- ***Looks at how services have changed in recent years***
- ***Describes general performance in the NHS and Local Authority***
- ***Outlines specific performance of mental health services***
- ***Outlines specific performance against the Healthcare Commission/CSCI review of community services***

Service changes in recent years

The key strategic changes in mental health provision across Buckinghamshire in recent years need to be understood within the context of the delivery of the National Service Framework for Mental Health. This National Service Framework is a ten-year plan. The modernisation of mental health services both nationally and locally needs to continue to reflect the scale of the reform and a recognition that this will not occur overnight. These changes can be characterised generally by specialist mental health services including:-

- Reduction of inpatient care.
- Development of new community teams offering alternatives to admission and home treatment, early intervention or intensive support for people with complex needs.
- New specialist mental health workforce within primary care.
- Social care services that promote recovery, social inclusion and self-determination and to reduce social isolation.

On the following page are the new service developments that have taken place over the lifetime of Buckinghamshire's previous Mental Health Commissioning Strategy. This current strategy will build on service modernisation and support the full implementation of those priorities that commenced during the earlier strategy, as well as identifying new areas for development.

Tier 1. Mental Health Promotion	Limited progress was made in this area during 2003-2006. The developing strategy is currently being finalised and implementation will be a key area for action during 2008-2011.
Tier 2. Primary Care Mental Health	Since 2005, £750,000 recurrent new investment to develop three Primary Care Mental Health Teams, one in each of the old three PCT localities of Buckinghamshire.
Tier 3 Specialist Mental Health Services	<u>Acute care pathway</u> New services have been developed which support the delivery of intensive, round the clock home treatment as a first line of response instead of admission to hospital • Since 2004, £529,000 New Crisis Resolution and Home Treatment Services provided by OBMHT and Berkshire Healthcare Trust • Since 2006 reconfiguring services to provide acute day hospital services seven days a week
Tier 3 Specialist Mental Health Services	<u>Long term conditions pathway</u> • Since 2003, £635,000 per year has been spent on delivering the assertive outreach services. Since 2005, £250,000 per year has been spent on delivering early intervention and psychosis services. • Since 2005, £2 million pounds capital investment has been made available to purchase 22 self-contained flats distributed across the county • Since 2005, £210,000 worth of new investment for six new flats in High Wycombe with access to 24-hour on site support • Since 2005, a framework to purchase individual packages of care so people have access to intensive and flexible community support in their own homes 24 hours a day, 365 days per year. • Since 2005, £210,000 has been made available to support people with long term mental health needs find meaningful paid employment • Since 2004, five new carer support workers to support informal family carers of people with long-term mental health conditions
	<u>Sub Speciality Services</u> • Since 2004, £117,000 has been made available to provide Prison In-reach to Aylesbury Young Offenders • Since 2005, £210,000 new investment for community based services for people with a personality disorder working as part of a service across Berkshire, Buckinghamshire and Oxfordshire.

'Putting People First' Public Consultation

In 2005 a public consultation was led by the three former PCTs in partnership with the then Buckinghamshire Mental Health Trust to establish the future shape of specialist mental health services provided in tier three of this document. This consultation formed the Mental Health element of 'Shaping Health Services' and sought views on the following:-

- Changing the management of specialist mental health services for South Bucks District
- Developing high quality community and inpatient services for adults of working age, older adults and people with a learning disability across Buckinghamshire.
- Developing services for people who have a long- term mental health condition across Buckinghamshire.

A decision-making meeting was held in January 2006 with executive level representation from the three PCTs and the Mental Health Trust supported by the Public Health Overview & Scrutiny Committee, Buckinghamshire County Council and the Patient Public Involvement Forum. This Board made the decision to support the following changes in specialist mental health services:-

- Develop a new inpatient unit for adults of working age at Manor House in Aylesbury, replacing the inpatient wards in Amersham and Aylesbury.
- Transfer the management of services for people in South Bucks district to OBMH in late 2006.
- Develop two Crisis Resolution and Home Treatment Teams and extend the two-day hospitals in High Wycombe and Aylesbury from five to seven days a week.
- Resettle people who do not require continuing hospital care into suitable community based accommodation and support the closure of an inpatient rehabilitation unit in High Wycombe, leaving one unit in Aylesbury

Whilst a number of outcomes of the decisions made as part of 'Putting People First' have now been delivered, this commissioning strategy will support the continued prioritisation of the formal decision made in respect of this consultation, particularly in relation to the development of a new single site on the Manor House site in Aylesbury. Full details on the consultation are available on the 'Putting People First' website www.mentalhealthinbucks.nhs.uk

Organisational Performance for 2006/07

The annual Health Check is a comprehensive assessment process that assesses NHS Trust's performance. It scores NHS organisations against their:-

- Use of resources based on how well an organisation in the NHS manages its finances. This could include how it plans and reports on its financial performance, how it monitors the money it spends, and how it makes sure that the services it offers to patients represent good value for money.
- Quality of services covers a range of areas within a healthcare organisation that can affect the care and treatment a patient receives, including access to services, safety and the way an organisation is run. In particular, it reflects whether an organisation provides the basic standards of care required by the Government and whether it strives to improve the care and treatment it provides for patients.

Both parts of the assessment process are scored on a four-point scale of 'excellent', 'good', 'fair', and 'weak'. The performance of NHS organisations with either responsibility for commissioning or providing services for people with mental health difficulties is set out below.

Organisation	Quality of Service	Quality of Resource
Oxfordshire and Buckinghamshire Mental Health Trust	Fair	Good
Buckinghamshire PCT	Fair	Weak

Local Authority - Adult Social Services Performance

The Commission for Social Care Inspection (CSCI) has rated Adult Social Services as being a two-star authority, which is achieving good outcomes with promising prospects for 2006/07. The following table sets out the CSCI judgement against the new outcome framework

Areas of Judgement	Grade Awarded
Delivering Outcomes	Good
Improved health and emotional well-being	Good
Improved quality of life	Good
Making a positive contribution	Good
Increased choice and control	Good
Freedom from discrimination or harassment	Good
Economic well-being	Good
Maintaining personal dignity and respect	Adequate
Capacity to Improve (Combined judgement)	Promising
Leadership	Promising
Commissioning and use of resources	Promising
Star Rating	**2 Stars**

Each year the local 'mental health system' in Buckinghamshire is required to carry out a structured self assessment against a number of criteria relating to deliverables in the National Service Framework – this is called the Autumn Assessment. Set out below is the most recent self-assessment developed by the Buckinghamshire LIT. The Commissioning Strategy will have to support improved performance against those areas that are rated amber or red.

Key:

- **Green = national target fully achieved**
- **Amber = national target partially achieved**
- **Red = national target not achieved at all**
- **NB = where target date has not yet passed (red is not on track to hit target and amber is on track)**

Self Assessment Theme	Performance in previous year	Performance in 2006/2007
Graduate Workers		
Primary Care – Secondary Care Interface	N/A	
Crisis Resolution		
Early Intervention in Psychosis		
Secure Places/Intensive Care		
StaR Workers		
Local Strategic Partnerships		
The Mental Health of People with Learning Disabilities		
Vocational Support	N/A	
BME Services	N/A	
Delivering Race Equality in mental health care		
Community Development Workers		
Co-ordination between age specific services		
Governance		
Service User Involvement		
Carer Involvement		
'Not for profit' sector involvement		
Employment of service users		
Suicide prevention		
Advocacy		
Mental Health Promotion		
Specialist services		
Personality disorder services	N/A	
S135/136 Place of Safety		
Improving access to psychological therapies	N/A	
Choice	NA	

In addition to the National Service Framework performance 'themes' above, there are a number of specific adult mental health indicators that impact on the organisational performance of both the NHS and Local Authority. In order to compare 'like-for-like', what is set out below is the

Performance Target Indicator	Target source	Who owns the Target	Target	Performance
Prevalence rate of patients on practice register of people with severe long-term mental health problems who require and have agreed to regular follow–up (rate per 1000 of population)	Choosing Health - LHP indicator	Bucks PCT		
The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	QOF Target – MH6	Bucks PCT		
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by practice team within 14 days of non-attendance.	QOF Target – MH7	Bucks PCT		
The percentage of patients with diabetes and/or heart disease for whom case finding for depression has been undertaken on one occasion during the previous 15 months using the two standard screening questions	QOF Target – DEP 1	Bucks PCT		
In those patients with a new diagnosis of depression, recorded between the preceding 1st April and 31st March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care.	QOF Target – DEP 2	Bucks PCT		
Delivery of NICE guidance for depression • CBT • Computerise CBT	NICE	Bucks PCT	No target set	
New Workforce - Community Development workers	LDP Return HCC	Bucks PCT	3	

New Workforce – Gateway Workers	LDP Return HCC	Bucks PCT	3	
New Workforce - Graduate Primary Care Workers	LDP Return HCC	Bucks PCT	7	
Early Intervention in Psychosis (EIP) Team number	LDP Return	OBMH	1	
Numbers of people in receipt of EIP	LDP Return	Bucks PCT	159	
Minimum Data Set completeness	Key target HCC	OBMH	80%	
Crisis Resolution and Home Treatment Team	LDP Return HCC	OBMH PCT	2	
Numbers of people to receive Crisis Resolution and Home Treatment	LDP Return HCC	Bucks PCT	Target 706 cases	
Psychiatric Re-admissions	PSS PAF target A10 joint with health	BCC/ OBMH	Less than 5%	
Average Length of inpatient stay	Not a formal indicator	OBMH		
Bed occupancy levels	Not a key target	OBMH	86%	
Delayed Transfers of Care	Not national target. Now a central return.	LA / PCT		
CPA 7-day follow-up	LDP Return – HCC	Bucks PCT		
Assertive Outreach Team caseload	LDP Return HCC	OBMH	169	
Number of people in receipt of a direct payment	PSS PAF – C51	BCC in partnership with OBMH		
Number of people helped to live at home – C31	PSS PAF – C31	BCC		
Carers Services	PSS PAF – C62	BCC		
New Workforce - Support Time Recovery Workers	LDP Return HCC	Buckinghamshire PCT / BCC	21	
New Workforce - Carers Support Workers	LDP Return HCC	Buckinghamshire PCT / BCC	5	

Permanent admissions (aged 18-64) to residential or nursing care	PSS PAF C73	LBB	12 admissions PA	
Intensive Home Care as a percentage of intensive home and residential care	PSS PAF B11	LBB	24%	
Percentage of people receiving a statement of their needs and how they will be met	PSS PAF D39	BCC in partnership with OBMH	97%	
Clients receiving a review (% of total number of people receiving a service in any one year)	PSS PAF D40	BCC in partnership with OBMH	85%	
Achieve year on year reductions in MRSA levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available.	HCC – Core Standard	OBMH		
Reduce health inequalities by 10% by 2010 (from a 1997 - 1999 baseline) as measured by infant mortality and life expectancy at birth.	HCC Core Standard	OBMH		
Reducing adult smoking rates (from 26% in 2002) to 21% or less by 2010, with a reduction in prevalence among routine and manual groups (from 31% in 2002) to 26% or less.	HCC Core Standard	OBMH		
Secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their health care, including choice of provider, as measured by independently validated surveys. The experience of black and minority ethnic groups will be specifically monitored as part of these surveys.	HCC Core Standard	OBMH		
Substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20%	HCC Core Standards	OBMH		

