Joint Commissioning Strategy for Mental Health 2013-2018

December 2013
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>3</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>4</td>
</tr>
<tr>
<td>Introduction</td>
<td>6</td>
</tr>
<tr>
<td>Chapter 1 Mental Health in Bedford Borough</td>
<td>8</td>
</tr>
<tr>
<td>Chapter 2 National and Local Context</td>
<td>24</td>
</tr>
<tr>
<td>Chapter 3 Strategic Priorities for People with Mental Health Needs</td>
<td>46</td>
</tr>
</tbody>
</table>

**Strategic Priority 1:** More people will have good mental health  
**Strategic Priority 2:** More people with mental health problems will recover  
**Strategic Priority 3:** More people with mental health problems will have good physical health  
**Strategic Priority 4:** More people will have a positive experience of care and support  
**Strategic Priority 5:** Fewer people will suffer avoidable harm  
**Strategic Priority 6:** Fewer people will experience stigma and discrimination  
**Strategic Priority 7:** More people from ethnic minority backgrounds will have access to local mental health services

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Plan</td>
<td>59</td>
</tr>
<tr>
<td>Glossary</td>
<td>70</td>
</tr>
</tbody>
</table>
Foreword

Welcome to the Bedford Borough Council and Bedfordshire Clinical Commissioning Group Joint Commissioning Strategy for Mental Health. This strategy incorporates the views of all of our key stakeholders including, most importantly, the views of users and carers.

This strategy is underpinned by Bedfordshire Clinical Commissioning Group’s Mental Health Strategic Objectives 2013-2016 and Bedford Borough Council’s commissioning intentions.

This strategy also includes health and social care needs which have been identified through our Joint Strategic Needs Assessment and the views of our community expressed through the Bedford Borough Assembly conferences.

One of the key aims in the Bedford Borough Sustainable Community Strategy is to ensure that “everybody has access to high-quality health and social care services when they need them and the help they need to lead healthy and independent lives”. The Bedford Borough Health and Wellbeing strategy explicitly prioritises mental health.

We have produced this strategy in challenging times with increasing demand and budget reductions under way. We remain determined to deliver services which are seen as excellent by those who use, depend on or inspect them. We will take the opportunity to do things differently with the resources that remain available.

We are committed to making changes to transform the way services are delivered over the next five years. This will mean concentrating more on prevention and early intervention. When people need services we will provide them effectively, efficiently and in a personalised way with all our partners.

Good mental health is a basic foundation to the wellbeing of individuals, families and communities. It affects our quality of life, our relationships and aspirations. The consequences of mental ill health on sufferers and their families can be devastating.

Stigma and prejudice can hinder recovery and exclude people from opportunities that most of us take for granted – such as family life, decent homes and careers. People with Mental Health needs need to be fully included in our community and have choice and control in their lives.

We hope you find this document helpful and informative. It will be updated as required to reflect changing needs, legislative and regulatory requirements and commissioning priorities. We remain absolutely committed to providing the best possible services to people with mental health needs and working in partnership to provide safe, sound and supportive services based on an accurate assessment of the needs of our community.
Executive Summary

This is the joint commissioning strategy for mental health from Bedford Borough Council and Bedfordshire Clinical Commissioning Group. It demonstrates our continuing commitment to supporting people with mental health needs to have maximum independence, choice and control in how they live their lives. The strategy will drive commissioning, planning and decision making processes for people with mental health needs in Bedford Borough.

The vision for people with mental health needs in the Borough is:

‘To provide excellent, safe, sound, supportive, cost effective and transformational services for people with mental health needs that promote independence, well being, and choice and are shaped by accurate assessment of community needs.’

We will bring this vision closer by improving outcomes for mental health in seven strategic domains between 2013 and 2018.

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination
- More people from ethnic minority backgrounds will have access to local mental health services

The Joint Commissioning Strategy for Mental Health Action Plan can be found on page 59.

There is “No health without mental health”. Mental well-being is fundamental to a person’s quality of life. It is linked to good physical health, better cognitive and physical functioning, increased productivity, better interpersonal relationships, longer life expectancy and greater capacity to deal with stress and adversity.

The life of this strategy will take place in a new national and local context defined change from Primary Care Trusts to Clinical Commissioning Groups (CCGs).

The last few years also produced focused pieces of work which inform mental health commissioning, in particular Mind’s review of acute care, and Schizophrenia’s Commission work on review of care for people with schizophrenia.

There are strong links between social deprivation and mental ill health, therefore service provision and treatment should be focused towards more deprived areas of the Borough such as Harpur, Cauldwell, Queens Park and Castle wards.

The prevalence of dementia will rise significantly with the aging population, estimated to increase by 16% between 2010 and 2016 in Bedford Borough. A separate specialist dementia strategy is in place to complement this general mental health strategy.

Similarly, a separate autism strategy (Fulfilling and Rewarding Lives in Bedfordshire), has been developed to meet the particular needs of people with autism.
This strategy considers mental health needs of military veterans. A significant minority of non-elderly military veterans experience a range of mental health problems related to their service in the military which can have serious consequences for their health outcomes and those of their families. The most common disorders among recent or younger veterans are depression, anxiety disorders, Post Traumatic Stress Disorder (PTSD) and substance - particularly alcohol - misuse.

Bedford has one of the most ethnically diverse communities in the eastern region and is home to people from an estimated 80 countries, including large Italian and Asian populations.

Research shows men from Black Caribbean, Black African, and other Black groups are more likely than other groups to be detained under the Mental Health Act. Research also shows that the highest levels of depressive episodes are reported by Pakistani women and Indian women. Bedford Borough’s Indian and Pakistani population is higher than the national average. The reasons for these differences need to be understood and effective support made available.

We will be implementing this strategy for all people with mental health needs in our Borough and will monitor carefully the difference it is making for people with mental health needs from all our diverse groups.

In summary this strategy will drive a partnership approach to developing support for people with mental health needs in the Borough and sustaining the best possible quality of life for them and their families.
Introduction

This is the joint commissioning strategy for mental health from Bedford Borough Council and Bedfordshire Clinical Commissioning Group. It demonstrates our continuing commitment to supporting people to live their lives the way they want to. It will drive commissioning, planning and decision making processes for people with mental health needs in both Bedford Borough Council and Bedfordshire Clinical Commissioning Group.

Vision

The vision in Bedford Borough for mental health is;

‘To provide excellent, safe, sound, supportive, cost effective and transformational services for people with mental health needs that promote independence, well being and choice and are shaped by accurate assessment of community needs.’

Bedfordshire Clinical Commissioning Group are continuing with the work already started with our partners to redesign all our mental health services to improve quality, health outcomes, increase capacity, reduce gaps in provision and remove duplication. We need to increase the pace and scale of the transformation and will be focusing on the following key priorities:

- Prevention and Early Intervention
- Improving Quality in General Practice
- Steps 1 to 3 (Primary Care)
- Steps 4 to 5 (Secondary care)
- Complex Needs
- Rehabilitation and Recovery
- Dementia
- Liaison Psychiatry
- Transition to Adult Services
- Services for Children and Young People

Delivery

This strategy will be delivered through annual action plans. During the strategy we will continue to consult and invite feedback to ensure annual action plans reflect any changes to local or national priorities.

Our challenge is to support people with mental health needs with specific services and also to ensure mental health is included in the modernisation of mainstream health and social care services. This will require a joined-up approach across all agencies with a role in the health and well being of the Borough.

Individuals also need help to take responsibility for their own health and access advice and information that will enable them to make informed lifestyle choices.

A wide-range of public, private and voluntary organisations have come together as the ‘Bedford Borough Partnership’ to identify how to make sustainable improvements to health and wellbeing for the local population. (Please see chapter about Local Context).
This strategy complements the Sustainable Community Strategy, Joint Healthier Bedford Borough Strategy, Health and Wellbeing Strategy, the Bedford Borough Adults Services Plan and the Bedford Borough Children and Young Peoples’ Plan, by providing an overview of the strategic work areas required to improve mental health outcomes for people in the Borough.
Chapter 1: Mental Health in Bedford Borough

Demographic Information

1.1 Bedford Borough covers an area of 476 sq km and in 2011 was home to approximately 157,840 people living in over 65,000 households. Just under two thirds live in the urban areas of Bedford and Kempston, with almost 36% in the surrounding rural areas. The population is forecast to rise to more than 173,000 by 2021.

1.2 Bedford is one of the most ethnically diverse communities in the eastern region and is home to people from more than 80 countries, including large Italian, Polish and Asian populations.

1.3 The 2011 Census indicates that 28.5% of the population was from Black and Minority Ethnic (BME) groups\(^1\), compared to 20.2% in England (though only 13.9% when the London Boroughs are excluded) and 14.7% in the East of England.

1.4 In particular, Bedford Borough has significantly higher proportions of Asian and Other White\(^2\) groups than England:

Figure 1: Ethnic makeup of Bedford Borough compared to England.

Bedford Borough

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>71.5%</td>
</tr>
<tr>
<td>Other White</td>
<td>11.4%</td>
</tr>
<tr>
<td>Mixed</td>
<td>3.4%</td>
</tr>
<tr>
<td>Asian</td>
<td>3.9%</td>
</tr>
<tr>
<td>Black</td>
<td>0.7%</td>
</tr>
<tr>
<td>Other</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

England

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>79.8%</td>
</tr>
<tr>
<td>Other White</td>
<td>7.8%</td>
</tr>
<tr>
<td>Mixed</td>
<td>5.7%</td>
</tr>
<tr>
<td>Asian</td>
<td>3.5%</td>
</tr>
<tr>
<td>Black</td>
<td>2.3%</td>
</tr>
<tr>
<td>Other</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

1.5 The Borough’s BME population increased significantly between 2001 and 2011. ONS estimates that the non-White British population grew by approximately 16,400 from 19.2% in 2001 to 28.5% in 2011, while the White British population declined by almost 6,900. There were substantial increases in all BME groups:

---

\(^1\) Defined as all ethnic groups other than White British

\(^2\) Other White comprise White Other, White Irish and White Gypsy or Irish Traveller
### Table 1: Ethnic Composition and Change 2001-2011, Bedford Borough

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2011</th>
<th>2001-2011 Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>White British</td>
<td>119,467</td>
<td>80.8</td>
<td>112,588</td>
</tr>
<tr>
<td>Other White*</td>
<td>9,191</td>
<td>6.2</td>
<td>14,258</td>
</tr>
<tr>
<td>Mixed</td>
<td>2,923</td>
<td>2.0</td>
<td>5,386</td>
</tr>
<tr>
<td>Asian/Asian British</td>
<td>12,071</td>
<td>8.2</td>
<td>17,932</td>
</tr>
<tr>
<td>Black/Black British</td>
<td>3,846</td>
<td>2.6</td>
<td>6,202</td>
</tr>
<tr>
<td>Arab**/Other</td>
<td>427</td>
<td>0.3</td>
<td>1,113</td>
</tr>
<tr>
<td><strong>All Groups</strong></td>
<td>147,925</td>
<td>100.0</td>
<td>157,479</td>
</tr>
</tbody>
</table>

Sources: ONS, 2001 Census, Table ST101 and 2011 Census, Table KS201EW

1.6 The ageing of the Borough’s population will accelerate in future years with the 75-84 age range population forecast to rise by 22% and the 85+ population by 46% from 2010 to 2021.

1.7 Health in Bedford Borough is generally close to the England average. The average life expectancy is 78.9 years for men and 82.6 years for women. However, life expectancy for both men and women in the most deprived parts of Bedford town is estimated to be 12 years less than in the Borough’s most affluent areas.

1.8 The Joint Strategic Needs Analysis (JSNA) provides a unique understanding of the health and social care needs of Bedford Borough’s population. It brings together a wealth of information on current needs and in key areas such as demographic changes, predictions of future health and social care needs. This is particularly important given the stringent financial climate over the next few years. More information on the JSNA is to be found at: [www.bedford.gov.uk/health_and_social_care/bedford_borough_jsna.aspx](http://www.bedford.gov.uk/health_and_social_care/bedford_borough_jsna.aspx)

### Mental Health in Bedford Borough – Key Findings

1.9 The number of people with a mental health condition in Bedford Borough is predicted to rise primarily as a result of the changing population.