Key:

- **Green = national target fully achieved**
- **Amber = within 20% national target locally**
- **Red = below 20% against national target**
- **NB = where target date has not yet passed (red is not on track to hit target and amber is on track)**

Improvement review of adult community mental health services

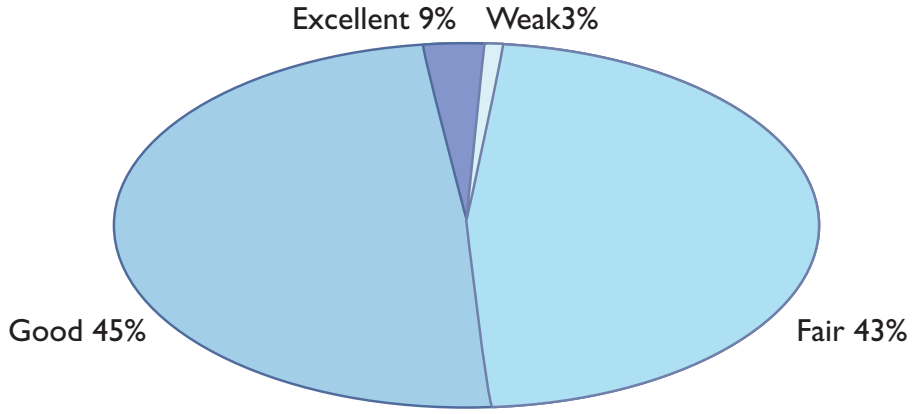
The national Joint Review of Adult Community Mental Health Services was the first joint inspection of mental health services undertaken by the Healthcare Commission and the Commission for Social Care Inspection (CSCI). The review took place in 2005/06 and contributed to the Annual Health Check Score of the PCT and Star Rating for Social Services for 2006.

The review assessed our performance against key mental health community services in all Local Implementation Team areas across England. Whilst this review took place some time ago a number of the recommendations need to inform the priorities set out in this Commissioning Strategy.

Buckinghamshire LIT achieved an overall score of four, delivering an excellent rating. The LIT was assessed against three criteria against which were a number of key measures:-.

- Criteria one. Community services are accessible to people according to their presenting circumstances = 3
- Criteria two. Care arrangements focus on a range of needs and outcomes for people who use services = 4
- Criteria three. People who use services, and where appropriate their carers, are involved in decisions and are able to make choices about their care = 4

Distribution of LIT scores
Review of AMH Community Services



Set out in the above chart is the distribution of the overall score against all LITs' areas in England. Buckinghamshire's overall score contributed to the 8.4% of LITs to achieve an excellent rating. It is important to note however that the measures making up the criteria score and overall score did identify areas where we scored a weak rating.

The areas set out below were the areas Buckinghamshire LIT scored a weak rating and will need to inform the commissioning priorities in this document:-

Criteria No. Two. Q1. Appropriate access to psychological therapy services:

- The total number of service users sampled who have received at least one session of Cognitive Behaviour Therapy (CBT) in the last 12 months, who are offered CBT in the same period.

Criteria No. Two. Q2. Appropriate medicine regime:

- Number of service users sampled whose response to treatment and side effects has been documented in their care records.

Criteria No. Two. Q3. Service provision for diversity:

- Proportion of people receiving mental health services from ethnic minority groups per LA in 2004/05 aged 18 or over.

Criteria No. Three. Q1 Availability of information to service users and carers:

- Do any of the available advice and information services offer complete out of hours availability?
- The total number of service users who received written material relevant to their clinical condition.
- Do any services in the Directory of Services offer electronic booking?

Understanding Needs

Understanding Local Needs

A range of risk factors influences the development and course of mental illness. These include socio-economic disadvantage, homelessness, unemployment, and poor educational attainment, being a member of a minority group, being a lone parent or a teenage mother. Undertaking a thorough needs population in Buckinghamshire is necessary to enable commissioners to establish the following:-

- How many people are likely to need mental health services?
- The level and type of service response required to meet clinical and social need.
- Whether the available resources are targeted in the right places.

This is done through looking at national prevalence data, national and local epidemiological studies, statutory returns and activity against existing service provision as a proxy measure of need.

The National Picture of Mental Health and Well-Being

- Mental health problems can affect anyone. Common mental health problems are as frequent and as common as a common physical disorder such as asthma. Poor mental health significantly affects life chances and health outcomes.
- One in six of the population has a common mental health problem at any one time.
- WHO predict that depression will be the leading cause of disability internationally by 2020.
- Suicide is the most common cause of death in men under 35
- Nationally, 900,000 people on incapacity benefit are off work because of mental health problem.

- The cost of mental illness has been estimated at £77 billion per annum. People with mental illness are 1.5 times more likely to die prematurely than those without mental illness partly due to suicide but also due to death from respiratory and other diseases.

Local Population Profile

Buckinghamshire has a population of 479,026 people (source ONS 2001 census). Of its four districts Aylesbury Vale is the largest, followed by Wycombe. Chiltern and South Bucks is the smallest. Throughout the county there is a near-even gender split. Population totals and gender division of each district are shown in the table below.

County and district population totals and population by gender (ONS Census 2001)

District	Total population		Males		Females	
	Count	(%)	Count	(%)	Count	(%)
Aylesbury Vale	165,789	35	82,309	50	83,439	50
Chiltern	89,228	19	43,128	48	46,100	52
South Bucks	61,945	13	40,003	48	31,942	52
Wycombe	162,105	34	79,299	49	82,806	51
Bucks	**479,026**		**239,739**		**244,287**	

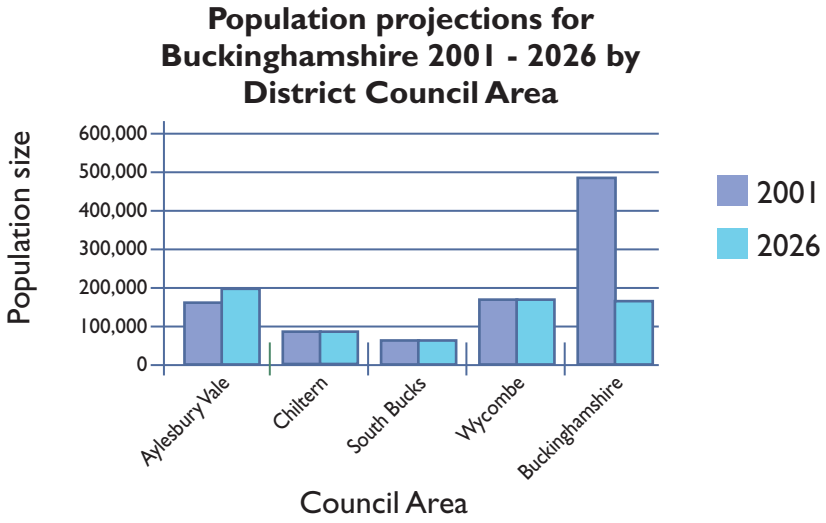
(ONS Mid Year Estimates)

Age Group	Mid 2001	Mid 2002	Mid 2003	Mid 2004	Mid 2005
Bucks pop 18+	366,680	365,559	365,790	366,026	368,449
Bucks pop 18-64	296,822	294,883	293,985	293,290	294,496
Bucks pop 65-74	37,841	38,286	38,965	39,372	39,791
Bucks pop 75-84	23,129	23,558	24,165	24,702	24,998
Bucks pop 85+	8,888	8,832	8,675	8,662	9,164
Bucks pop 65+	69,858	70,676	71,805	72,736	73,953

Population Growth

Between 2001 and 2026 there will be a 6.8% increase in the overall population of Buckinghamshire.

- Chiltern and Wycombe District will see a reduction in the population between the period 2001- 2026.
- Aylesbury Vale District will see an increase in population size of 32,800 (19.8%) by 2026. This considerable increase in Aylesbury Vale District Council is due to the new housing proposals in the South East Plan. Regional policy has identified that these growth regions will impact on the Aylesbury Vale area. This will result in 16,000 new households and is predicted to attract a younger and more diverse population. With changes in age structure of the local population as well as population growth, there will be a much larger cohort of adults aged 30-59 living in Buckinghamshire by 2026. The service design and planning should reflect these changes if it is to address the need of the new and changed population.



Mental Health Needs

The association between rates of mental illness and certain population characteristics, notably poverty, unemployment and social isolation is well established. For the planning and evaluation of mental health care it is helpful to have quantitative estimates of the extent to which rates are likely to vary between different parts of the country. Different statistical models have been established as predicator of the likely rates of mental health problems. The table below sets out four needs indices. Two relate specifically to the more severe types of mental illness that are the main work of secondary mental health services.

One relates to types of common mental illness not normally referred to specialist services, the other covers both types.

These indicators are all calculated by taking some measure of mental health need. The two used are rates of hospital admission and the proportion of people rated as having a mental health problem in general population surveys. These are correlated mathematically with a range of population characteristics thought to be associated, such as poverty, unemployment or social isolation. The final column in the table shows the local cost adjustment factor. The population weighted for mental health need is weighted again by the local cost index to provide populations for comparing spend figures.

Population Weighted Indices

LIT Area	Adult Population Unweighted[1]	MINI Index[2]	M2K Index[3]	NPMS dep Index	NPMS CISR2 Index	AREA Index	Combined Cost Index
Bucks	281619.480	0.568	0.535	0.708	0.756	0.730	1.064

ONS 'Psychiatric Morbidity Survey' is conducted on a national basis to examine the levels of psychiatric morbidity across the country, drawing conclusions on the expected levels of morbidity for different parts of the country to take account of different population characteristics. Based on this survey, the table below shows the estimated number of Adult Population suffering from a mild to moderate mental health difficulty in Buckinghamshire mid 2005.

Disorder	% Prevalence	Buckinghamshire
Mixed anxiety and depressive disorder	8.4	24,737
Generalised anxiety disorder	5.3	15,608
Depressive episode	3.6	10,601
All phobias	2.1	6,184
Obsessive compulsive disorder	1.6	4,711
Panic disorder	0.9	2,650
Any neurotic disorder	**18.2**	**53,598**
Psychotic disorders	0.4	1,177

Generally it is reasonable to assume that mild to moderate mental health difficulties will be supported through primary care services – tier two.

Source: Prevalence of Common Mental Health Problems. London Health observatory, 2005

The original Mental Illness Index. Most applicable to mental illnesses which may, from time to time, need hospital treatment, based on data relating to 1991 (Glover et al.).

The MINI 2000. Based on illnesses severe enough to need hospital treatment from time to time. Derived from data relating to 1998 (Glover et al. 2004).

An index for common mental illnesses, based on 1993 National Psychiatric Morbidity Survey. People with common mental illnesses would not normally use specialist mental health services.

People experiencing a psychotic disorder will need specialist mental health services through tier three. In considering tier three services it is important to look at the ethnicity of the local population as there are differing prevalence rates for psychotic disorders for different minority ethnic groups. Buckinghamshire is a diverse county and the ethnicity breakdown of the population based on the 2001 census is set out in the table below. This is the total Buckinghamshire population and includes people under 18 and over 65.

Ethnic Group	Bucks as a %age	Aylesbury Vale as a %age	Chiltern as a %age	South Bucks as a %age	Wycombe as a %age
White	94.7	96	97.7	96.7	91.7
Black Caribbean	1	0.7	0.1	0.2	2
Black African	0.2	0.2	0	0	0.1
Black Other	0.3	0.2	0.1	0.1	0.4
Indian	1	0.5	0.4	1.6	0.6
Pakistani	1.5	1.3	0.9	0.2	3.7
Bangladeshi	0.1	0	0	0.1	0.1
Chinese	0.3	0.2	0.2	0.3	0.2
Other groups Asian	0.3	0.3	0.2	0.3	0.3
Other groups	0.6	0.5	0.3	0.5	0.9

The Annual Prevalence of psychosis by ethnicity and sex in 2002 suggests differential prevalence rates by ethnicity and sex as set out below

Ethnic Group	Sex	% of population
White	Male	1.0
	Female	0.7
	Total	0.8
Black Caribbean	Male	1.6
	Female	1.7
	Total	1.6
Indian	Male	0.9
	Female	1.3
	Total	1.1
Bangladeshi	Male	0.6
	Female	0.6
	Total	0.6
Pakistani	Male	1.4
	Female	1.3
	Total	1.3

Estimated Number of Adults Experiencing Personality Disorders in Buckinghamshire

Disorder	% Prevalence	Buckinghamshire
Personality disorder	4.4	11,779

People with a personality disorder utilise services across all of the four tiers set out in this strategy. It should be noted that under the Mental Health Act, adult mental health services would be required to provide compulsory services for people with a personality disorder who are deemed to be a risk to themselves or others, regardless of treatability. When using the prevalence figures above to estimate need, it is important to factor in that many people will experience mental distress as a one-off episode. However for some, mental illness can be severe and enduring.

Deprivation Indices

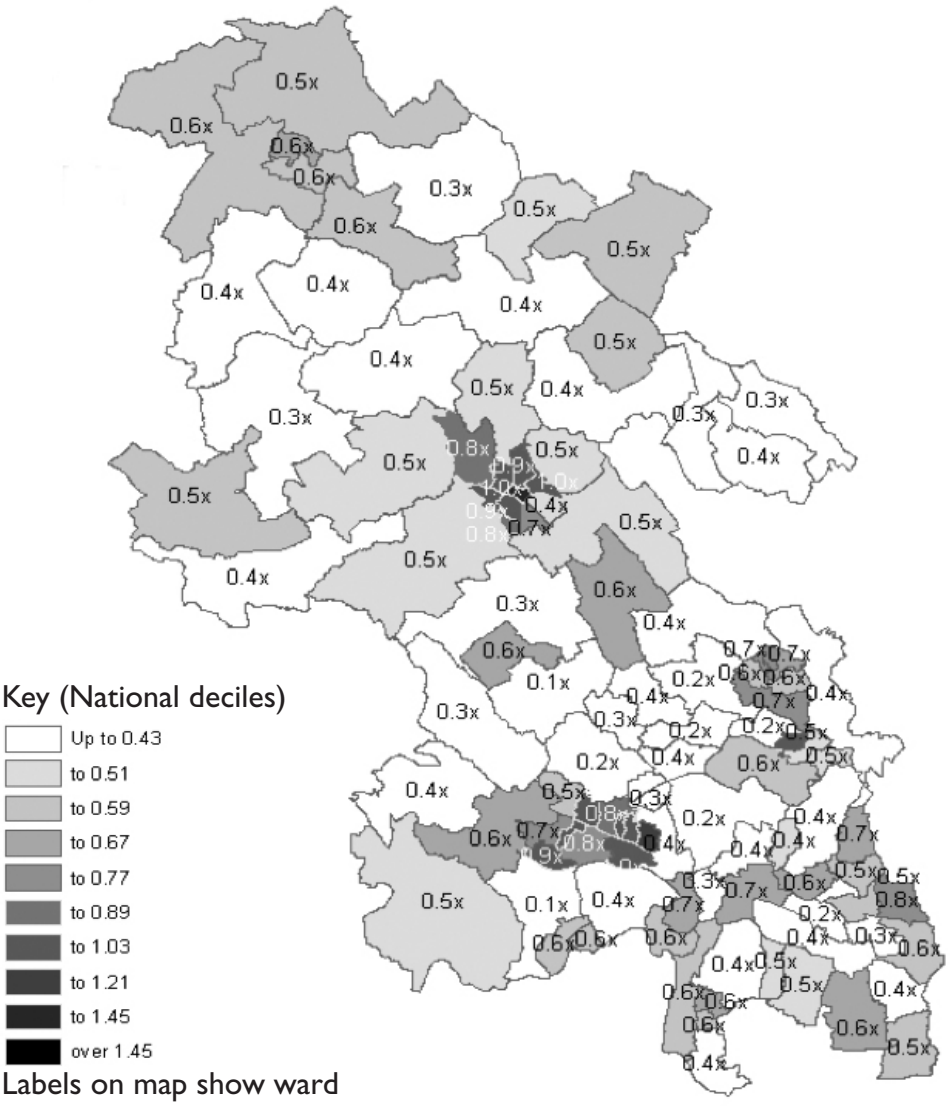
There is a strong association between poor mental health and the experience of poverty and deprivation both at individual and population level. People in good mental health are more likely to be, and remain, in work and be financially independent. People with mental illness are more likely to experience poverty, and poverty is both a cause and consequence of poor mental and physical health.

Analysis of social class suggests that people are nearly twice as likely to suffer from mental distress as those in higher social classes - ten percent of social class I compared to 18% of social class V.

The Mental Illness Index (MINI) has been employed to rank populations of deprivation against a nationally defined average of 100. Buckinghamshire has low levels of deprivation. It is identified as 'prosperous' by the Office of National Statistics, and is grouped within a 'cluster' of similar areas with similar characteristics.

Using the MINI index Buckinghamshire is the third least deprived district in England. However, this relative prosperity masks at the other extreme pockets of considerable relative deprivation. A number of wards are in the top 25% of the least deprived in the country. These are clustered in the urban areas of Buckinghamshire, specifically Aylesbury (Aylesbury Central, Gatehouse) and High Wycombe (Micklefield and Castlefield). This information is of significance to planners, particularly in considering the service response required for local mental health services delivered within a tier two of the model.

Original MINI score, remapped to 2001 census wards: Buckinghamshire LIT



- For Social Care services based on the 2006/07 statutory RAP return, Adult Social Services provided a service for 652 adult mental health clients. Of this 216 clients were offered a new assessment during the last financial year. It is expected that all Adult Social Services mental health service users will also be in receipt of specialist secondary care mental health services. Adult Social Services provides services for people on the basis of risk and need as set out through the Fair Access to Care eligibility criteria, with people being eligible for a service if they have critical or substantial levels of need.

Relating Needs to Supply

This section of the strategy:

- Considers the range and volume of services currently provided across Buckinghamshire
- Considers recent data activity benchmarked against LIT areas within the South Central SHA

Relating Supply to Need

A detailed supply-mapping is conducted on an annual basis by the Buckinghamshire Local Implementation Team. This forms part of the Autumn Assessment process that has been developed nationally to evaluate progress against the delivery of the National Service Framework for Mental Health. http://www.amhmapping.org.uk.

Tier One - Building a Healthy Community – Mental Health Promotion and Prevention

Mental health promotion is the first target in the National Service Framework and its importance has been re-emphasised both in the five year review of the National Service Framework and in the public health white paper 'Choosing Health'. Two items in the annual self-assessment explore the state of implementation. The first asks whether a mental health promotion lead officer is in place. In 2005 Buckinghamshire was rated as amber, reflecting the fact that there was a dedicated lead in this area but without adequate dedicated time for the required co-ordination and leadership. Since 2005 there has not been a named lead. The outcome of this is reflected in 2006/07 Autumn Assessment process where Buckinghamshire LIT assessed itself as having no Mental Health Prevention Strategy in place. This was one of only two 'red' areas within a traffic light rating system for the Buckinghamshire LIT. During 2007 there has been development in this area and a Mental Health Prevention Strategy will be in place by the end of 2008/09.

As set out in 'Review of the Integrated Commissioning Strategy 2003-2006' some progress has been made in this key area. As the focus of the modernisation agenda moves away from specialist mental health services to addressing the causes of poor mental health more broadly, effective mental health promotion and prevention will be a priority area for this document. During 2007/2008 the 'because Every Adult Matters' programme (bEAM) in Buckinghamshire has seen the prevention agenda developing with the result of an increasing number of adults helped to live at home. This has been achieved through the development of the 'In-touch' Service.

Tier Two – Needing support - Primary Care Mental Health

Service mapping within primary care will include any services that can be accessed directly by clients, organised around and delivered by, the primary health care teams. These teams frequently extend beyond the traditional model of family doctors, administrative staff, practice and community nurses and health visitors. Based on national research, 40% of attendees to a GP practice will have a mental health problem and 30-35% of people with a severe and enduring mental illness will be managed solely within primary care services. In Buckinghamshire the ONS mid-year population statistics for 2005/06 show that over 53,000 people within the adult population were suffering from a mild to moderate mental health difficulty which could be treated within a primary care setting as opposed to specialist mental health services.

To respond to this level of need the development of effective primary care mental health services has been a key priority. Since the 2003-2006 commissioning strategy £750,000 new investment has been made available to develop specialist mental health capacity within a primary care setting to support people with mild and moderate mental health difficulties. Three teams consisting of 26 specialist workers and an overarching service manager provide a range of brief psychosocial interventions. These teams receive referrals directly from all GP practises across Buckinghamshire and form part of a fully integrated pathway with the Community Mental Health Teams, with a fully established gateway function to avoid unnecessary delay in the referral process. This new service has supported the LIT to achieve its new workforce targets, as set out in the NHS Plan, and a green assessment in the 2006/07 Autumn Assessment process against the interface indicator between primary care and secondary care services, as well as contributing significantly towards the 2006/07 excellent rating in the joint CSCI and Healthcare

Commission review of Community Mental Health Services. However this service is significantly over-performing.
During the lifetime of this commissioning strategy it will be critical that we further extend capacity within primary care by supporting people with mild and moderate mental health difficulties to retain, or move back into, paid work. In 2008 the Department of Work and Pensions (DWP) will be making available an investment of over £1million to support people locally to reduce the number with mental health difficulties on incapacity benefit, through the Pathways to Work scheme. It will be a key priority of this strategy to ensure that we integrate local primary care based psychological therapies with social interventions developed through this DWP funding.

In 2006 the Supporting People Commissioning Board undertook a competitive tender process to provide generic floating support across all of the care group areas including mental health. This process was completed in March 2007 and as a result of this £400,000 from the existing mental health Supporting People contracts have been redeployed to provide support services.

It will be a key priority of this strategy to ensure that people with support needs who do not meet the FAC's criteria for social care services as a result of a mild to moderate mental health difficulty, and who are seen by primary care mental health services, are able to access floating housing-related support.

Prior to the creation of a single Buckinghamshire PCT in autumn 2006/07 there was no Buckinghamshire-wide approach to the delivery of primary care based counselling services. In 2006/07 the PCT spent £400k per year on GMS contracts with voluntary sector providers and practise-based counsellors to deliver counselling. The approach taken by each of the three predecessor PCTs has resulted in an inequitable distribution of counselling; differences in the model and modelities offered; significant variance in investment levels across the three former PCTs; different access arrangements and charging policies; and compliance with NICE guidelines. Currently Buckinghamshire is one of ten 'pathfinder' sites across the country developing the Improving Access to Psychological Therapies programme. To date this has seen cognitive behavioural therapy services being developed in Aylesbury. The Improving Access to Psychological Therapies programme will receive increased national funding to take forward a three-year development programme

nationally. Buckinghamshire PCT will use this funding to develop new services during this period and will also ensure that counselling and other psychological therapy services continue to be available.