<table>
<thead>
<tr>
<th>Mental health - all people</th>
<th>2012</th>
<th>2015</th>
<th>2020</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 18-64 predicted to have a common mental disorder</td>
<td>16,429</td>
<td>16,732</td>
<td>17,351</td>
<td>5.6</td>
</tr>
<tr>
<td>People aged 18-64 predicted to have a borderline personality disorder</td>
<td>459</td>
<td>468</td>
<td>485</td>
<td>5.6</td>
</tr>
<tr>
<td>People aged 18-64 predicted to have an antisocial personality disorder</td>
<td>357</td>
<td>363</td>
<td>376</td>
<td>5.3</td>
</tr>
<tr>
<td>People aged 18-64 predicted to have psychotic disorder</td>
<td>408</td>
<td>416</td>
<td>431</td>
<td>5.6</td>
</tr>
<tr>
<td>People aged 18-64 predicted to have two or more psychiatric disorders</td>
<td>7,345</td>
<td>7,481</td>
<td>7,755</td>
<td>5.6</td>
</tr>
</tbody>
</table>

Source: [www.pansi.org.uk](http://www.pansi.org.uk)
1.10 The most recent adult psychiatric morbidity survey\(^3\) found that:

- Women were more likely than men to have a common mental disorder such as anxiety and/or depression, particularly amongst women aged between 45-54 years.
- Rates of probable psychotic disorder were higher in men aged 25-44 years and women aged 45-64 years.
- 16.2% of the population experience at least one common mental disorder (anxiety and depressive disorders) in the previous week.
- 23% of adults with a common mental disorder receive treatment.
- 14% receive psychoactive medication only.
- 5% receive counselling or therapy, and
- 5% receive both medication and therapy.
- Most (38%) of those with common mental disorders accessed GP services and 18% made use of community or day care services.

1.11 For those with two or more common mental disorders:

- 16% made use of community day centres,
- 10% accessed psychiatry and
- 10% received social work input

1.12 Mental health problems affect about one in four people – that is, 250 per 1000 at risk. Of those 250 people, the vast majority – about 230 (92%) – attend their general practice. Of these 230, about 130 (52% out of 250) are subsequently diagnosed as having a mental health problem, only between 20 (8% out of 250) and 30 (12% out of 250) are referred to a specialist mental health service, and fewer than 10 (4% out of 250) are ever admitted to a mental health hospital. This is summarised in figure 2 below.

1.13 For Bedford Borough this means (based on 2013 population figures):

- Total Population: 157,840
- Total population at risk on mental health problem: 39,460
- Total number attending GP because of mental health problem: 36,303
- Total number of people diagnosed by a GP: 20,329
- Total number referred to a specialist mental health team: Between 3,049 and 4,675
- Total number admitted to a mental health hospital: only fewer than 1524 are ever admitted to a mental health hospital.

---


The Community Mental Health Profile (CMHP) presents a range of mental health information for local authorities in England, specifically selected to reflect the national strategy “No health without mental health”. The full 2013 profile can be seen at [www.nepho.org.uk/cmhp/index.php?view=E06000055](http://www.nepho.org.uk/cmhp/index.php?view=E06000055).

Please, note about all presented figures: Bedford figures may appear only a little bit higher or lower compared to the national average. However in statistical terms they are significantly different therefore we pay attention to them.

The following areas identified in Bedford Borough’s CMHP are significantly worse than the England average.

**Episodes of violent crime, rate per 1,000 population (low is good)**

<table>
<thead>
<tr>
<th>Period</th>
<th>England Average</th>
<th>East of England</th>
<th>Bedford</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>14.6</td>
<td>12.1</td>
<td>17.2</td>
</tr>
</tbody>
</table>

Crime levels are associated with illness and poverty, increasing the burden of ill health on those communities least able to cope. Violent crime can result directly in psychological distress and subsequent mental health problems.

**Percentage with depression aged 18+ (low is good)**

<table>
<thead>
<tr>
<th>Period</th>
<th>England Average</th>
<th>East of England</th>
<th>Bedford</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/2012</td>
<td>11.68</td>
<td>11.55</td>
<td>12.69</td>
</tr>
</tbody>
</table>

This indicator estimates the prevalence of depression from General Practice records. Depression is common and disabling. The estimated prevalence of major depression among 16-65 year olds in the UK is 21/1000 (males 17, females 25). Mixed anxiety and depression is prevalent in a further 10 per cent of adult patients attending general practices. It contributes 12 per cent of the total burden of non-fatal global disease and by 2020, looks set to be second after cardiovascular disease in the world’s disabling diseases.

1.19 Numbers of people using adult & elderly NHS secondary mental health services, rate per 1000 population (not too far from average is good)

<table>
<thead>
<tr>
<th>Period</th>
<th>England Average</th>
<th>East of England</th>
<th>Bedford</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>2.55</td>
<td>2.48</td>
<td>1.98</td>
</tr>
</tbody>
</table>

This indicator measures those individuals using adult and elderly NHS secondary mental health services as recorded in the Mental Health Minimum Dataset, collated by the NHS Information Centre.

1.20 Numbers of people on a Care Programme Approach, rate per 1,000 population (not too far from average is good)

<table>
<thead>
<tr>
<th>Period</th>
<th>England Average</th>
<th>East of England</th>
<th>Bedford</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>6.39</td>
<td>5.32</td>
<td>4.79</td>
</tr>
</tbody>
</table>

The Care Programme Approach is a way of co-ordinating community mental health services for people with severe and enduring mental health problems. It involves carrying out a comprehensive assessment and producing a care plan for each patient. This indicator measures the number of individuals who are on the Care Programme Approach per 1,000 population.

1.21 Number of contacts with Community Psychiatric Nurse (CPN), rate per 1,000 population (not too far from average is good)

<table>
<thead>
<tr>
<th>Period</th>
<th>England Average</th>
<th>East of England</th>
<th>Bedford</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>168.53</td>
<td>175.35</td>
<td>89.26</td>
</tr>
</tbody>
</table>

This indicator records the number of contacts that Outpatient and Community Psychiatric Nurses have with patients each year, per 1,000 population. The data is sourced from the Mental Health Minimum Dataset.

1.22 Number of total contacts with mental health services, rate per 1,000 population (not too far from average is good)

<table>
<thead>
<tr>
<th>Period</th>
<th>England Average</th>
<th>East of England</th>
<th>Bedford</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>313.23</td>
<td>313.51</td>
<td>194.67</td>
</tr>
</tbody>
</table>

This indicator measures all contacts with mental health staff, including Consultant Psychiatrists, Community Psychiatric Nurses, Clinical Psychologists, Occupational Therapists, Physiotherapists, Consultant Psychotherapists and Social Workers.
1.23 Percentage of 16-18 year olds not in employment, education or training, 2010/11 (low is good)

<table>
<thead>
<tr>
<th>Period</th>
<th>England Average</th>
<th>East of England</th>
<th>Bedford</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>6.2</td>
<td>6.0</td>
<td>7.2</td>
</tr>
</tbody>
</table>

Young people aged 16-18 years old who are not in education, training or employment (NEETS) are more likely to have poor health and die an early death. They are also more likely to have a poor diet, smoke, drink alcohol and suffer from mental health problems.

1.24 (Directly standardised) Rate for hospital admissions for schizophrenia, schizotypal and delusional disorders, 2009/10 to 2011/12 (not too far from average is good)

<table>
<thead>
<tr>
<th>Period</th>
<th>England Average</th>
<th>East of England</th>
<th>Bedford</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10 to 2011/12</td>
<td>57</td>
<td>43</td>
<td>69</td>
</tr>
</tbody>
</table>

Schizophrenia is one of the most common serious mental health conditions. The illness has a range of symptoms including hallucinations, delusions, and difficulty in thinking. Doctors describe schizophrenia as a psychotic illness.

1.25 In-year bed days for mental health, rate per 1,000 population (not too far from average is good)

<table>
<thead>
<tr>
<th>Period</th>
<th>England Average</th>
<th>East of England</th>
<th>Bedford</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>193</td>
<td>187</td>
<td>168</td>
</tr>
</tbody>
</table>

Knowing the number of bed days used by patient each year helps commissioners with the planning of mental health services.

1.26 The Borough is significantly lower on contacts with secondary mental health services. The Borough also has a low employment rate for young people. The depression rate for adults is also higher than the national and regional average.

**Other Aspects Related To Mental Health in Bedford Borough**

**Physical Health**

1.27 There is increasing evidence that physical health and mental health are more closely linked than previously believed and significant improvements in people’s health and wellbeing can be made by considering and treating the two more closely together. This can lead to better outcomes from treatment and also save money in the NHS as well as for the wider public sector.

1.28 The 2011 Government publication ‘No Health Without Mental Health’ provides information about the evidence and recommendations about how to approach this issue. Examples include:
• Having a mental health problem increases the risk associated with physical ill health. For example, depression increases the risk of dying by 50% and doubles the risk of coronary heart disease.

• People with severe mental health problems, such as schizophrenia or bipolar disorder die on average 16-25 years sooner than the general population, with higher rates of respiratory, cardiovascular and infectious disease and more problems with obesity, raised cholesterol and diabetes. Most of these premature deaths are due to smoking, as a much higher percentage of this group of people smoke compared to the general population.

• Mental health problems such as depression are also much more common in people with physical illness. Having co-morbid physical and mental health problems delays recovery in both.

• People with one long-term condition are two to three times more likely to develop depression than the rest of the population. People with three or more conditions are seven times more likely to have depression.

• Adults with both physical and mental health problems are much less likely to be working.

1.29 We have considered the recommendations in the supporting document ‘No Health Without Mental Health Implementation Framework’, published in July 2012 when developing our priorities.

Early Death

1.30 The national suicide rate is 8 suicides per 100,000 populations, giving an expected rate of 13 suicides per year in Bedford Borough. In terms of suicides and undetermined injuries Bedford Borough is not significantly different compared to national average.¹

1.31 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. People with mental ill-health are also more likely than others to have strokes and coronary heart disease (CHD) before the age of 55.

Inequalities and Vulnerable groups

1.32 The Equality Act 2010 introduced public sector equality duties covering nine ‘protected characteristics’ (Table 3).

1.33 Out of all protected characteristics, the following groups experience the biggest inequalities in terms of mental health services.

Black and minority ethnic groups

1.34 People from BME groups can have different presentations of problems and different relationships with health services. Some black groups have mental health hospital admission rates around three times higher than average.

1.35 African–Caribbean people are particularly likely to be subject to compulsory treatment under the Mental Health Act.

1.36 The rates of mental health problems for migrant groups and subsequent generations are also sometimes higher which can then be compounded by access issues for example South East Asian women have been found less likely to receive timely and appropriate mental health services.

**People with physical, sensory, and learning disabilities**

1.37 Disabled people with mental health problems can face physical barriers to physical access as well as communication barriers which effect deaf people in particular.

1.38 An estimated 25-40% of people with learning disabilities have mental health problems.

1.39 People with autism may be refused support because they do not fit easily into mental health or learning disability services. The autism strategy “Fulfilling and Rewarding Lives”\(^6\) aim to identify solutions to this problem.

**Lesbian, gay and bisexual people**

1.40 People from this group all have higher risk of mental health problems and of self harm. Detailed information on sexual orientation is patchy, making it less easy to develop tailored services responses.

**Gender inequality – Women**

1.41 Recorded rates of depression and anxiety are between one and a half and two times higher for women than for men. Rates of deliberate self-injury are two to three times higher in women than men. Women are at greater risk of factors linked to poor mental health, such as child sexual abuse and sexual violence – an estimated 7–30% of girls (3–13% of boys) have experienced childhood sexual abuse. Around one in ten women have experienced some form of sexual victimisation, including rape. Studies have shown that around half of the women in psychiatric wards have experienced sexual abuse.