We will also be seeking to improve the physical health of people with severe mental illness. Whilst performance against the SMI QOF indicators show good progress in this area, the 2006 CSCI and Healthcare Commission review of Mental Health Services shows that our overall performance in addressing physical health needs is only fair, representing one of the weakest results of the assessment. Particular progress needs to be made over the lifetime of this document to ensure (1) progress is made to support the total numbers of service users who have had at least one physical health review in line with the recommended good practice and that (2) all CPA records/plans formally recording physical health checks are actioned and linked to QOF. Services to support and address the significant health inequalities of people with a severe and enduring mental illness will be a key priority of this strategy

Tier Three - Specialist Mental Health Services

Acute Care Pathway Services

Community Acute Service

Crisis resolution, home treatment, and acute day hospitals continue to be managed within the Crisis Assessment Service (CAS) with two teams covering the North and South of Buckinghamshire. The pathway is strengthened by close working with the acute wards.

Crisis Resolution and Home Treatment Teams

There are two crisis resolution and home treatment teams in Buckinghamshire providing 24 hour / seven days a week services to reduce hospital admissions and support the modernisation of the acute care pathway. The Crisis Resolution and Home Treatment Service in Buckinghamshire has been assessed as having passed the fidelity and flexibility test, meeting the following nationally agreed good practice characteristics:

- A multi-disciplinary team.
- Availability to respond 24 hour / seven days a week.

- Staff in frequent contact with service users, often seeing them at least once a shift in their own homes.
- Provision of intensive contact over a short period of time.
- Staff stay involved until the problem is resolved.

The delivery of effective alternatives to admission services is a key priority for this strategy which will underpin the modernisation of inpatient services in accordance with the decisions made as an outcome of the 'Putting People First' consultation. It continues to be a priority that OBMH achieve their trajectories in respect of Crisis Resolution and Home Treatment and deliver the national target in respect of Home Treatment episodes.

Inpatient services

During 2006/07 acute adult inpatient care was provided across three locations, the Tindal Centre, Aylesbury, Haleacre Unit, Amersham, and Wexham Park in Berkshire for the population of South Buckinghamshire. Buckinghamshire PCT contracted for 63 acute inpatient beds (excluding the Psychiatric Intensive Care Capacity) during 2006/07. Occupancy levels during this period were running at 94%, however acute bed-day leave was significantly over- performing by a further 12 beds for people who had not been formally discharged.

The 2006 Service Mapping shows that the Buckinghamshire PCT commissions 23 beds per 100k population. When compared to other LIT areas, 89% of the 177 LIT areas across England commission more acute adult inpatient capacity per 100k population than Buckinghamshire. However, it should be noted that the level of commissioned beds is in line with national evidence that approx 20 beds per 100,000 population are required for an area with a fully functioning Crisis Resolution and Home Treatment Service.

In February 2007 services for South Bucks District were decommissioned from Berkshire Healthcare Trust and the resource transferred to OBMH.

The outcome of the public consultation 'Putting People First' agreed to the development of a new-build mental health inpatient unit for adults of working age, replacing the existing Haleacre and Tindal sites. This new unit will be built on the Manor House site in Aylesbury.

It will be a priority of this strategy to ensure that the outcome of this consultation in respect of inpatient services is delivered and that the new Buckinghamshire PCT and OBMH agree a timetable to progress this priority area.

Psychiatric Intensive Care Unit (PICU)

The PICU unit for the population of Buckinghamshire is currently based at the Littlemore site in Oxfordshire. This strategy is not currently proposing to make any recommendations for changing the numbers of PICU beds or the location of this service at the present time. The service will need to be reviewed to ensure that it is properly managed within the acute care pathway locally.

A&E liaison

Since 2007/08 the PCT has made available resources for the development of Acute A&E liaison services in High Wycombe, Aylesbury and Slough to support timely access into mental health's acute care pathway. This supports the delivery of the PCTs delivery of the four-hour wait target within A&E.

Prison In-Reach

During 2007/08 the services provided to prisoners with mental health needs in the three custodial sites (YOI Aylesbury, HMP Grendon and HMP Springhill) have been reviewed. As a result an additional £300,000 has been made available via the PCT for the development of an integrated prison in-reach service to cover all three sites. This will need to be developed and its implementation monitored during the life of this strategy.

Community Mental Health Services

The Partnership commissions six community mental health teams for adults of working age. These are multi-disciplinary teams for people with long-term mental health needs. These teams provide direct health and social care interventions, as well as assessments and packages of care, to enable people to access a much broader range of community based services. In 2006/07 OBMH reviewed the configuration of CMHTs to ensure that the coverage of teams was more equally distributed in accordance with levels of need. The outcome of the financial mapping process shows that investment levels in CMHTs are significantly higher than the ONS cluster, England and SHA average, with the LA contributing to almost a third of the investment making full integration critical.

Whilst integration between health and social care has taken place at a structural level, consolidated in March 2007 with the signing of the S75 provider agreement, there are still issues around the delivery of integrated services at a practical level.

These include:

- Partial integration of information systems, although eCPA is in place. Further integration of IM+T systems is required as there are current difficulties in recording performance management information for both the commissioners and providers.
- A lack of 'trusted assessor' roles by health staff of the Community Care Assessment function in order for CPAs to link people to a broad range of community services not provided by OBMH.
- Patchy knowledge of commissioned social care services by health staff within the Trust
- Issues around recruitment and retention of health and social care staff.

These issues supported through the new S75 agreement must be addressed to ensure that resources are effectively targeted. This will be a key priority of this strategy.

Assertive Outreach Teams (AOT)

There are two Assertive Outreach Teams in Buckinghamshire in the north and south of the county. These teams continue to just meet their caseload targets for people requiring an assertive outreach approach.

Early Intervention in Psychosis Team (EIPT)

In 2005/06 the PCT invested £250,000 in an Early Intervention in Psychosis service to support the early detection and improve the longer-term prognosis of people aged 14-35 with a first episode psychosis. In spring 2006, Buckinghamshire formed one of the 51% of the 177 LITs to have an EIPT, and one of the few to have met all of the Policy Implementation Guidance criteria to deliver effective EIP services. It will be a priority to ensure that the staffing levels of this service meet the needs of people in Buckinghamshire. Currently this service is delivering its full commissioned capacity. It will be critical that, in order to ensure that service users benefit from this service, close links continue with the Primary Care Mental Health Teams and child and adolescent mental health services.

Accommodation and Support

The aim of the last commissioning strategy was to reduce the numbers of people inappropriately living in registered residential care through the provision of intensively staffed supported living services, accommodation with floating support and direct payments. Significant progress has been made over the lifetime of the 2003-2006 Commissioning Strategy to modernise the existing services and to address the historic oversupply of residential care. The table below shows the numbers of placements in each type of accommodation without nursing staff within Buckinghamshire, benchmarked against geographically similar LIT areas based on the configuration of services in Spring 2006.

Local Implementation Team	All Residents Care Non-Nursed Beds	All Residents Care Non-Nursed Beds.100k MINI pop	% Hostel	% Adult Placement	% Board and Lodging	% Staffed Group Home	% Supported Housing	% Un-staffed Group Home	% Registered Care Home
Bedfordshire	112	108.938	5.4	0	0	24.1	33.9	8	28.6
Bucks	250	202.067	20.5	0	0	0	19.5	29.8	30.2
East Surrey	290	268.763	0	6.2	0	19	54.8	3.4	16.6
Guildford and Waverley	42	39.098	28.6	0	0	0	71.4	0	0
Hertfordshire	307	287.032	3.9	0	0	2	59.6	14.3	20.2
Huntingdon	6	6.031	100	0	0	0	0	0	0
North Essex	907	888.971	8.6	0	0	0	23.6	7.6	60.2
North Hampshire	53	51.06	11.3	0	0	0	0	0	88.7
Oxon	287	276.897	26.8	0	0	8	49.5	0	15.7
Total	2219	2118.401	10.9	0.8	0	5	36.4	8.8	38.1

There are two key projects underway which are critical to the delivery of high quality accommodation and support. These projects began during the 2003-2006 strategy and will be completed during the lifetime of this strategy.

The mental health services previously provided by the Fremantle Trust have been subject to a competitive tender process. A new contract with Hightown Praetorian Churches Housing Association (HPCHA) was awarded on the 1st April 2007 for the development of 74 beds over the next three years. This includes the re-provision of the 56 residential care beds previously supplied by The Fremantle Trust as well as an additional 18 beds to meet the future needs of people with an SMI. The modernisation of these services will be funded through £4.385m capital

from the Council with a further £6.4m investment from HPCHA to deliver the new model of service over the next three years.

As a result there will be a full range of registered care homes, shared supported living and independent supported living developed and provided for.

We will need to ensure that the contracted development plan is now delivered within the timetable. This development will also be key in ensuring that we improve our performance against PAF C31 numbers of people with mental health difficulties helped to live at home and meeting the new workforce requirements in respect of STR workers.

A programme of work is underway to modernise the Social Care Group Homes across Buckinghamshire. This model of service was set up to accommodate people moving from St John's in the 1980s and 1990s supported largely at that time through the rehabilitation workers. The Group Home provision constitutes 29% of the total availability of accommodation and support. In August 2007 there were 17 unstaffed Group Homes provided by seven independent sector providers and the County Council and District Councils. The service model is now outmoded and a number of factors including high voids rate (22%) costing Adult Social Care over £40k per year; loss of Supporting People monies; and poor environmental standards have required us to review how these services are provided in the future. Since August 2006 Buckinghamshire County Council and the four District Councils have worked in partnership to close five Group Homes and supported individuals to move into their own flats. It is a key priority to continue with this programme of modernisation.

In spring 2007 there were 38 people placed in out of county spot residential care and nursing placements with a gross cost of approximately £1.75million per year. Placements have been made through the care management process. It will be a key priority to target these placements to ensure we are supporting people to move on and that we are getting value for money.

Supporting People Services

In spring 2007 the Supporting People Commissioning Body completed a competitive tender to re-profile existing expenditure towards generic floating support services. The development of floating support has had an impact on the sustainability of current social care contracted mental

health services, as funding is withdrawn to deliver the new service. During 2006/07 there were six mental health providers delivering 76 units of accommodation with a further 153 units with floating support. In 2007/08 changes to Supporting People funding included a reduction in SHMG and SP grant against mental health schemes and a reallocation of the floating support resource to deliver the new generic floating support across Buckinghamshire.

It will be a key priority of this strategy to ensure that we use the new Supporting People funded floating support services as part of a pathway to provide accommodation and support for people with mental health difficulties, and that access arrangements are clear and streamlined. This will require us to review how we are currently providing home support.

Support in the Home

There are currently three key ways in which people with mental health difficulties receive social care support in their own homes. This is delivered through the Rehabilitation Officers based within the CMHTs, externally purchased and provided domiciliary care, and the Supporting People floating support services. These three types of home support services are not clearly differentiated and there are different access arrangements and charging policies for people presenting with similar needs.