**Gender inequality - Men**

1.42 Three-quarters of people who commit suicide are men. Men are three times more likely than women to be dependent on alcohol and more than twice as many men in psychiatric units are compulsorily detained. Services should be sensitive to the ways in which men present mental health problems.

**Gender Reassignment**

1.43 People who undergo gender reassignment are subject to some of the greatest discrimination in our society. They are at increased risk of alcohol and substance


London: The Stationery Office
misuse, suicide and self-harm. It is important that staff in health, social and education services are aware of the raised risks.

**Religion and Belief**

1.44 Inequalities in this area arise in four main ways:

a. Service data shows that more people from BME backgrounds identify themselves as religious. By failing to address religion, services disproportionately affect people from BME backgrounds.

b. People who hold religious or other beliefs may have poorer experiences of services because core aspects of their identity are overlooked or they have no means of religious expression.

c. Evidence indicates that religion may have a protective role for individuals who are vulnerable to suicide.

d. The role of religion or belief in people’s explanations for their mental health problems – different conceptualisations and language between an individual and services will affect engagement and success of treatment and care.

Table 3: Summary of inequalities for protected characteristics

<table>
<thead>
<tr>
<th>Protected characteristic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Access for older people to services available to working age adults; failure to recognise mental health needs of older adults.</td>
</tr>
<tr>
<td>Disability</td>
<td>Access to physical and mental health care for people with other disabilities – e.g. people with learning disability who can be overlooked both by mental health services and public health initiatives such as screening.</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>Rights and recognition of same sex partnerships.</td>
</tr>
<tr>
<td>Race</td>
<td>Inequalities in health and health outcomes; poorer access to and experience of services.</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>Provision of appropriate facilities, sensitive services.</td>
</tr>
<tr>
<td>Gender</td>
<td>Safety issues, single sex accommodation, mental health impact of violence and abuse, gender variations in mental disorders and access to treatments; gender reassignment.</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>Gaps in service provision for lesbian, gay, bisexual and transgender people; discrimination.</td>
</tr>
</tbody>
</table>

**Major Inequality Challenges in Bedford Borough**

1.45 The Mental Illness Index (MINI) ranks the prevalence of mental illness in small areas against a nationally defined average of 100. Higher scores representing a greater than average prevalence (e.g. 1.2 represents 20% above average) and lower scores representing a lower than average prevalence (e.g. 0.60 represents 40% below average).
MINI scores at the ward level\textsuperscript{7} in Bedford Borough are highly correlated with deprivation. The Bedford town wards of Harpur (1.59), Cauldwell (1.35), Castle (1.34) and Kingsbrook (1.23) all have areas within the top 10\% or 20\% most deprived areas in England as measured by the Index of Multiple Deprivation 2010:

Figure 3: Index of Multiple Deprivation (IMD) 2010: Areas in Bedford Borough among 30\% Most Deprived in England

Queens Park ward, which is largely among the 30\% most deprived areas in England and has a majority non-White British population (57.8\%), including large Asian communities, has a score of 1.38.

\textsuperscript{7} MINI scores refer to the former Bedford Borough wards which were replaced by the Borough’s new ward structure in May 2011. However, the strong correlation between MINI scores and deprivation is unaffected.
1.48 The more affluent rural wards have low MINI scores - Oakley (0.19), Carlton (0.32), Riseley (0.35) and Great Barford (0.36).

1.49 Research also shows that the highest levels of depressive episodes are reported by Pakistani women (6.3 per cent) and Indian women (5.7 per cent). Bedford Borough’s combined Indian and Pakistani population is higher than the national average.

1.50 This information is significant, particularly in considering where resources should be directed for mental health and wellbeing in the Borough.

1.51 There are also a number of groups who are more likely to suffer from mental health problems, including:

- People with drug and alcohol problems
- People who have been abused or who have been victims of domestic abuse
- Prisoners
- Homeless people
- Lesbian, gay and bisexual people
- Military Veterans

Public Voice and Involvement

1.52 Feedback from service users and their carers collected via the Mental Health Partnership Board and advocates has resulted in emerging themes about mental health in Bedford Borough:

- People would prefer to have their mental health managed in primary care.
- There is a perceived need for early diagnosis and support to remain in the community.
- Admission to inpatient units and contact with specialist mental health services is considered a last resort.
- The need for effective crisis response services, particularly out of hours, with alternatives to admission being a high priority.
- Many people feel that housing and supported accommodation is a particular need.
- There are issues with the appropriateness of some services currently on offer, with many people still feeling marginalised as a result of their condition.
- The need of people with mental health problems to be able to meet, to support each other, to learn that they are not alone. The Council should consider "centres of mutual support", which will not be primarily about providing activities. Their over-riding purpose and concern will be in providing a haven for mutual support and recovery.

1.53 In 2012 the Mental Health Partnership Board decided to address the above themes as well as national priorities via four working subgroups priorities.

- Patient Experience
- Housing
- Employment
Personalisation

1.54 In a recent stakeholder survey, 29% of the 77 people who responded rated local mental health services as good, very good or excellent and a further 35% rated them as fair. However, it is worrying that 31% rated local provision as poor or very poor. The key priorities for improvement listed by people completing the survey included:

- More focus on prevention
- Earlier intervention, including more support for people with non-severe mental health problems to prevent their condition deteriorating and to avoid crisis
- Easier and quicker access to services
- More focus on the holistic needs of people with a mental health problem and greater integration and co-ordination across and between services
- Better communication with patients and service users and between services, and better continuity of care
- Improved services for people with dementia
- Better support for people with a range of complex problems, including people with both a mental health problem and an alcohol/drug addiction, or learning disability/autism/ADHD
- Better support for teenagers.

1.55 These priorities were echoed by attendees at a well attended stakeholder event which took place in October 2012. Whilst a vast range of issues and opportunities for improvement were discussed at the event, the key priorities to emerge were:

- To commission recovery orientated services
- Have a greater focus on prevention
- Provide more employment support for people with mental health and psychological disorders
- To simplify the structure of mental health services and the referrals process in order to make it easier to access support and treatment earlier
- Increase the provision of talking therapies, including for children and young people, and reduce waiting times
- Improve the physical health of people with mental health problems, and provide better mental health support for people with physical conditions
- Ensure that everyone with a mental health problem has access to assessment, treatment and support from a Primary Care Mental Health Link Worker, with earlier access to help and intervention and improved communication with GPs.
- Improve the transition from children’s services

1.56 We have taken all of these views into account when considering what we want to change during 2013/14 and beyond. However, in general, these match our own priorities.

Dementia

1.57 Dementia is characterised by a collection of symptoms, including a decline in memory, reasoning and communication skills needed to carry out daily activities. It can affect adults of working age, but is most common in older people. One in six people over 80 years and one in 14 people over 65 years have a form of dementia.
1.58 The prevalence of dementia will rise significantly with the aging population, estimated to increase by 16% between 2010 and 2016 in Bedford Borough. There are estimated to be a total of 1,670 currently living with dementia and 722 people develop dementia each year in Bedford Borough.

Table 4: Estimated number of prevalent and incident cases of dementia in Bedford Borough

<table>
<thead>
<tr>
<th>Age</th>
<th>Prevalence (total)</th>
<th>Incidence (new each year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>65 - 69 yrs</td>
<td>51</td>
<td>36</td>
</tr>
<tr>
<td>70 - 74 yrs</td>
<td>84</td>
<td>74</td>
</tr>
<tr>
<td>75 - 79 yrs</td>
<td>112</td>
<td>176</td>
</tr>
<tr>
<td>80 - 85 yrs</td>
<td>163</td>
<td>279</td>
</tr>
<tr>
<td>85+</td>
<td>184</td>
<td>511</td>
</tr>
<tr>
<td>TOTAL</td>
<td>594</td>
<td>1076</td>
</tr>
</tbody>
</table>

Source: Dementia Executive toolkit using 2008 ONS midyear population estimates

1.59 The incidence and prevalence of dementia rises exponentially with age and affects men and women in all social and ethnic groups. Therefore the wards with the highest proportion of older people are likely to be those with higher numbers of people with dementia. These include Brickhill and Carlton wards particularly, followed by Great Barford, Putnoe, Bromham, Clapham, Goldington, Harrold, Sharnbrook and Turvey.

1.60 The mean survival time following diagnosis is 4.5 years but this is significantly influenced by access to good quality early diagnosis.

1.61 There is evidence that early provision of support at home can decrease institutionalisation by 22% and even in complex cases, case management can reduce admission to care homes by 6%.

Dementia Priorities

1.62 The following priorities have been identified for dementia:

- Improve public and professional awareness and understanding of dementia.
- Earlier diagnosis and Intervention.
- Improve quality of care in general hospitals.
- Improve quality of care in care homes.
- Reduce the use of anti-psychotic medication.
- Improve community support services

1.63 Dementia is such an important mental health issue that a separate dementia strategy is being implemented, overseen by the mental health partnership board.
Autism

1.64 There is a developing body of evidence that adults with autism, and their families, face many barriers in their everyday lives and in accessing the services and support that they need, including:

- their condition being overlooked or misunderstood by professionals and by society (mental health profession included).
- difficulties with the services and support they need to live independently within the community.
- difficulties in gaining long-term, meaningful employment.

1.65 Recent years have brought new statutory duties to local authorities and NHS bodies through:

- The Autism Act (2009)
- Fulfilling and rewarding lives - the national strategy for autism (2010)
- Statutory guidance for implementing the national strategy (2010)

1.66 Difficulties that people with autism experience, mental health problems included, is such an important issue that a separate autism strategy, Fulfilling and Rewarding Lives in Bedfordshire, was developed with five main priorities:

1. Increase awareness and understanding of autism among frontline staff across the whole community (including mental health professionals).
2. Develop a clear consistent pathway for diagnosis in every area, which will be followed by the offer of a personalised needs assessment and considerations for appropriate community services. Mental health service must be fully inclusive and able to support mental health needs of adults with autism.
3. Plan in relation to the provision of services to people with autism in transitions.
4. Enable local partners to plan and develop appropriate services for adults with autism to meet identified needs and priorities.
5. Help adults with autism with work

Veterans

1.67 The term veteran refers to anyone who has experienced military service, or who is ex-military personnel. For example, the Ministry of Defence definition of a veteran is:

“anyone who has served in HM Armed Forces at any time, irrespective of length of service… including National Servicemen and Reservists.”

1.68 Being in the armed forces is an overwhelmingly positive influence for the majority of service personnel, giving them the skills and experiences to live a positive and flourishing life beyond their time serving in the military.
1.69 But there are some significant physical and mental health implications for those who have served in the army.

1.70 A best estimate for the Bedford Borough veteran population, extrapolating from the 2006 UK level data profiles, and based on the county population of approximately 160,800\(^8\), would be somewhere in the region of 12,400. Local stakeholders suggest that this figure is not unrealistic, but there is no reliable data to either support or contest the figure.

Table 5: Estimation of the Number of Bedford Borough Veterans, by age

<table>
<thead>
<tr>
<th>Age of Veterans</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25 years</td>
<td>161</td>
</tr>
<tr>
<td>25 – 44 years</td>
<td>1,736</td>
</tr>
<tr>
<td>45- 65 years</td>
<td>3,013</td>
</tr>
<tr>
<td>Over 65 years</td>
<td>7,490</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12,400</strong></td>
</tr>
</tbody>
</table>

1.71 Royal British Legion’s Bedfordshire contacts over the past 5 years suggest slightly more veterans under 50 years old in the figures than would be expected:

Table 6: Proportion of Local Royal British Legion Applicants by age (Beds, Hunts, Cambs RBL)

<table>
<thead>
<tr>
<th>Age of Veterans</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 31 years</td>
<td>6.2</td>
</tr>
<tr>
<td>31 – 50 years</td>
<td>20.0</td>
</tr>
<tr>
<td>51- 65 years</td>
<td>15.0</td>
</tr>
<tr>
<td>Over 65 years</td>
<td>58.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

1.72 One suggestion offered for the slightly higher proportion of under 50 year old veterans in this contacts list was that they were perceived to have more issues and are more likely to feel that they are entitled to, and can ask for, help.