There are no block contracts for home support. In 2003/04 a competitive tender process was completed to commission a standing list of providers for specialist and generic domiciliary care for people with mental health difficulties who have FACs eligible needs. The intention was that all new spot purchasing would be directed at these four voluntary sector providers. Analysis of the current market however, highlights that there are currently 17 external providers of spot purchased domiciliary care and of the approximate £200,000 that we spent in 2006/07 over nine providers had less than £5,000 worth of commissioned activity. The standing providers have identified that in the absence of a clear commitment around future demand, they are unable to take the risk of recruitment and therefore not able to meet the need as it presents. It is a priority of this strategy to consider how we develop a sustainable market in this area delivering value for money, responsiveness and mental health expertise that focuses on recovery, flexibility and service user control and choice.

Social Care Rehabilitation Officers used to be based within the Community Mental Health Teams, however, £178,000 of Supporting People funding was withdrawn from this service to fund the new generic floating support service. It will be important that we do not duplicate the role of the rehabilitation officers with external home support/domiciliary care providers and the Supporting People Floating Support service. These workers have a key role to play in promoting the recovery of people in long-term nursing and registered residential care placements working with the Housing Support Workers to facilitate move-on into independent living where appropriate. This is consistent with the original role and purpose for the rehabilitation officers and is consistent with the unit cost for the rehabilitation officers which reflects the skills and mental health background of this group of staff.

Meaningful Days

Day services are provided through the voluntary sector and local authority managed services and serve a high number of people. Buckinghamshire spend on day services is slightly above the ONS, SHA area average. Of the £1,472,000 we spend on social care day service provision, £538,000 per year is spent on spot purchase arrangements through the care management process.

OBMH through the S31 provider agreement provide two-day services in the South of the County. The distribution and models of day service provision across the county is not equitable. It is important that day opportunities and mainstream services identify the role that they play in supporting and promoting healthy lifestyles. It will also be important to consider the models of day service required by people who have non-FACs eligible needs through the Pathways to Work agenda.

During 2008/09 there will be a full and systematic review of all adult mental health day services with the intention of having in place, by April 2009, day services which meet the needs of service users and promote independence, provide equity in availability across the county, and promote stability in the provider market.

Advocacy

Advocacy schemes are available to people with mental health needs. At present the level of services provided is funded through both the Mental Health Grant and PCT funds, and is viewed as appropriate for the demand. The Independent Mental Capacity Advocacy has been

developed during 2007/08 to support the delivery of the Mental Capacity Act. All advocacy services across care groups will need to be reviewed to ensure that the resource is prioritised to support the delivery of self-directed care and the development of capacity, to support the Deprivation of Liberty agenda and implementation of the new Mental Health Act. A cross-care group review will support us to improve efficiency and preserve capacity.

Carer Services

There are five Carers' Support Workers in Buckinghamshire for Adult Mental Health in line with the new workforce target. This dedicated team managed by OBMH has had a significant impact on the assessment and availability of services for carers. In 2006/07, 23% of all carers were assessed and of the 154 people assessed 145 received a service as a result. This placed us in the top banding of performance against our comparator group.

It is important, however, to note that, with the expectation in 2007/08, we will support over 400 more adults with mental health difficulties to live at home. This increase in the client base has been achieved by the Primary Care Mental Health Teams assessing and offering services to additional service users and carers. It will be a priority of this strategy to consider how we will continue to meet the needs of carers and increase the numbers of carers who receive a direct payment.

Safeguarding.

Levels of safeguarding referrals have not appeared to be proportionate to the population as other authorities, due to inconsistent recording. A more robust recording system has been established. Safeguarding will continue to receive a high profile through the work of the Safeguarding Vulnerable Adults Board.

In the past twelve months 343 people have been referred to Buckinghamshire's Safeguarding Vulnerable Adults Board, of which 32% of these cases were people with a mental health difficulty.

Significant work has been undertaken to strengthen safeguarding arrangements which have included:-

- A strengthened multi-agency Safeguarding Board. This brings together representatives of BCC, Buckinghamshire District Councils, Buckinghamshire PCT, Buckinghamshire NHS Hospital Trust, Thames

Valley Police and independent sector providers. The Board has four sub-committees which deal with training, employment, policy and procedures, the Mental Capacity Act, and is also establishing a consultation forum for service users and carers.

- Significant investment by Buckinghamshire County Council has gone into safeguarding over the past two years -
    - 2006/07 £89,097
    - 2007/08 £195,839
    - 2008/09 £329,054.

This has been used to enhance capacity of the Safeguarding Team which now comprises a newly appointed Safeguarding Manager / Lead Investigator, a Performance Officer and administrative support.

Tier Four – Tertiary Services

Tertiary services, sometimes referred to as a 'specialist service', are generally services that have the following characteristics – low volume, complex cases with high clinical risk that necessitate a commissioning response which is not defined by a small planning area but a sub-regional or regional approach. Key indicators of under-supply are the increasing number of out of area treatments, particularly for longer term medium secure beds, low secure beds, women only service and eating disorders.

Tertiary services are commissioned on a South Central Strategic Health Authority basis. It was intended that during the 2003-2006 strategy that resources to deliver the specialist mental health agenda would be pooled. This has not happened to date and the commissioning responsibility and financial risk still rests with the local PCTs. In Buckinghamshire the PCT continues to commission medium secure and low secure beds from OBMH. It is the intention that the Forensic Services provided by OBMH, for the whole of the Thames Valley area (Buckinghamshire, Milton Keynes, Oxfordshire and East and West Berkshire), will, over time, be commissioned via the SHA. At present, although there are clear numbers of beds commissioned by each of the PCT areas, there is agreed flexibility in usage in order to increase potential access to services, particularly in times of crisis.

Service Model	Commissioned Beds Plan 2006/07	Actual Performance 2006/07	Occupancy
Low secure Inpatient beds, including leave	12	9	72%
Medium Secure Inpatient beds	12		-

Financial Resources

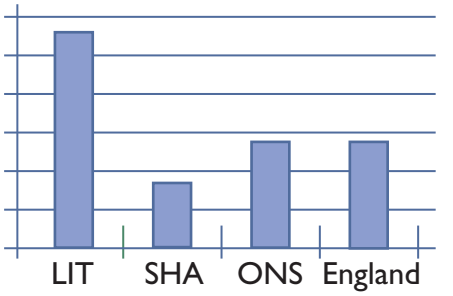
Financial Resources for Adult Mental Health

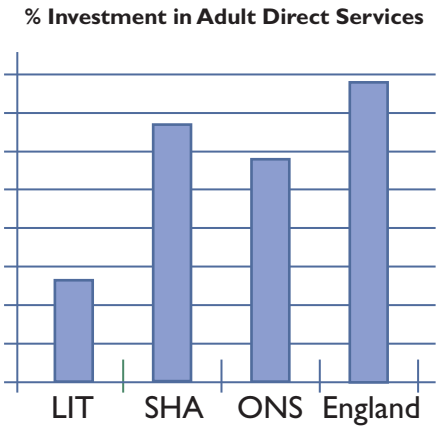
Benchmarking Financial Investment

Results from the LIT Financial Mapping

The Department of Health has published the outcome of the financial mapping exercise for Adult and Older People Mental Health based on the Autumn 2006/07 submission in Spring 2007. This is the most current financial mapping and forms a key part of the annual assessment process against the National Service Framework for Mental Health for all LITs across England.

Set out below is our record of investment against adult mental health services for Buckinghamshire for health and social care. The report shows that Buckinghamshire LITs total investment per weighted adult population per head, when compared against the Strategic Health Authority, ONS cluster (Prospering Southern England) and national figures are above average.





However when the Buckinghamshire LITs total investment is broken down into four groupings - direct costs, indirect costs, overheads and capital charges the percentage investment in adult direct services is below average. This is because Buckinghamshire LIT spends considerably more on indirect costs than the SHA, ONS and English LIT average. Over the lifetime of this Commissioning Strategy there needs to be a realignment of investment between indirect costs to direct costs. The table below shows the Buckinghamshire LITs Total Investment in Adult Mental Health Services

Service Category	**£'000s**	**Percentage**			
		This LIT	**This SHA**	**This ONS**	**English LITs**
Direct Costs	£29,214	75%	78%	77%	80%
Indirect Costs	£6,498	17%	11%	11%	8%
Overheads	£1,875	5%	8%	8%	8%
Capital Charge	£1,234	3%	3%	4%	3%
Total adult investment in £'000s	**£38,821**	**100%**	**100%**	**100%**	**100%**

Buckinghamshire PCT and Buckinghamshire County Council invested £38,821,000 in Adult Mental Health services in 2006/07. Of this £29,214,000 was spent on direct services. The table shows PCT and Council Investment by Service Category and Provider Type for the Buckinghamshire LIT area by £'000s

	Provider Type				
Service Category	**NHS**	**NGMS**	**Social Services**	**Non Statutory**	**Total**
Access and Crisis Services	2,724	0	603	9	**3335**
Accommodation	1,000	0	84	3017	**4100**
Carers' Services	0	0	246	0	**246**
Clinical Services	3,973	0	41	131	**4144**

Community Mental Health Teams	4,713	0	1914	0	**6627**
Continuing Care	675	0	0	2014	**2689**
Day Services	0	0	638	834	**1472**
Direct Payments	0	0	0	169	**169**
Home Support Services	0	0	20	90	**110**
Mental Health Promotion	0	0	0	11	**11**
Other community & Hospital Professional Teams	775	0	96	162	**1034**
Personality Disorder Services	193	0	0	10	**203**
Psychological Therapies	439	0	0	395	**834**
Secure and High Dependency services	2,941	0	0	924	**3865**
Services for Mentally Disordered Offenders	127	0	5	0	**132**
Support Services	20	0	0	221	**241**
Total direct services in £'000s	**17,579**	**0**	**3648**	**7987**	**29,214**
% Provided by each provider type	**60%**	**0%**	**12%**	**27%**	**100%**

This table shows that over 95% of the LA and PCT investment of adult mental health services is spent on specialist mental health service provision. With less than 5% of the overall investment being spent on mental well-being and primary care mental health services in Tier One and Tier Two.

	Percentage				
Service Category	**£'000s**	**This LIT**	**This SHA**	**This ONS**	**English LITs**
Access and Crisis Services	3335	11%	11%	12%	10%
Accommodation	4100	14%	9%	9%	10%
Carers' Services	246	1%	1%	1%	0%
Clinical Services	4144	14%	17%	20%	21%
Community Mental Health Teams	6627	23%	17%	18%	15%
Continuing Care	2689	9%	11%	11%	11%
Day Services	1472	5%	4%	4%	5%
Direct Payments	169	1%	0%	0%	0%
Home Support Services	110	0%	1%	3%	3%
Mental Health Promotion	11	0%	0%	0%	0%
Other Community & Hospital Professional Teams	1034	4%	2%	1%	2%
Personality Disorder Services	203	1%	0%	0%	0%
Psychological Therapies	834	3%	3%	3%	4%
Secure and High Dependency Services	3865	13%	22%	16%	18%
Services for Mentally disordered offenders	132	0%	1%	1%	1%
Support Services	241	1%	1%	1%	1%
Total direct services in £'000s	**29,214**	**100%**	**100%**	**100%**	**100%**

Future Financial Resources - NHS and Adult Social Care Investment and Disinvestment

Buckinghamshire PCT

The three predecessor PCTs had a history of financial problems in the two years before and in the year of establishment. Buckinghamshire PCT was formed in October 2006. The cumulative debt to March 2007 was £22.5 million. In particular Vale of Aylesbury PCT had significant deficits in all three years and most of the system and process issues faced by the PCT in the last eighteen months had stemmed from this part of the organisation. The history is a key influence on the current strategy as it is imperative that the PCT returns to sustainable long-term financial balance and repays histroic debts accumulated over this period.