1.73 Assuming that there is an even national average spread there should be approximately 50 new veterans in Bedford Borough each year, but local stakeholders suggested that there may be fewer than this because of the absence of large forces bases in the county and a lack of established ex-forces communities.

1.74 There is no evidence of ethnicity amongst veterans in Bedford Borough.

1.75 A significant minority of non-elderly veterans experience a range of largely mental health problems related to their service in the military, which can have a number of serious consequences for their health outcomes and those of their families.

---

\(^8\) Mid-year Population Estimates 2010, ONS.
1.76 The most common disorders among recent or younger veterans are depression, anxiety disorders, Post Traumatic Stress Disorder (PTSD) and substance - particularly alcohol - misuse. The available evidence often suggests co-morbidity.

1.77 Effectively meeting the welfare needs of veterans is very important in the prevention and management of mental health problems, so ensuring effective systems and pathways to support veterans’ welfare needs should be a priority.

1.78 Veteran’s mental wellbeing is a high priority for Bedfordshire Clinical Commissioning Group and Bedford Borough Council. Multi agency subgroups have been created as part of the Military Covenant for Bedford Borough which was signed in 2012.
Chapter 2: National and Local Context

Legal Basis

2.1 Local Authority’s duties are set out in:

2.2 **NHS & Community Care Act 1990 - Section 47(1):**
  The Local Authority has a duty to carry out an assessment of need for community care services where a person appears to be someone for whom community care services could be provided, AND a person’s circumstances may need the provision of some community care services.

2.3 **Section 47(2)**
  If the Section 47(1) assessment identifies a person as being disabled, that person has additional rights as set out in Section 47(2) which requires local authorities to decide as to the services required.

2.4 **Disabled Persons (Services and Consultation and Representation) Act 1986 - Section 4:**
  Requires local authorities to decide whether the needs of a disabled person require any services provided under the **Chronically Sick & Disabled Persons Act 1970.**

2.5 **The National Assistance Act 1948 - Section 29(1)** defines a ‘disabled person’.

Safeguarding from abuse, maltreatment and neglect.

2.6 Safeguarding vulnerable adults from abuse, maltreatment and neglect is our number one priority. It is a vital part of the Council’s core responsibilities and also an essential function of health services.

2.7 Safeguarding is about more than just adult protection, it is about enabling vulnerable people to choose lifestyles and services to support their needs which ensures their independence, health, safety and wellbeing. Services need to deliver flexible support based on the principles of human rights, dignity and independence.

2.8 Safeguarding is “all work which enables an adult who is or may be eligible for community care services to retain independence, well being and choice and to access their human right to live a life that is free from abuse and neglect”

*Safeguarding Adults, A national framework of standards for good practice and outcomes in adult protection work* 
ADSS 2005.

2.9 Abuse comes in many forms – physical, sexual, psychological, financial, neglect or discriminatory abuse. Institutional abuse happens in services where poor care is delivered. These forms of abuse can be deliberate or the result of ignorance, lack of training, non compliance or management oversight.

2.10 Safeguarding across Bedfordshire is monitored by the multi-agency Safeguarding Adults Board. Membership includes service users and carers alongside key statutory, voluntary and private agencies.
2.11 The Safeguarding Adults Board sets priorities for improvement in policy, practice and performance. It continually strives to reduce the occurrence of abuse by taking a ‘lessons learnt’ approach to prevention. A detailed improvement action plan is in place and regular monitoring reports will continue to be provided to the Board.

2.12 The key priorities for the Safeguarding Adults Board in 2012/2013 are:
1. Prevention / raising awareness
2. Workforce development
3. Partnership working
4. Quality Assurance
5. Involving people in development of safeguarding services
6. Outcomes and improving people’s experience

Strategic Framework - The Changing Commissioning Landscape

GP commissioning consortia

2.13 Equity and Excellence: Liberating the NHS and the Health and Social Care Act 2012 both describe a different NHS and local government landscape and architecture.

2.14 The Bedfordshire Clinical Commissioning Group will replace the Primary Care Trust and is responsible for commissioning the bulk of primary and secondary mental health services, supported by and accountable to the new, independent, national NHS England.

NHS England

2.15 NHS England will have two main roles: it will support BCCG and it will have a national commissioning function for some national and regional specialist services, including prison and custody health care, high security psychiatric services, and health care for the armed forces and their families.

Health and wellbeing boards

2.16 The Bedford Borough Health and Wellbeing Board is leading the strategic co-ordination of prevention and health promotion services by joining up commissioning across the NHS, public health and social care. The Board will secure better health and wellbeing outcomes for their whole population, better quality of care for service users and better value for the taxpayer.

2.17 Following transition to the new NHS and expanded role of local government, new local commissioning responsibilities and overlaps are shown below. The diagram emphasises the need for inter-connectedness between all parts of the new system as it evolves.
Other associated developments relevant to mental health commissioning

2.18 Accompanying these major structural changes will be a number of other important developments in commissioning. These include:

- closer collaboration between primary and secondary care clinicians and professionals to enhance clinical leadership in commissioning. This collaboration should be built on the principles of integration and joint working in both commissioning and delivering a comprehensive mental health service across primary, secondary and social care sectors.
- a major expansion of choice and involvement opportunities for individuals receiving primary, community and secondary care, with greater personalisation of services, increased freedom, choice and control and, crucially, a concentrated focus on improved health, public mental health and social care outcomes.
- roll out of Payment by Results (PbR) for mental health services

“No health without mental health” (2011)  

2.19 In 2011, the government published its new mental health strategy – “No health without mental health”.

2.20 Mental health is everyone’s business – individuals, families, employers, educators and communities all need to play their part. Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential.


2.21 “No health without mental health” looks to communities, as well as the state, to promote independence and choice, reflecting the vision for adult social care. It sets out how the Government, working with all sectors of the community and taking a life course approach, will:

- improve the mental health and wellbeing of the population and keep people well; and
- improve outcomes for people with mental health problems through high-quality services that are equally accessible to all.

2.22 In recent times, increased attention has been paid to the importance of employment and housing in the recovery process. Progress has been uneven between different areas and across different conditions. Critically, not all groups have benefited equally from improvements – for example, those from black and minority ethnic communities. Access to services is uneven and some people get no help at all. This contributes to health inequalities within and between groups with ‘protected characteristics’.

2.23 A wide range of partner organisations, including user and carer representatives, providers, local government and government departments, worked with the Department of Health to agree shared objectives to improve mental health outcomes for individuals and the population as a whole. The six shared objectives are as follows:

Figure 5: “No health without mental health” Strategic Outcomes

<table>
<thead>
<tr>
<th>1. More people will have good mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>More people of all ages and backgrounds will have better wellbeing and good mental health and fewer people will develop mental health problems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. More people with mental health problems will recover</th>
</tr>
</thead>
<tbody>
<tr>
<td>More people will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, improved chances in education, better employment rates and a suitable and stable place to live</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. More people with mental health problems will have good physical health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer people with mental health problems will die prematurely and more people with physical ill health will have better mental health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. More people will have a positive experience of care and support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment; and should ensure people’s human rights are protected</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Fewer people will suffer avoidable harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Fewer people will experience stigma and discrimination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will reduce</td>
</tr>
</tbody>
</table>
“No health without mental health”: implementation framework

2.24 The framework was developed in collaboration with third sector organisations campaigning on mental health issues. It provides a systematic outline of the potential contribution and the expectations of Government for a number of sectors and organisations in relation to improving mental health. Unlike previous outcomes frameworks for health and social care, it does not list specific mental health outcomes against which progress can be measured. Instead it refers to the outcomes in the other frameworks and indicates that they will be used to measure progress in improving mental health.

2.25 The framework reinforces that mental health should be given parity of esteem with physical health. There is a further commitment to producing a “payment by results” system for mental health which will reward service providers for achieving certain defined standards. There is no detail on the proposed system yet.

2.26 Part 3 of the framework sets out what local organisations, including local authorities and clinical commissioning teams, can do to help improve the mental health and wellbeing of their communities. These actions are reflected in the action plan in Chapter 3 of this strategy.

Mind - Listening to Experience: An independent inquiry into acute and crisis mental healthcare.  

2.27 The mental health charity MIND carried out a year-long investigation into acute and crisis mental health care in England and Wales, including the response to emergency situations of community mental health teams.

2.28 Crisis and acute mental health services are a crucial part of mental healthcare, providing for people when they are most unwell and vulnerable. The panel identified four key areas where work should be focused.

a) Humanity

2.29 The panel makes the general point that some mental health services have lost touch with basic humane principles when dealing with people in crisis – as shown by dirty wards, lack of human contact, a lack of respect often bordering on rudeness by staff, and a reliance on force. It recommends not only organisational commitment to a culture of humane values, service and hospitality, but also a rethinking of ‘professional values’, continual checking with those receiving services, staff support

---


and development, including training in prevention, de-escalation and management of disturbed behaviour.

2.30 It also argues that face-down restraint should be ended and that acute services should work towards eliminating seclusion and restraint altogether. These recommendations have implications for mental health care in the community, as they would involve more such care in general and more acute care closer to people’s homes in smaller, less ‘medicalised’ units.

b) Commissioning for people’s needs

2.31 The main point under this heading is that commissioners should not assume that one model will fit all. Commissioners of acute and crisis care and local health boards should encourage flexibility and creativity in providing personalised and community-specific solutions.

c) Choice and control

2.32 The panel argues that there is an urgent need for more direct access options to urgent care services. This would mean that there should be an explicit acknowledgement that people with mental health problems know their own needs and should be able to self refer to services. The panel heard that often people were told that they were not ill enough or were too ill to meet the criteria for particular services. It points out that crisis plans that are jointly developed in an independently facilitated process have been shown to reduce the use of statutory powers to detain and treat people against their will.

d) Reducing the medical emphasis in acute care

2.33 The panel accepts that doctors can play a valuable role in supporting people with mental health problems, but points out that the needs people described in the course of their inquiry – care, safety, someone to listen, something to do – did not require a medically dominant response. Many people would prefer more peer support from people who have themselves experienced mental health problems.

The Abandoned Illness: A report by the Schizophrenia Commission

2.34 In November 2012, Rethink Mental Illness launched the Schizophrenia Commission. Chaired by Professor Sir Robin Murray, this expert panel scoped the state of support, treatment and quality of life for people with schizophrenia and psychosis. People with schizophrenia are dying 15-20 years earlier than average, mostly due to preventable physical conditions

- Only 10% of people with schizophrenia are being offered potentially life-transforming talking therapies such as CBT and very few get the level of care recommended by NICE

---


(Accessed on 10/12/2012).
• Mental health hospital wards are often such appalling places they make patients worse rather than better
• 1 in 3 people affected say they can’t get quick access to services when they need it - and many don’t know where to go for help
• Major concerns remain about the lack of efficacy and side effects of anti-psychotic drugs, which can lead to rapid weight gain, diabetes, and heart disease
• Staff are often demoralised and “burnt out” and pessimism pervades the system

2.35 Recommendations for local authorities and clinical commissioning groups include:

• We recommend that all Clinical Commissioning Groups commission Early Intervention in Psychosis services with sufficient resources to provide fidelity to the service model.
• We recommend that all mental health providers should ensure that people with schizophrenia and psychosis (in hospital and the community) are aware of their right to request a review of their medication including, where appropriate, access to a specialist pharmacist, and are encouraged to exercise it in practice.
• We recommend that Clinical Commissioning Groups should ensure that they commission services for people with schizophrenia and psychosis in line with NICE and other good practice guidelines, including CBT for psychosis.
• We recommend that each mental health provider works with the local Director of Public Health to ensure that there is targeted smoking cessation provision for smokers with schizophrenia and psychosis, with guidance from Public Health England.
• We recommend that all NHS Mental Health Trusts and other providers adopt the Individual Placement and Support (IPS) model and ensure that employment support is effectively integrated with clinical services.
• We recommend that all local authorities, NHS Trusts and Clinical Commissioning Groups should integrate and actively promote personal budgets, where appropriate, for people with schizophrenia and psychosis and ensure that adequate support is available for those who choose to manage a direct payment.
• We recommend that clinical commissioning groups and providers work together to deliver a range of preventative, secondary and acute care services underpinned by cultural competency principles to meet the needs of diverse local populations.
• We recommend that Clinical Commissioning Groups and local authorities should ensure that the needs of people with schizophrenia and psychosis who are homeless are captured in their Joint Strategic Needs Assessment and reflected in local commissioning plans.
• We recommend that Clinical Commissioning Groups and local authorities commission an appropriate range of services to support the needs of carers of people with schizophrenia and psychosis including information and advice along with arrangements for respite care.
Mental Wellbeing Impact Assessment (MWIA)\textsuperscript{14}

2.36 Mental health and well-being underpins the health and functioning of all individuals and communities. It affects us economically and socially. Good mental health and well-being enables individuals, families, communities and organisations to flourish. Without it, we experience poor health, isolation, discord, underachievement, unemployment and exclusion.