For 2008/09 the PCT has produced a plan that supports the return to long-term financial sustainability. To achieve this it has identified a level of cost improvement in 2008/09 of £22 million that represents 3.5% of total expenditure. This has involved commencing a major redesign of services coupled with continuing financial control.

For 2008/09 this means that there is a saving target in respect of mental health services of £150k against contract efficiencies. This Strategy will need to support the delivery of this saving.

Adult Social Services

Buckinghamshire County Council has developed a medium term financial plan that covers the period of this commissioning strategy. This medium term financial strategy has been developed to take account of the political ambition to deliver a low council tax increase with high quality services. Each of the service areas has been asked to modernise services to achieve efficiency savings and manage pressures within budget.

The analysis of the budgets for Adult Mental Health is set out below for 2008/09 to 2010/11. The budget set out below will have to be deployed to support the delivery of this Commissioning Strategy both in terms of commissioning and decommissioning priorities.

2007/08 Base Budget	Budget Adjustment	Inflation	Committed Expenditure	Efficiency Saving	Increased Income	Service Reduction	Investment Bids	Total Budget for following year (£000s)
6,236	(89)	177	298	(79)	(2)	(106)	110	6,545
6,545		205	82	(170)	(2)	(117)	0	6.543
6,543		176	31	(60)	(2)	(145)	0	6,543

Supporting People Funding

Supporting People investment in mental health services in Buckinghamshire is very low compared to its comparator groups. This position is supported by the published benchmarking data for Personal Social Services Expenditure and Unit Costs Report 2005/06 data and the outcome of the recent Healthcare Commission and CSCI review of Community Mental Health Services.

Way Forward

Our six 'Big Ideas for Action' in Buckinghamshire

As a result of workshops and consultation in 2007, we have developed six 'Big Ideas for Action' for this strategy with actions against each of the four tiers. There is not a specific 'Big Idea' related to specialist (tertiary) services as these will be commissioned on a South Central basis. However, the need for an adequate supply of tertiary services is critical to the development of effective care pathways particularly in relation to the acute care pathway and community mental health services.

Each of the six 'Big Ideas for Action' will be taken forward as a sub-group of the Mental Health Partnership Board.

Big Idea One
Increasing Choice and Control
personalised services for people with a mental health difficulty

NSF Standard

The development of self-directed care is not explicitly referenced in the NSF Personalisation and the development of individual budgets form part of a newly emerging policy agenda, originally set out in 'Independence. Well-being and Choice' (DH, March 2005) and followed in 'Our Health, Our Care, Our Say' (DH, January 2006) and more recently the concordat 'Putting People First' (DH, December 2007) and the 'Transforming Social Care' (LAC January 2008).

Tiers One and Three

'Our Health, Our Care, Our Say'. Outcomes supported.

'I have the same life chances as other adults': Exercise of choice and control.

'I am able to live a fulfilled life': Improved quality of life.

High 10 Impact Changes

HIC No 7 Apply a systematic approach to enable the recovery of people with long-term conditions.

Case for change

Adult Social Care Portfolio in Buckinghamshire has signed up to an ambitious programme of change to support the transformation of social care. The national strategy states that all Councils in England must now implement personal budgets in order to give people greater control of their social care:-

- The current system of social care is based upon local authorities matching a limited range of services to people's assessed needs. Demographic pressures are leading to spiralling costs particularly in placements and there is a widespread belief that there needs to be a fundamental rethink of how we provide social care services. This is required to address the increased pressures on budgets as a

result of demography and increased expectations on the services by people who use them.

- Two recent documents from the DH set out the central role the Government sees for personalisation and personal budgets to play in the future delivery of social care services.
- In December 2007 'Putting People First' set out a shared vision and commitment to the transformation of social care. This includes a vision which sets out that over time people who use social care services, and their families, will increasingly shape and commission their own services. Personal budgets will ensure that people receiving public funded services use available resources to choose their own support – a right previously only available to self-funders. The role of social care will change in this model with a much greater focus on enablement, advice and giving information.
- In January 2008 'Transforming Social Care' provided further details on the significant resources which are being made available to support the transformation agenda and the delivery of personal budgets is stated to be an essential part of the overall agenda. In Buckinghamshire this resource will be deployed to manage the transformation agenda and a significant proportion of this allocated to support the move to individualised budgets. This agenda will underpin all of the commissioning priorities that relate to social care within this document. 'Valuing People Now' is very clear that individualised budgets are not simply fleeting experiments but central to the direction of travel for social care over the next decade and beyond. In 2008 this will be developed further within the new Green Paper for Adult Social Care.

Service delivery components

There are a number of stages to self–directed support, which are set out below. It is important to note that this process will have to continue to support the delivery of all of the existing legal requirements that ASC operates within:-

a. Setting the budget

Every individual who receives services from ASC has a budget already identified to pay for their services. At the moment there is no transparent way of ensuring that the amount of money spent on someone is related to the level of need. Often, for the establishment of individual packages of care, it is the market that determines the price. The development of individual budgets is predicated on the establishment of a Resource Allocation System (RAS). This determines the true costs

of need and will result in the allocation of a budget. The RAS will have to be modelled within the context of the total ASC budget to ensure that individual allocations never exceed the budget. The RAS will need to be simple, transparent, fair, controllable and eventually integrated with other funding streams.

The RAS will be constrained by the available Adult Social Care budget. The development of the RAS is complex and will introduce a whole number of issues, which will need to be worked through, and agreed, as a portfolio.

b. Plan the support

Once a person is aware of their allocated funding, they will need to decide how best to use it to meet their support needs. Support plans will be developed instead of existing care plans through the care management process. The support plan will describe what an individual wants to change or maintain in their lives and how the individualised budget will be used to support this. The support planning process encourages people to build on the support networks already in their life. Infrastructure will need to be established to support the planning process. This could come from care managers, independent support brokers or advocacy organisations. As part of the implementation of self-directed support Buckinghamshire will need to consider the preferred model for these. It will be important however that we do not make any decision around the future model of brokerage without setting it within the bigger context of the transformation agenda for social care.

c. Agree the plan

The proposed plan, once defined, will require agreement from the local authority. If the plan could not be bought in within the individual budget level allocated this would need to be addressed. The plan will have to demonstrate that it is meeting the needs of the person and improved outcomes. It will have to be signed off by care managers.

d. Manage the individual budget and organise the support

There are a number of different ways that an individual budget can be deployed. This gives individuals real choice over the day-to-day involvement they have in managing the support. There are a number of different approaches: -

Using a Direct Payment in lieu of social care provision for an individual:

- Through a care manager – who might either arrange LA provided services or contract manage an individually specified service with a service provider.

- Through an Individual Service Fund – ring-fenced budgets held and deployed by a services provider.

e. Review and Lead

The review process will centre on how well the outcomes set out in the support plan have been achieved, and what has been learned along the way. This process will be a partnership between the person and the LA.

Commissioning Priorities

- 2008. Development of a high level vision for all of Adult Social Care for Individualised budgets which includes clarifying precisely the scope of the change activities and to define the evaluation criteria which will support us to determine whether we are moving towards total transformation after year one.
- 2008. Development of a detailed implementation plan using a programme methodology that will support us to manage the change programme, agreeing an approach to risk management and refinancing decision points for the future programme to ensure delivery. This will need to include in year one:
- 2008. Development of a detailed communication strategy to support Adult Social Care to convey the vision and the scale of whole system change that this will necessitate. This will need to consider all stakeholders affected by the change.
- 2008. Development of a detailed financial case that will include the development for a Resource Allocation System for all Adult Social Care services.
- 2008. Pilot individualised budgets for people in transition and people with a Physical and Sensory Disability.
- 2008. Develop a model for brokerage that will support the move to self-directed care.
- 2008. Review and develop a model for advocacy services to support people to manage an individualised budget
- 2008. Secure commitment to partially use the Transforming Social Care Grant to support the move to self-directed care
- 2008. All people with mental illness meeting the FACS threshold for services will be offered a Person Centred Plan to ensure that their aspirations are integrated into their care plan and their needs are met. Priority will be given to all people who will be directly affected by the commissioning priorities in this document.

- 2008. Full implementation of the SECE costing model with full integration at the point of decision making for new placements and embedded in the reviewing process.
- 2009 onwards. Decision made by decision makers and stakeholders as to whether we proceed to implementation phase.
- 2009 onwards. Programme Team established to support change management with clear governance and work streams

Impact on improved performance

We expect that this shift towards individualised budgets will impact positively against the following key target areas:-

- Performance against C30 – the number of adults with mental illness supported to live at home.
- Performance against NI 130.
- Financial balance – we expect that this approach will support cost containment.

Furthermore individualised budgets, if implemented well, will enable demonstration against the outcome framework for social care especially against:

- ***Improved quality of life – 'I am able to live a fulfilled life'.***
- ***Exercise of choice and control – 'I have the same life chances as other adults'.***
- ***Making a positive contribution – 'I can participate as a full and equal member of my community'.***

Resource requirement to make it happen

This agenda will be managed within available social care budgets.
The Social Care Transformation Grant will be utilised to support the programme of change to self-directed care over the next three years.

Commissioning lever to be applied

Service Users themselves commissioning their own services directly.

Big Idea Two

Long-term conditions and mental health, working together to improve physical and mental well-being

NSF Standard

Standard Two - Any service user who contacts their primary health care team with a common mental health problem, should:-

- Have their mental health needs identified and assessed
- Be offered effective treatment, including referral and specialist advice for further assessment, treatment and care if they require it

The NSF Standard states that people should be able to receive adequate care which includes physical healthcare.

Mental Health is a priority for 'Choosing Health' with a focus on reducing health inequalities and physical well-being.

Tiers one and two

'Our health, Our care, Our say'. Outcomes supported.

'I am as healthy as I can be': Improved health and emotional well-being.

'

I have an equal chance to live free from avoidable harm, fear, discrimination and prejudice': Freedom from discrimination and harassment

10 High Impact Change

HIC No 7 Apply a systematic approach to enable the recovery of people with long-term conditions.