2.37 MWIA theory and practice has been developed by a partnership in England that has been building MWIA practice and has produced a toolkit to support the process. The toolkit provides a robust and evidence based process based on what determines mental well-being.

2.38 The outcomes from undertaking MWIA have been positive and suggest that MWIA has a central role to play in:

- Re-focusing efforts to create better and new services and responses to improve well-being
- Developing shared understandings and coherence of mental well-being with a range of stakeholders Ensuring policies, programmes and projects have a positive impact on mental well-being
- Actively engaging all partners in service development and fostering co-production of mental well-being, and
- Supporting community needs assessment and the development of relevant and meaningful local indicators.

2.39 This strategy should be subject to a mental well-being impact assessment.

Recovery\textsuperscript{15}

2.40 There is no single definition of the concept of recovery for people with mental health problems, but the guiding principle is hope – the belief that it is possible for someone to regain a meaningful life, despite serious mental illness. Recovery is often referred to as a process, outlook, vision, conceptual framework or guiding principle.

2.41 The recovery process:

- provides a holistic view of mental illness that focuses on the person, not just their symptoms
- believes recovery from severe mental illness is possible
- is a journey rather than a destination
- does not necessarily mean getting back to where you were before
- happens in 'fits and starts' and, like life, has many ups and downs


• calls for optimism and commitment from all concerned
• is profoundly influenced by people’s expectations and attitudes
• requires a well organised system of support from family, friends and professionals
• requires services to embrace new and innovative ways of working.

2.42 The recovery model aims to help people with mental health problems to look beyond mere survival and existence. It encourages them to move forward, set new goals and do things and develop relationships that give their lives meaning.

2.43 Recovery can be a voyage of self-discovery and personal growth. Experiences of mental illness can provide opportunities for change, reflection and discovery of new values, skills and interests.

Think Local Act Personal

2.44 Think Local Act Personal Partnership comprises over 30 national and umbrella organisations representing a broad interest in personalisation and community-based support. These organisations, through joining this Partnership, have committed to supporting a small central team in working to improve practice in six priority areas; as well as advising and influencing government and other bodies.

2.45 The main priorities of the partnership are:

1) Co-production: a commitment to working together with people who use services and carers to initiate effective change.

2) Personalisation and self-directed support: Think Local, Act Personal remains committed to personalisation and to supporting self-directed support across the sector.

3) Cost effectiveness and efficiency: We understand the challenges facing organisations across the sector that are charged with delivering personalised support and care whilst being cost effective and efficient.

4) Providers and workforce development: We are committed to supporting providers of services and their commissioners to adapt to personalisation – including, building a new market and ensuring that the workforce are supported, respected and valued as they develop their roles.

5) Information to the public: We understand that people need the right information and advice so that they can make decisions about the right care and support for them.

6) Community capacity: Think Local, Act Personal strongly believe that building community capacity – so that people can find support and make contributions within their local networks, families and friends – is key to the changes needed.
2.46 If power and control is devolved to communities, then people – including the most vulnerable – can lead more independent and fulfilled lives. This is the challenge at the heart of the vision.

2.47 The Coalition’s vision for a modern system of social care is built on seven principles:

- Prevention
- Personalisation
- Partnership
- Plurality
- Protection
- Productivity
- People

Mental Health Services Design - Best Practice

2.48 “No health without mental health” focuses on how people can be best empowered to lead the lives they want to lead and keep themselves and their families healthy, to learn and be able to work in safe and resilient communities, and on how practitioners on the front line can best be supported to deliver what matters to service users within an ethos that maintains dignity and respect.

2.49 Mental Health and Wellbeing Integrated Stepped Care Model for Bedfordshire produced by Bedfordshire Clinical Commissioning Group is a local answer to strategic and best practice evidence.

2.50 Part of this strategy is to introduce a Mental Health and Wellbeing Integrated Stepped Care Model (as outlined in the NICE guidelines for Depression and Anxiety) that will allow for the development of clearly defined pathways and protocols for stepping patient up/down in a number of mental health services.

2.51 The Stepped Care Model as the common framework will ensure that:

- evidence-based interventions as outlined in different NICE guidelines are implemented
- patients will receive the least intrusive intervention first and be stepped up and down as appropriate
- patients will be treated earlier and closer to home in their local community
- patients will receive proactive case management within primary care setting and thus reducing the burden on the more expensive secondary care services.

---


Figure 6: Mental health and wellbeing integrated stepped care model

Mental Health and Wellbeing Integrated Stepped Care Model

<table>
<thead>
<tr>
<th>Step 1</th>
<th>GPs, Practice Nurses</th>
<th>Recognition</th>
<th>Assessment, watchful waiting, active monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2</td>
<td>Primary Care Team, Primary Care Mental Health Worker, Star Recovery Workers, Volunteer sector wellbeing support</td>
<td>People with “mild” mental health problems – services mostly focussed on people with depression and anxiety</td>
<td>Guided self-help, computerised CBT, exercise, brief psychological interventions, referral for further assessment and interventions</td>
</tr>
<tr>
<td>Step 3</td>
<td>Primary Care Team, Primary Care Mental Health Worker</td>
<td>People with moderate mental health problems – services focussed on people with long term mental health issues, who may sometimes have some form of crisis needing more hands on support</td>
<td>Medication, psychological interventions, social support</td>
</tr>
<tr>
<td>Step 4</td>
<td>Mental Health Specialists, including Crisis Team</td>
<td>People with serious/complex mental health problems; services for people who need specialist input from multi-discipline team &amp; services managed through a Care Programme Approach</td>
<td>Medication, complex psychological interventions, combined treatments</td>
</tr>
<tr>
<td>Step 5</td>
<td>Residential/Inpatient Care, Crisis Team</td>
<td>The most specialist services – services for very small numbers of people in specialist areas</td>
<td>Medication, combined treatment, ECT</td>
</tr>
</tbody>
</table>

All of us – healthy people in healthy communities
Services focussed on good mental health and prevent problems emerging

Social Wellbeing
- Independence
- Inclusion, Personalisation
- Employment
- Housing

Mental Wellbeing
- Resilience
- Life skills
- Creativity
- Self worth
- Safeguarding

Physical Wellbeing
- Lifestyle
- Long Term Conditions

Personal (Health) Budgets, Direct Budget, Choice, Control, Service User Voice, Recovery Model
2.52 Currently most health resources are tied up at inpatient specialist services. But many of the quality and efficiency actions needed to change the profile of future demand rely on a connected approach, addressing population and public mental health, prevention, early intervention, personalisation and social care.

2.53 Delivery of government policy for mental health and wellbeing, coupled with the quality and productivity challenge for the NHS and the need to improve value for money in local authorities, requires a double shift in investment. Overall spend has to be reduced through increased productivity, and a proportion of the investment currently funding acute, specialist and other secondary care services (covering all tiers of provision) needs to be moved upstream, where appropriate, to preventive and early intervention services, in order to reduce demand on these downstream services in the longer term.

2.54 In this way, it will be necessary to free up resources in order to both deliver efficiencies in the short term and to re-invest in public mental health, social care, employment, housing, psychological therapies, prison health care, the criminal justice system and other areas. Such investments have the potential to deliver further medium and long-term reductions on the demand side.

Figure 7: Changing mental health investment profiles

2.55 There are a number of local drivers influencing how we commission services for people with mental health needs.

Bedford Borough’s Health and Wellbeing Strategy identifies priorities for promoting health and wellbeing in the Borough.

**Figure 8: Summary of Health and Wellbeing Strategy Bedford**

<table>
<thead>
<tr>
<th>Category</th>
<th>Objective</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VISION</strong></td>
<td><strong>All children and young people are able to lead healthy, safe lives, and are provided with opportunities to realise their full potential.</strong></td>
<td><strong>All adults have the support they require to lead healthy and independent lives and timely access to high quality, appropriate health and social care services.</strong></td>
</tr>
<tr>
<td><strong>CHILDREN</strong></td>
<td><strong>Teenage Pregnancy</strong></td>
<td>We will reduce the number pregnancies in young women aged under-18 and improve outcomes for teenage mothers.</td>
</tr>
<tr>
<td></td>
<td><strong>Looked After Children</strong></td>
<td>We will improve the health and educational outcomes of looked after children through high quality health, and social care support.</td>
</tr>
<tr>
<td></td>
<td><strong>Mental Wellbeing</strong></td>
<td>We will improve mental health in children and adults by providing high quality, effective services which identify mental disorders and intervene early.</td>
</tr>
<tr>
<td></td>
<td><strong>Healthy Lifestyles:</strong> <strong>Tobacco Control</strong> <strong>Alcohol Consumption</strong> <strong>Healthy Weight</strong></td>
<td>We will further reduce smoking prevalence by preventing people from starting to smoke and helping people to stop smoking. We will promote sensible drinking and increase the number of people receiving effective and timely support for alcohol related problems. We will maintain or increase the number of people who are a healthy weight, by providing a range of evidence based interventions.</td>
</tr>
<tr>
<td></td>
<td><strong>Safeguarding</strong></td>
<td>We will safeguard children by introducing multi-agency early interventions. We will safeguard adults through elimination of maltreatment, neglect and abuse, including prevention of avoidable pressure ulcers.</td>
</tr>
<tr>
<td></td>
<td><strong>Wider Determinants of Health</strong></td>
<td>We will address wider determinants of health focusing on educational attainment, reducing the number of people who are fuel poor and those young people who are not in education, employment or training.</td>
</tr>
<tr>
<td></td>
<td><strong>Independence</strong></td>
<td>We will maximise independence in older people by improving stroke care and rehabilitation services, preventing falls and reducing preventable hospital admissions.</td>
</tr>
<tr>
<td></td>
<td><strong>End-of-Life Care</strong></td>
<td>We will provide high quality care and support for people at the end of their lives and their carers, including increasing...</td>
</tr>
</tbody>
</table>
2.57 The strategy explicitly states mental wellbeing to be one of the key priorities. Bedford Borough will improve mental health in children and adults by providing high quality, effective services which identify mental disorders and intervene early.

2.58 The strategy wants to do this by increasing access to community based (primary care) mental health services, avoiding hospitalisation where possible, but ensuring integrated pathways into hospital (secondary) mental health services where needed.

2.59 Additional priorities which are linked to people with mental health problems are safeguarding, smoking, healthy weight and wider determinants of health.

**Bedford Borough Partnership and Sustainable Community Strategy**

2.60 The Bedford Borough Partnership is committed to:

- Increasing healthy life expectancy and tackling health inequalities
- Ensuring access to high-quality health and social care services and enabling people to maintain their independence for as long as possible
- Improving employment opportunities
- Ensuring access to high quality education and promoting skills development
- Tackling poverty
- Encouraging a high-quality natural and built environment
- Tackling drug dependency and alcohol misuse
- Supporting people and communities so that they can play a full part in the cultural, sporting and civic life of the Borough

2.61 In addition, Bedford Borough’s Sustainable Community Strategy (2009-2021), outlines a series of goals organised around seven themes which will be delivered in order to make a step change in people’s quality of life.

2.62 One of the themes, ‘A Healthy Borough’, sets out the following goal:

“A Borough where everybody has access to high quality health and social care services when they need them and the help they need to lead healthy and independent lives”

2.63 This goal is underpinned by six aims:

- Aim 1: Increase healthy life expectancy for all across the Borough.
- Aim 2: Reduce health inequalities by focussing effort on deprived areas and increasing opportunities for healthier lifestyles.
• Aim 3: Improve help and advice to vulnerable adults and people with mental health needs to enable them to continue living in their own homes and so maintain their independence for as long as possible

• Aim 4: Transform adults social care services by improving access, choice, control and advocacy for users and carers through the provision of self directed care.

• Aim 5: Improve dementia services by raising awareness and understanding and providing earlier diagnosis, intervention and higher quality of care

• Aim 6: Improve the safeguarding and wellbeing of vulnerable adults and people with mental health needs.

Bedfordshire Clinical Commissioning Group Commissioning Intentions and Delivery Plan

2.64 Bedfordshire Clinical Commissioning Group is committed to modernising local mental health services. The BCCG delivery plan includes:

• Complete new build for acute in-patient and assessment provision in Bedford.
• Review Community Mental Health teams (CMHT’s) to deliver a new model of community intervention.
• Develop Primary Care Mental Health services.
• Review and redesign rehabilitation in-patient services that support an integrated community pathway.
• Deliver Eating Disorder pathway / community service for children and adults.
• Develop a local Autistic spectrum disorder service.
• Review day services in partnership with Local Authorities and agree new.
• Develop a Dementia Pathway in line with each of the locality Dementia groups’ needs and priorities.
• Develop model for liaison psychiatry.
• Agree a mechanism for agreeing Section 117 aftercare placements and other spot placements as well as a review process for each placement.
• Review NHS continuing care commissioned beds.
• Develop an Offender Health pathway.
• Review Specialist Learning Disability in-patient and Community Services.

Quality, Innovation, Productivity and Prevention (QIPP)

2.65 QIPP in the NHS and similar approaches in local authorities to delivering efficiency and value for money are intended to enable commissioners to drive up quality while improving productivity. A wide range of actions can and are being taken in health and social care economies nationally to improve quality and efficiency in mental health and related services. These actions can impact in the short, medium and long term to help create a sustainable service and financial strategy. In terms of productivity and savings, some of these actions will provide one-off benefits, while others will be recurrent in full or in part.

2.66 Local QIPP Projects are:
2.67 **Dementia**
The aim is to deliver a holistic integrated dementia care pathway across the local health & social community that will positively transform care for patients with dementia and their carers throughout Bedfordshire & Luton.

2.68 **Common and Severe Mental Health**
The aim is to implement a holistic integrated Stepped Care to deliver evidence based preventative therapies and support in the appropriate setting at the appropriate time for the patients of Bedfordshire & Luton.

2.69 **Eating Disorders**
To develop an integrated pathway for children and adults that delivers evidence based local care and treatment.

2.70 **Autism**
To enhance local services for people with autism, including the provision of a local based diagnosis service based on Rewarding and Fulfilling Lives and NICE Guidance.

2.71 **Services for People with Learning Disability**
To review local specialist services to enable people to access mainstream services, including mental health services, when needed and for specialist services to be available to those people with complex needs and severe learning disabilities who need it.

2.72 **Adult Services Rationalisation**
A review of community Mental Health services will be undertaken to ensure that they are outcome focussed and evidence based in their delivery.

2.73 **Community Based Rehabilitation**
Agree a model for community based rehabilitation and to review in-patient rehabilitation services within existing Mental Health services.

2.74 **Section 117**
To develop a S117 process to ensure people have appropriate and effective access to after care services.

2.75 **Day Services Review**
To develop a model for support and rehabilitation in line with recovery principles and national best practice.

**Organisational Change**

2.76 Following the creation of the Bedford Borough unitary authority, and subsequent merge of housing, leisure and social care directorates the opportunity must be taken to further develop joint working for people with mental health needs in services that were previously in separate organisations, such as social care, housing and leisure.

2.77 Additionally, Bedfordshire Clinical Commissioning Group is assuming NHS commissioning responsibilities. This is a new opportunity to continue with
partnership working and outcomes focused commissioning under new arrangements.

**Housing**

2.78 Rethink - Bedfordshire Carers Support Services, Supported Housing event was organised on 1 July 2011. This event was attended by 20 carers who presented their views, concerns and issues.

2.79 The carers concluded that they do not feel there is enough community based housing for people with mental health problems. Clear understanding of housing demand, supply and local market for people with mental health problems has to be established.

2.80 In July 2012 the Mental Health Housing Needs Research Report for Bedford Borough was prepared for Supporting People Partnership.

2.81 The key recommendations of this report are:

1. Provision of a supported housing service for people with complex needs
2. Look at whether existing provision could be re-modeled to better meet needs
3. Consider alternative supported housing models (e.g. ‘sheltered’ model)
4. More innovative and creative use of self directed support and personal budgets (e.g. use of personal assistants to meet some support requirements, use of personal budgets to provide respite opportunities)
5. Better joint working and care support planning
6. Dedicated housing worker or ‘housing champion’ within SEPT who is able to assist frontline staff who experience difficulties in housing their clients (e.g. those ineligible for social housing)
7. Review residential provision and look at move-on options
8. Ensure there is early identification of housing needs for those admitted to wards or crisis units to enable housing needs to be addressed (fully or partially) prior to discharge
9. Establish the numbers of clients unable to access social housing due to rent arrears and the origins of these arrears, and then look at how this barrier to social housing could be removed for some current clients and avoided for future clients
10. Establish how many people currently supported by carers are likely to require alternative accommodation within the next 10 years and what their accommodation and support needs are likely to be.

**Personalisation**

2.82 There has been a gathering policy momentum leading to local authority and health service reform. A fundamental re-think of the relationship between citizens and public services runs through, for example:

- *Improving the Life Chances of Disabled People*,
- *Our Health, Our Care, Our Say*,
- *Putting People First*,
- *NHS Next Stage Review*.
- *Vision for Adult Social Care- Capable Communities and Active Citizens 2010*
2.83 The main messages are very clear. We should expect a personalised approach, which means a relationship with public services which ensures that:

- We are empowered to have more say and control in all aspects of public life and participate as active and equal citizens.
- We have maximum control of our own lives, including control of our own health and social care.
- We are supported to live independently, stay healthy and recover quickly.
- We have choice and control so that any support we may need fits the way we wish to live our lives.

2.84 This is an approach requiring comprehensive cultural and organisational changes to encourage creativity, innovation, positive risk taking and to change the balance of power between citizens and public services. Therefore Bedford Borough Council in cooperation with SEPT works closely in partnership in order to deliver the personalisation vision to mental health services.

**Employment**

2.85 For those people with disability covered by Disability Discrimination Act, around a third had a part-time job (33.8 per cent), compared to only a quarter of working people without a disability (24.6 per cent) so as well as a lower percentage in work, those working tend to work fewer hours.

2.86 Employment rates were lowest for people with:

- Severe learning difficulties (12.0 per cent)
- Mental illnesses or nervous disorders (14.2 per cent)
- Depression or anxiety (27.2 per cent).

Figure 9: Percentage of DDA disabled people in employment by main impairment, Q2 2011, UK
2.87 A range of public, private and voluntary organisations provide and support employment-related recovery in Bedford. It would appear that they need to work more effectively together in order to tackle the challenges and join up employment services for the benefit of those that need them, identifying what needs to be done and taking action to make sustainable improvements.

Patient Experience

2.88 Local experience of service users and their carers were presented through various channels in 2011/2012, for example: mental health panel, mental health partnership board, military veterans’ forum, user engagement forums, carers’ reports.

CQC Survey of people’s experiences of community mental health services

2.89 CQC conducts the survey annually to find out about the experiences of people who receive care and treatment. Responses were received from 250 service users at SEPT (Please note: the results are available on the trust level only).

2.90 CQC asked people to answer questions about various aspects of their care and treatment. Based on their responses, CQC gave each NHS trust a score out of 10 (the higher the score the better).

2.91 SEPT scores strongly 8.5 out of 10 on Health and Social Care Workers in areas such as listening, involvement, trust, respect and dignity (very strong score), time.
2.92 On the other hand, the lowest score for SEPT was Day to Day Living support in areas such as asking about drugs and alcohol, asking about physical health, and supporting those with care responsibilities.

2.93 Overall SEPT performs, according to the survey, about the same as most other trusts that took part in the survey (6.9 out of 10)

**Current Services**

2.94 SEPT is commissioned by Bedfordshire Clinical Commissioning Group and Bedford Borough Council to provide specialist health and social care services to people with mental health needs who live in the Borough.

2.95 The aim is to provide an integrated health and social care service focusing on recovery outcomes and social inclusion. Staff work to empower service users and carers to manage their mental health problems well and gain the confidence and skills to live more independently.

2.96 Services are multidisciplinary, with medical staff, social workers, nurses, psychologists, occupational therapists and support workers providing a range of support and interventions.

**Acute and Crisis Service**

2.97 The inpatient service for Bedford Borough is at the Weller Wing in Bedford Hospital. People are admitted if they need in-patient assessment of their mental health needs, or for treatment, care and support that will help them recover and regain their well-being and independence.

**Acute Assessment Unit (AAU)**

2.98 This unit offers multi-disciplinary assessment and care to people aged between 16 and 65 who are experiencing an acute episode of mental illness.

2.99 After AAU, service users are discharged into the care of either their GP, the Community Mental Health Team (CMHT), the Crisis Resolution and Home Treatment Team (CRHT) or admitted as an inpatient.

2.100 **EMPOWA** in Bedford (formerly known as Renaissance) provides specialist support for people with mental health problems, by offering guidance to help them seek, gain and maintain voluntary work or employment opportunities.

2.101 **Crisis Resolution and Home Treatment Team (CRHT)** delivers safe and effective home-based treatment to prevent admission to hospital and facilitate the resolution of crisis. Also based at Weller Wing at Bedford Hospital.

2.102 **Community Mental Health Team (CMHT)** is a multi-disciplinary team of doctors, clinical psychologists, psychiatric nurses, social workers and support workers. CMHTs support individuals with more complex mental health problems whose needs cannot be met in primary care settings and who require targeted clinical interventions. They work closely with primary care services to ensure seamlessness of care.
2.103 **Day Centres** provide services that give people meaningful days and promote the use of community resources. The centres at Kimbolton Road and Barford Avenue in Bedford provide a broad range of community orientated interventions and work closely with community mental health services. One service user commented:

2.104 **Assertive Outreach Teams (AOT)** a multi-disciplinary team of doctors, clinical psychologists, psychiatric nurses, social workers, occupational therapists and support workers. They aim to support people with severe and enduring mental health problems.

2.105 AOTs provide intensive support on a frequent basis, including weekends, to assist people in managing their mental health problems. Care plans are client centred and are aimed at achieving individual goals. This level of intensive support reduces the need for re-admission into inpatient settings.

2.106 The **Complex Needs Service** works closely with community and specialist mental health teams to improve the care delivered to service users with diagnoses of personality disorder and their families/carers. It is based at the Disability Resource Centre in Dunstable.

2.107 **Residential Recovery Service** works with individuals in supported living, helping them to achieve recovery in a sheltered environment.

2.108 **Drug and Alcohol Services:** At the time of writing this strategy there are two teams in Bedford offering drug and alcohol dependency treatment. This comprises care coordination (including assessment for residential rehabilitation) outreach into the community to support people with alcohol, drug, poly-drug abuse and people with a dual diagnosis of mental health problems and substance misuse. There are also inpatient beds for detoxification treatment on Weller Wing at Bedford Hospital. A thorough review of the drugs and alcohol services will incorporate these services into a unified new pathway.

2.109 **Psychiatric Intensive Care Unit (PICU) and Low Secure Services** are located in Luton. The Robin Pinto Unit is a low secure environment which provides intensive psychiatric care to individuals whose illness requires a secure and safe environment. Clients who use this service have a history of challenging behaviour or offending. There is a community element to this service which works closely with the local magistrate service.