Case for change

The Disability Rights Commission is formally investigating the physical health inequalities of people with a mental illness. The interim report 'Closing the Gap', has found that people with mental health problems are significantly more likely to experience physical health issues than other citizens. This is therefore an equalities issue which must be addressed under the Disability Discrimination Act:

- One in three people with severe mental illness state that physical health care checks are a top area of priority. (Source: Rethink National Survey).
- NICE guidelines for schizophrenia require physical healthcare checks to be undertaken on an annual basis. This has been included within the nGMS contract for GPs.
- Under nGMS, QOF targets for health checks of people with schizophrenia and bi-polar disorder. These health checks should include measurement of blood pressure and weight, regular dentistry and optical appointments, early detection of diabetes and cancer, monitoring of chest and heart and detecting and monitoring side effects of medication. However, quality is variable across practices.
- There are higher mortality rates for people with schizophrenia. People with schizophrenia are 2.5 times more likely to die from respiratory disease, 1.8 times more likely from digestive disorders, 1.6 times more likely from genito-urinary problems and 1.1 times more likely to die from cardio-vascular disease.
- People with schizophrenia are twice as likely to have diabetes and 74.6% of people with schizophrenia living in mental health settings smoke, compared to 27% of the general population
- Poorer physical health together with mental health needs is linked to poverty, social exclusion exacerbated by poorer motivation and tiredness, poor lifestyle including diet, smoking and a lack of exercise.
- Health services are often divided down the middle, split between physical health and mental health. This can lead to diagnostic overshadowing and can result in physical health care issues being ignored and attributed to mental health problems.
- There is a clear relationship between substance misuse (especially alcohol and cannabis) and mental illness.

Service delivery components

- Delivery of physical health care checks for all people with a severe mental illness on practice based registers which are holistic, take account of known health inequalities and facilitate access to further services linked to the CPA.
- Integrated approach between specialist mental health services and primary care for meeting physical health care needs of people with severe mental illness. The characteristics of this include:-
    - Good quality information on components of mental well-being and their relationship with mental ill-health, referred to in 'Choosing Health' as 'marketing health'.
    - Physical health care screening in community teams with identified link workers to refer directly to primary care.
    - Provision of well-being assessments with dedicated well-being nurses in primary and secondary care.
    - Direct access from secondary care into exercise on prescription programmes.
    - Physical health care checks routinely undertaken on inpatient wards.
    - Access to nutritional and dietary advice in primary healthcare.
    - People with severe and enduring mental illness targeted as part of broader health promotion programmes, for example targeted programme of smoking cessation for people with mental illness.

Commissioning Priorities

- 2008/09. To identify six well-being practitioners to be targeted at GP practices in the most deprived wards in Buckinghamshire.
- 2008/11. Ensure all projects are subject to disability equality impact statements and that tracking poorer health outcomes for people with a severe mental illness is part of Buckinghamshire PCT disability equality scheme.
- 2008/09. Anti-stigma and discrimination training programme developed and rolled out for all primary care practice staff in partnership with the primary care mental health team.

- 2008/09. Exercise on prescription for people with mental illness prioritised in year one at Council Leisure Centres and year two and three at Leisure Centres more broadly.
- 2008/09. Information leaflets for service users in respect of QOF MH entitlements.
- 2008/09. QOF quality audit based on CSIP good practice guidance and recommendations delivered in years two and three of this strategy.
- 2008/09. Build into all Residential Care and Supported Living contracts that providers will be expected to establish a targeted training and awareness programme on physical health for staff.
- 2008/09. To ensure that the new LAA has mental health with a significant profile within the prevention agenda.
- Improved performance against the 'Choosing Health' mental health target. This is the main target for this big idea.

Impact on improved performance

- Deliver NICE requirements for schizophrenia.
- Deliver 100% attainment against the mental health specific QOF indicators for severe and enduring mental illness.
- Narrowing of health inequalities in Buckinghamshire.
- Reduction on the demand for secondary physical and mental health services.
- Reduction in the number of non-mental health specific consultations in primary care by people with severe and enduring mental illness.

Resource requirement to make it happen

- QOF, nGMS monies to drive improvement in primary care.
- Reconfiguration of investment in OBMH in order to create well-being practitioners.
- Local Authority contract for Leisure Services.

Make it happen

Small resource for promotional and information giving materials.

Commissioning lever to be applied

- Practice based commissioning.
- Enhanced services with nGMS.
- Local Area Agreement – health inequalities.

Big Idea Three

Increase the range of services for people with a mild and moderate mental health difficulty in primary care outside of special mental health services.

NSF Standard

Any service users who contacts their primary health care team with a common mental health problem, should:-

- Have their mental health needs identified and assessed.
- Be offered effective treatments including referral and specialist advice for further assessment, treatment and care if they require it.

Tier One and Two

'Our Health, Our Care, Our Say'. Outcomes Supported

'I am as healthy as I can be' Improved health and emotional well-being.

People living longer and with better physical, mental and emotional health. More people living healthier lifestyles.

10 High Impact Change

HIC No. 2. Improve flow of service users and carers across health and social care by improving access to screening and assessment.

HIC No. 4. Manage variation in access to all mental health services

Case for change

- In 2005/06 53,000 adults in Buckinghamshire had a mild to moderate mental health difficulty that could be met within a primary care setting in any one year.

- Of the £38,821,000 that is spent on adult mental health services for the Buckinghamshire LIT only £1.3million is spent on dedicated primary care based mental health services. This excluded nGMS QOF mental health funded activity.
- Failure to meet the NICE requirements in respect of the delivery of CBT and computerised CBT.
- Un-equitable access to primary care counselling services in the old PCT locality areas.
- Additional resource through Supporting People and Welfare to Work agenda needs to be linked into the Buckinghamshire model of primary care mental health services.
- Requirement to support 409 more FACS eligible people (based on the 2006/07 baseline) with mild to moderate mental health difficulties to live at home as part of the Council's requirement to drive up performance against C31 performance indicator.
- Failure to deliver NICE requirements for CBT and CCBT.

Service delivery components

- An agreed model for primary care mental health services which not only fully integrates all service elements within primary care, but also forms part of an integrated care pathway into specialist mental health and social care services.
- Gateway function into specialist mental health services with clear referral protocols in place.
- Signposting function within primary care.
- Provision of well-being assessments.
- Provision of a range of short–term psychological interventions including brief talking therapies.
- Formalising links to 'Pathways to Work' to support people to retain their employment or move back into employment.
- Access to self-help materials.
- Intensive case management of people with a first episode psychosis.

- Education programmes to support early detection of mental illness to primary care services.
- Targeting resources at excluded groups, e.g. BME.

Commissioning Priorities

- 2008/09. Further development of primary care mental health services with 3 STR workers to contribute towards the additional 400 people to be supported to live at home.
- 2008/09. Ensure that Early Intervention In Psychosis Service successful in winning continued financial resources to continue and develop in terms of staffing establishment and case load activity and that there is direct access arrangements from primary care services.
- 2008/09. Review practice based counselling services across the PCT to support the development of business case to deliver NICE CBT and cCBT requirements
- 2008/09. Implement review of counselling services and integrate with Improving Access to Psychological Therapies
- 2008/09. Bid to DH to apply for pilot monies for counselling and employment advisors as an outcome of the Layard Report which will form part of the national Comprehensive Spending Review.
- 2008/09. Formalise relationship between the Primary Care Mental Health Teams and Pathways to Work agenda for Mental Health through the maximisation of the Pathways to Work funding.

Impact on improved performance

- Deliver against full NHS Plan Primary Care workforce requirements.
- Deliver Autumn Assessment Self Assessment indicators for integration between primary care and secondary mental health services.
- Deliver NICE requirements for CBT and cCBT.
- Deliver MH specific QOF indicators for mild to moderate MH.
- Support the management in prescribing rate of anti-depressants benzodiazepine SSRI.

- Increased number of people with mental health problems supported back into employment with a corresponding reduction in the number of people in receipt of incapacity benefit.
- Increase our performance against C31 Helped to Live at Home, national indicator set.

Resources to make it happen

- Reconfiguration of existing services for Early Intervention Psychosis.
- STR workers in primary care mental health to be funded from 'because Every Adult Matters' funding for AMH within BCC.
- Delivery of other commissioning priorities will have to be achieved through reallocation of resource and service redesign.
- Ensuring MH maximises Supporting People and 'Pathways to Work Resources.

Commissioning lever to be applied

- Practice Based Commissioning.
- Enhanced services within nGMS.

Big Idea Four

Increase the numbers of people living in supported living services and reduce the numbers of people living in registered (residential / nursing) care

NSF Standard

NSF Standard four - Specialist Care. As previously stated the NSF is silent on the critical role of accommodation and support. This priority area receives much greater focus in the Mental Health and Social Exclusion Unit Report.

Tier three

'Our Health, Our Care, Our Say'. Outcomes supported.

'I am able to live a fulfilled life': Improved quality of life.

'I can participate as a full and equal member of my community': Making a positive contribution.

'I have the same life chances as other adults': Exercise of choice and control.

'I have an equal chance to live free from avoidable harm, fear, discrimination and prejudice': Freedom from discrimination and harassment.

'I am financially stable and have as much control as possible over my money': Economic well-being.

10 High Impact Change

HIC No 7 Apply a systematic approach to enable the recovery of people with long term conditions
HIC No 3 Manage variations in service user discharge processes

Target

By the end of this strategy supported living units within a core and cluster model will be developed for people with severe and enduring mental health problems

Case for Change

- For Ault Social Care the priority is to shift the investment away from residential care to supported living models of accommodation with support.
- The current models of service delivery are outmoded and do not support the delivery of a recovery based approach nor services which will promote social inclusion of people with mental health difficulties. The case for change in respect of this priority commenced during the 2003-2006 mental health strategy. This strategy is now about delivery.
- Comparatively low levels of performance against C31 with a requirement to support a further 408 people during year one of this strategy.
- C73: Permanent admission (aged 18-64) to residential and nursing are too high for adult mental health. This care group is an outlier against this indicator based on current performance at both a national and comparator group level.
- Adult Social Services fund 38 people in spot out-of-county residential and nursing placements costing over £1.75million per year.
- If we continue to use residential services based on 2007/08 trend we will overspend on the purchasing budgets during 2008/09.
- Changes in the current Supporting People Funded Floating and Accommodation services will have an impact on the sustainability of social care commissioned contracts.

Service delivery components

- Ethos of supported living is recovery based.
- Separating the provision of housing and support, giving people greater choice and flexibility to change support provider without having to move.
- Zero rejection – supported living is for everyone not just people with low level needs.
- People have choice and control about who they live with.
- Supported living builds on natural support networks and community links. It is vital that the placement of any new service enhances this for people.

- Ability to maximise welfare benefits
- Affordable rent levels which do not deter people from moving back into paid employment
- Maximise other income streams to including Housing Benefit and Independent Living Fund

Commissioning Priorities

- 2008/10. Delivery of Project Home Options resulting in an additional 74 beds (including an additional 60 Supported Living units to replace Registered Residential capacity)
- 2008/09. To complete phases two and three of the Group Home Modernisation
- 2008/09. To establish an annual supported housing allocation for adult mental health with the four district councils.
- 2008/09. To develop an integrated model for home care services identifying care pathways and clear roles which includes Rehab Workers and STRs, current external domiciliary care and Supporting People floating support services to maximise the use of the STR role.
- 2008/09. To deliver the model based on above
- 2008/09. Formalise strategic links to ensure that mental health receives an allocation of housing within the new growth areas to support the South East Plans in Aylesbury Vale.
- 2008/09 and onwards. Secure greater contracting efficiencies through the use of the Fairer Pricing Tool Kit against all spot purchased placements including Home Support. To target this at the 38 out of county placements
- 2008/11. Five people per year to be part of Shared Ownership schemes
- 2008/09. To drive up performance against National Minimum Standards for domiciliary and registered care for both internal and externally provided services through the incentivisation of contracts and targeted training

Impact on improved performance

- Improvement against PAF Target C31 Helped to live at home

- Improvement against PAF C73 Target - Permanent admissions (aged 18-64) to residential or nursing care.
- Delivery of 27-point action plan within the Social Exclusion Report against Getting the Basics Right.
- Reduction in Delayed Transfers of Care and Average Length of Stay in line with the LAA target.
- Reduction of numbers of people with mental health problems on homeless register or in temporary accommodation.