2.110 The **Prison In-Reach Team** supports prisoners in Bedford prison with mental health problems.

2.111 **Specialist services** for people of working age include:

- Eating Disorders Service
- Electro-Convulsive Therapy (ECT)
- Direct Access Psychology Service
- Clinical Health Psychology Service
- Acquired Brain Injury Psychology Service
Advocacy

2.112 Bedford Borough Council, Bedfordshire Clinical Commissioning Group and Central Bedfordshire Council, jointly tendered for and appointed a single provider of advocacy services in Bedfordshire – POhWER. POhWER provides advocacy services to all vulnerable people in Bedfordshire including people with mental health problems.

Carers Services

2.113 Carers support was subject to a similar joint procurement as advocacy services in 2011. Carers in Bedfordshire is a provider of support to all local carers, carers for people with mental health problems are included.

Bedford Wellbeing Centre and Mind Clubs

2.114 Bedford Borough Council in cooperation with Mind opened the Wellbeing Centre. The main aims of the centre are:

- An Information Point providing face to face, telephone and email information about and signposting to health, welfare and community services, including support to stay in work or to get back to work
- Wellbeing support for the local population
- Support to manage common mental health problems
- Increased opportunities, community participation and quality of life
- Good PR for mental health, reducing health inequalities, stigma and
- The Bedford Mind club provides opportunities for mutual support among people with mental health problems
Chapter 3: Strategic Priorities for People with Mental Health Needs – Delivering Better Mental Health Outcomes

3.1 This section sets out what local organisations can do to help improve the mental health and wellbeing of their communities, with a focus on improving outcomes for all and ensuring best value for money.

Strategic Priority One: More People Will Have Good Mental Health

3.2 More people of all ages and backgrounds will have better wellbeing and good mental health; and fewer people will develop mental health problems – by starting well, developing well, living well, working well.

3.3 Key areas to achieve this high level objective are:

- Starting well
- Developing well
- Living well
- Working well
- Ageing well

Starting well- ensuring that everyone has the best start in life.

3.4 This is an adult joint commissioning strategy. However the body of evidence presented in “No health without mental health” clearly indicates the importance of appropriate and targeted support for both parents and children in order to avoid mental health problems.

3.5 A mother’s mental health during pregnancy is an important factor in determining the child’s mental health. Maternal mental health problems during pregnancy increase the risk of adverse pregnancy outcomes.

- We will review how mental health support is incorporated in local parenting support programmes.

3.6 Anxiety and postnatal depression affect 13% of mothers shortly after birth and 22% of mothers one year after birth. Teenage mothers are particularly at risk with a three time higher risk of postnatal depression and poor mental health for three years after birth. NICE guidance on antenatal and postnatal mental health recommends the establishment of clinical networks for perinatal mental health services.

- Common and Severe mental health pathway redesign work will include appropriate support for young mothers.

---

3.7 The government has pledged to increase the health visitor workforce by further 4,200 posts. Health visitors will work to a new model of practice which includes a stronger focus on maternal and infant mental health.

- We will ensure that health visitors focus adequately on mental health support for mothers and infants and children as they get older.

**Developing Well**

3.8 As children grow and become young adults, they continue to need a stable and nurturing environment. Adolescence is a particularly important transition point. It is a distinct developmental stage in its own right, and a time of major physical, emotional and neurological change.

3.9 Increased health risk behaviours are associated with increased level of mental ill health and lower level of wellbeing. Smoking, alcohol and substance misuse are all much more common in adolescents with mental health problems and low levels of wellbeing.

- We will ensure that cooperation (early identification and stepped care approaches) between adult drugs and alcohol services provider and children and young substance misuse support providers takes place.
- Adult mental health services will work with NHS and Local authority commissioners to explore pooled resources for best practice activities as identified in “No health without mental health”.
- Think family protocol will include emphasis on evidence based family interventions such as Multisystemic Therapy.

3.10 Eating disorders start most commonly in adolescence and are associated with high levels of mortality; physical health problems, and psychological distress, as well as impaired quality of life. Access to high quality mental health care is critical to meeting the specific needs of this group of young people.

- We will review eating disorders support services, and ensure they support young people appropriately.

**Living Well**

3.11 Interventions that encourage increased physical activity can achieve improvements in mild and moderate depression and benefit mental health wellbeing generally. There is evidence that leisure and activities, including learning arts and creative activities, can increase mental health and wellbeing.

- We will increase update of personal budgets for physical, leisure and learning activities as specified in BBC business plan and acute trust provider’s personalisation plan.
- We will consider smoking cessation services being integrated into common and severe mental health problems care pathway, including in reach programmes to psychiatric hospitals and mental health units.
- Debt is known to be strongly associated with higher rates of mental health problems.
• We will promote financial advising local services such as Citizens Advice Bureaux and national advice resources such as moneyadviceservice.org.uk and moneyexpert.com via the care management team and the Wellbeing Centre.

Clinical and social services will be aware and refer appropriately to Consumer Financial Education Body (CFEB) – an independent organisation to help people to understand and manage their finances.

Working Well

3.12 Being in work has important psychological and economic benefits. People who become unemployed are at risk of developing mental health problems. The longer a person is out of work, the harder it is for them to return back to work. Early intervention can help to prevent deterioration of mental health and support job seeking.

3.13 Some employers find it hard to understand the difficulties faced by people experiencing mental health problems. They may need advice in order to support employees to remain in or return to work.

3.14 Employment support is one the local priorities. Variety of activities are currently taking place to support local people with mental health problems into employment.

• We will increase the number of people with mental health problems in employment.

Ageing Well

3.15 Depression is the most common mental health problem in older people and is associated with social isolation, long term physical health problems, or caring roles and living in residential care.

• We will reduce isolation, and increase social networks and opportunities for community engagement.
• We will improve support for informal carers of people with mental health problems.
• We will promote physical activities and physical health among service users and their carers.

3.16 How we will measure this outcome?

A pool of relevant indicators to be considered:

• Increased healthy life expectancy
• Reduced difference in life expectancy and healthy life expectancy between communities and groups e.g. people with mental health problems
• Proportion of people with mental health problems in employment
• Fuel poverty rates
• Smoking prevalence in adults (mental health population measured separately)
• Under 18 conception rates
• Self reported wellbeing (National office of statistics data, GHQ 12 – Health Survey for England)
• Substance misuse services data
• Recovery star data as collected by providers
• Mortality rates of people with mental health problems

**Strategic Priority Two: More People with Mental Health Problems Will Recover**

3.17 *More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable accommodation.*

3.18 Mental health problems are common and vary in their nature and severity. Some people experience long term and severely disabling effects, many people will recover fully. There are many social and other determinants and consequences of mental health problems so we need approaches covering a broad range of outcomes.

3.19 We want to improve recognition of mental health problems and access to evidence based interventions in primary care and community services.

3.20 About 90% of people with mental health problems can be treated in primary care. NICE evidence based guidelines describe a co-ordinated, stepped care approach for the management of mental health problems in primary, secondary and specialist care.

• We will review our common and severe mental health pathways according to best practice.
• We will increase the availability of talking therapies interventions – Step by Step (formerly Increased Access to Psychological Therapies (IAPT)).

3.21 The last 10 years have seen the establishment of a specialised service model that provides evidence based interventions for treating psychosis in the early phase and a relatively early young age (14-35 years old). There is an increasing body of evidence that supports this approach as more effective than a traditional generic community mental health team approach.

• We will consider evidence for early interventions in psychosis and review the local support available accordingly.

3.22 Whether in custody or under community supervision, offenders experience many health inequalities. Mental health is a particular issue for this group. Prisoners have been shown to have significantly higher rates of mental health problems than the general public.

• We will ensure that recommendations of “No health without mental health” for support of offenders’ mental health needs are considered locally.
3.23 Personality Disorders are common conditions. People with complex problems may make frequent and chaotic use of primary care, A&E, mental health and social services. Lack of access to early community based treatment and support can mean that young people with a personality disorder graduate into institutional and secure care, and offenders continue to reoffend, with frequent spells in prison.

- We will improve access to mental health services for people with personality disorders through effective engagement and interventions by appropriate secondary care services, and through multidisciplinary specialist services.
- We will ensure that the Offender Personality Disorder strategy owned by NOMS (National Offender Management Service) links effectively with mental health services.

3.24 Four high impact areas to tackle acute distress have been identified by No Health Without Mental Health.

3.25 Delivering high quality acute care is paramount. Although the principles of high quality acute care are accepted and are applicable across the age range:

- We will ensure that the recommendations of “Triangle of Care – Carers Included” report, which was published by The Princess Royal Trust for Carers and the National Mental Health Development Unit, are considered in care planning process.
- We will incorporate the recommendations of MIND’s inquiry into acute and crisis mental health care into local services.

3.26 Improving access to mental health services for homeless people and other vulnerable groups is the second highest impact area to tackle acute distress.

- We will ensure that mental health services do not discharge patients from hospital with “nowhere to go”. Proper discharge planning and assessment process will consider housing needs of a service user, and the fact whether the environment from which service user was admitted is still suitable for their return.
- We will seek innovative approaches, in cooperation with vulnerable communities’ commissioners to improve access to acute and primary care.

3.27 Improving mental health services for ex-service personnel is part of the national Military Covenant and one of the local priorities. A comprehensive piece of work to identify exact local needs of military veterans to inform mental health commissioning was completed in July 2012.

- We will ensure that the recommendations of this review and the recommendations of the Military Veterans Wellbeing Forum are implemented by mental health services.

3.28 People with autism often live undiagnosed until a major acute mental health crisis. Although national and local drivers look at comprehensive autism pathways separately to the mental health strategy, it is crucial that local established pathways are able to prevent and support, if needed, acute mental distress episodes.
• We will ensure that the recommendations of the autism strategy in relation to mental health are incorporated with mental health pathways.

3.29 Hope, agency\textsuperscript{20} and opportunity are three main principles of high quality recovery based care.

• We will consider the results of “organisation recovery challenge” pilot conducted by the Centre for Mental Health and NHS Confederation to shape our mental health services.

3.30 As discussed above, employment is an important part of many people’s recovery from mental health problems. People with mental health problems have the lowest employment rate of any disability group, yet the overwhelming majority want to work and with the right support, many can. In addition to increasing employment rates for people with mental health problems:

• We will increase the profile of supported employment within Community Mental Health Teams (CMHT) to encourage service users to consider employment options where appropriate.

3.31 Stable and appropriate housing is important to people who use mental health services and their carers. Too often people become stuck in costly and inappropriate residential care or out of area placements, or their discharge from psychiatric hospital is delayed because of lack of appropriate housing.

• We will review our local housing provision, map local demand and commission or decommission accordingly in order to maximise community based provision.
• We will take into account and work on implementation of the housing review recommendations completed by Bedford Borough Supporting People Partnership Board.
• We will create an effective system of information exchange between care management, housing department and commissioning team in order to have reliable data to inform local commissioning.

3.32 Recovery in mental health is different from, although related to, clinical recovery. Recovery is unique to each individual and defined by them. As recovery includes improvement in many dimensions there is no ideal single instrument to measure it. Recovery star is an example of a tool that can measure progress towards recovery in 10 domains.

• We will ensure that the recovery star tool is included in outcomes reporting for mental health services in all contracts across Bedfordshire Clinical Commissioning Group and social services.

3.33 How we will measure this outcome?

3.34 There are a pool of relevant indicators to be considered:

\textsuperscript{20} The concept of agency implies an active organism, one who desires, makes plans, and carries out actions
• Employment rates of people with mental health problems
• Emergency admissions within 28 days of discharge
• Admissions to residential care per 1000 population
• Delayed transfers of care
• Proportion of social services spend of residential care
• Recovery star completions
• Overall recovery star measures as reported by providers
• Number of people in settled accommodation
• Monitoring numbers and self reported measures of veterans in mental health systems
• Monitoring numbers of people with autism in the mental health system via monitoring delivery of the autism strategy

Strategic Priority Three: More People with Mental Health Problems Will Have Good Physical Health

3.35 Fewer people with mental health problems will die prematurely, and more people with physical ill health have better mental health.