Impact on the system

- Strategy is based on the principles of recovery and social inclusion.
- Modernising the role of new community teams to facilitate the physical health needs of people in their own homes. This model will be used to address the continuing healthcare agenda.
- Introduction of an agreed approach to bed management and strategic targeting of community resources to:
    - Improve discharge planning.
    - Reduce the average length of stay
    - Fewer delayed discharge and delayed transfer of care.

Resource requirement to make it happen

With the exception of the additional revenue and capital investment in the MTP for Home Options and potential borrowing against the Support Housing Capital Grant new service development will have to be managed within available resources.

Commissioning lever to be applied

- Supporting People Contracting
- Strategic commissioning in partnership with Housing and Supporting People
- Individualised Budgets and Direct Payments

Big Idea Five
Increase the range of socially inclusive day time opportunities

NSF standard

Providing day opportunities which promote recovery and social inclusion is a key priority in the Mental Health and Social Exclusion Report June 2004. This report contains a 27-point action plan that needs to be delivered locally. This plan supports the delivery of evidenced based practice in vocational based services and enabling reintegration into the community, enabling people to lead fulfilling lives in the way they choose.

Increasing the take-up of Direct Payments and, more recently, Individualised Budgets is not explicitly referenced in the NSF. These programmes are both key to the extension of choice and control for people with long-term conditions for both the NHS and Social Care. They are identified as key priorities in 'Improving the Life Chances of Disabled People' (Strategy Unit, January 05), 'Opportunity Age' (DWP, March 05), 'Independence, Well-being and Choice' (DH, March 05) and followed in 'Our Health, Our Care, Our Say' (DH, January 06).

Tier three

'Our Health, Our Care, Our Say'. Outcomes supported.

'I can participate as a full and equal member of my community': Making a positive contribution.

'I am financially stable and have as much control as possible over my money': Economic well-being.

10 High Impact Change

HIC No 7 Apply a systematic approach to enable the recovery of people with long-term conditions.

Target

70% of people on enhanced CPA will have been supported in vocational and work based opportunities by 2011.

Case for change

- Day opportunities are traditional in profile with specialist services and limited throughput into work and paid employment.
- Uneven distribution of services across the county with little scope for people to move from service silos into communities.
- Community Mental Health Review identified that vocational outcomes are not routinely identified as part of the CPA process and the proportion of services users supported to help find work during the last 12 moths was only fair.
- There is limited support for non-critical/substantial levels of need, this will need to support the preventative agenda.

Service delivery components

- There needs to be a comprehensive range of day service provision designed to promote recovery, social inclusion and self-determination and to decrease social isolation. This will fulfil three functions:
    - Provide opportunity for social contact and support.
    - Support to retain existing and access new social roles, relationships and mainstream social/leisure opportunities of their choosing.
    - Provide opportunities for people with mental health problems to run their own services.

Commissioning priorities

- 2008/09. Review all day services (in-house and external) commissioned by Adult Social Care and Buckinghamshire PCT using the National development Team (NDT) Recovery and Inclusion Toolkit to identify priorities for directly commissioned day services. This will be supported by the NDT.

- 2008/09. Develop a new model of day services provision including an employment strategy for people with mental health needs in partnership with the Department of Work and Pensions who have non-FACs eligible needs.
- 2008/09. Implement the outcome of this review through the re-letting of day service contracts and establishment of individualised budgets.

Impact on improved performance

- C31 Helped to live at Home.
- C51 Direct Payments.
- Delivery of 27-point action plan within the Social Exclusion Report against Day Services.
- Improvements against Autumn Assessment and Joint Review of Community Mental Health Team indicators – Help with Employment and Vocational and Social Outcomes supporting move from fair to good.
- Improvements against the service user satisfaction survey.

Impact on the system

HIC No 7 Apply a systematic approach to enable the recovery of people with long-term conditions.

Other system changes include:-

- Reduction in the number of people in receipt of incapacity benefit.
- Increase in the number of people receiving Access to Work funding.
- More regular dialogue with the Learning and Skills Council to support uptake of educational and training opportunities.
- The Third Sector has an important role in transforming the support available and through marketing services directly with service users.

Resource requirement to make it happen

This is not about investment but rather reconfiguring existing investment in day services.

Commissioning lever to be applied

Individualised Budgets and Direct Payments to commission services for people with long-term conditions supported by strategic commissioning.

Big Idea Six

To enable more people, when they become acutely unwell, to stay in their own homes as opposed to being admitted to hospital.

NSF standard

NSF Standard four - Each service user who is assessed as requiring a period of care away from their home should have:

- Timely access to an appropriate hospital bed or alternative bed or place, which is:
  - in the least restrictive environment consistent with the need to protect them and the public;
  - as close to home as possible.
- A copy of a written after-care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care coordinator, and specifies the action to be taken in a crisis.

Tier three and four

'Our Health, Our Care, Our Say': Outcomes supported.

'I am as healthy as I can be': Improved health and emotional well-being.

'I feel valued by others': Maintaining personal dignity.

10 High Impact Change

HIC No 1 - Treat home-based care and support as the norm for delivery of mental health services.

HIC No 3 - Manage variations in service user discharge. processes.

HIC No 5 - Avoid unnecessary contact for service users and provide necessary contact in the right setting.

Target

By the end of this strategy to have reduced the average length of stay on acute adult mental health admissions wards to below 15 days.

Case for change

- The case for change has been set out in the 'Putting People First' consultation in respect of this big idea. The outcome of the consultation was to support the development of a single site for adults of working age and the strengthening of community based alternatives to admission services. This decision was made in January 2006 by the three PCT executives, OSC and PPIF and supported by BCC. This now needs to be implemented.

Service delivery components

Acute Care Services do not only encompass inpatient care. A fully-functioning acute care pathway should contain the following;

- A series of initiatives to restore the therapeutic status of acute admission wards and define their role in a comprehensive system of care
- The development of community based alternatives to hospital admission – to include crisis resolution and home treatment, acute day hospitals, A+E liaison and social care crisis house
- That crisis resolution and home treatment teams manage access to acute inpatient beds and promote early discharge for home treatment

Commissioning priorities

- 2008/09–2010. Implementation of single site.
- 2008/09. Implementation of the Mental Capacity Act and Deprivation of Liberty guidance.
- 2008/09. Development of a model for the transfer from the ASW function and the development of the AMHP role.

- 2008/09. To determine the model of social crisis capacity and links to acute care pathway being developed through Home Options.
- 2008/09 .Joint protocol for support for people with a learning disability in inpatient settings agreed, and monitored.

Impact on improved performance

- Reductions in the levels of emergency re-admissions.
- Fidelity to the model for crisis resolution and home treatment – OBMH key target.
- Delivery of crisis resolution and home treatment targets for activity – PCT key target.
- Delivery of improved performance against CPA 7-day follow-up a PCT LDP indicator.
- Reduction in average length of stay to under 15 days by the end of this strategy.
- Reduction in A+E waits.

Impact on the system

HIC 1 aims to avoid hospital admissions by ensuring that alternatives are in place as well as more efficient use of the whole service. This means that inpatient services should be seen as a specialist and intensive intervention and that there should be a range of self-help and home treatment and care options, including appropriate community based support and alternatives to hospital.

- Demonstrating the impact of Crisis Team in admission reduction.
- Developing a range of services from Primary Care.
- Developing Social Care Crisis services.

HIC 3 looks for a timely and consistent discharge regardless of the day of the week or clinician availability. Discharge from all services should be integral to care planning and in collaboration with service users and carers.

- Introduction of an agreed approach to bed management and targeted interventions.
- Whole-system approach to care pathway.
- Discharge planning.
- Reduction in length of stay.
- Fewer delayed discharge and delayed transfer of care.

HIC 5 requires planned and negotiated care. Specifically this ensures:-

- 7-day follow–up on all discharges.
- Effective caseload management.
- Follow-up contact determined by clinical needs or service user request.

Resource requirement to make it happen

- It is unclear what the resource implication will be of the new inpatient unit. This will be a priority for determination in early 2008/09.
- The social care Crisis Service has funding agreed through the MTP process. In respect of the dedicated out of hours ASW service funding will need to be reviewed through the redesign of EDT and existing resources

Commissioning lever to be applied

Strategic commissioning - through block and cost and volume contracting. For the future this will be for Payment by Results.

Strategy Implementation and Review

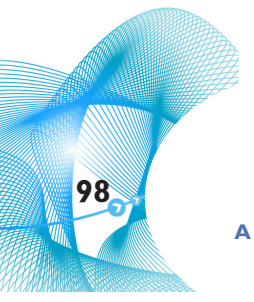
This Integrated Commissioning Mental Health strategy with its vision and key objectives is a long-term plan to be carried out over the next three years. The actions contained within the strategy based on the key priorities are to be achieved or commenced throughout the life of this document. It sets specific targets in terms of service, strategic and process developments. The Joint Management Group will be the key forum to monitor and review the progress of the implementation of this strategy. The Mental Health Partnership Board, in its position as a National Service Framework Local Implementation Team, will engage with the strategy and be regularly informed about progress in its implementation.

It is recognised that needs and supply within Adult Mental Health services are ever changing. Accordingly, this strategy will be subject to a yearly review overseen by the Joint Management Group and Mental Health Partnership Board. The commissioning team will ensure that the outcomes of this review are circulated to all parties to the strategy and will provide quarterly performance reports on progress to the Joint Management Group.

Appendix 1 – Glossary

ASC	Adult Social Care
ASW	Approved Social Worker
BCC	Buckinghamshire County Council
BPCT	Buckinghamshire Primary Care Trust
BME	Black & Minority Ethnic
CAMHS	Child & Adolescent Mental Health Service
CMHT	Community Mental Health Team
CBT	Cognitive Behavioural Therapy
CCBT	Computerised Cognitive Behavioural Therapy
CPA	Care Programme Approach
CSCI	Commission for Social Care Inspection
CSIP	Care Services Improvement Partnership
DAAT	Drug & Alcohol Action Team
DH	Department of Health
EDT	Emergency Duty Team
FAC	Fair Access to Care
FACS	Fair Access to Care Services
FT	Foundation Trusts
GMS	NHS Foundation Trust
HCC	Healthcare Commission
IBP	Integrated Business Plan
LAA	Local Area Agreement
LIT	Local Implementation Team
LDP	Local Delivery Plan
MTP	Medium Term Plan
nGMS	new General Medical Services
NICE	National Institute of Health & Clinical Excellence
NSF	National Service Framework
OBMH	Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust
ONS	Office for National Statistics
OSC	Overview & Scrutiny Committee

PAF	Performance Assessment Framework
PPI	Patient Public Investment
QOF	Quality and Outcomes framework

S31/S75 Section 31/Section 75 of the Health Act (S31 Health Act 2000 was replaced by S75 Health Act 2006 without changes to the content of the legislation)

SCSH	South Central Strategic Health Authority
SECE	South East Centre of Excellence
SHA	Strategic Health Authority
SHMG	Supported Housing Management Grant
STR	Support Time Recovery Worker
WHO	World Health Organisation