3.36 Having a mental health problem increases the risk of physical ill health.

3.37 People with mental health and substance misuse problems are more likely to smoke and to smoke more heavily, and as a consequence, experience smoking related harm. Smoking is therefore responsible for the largest proportion of health inequalities in people with mental health problems.

3.38 Some 70% of psychiatric inpatients smoke compared with 21% of the general population. Furthermore those with mental disorder consume 42% of all tobacco consumed in England.

3.39 Although smokers with mental illness are just as motivated to stop as the general population they are less likely to be offered cessation support.

• We will ensure that people with mental health problems who smoke are identified and supported to stop smoking through improved access to smoking cessation programmes.

3.40 Mental health problems are also much more common in people with physical illness. Having both physical and mental problems delays recovery from both conditions.
• We will ensure that talking therapies are integrated into the care pathways for people with physical conditions to improve recovery and clinical outcomes.

3.41 How we will measure this outcome?

There are a pool of relevant indicators to be considered:

• Increase life expectancy for Bedford Borough
• Reducing the difference in life expectancy and healthy life expectancy for people with mental health problems
• Smoking prevalence in adults
• Rates of hospital admissions per 100 000 for alcohol related harm
• Smoking rates of people with mental health problems
• Uptake of NHS Health Checks
• Mortality Rate of people of people with mental health problems

**Strategic Priority Four: More People Will Have a Positive Experience of Care and Support**

3.42 Care and support, wherever it takes place, should offer access to timely, evidence based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people’s human rights are protected.

3.43 “Choice listens to me, involves me, responds to me, values me, and supports me on my road to recovery. If we are serious about putting service users at the heart of modern mental health services, providing choice is essential”.

(Lauire Bryant, service user, quoted in “No health without mental health”, p.65)

3.44 This strategy defines the framework for adult mental health services. However we want to ensure that appropriate transition protocols are in place for transfer from children and adolescent mental health services (CAMHS) into adult mental health care.

• We will review our mental health transitions protocols in line with Social Care Institute for Excellence (SCIE) best practice recommendations on mental health transitions.

3.45 Untreated depression in older people can increase the need for other services—including residential care. Older people can however respond very well to psychological and medical treatments. We need to pay particular attention to ensuring appropriate access for people over 65 to psychological therapies services.

• We will monitor and improve access of over 65 into psychological therapies treatments.

3.46 Critical to this outcome is an understanding of the experience of all individuals, their families and carers. A number of surveys have been developed to better understand service users’ experience. One of them is CQC community mental health services survey.

• We will work with our mental health provider SEPT to incorporate patients voice and outcomes surveys into delivery of services.

3.47 The concept of personalisation and redefinition of the relationship between the citizen (service user) and health and social system places choice and control in the hands of people who use the services.
3.48 It is therefore vital that the local authority and mental health services provider develop effective business processes which allow maximum level of control for service users.

- We will be reshaping mental health services as suggested by personalisation via annual personalisation action plans until measured patient experience tells us that people are happy with the personalised support they are receiving.

3.49 How we will measure this outcome?

3.50 There are a pool of relevant indicators to be considered:

- Proportion of carers reporting being included or consulted in discussions about person they care for
- Number of people with personal budgets
- Information on access to mental health services from protected characteristics, and older people
- Rates of identification and treatments for older people with depression
- Step by Step (formerly IAPT) – experience of choice – location, time, therapist, treatment.
- CQC community mental health services survey – (currently on trust level only)

**Strategic Priority Five: Fewer People will Suffer Avoidable Harm**

3.51 *People receiving care and support should have confidence that services they use are of the highest quality and at least as safe as any other public services.*

3.52 People using mental health services should have confidence that the services they use are of high quality and as safe as any services in the world. Particular issues of concern have been safety and dignity in inpatient care, including secure environments.

- We will raise awareness of the dignity in care campaign among staff in acute settings.
- We will incorporate findings and recommendations of the MIND inquiry into acute and crisis mental health care particularly ones on dignity in acute settings.

3.53 A number of factors may increase the likelihood of someone taking their own life. These include having a mental health, alcohol or drug misuse problem, social isolation or painful illness.

- Mental health services will consider recommendations of government suicide prevention strategy when published.

3.54 The Department of Health has issued updated guidance on assessment and management of risk: *Best practice in Managing Risk: Principles and guidance for best practice in the assessment and management of risk to self and others in mental health services.*
• We will ensure that best practice principles of risk management guidance are fully incorporated in mental health pathways locally.

3.55 It is essential to assess implications of parental mental ill health for each member of the family. After assessment, appropriate additional support should be provided by effectively sharing information and working with local multi agency services for children and families.

• We will ensure that “Think Family” practice guide principles are included in mental health services pathways.

3.56 How will we measure this outcome?

3.57 There are a pool of relevant indicators to be considered:

• The proportion of referrals to safeguarding services which are repeated referrals
• The suicide rate for those in contact with specialist mental health services
• Rates of inpatient suicides
• Inpatient admissions and A&E attendances with diagnosis of self harm.
• Homicides by people in contact with mental health services.

Strategic Priority Six: Fewer People Will Experience Stigma and Discrimination

3.58 Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will reduce.

3.59 Stigma and discrimination continue to affect significant numbers of people with mental health problems.

3.60 A recent survey showed that more than one quarter of people in UK still thinks that people who have mental health problems should not have the same rights to a job as everyone else.

3.61 The Equality Act 2010 establishes the responsibilities of organisations and employers towards people with disabilities, including those with mental health problems.

3.62 But legislation is not enough. To shift public attitudes substantially requires a major and sustained social movement.

• We will ensure that the Wellbeing Centre provides education and information on reducing stigma to the general public.

• We will ensure increased local awareness of the “Time to Change” initiative supported by all local statutory and volunteer organisations.

3.63 How will we measure this outcome?

• Time to Change Campaign Indicators
BCCG Key Priorities

3.64 Prevention and Early Intervention

We will:
- Work with our 2 local councils to revise the Joint Mental Health Strategies.
- We will continue to promote the “Make Every Contact Count” campaign and the use of various screening tools.
- We will increase access to self help materials and tools, including via GP surgeries

in order that:
- Local services are focused on improving the mental health and wellbeing of residents.
- It is easier for people to adopt healthier lifestyles and help themselves to improve their mental health and wellbeing.
- There is an increase in the early diagnosis of mental health problems allowing for support and treatment to be offered at an earlier stage.

3.65 Improving Quality in General Practice

We will:
- Provide more information, including benchmarking data, training and support to GPs and their staff.
- We will also tackle the variation in the different services that exists between the different localities

in order that:
- There is a reduction in variation in care between different practices, which will help with earlier diagnosis, better support for patients, reduce inappropriate referrals and improve the quality of care.

3.66 Steps 1 to 3

We will:
- Develop comprehensive primary care mental health services that promote wellbeing and ensure that people are assessed and treated at the earliest point in their illness.

in order that:
- Primary care mental health services are able to deliver an increased range of interventions and support.
- There will be an increase in the availability of psychological therapies and this will be equally available to hard to reach groups.
- There will be increased support for people with physical conditions that impact on their mental wellbeing

3.67 Steps 4 to 5

We will:
- Review all community mental health teams to ensure that support is accessible, responsive and recovery focused

in order that:
- Community teams operate seven days a week and provide a service to all ages (from 18 years old).
There will be a specialist CMHT that will deliver services to people suffering with an organic disorder e.g. Dementia.
There will be a Crisis Service available for older people.
There will be increased focus on improving the physical health and wellbeing of patients with mental health problem.

3.68 Complex Needs

We will:
➢ Review the Complex Needs Service and develop a model that is accessible and able to meet local demand

in order that:
➢ People with complex needs can be assessed and treated locally and able to access a service promptly.

3.69 Rehabilitation and Recovery

We will:
➢ Review and redesign existing rehabilitation services and develop an integrated community pathway

in order that:
➢ There is a new integrated model of service delivery, which enables people access to recovery based treatment and support.

3.70 Dementia

We will:
➢ Increase the support to GP practices to aid early assessment and diagnosis of dementia.
➢ Develop a post diagnostic support service that enables people to live well, and live longer, with dementia
➢ Support carers to remain mentally and physically well and enable them to care for the person with dementia for as long as they are able/wish to

in order that:
➢ Best outcomes for treatment are ensured.
➢ There is an increase in the capacity of the Memory Assessment Service and waiting times are reduced.
➢ An organic CMHT is developed that is specialist and responsive.

3.71 Liaison Psychiatry

We will:
➢ Help to develop a system wide model for liaison psychiatry

in order that:
➢ In future, our local Acute Hospitals will have easy access to a psychiatric service which will include all aspects of Mental Health provision including dementia, learning disability liaison and general psychiatric support.

3.72 Transition to Adult Services
We will:
- Work closely with Local Authority Colleagues to implement the use of the Multi Agency Transition Tool (MATT), where appropriate, and support service providers to ensure that Transition Policies are in place and implemented fully.

in order that:
- Young people undergo a seamless transition between Children’s and Adult Services.

3.73 Services for Children and Young People

We will:
- 1. Review the local Diagnostic pathway for Children and Young People with Autistic Spectrum Disorders (ASD)
- 2. Review the specialist Child and Adolescent Mental Health Services that we commission

in order that:
- 1. Children and young people with suspected ASD will all receive a consistent, high quality assessment in line with NICE Guidance.
- 2. Children and young people with mental health problems are provided with a timely, effective, evidence based and flexible service.

How we will measure progress of the strategy – National Dashboard for Mental Health

3.74 To provide a picture of overall progress towards implementing the strategy, the Department of Health will publish a national mental health dashboard. This will bring together the most relevant measures from the three Outcomes Frameworks (NHS, Public Health, and Adult Social care) and elsewhere, and map them against the aims of the strategy.

3.75 We will monitor development of the national dashboard for mental health. We hope that this tool in combination with our local indicators will give us a clear picture of delivery of the local strategy.
This is the Joint Commissioning Strategy for Mental Health Action Plan. It is reviewed annually to incorporate any changes to government policy and local priorities.

**Joint Commissioning Strategy for Mental Health Strategic Action Plan**

<table>
<thead>
<tr>
<th>Strategic priority 1: more people will have good mental health</th>
<th>Objectives</th>
<th>Due date</th>
<th>Responsible</th>
</tr>
</thead>
</table>
| 1. We will review how mental health support is incorporated in local parenting support programmes, concentrating mostly on known areas of deprivation | 1. Complete review and produce recommendations  
2. Adjust local parenting support programmes based on recommendations | April 2015 | Children Services Commissioners from BCCG and BBC |
| 2. Common and Severe mental health problems pathway redesign will include appropriate support for young mothers | 1. Ensure that pathway redesign project scope includes support for young mothers  
2. Ensure new pathway model is fully inclusive of support for young mothers | April 2014 | Head of MH and LD Commissioning BCCG |
| 3. We will ensure that health visitors focus adequately on mental health support for mothers and infants and children as they get older | 1. Review health visitors mental health awareness  
2. Complete training needs analysis on mental health awareness for health visitors  
3. Deliver training as per training needs analysis  
4. Evaluate impact of change | April 2015 | Health visitors Commissioners |
| 4. We will incorporate SCIE guidance on mental health transitions into local mental health transition protocols | 1. Reviewed local MH transition pathway against SCIE recommendations  
2. Agree adjustments with stakeholders  
3. Adopt recommendations in local transition protocol  
4. Publicise and review implementation of recommendations | April 2015 | Children MH Services Commissioner  
Head of MH and LD Commissioning BCCG  
CAMHS and CMHTs Bedford locality clinical leads |
| 5. We will ensure that cooperation (early identification and stepped care) | 1. Establish clear awareness of individual service pathways for adult and | April 2015 | Substance Misuse Commissioners for |
| **approaches) between adult drugs and** | **Identify clear referral pathways** | **children substance misuse services** | **Children and Adult** |
| **alcohol services providers and children** | **between two services** | **Identify clearing referral pathways** | **Services** |
| **and young substance misuse support** | **between two services** | **between two services** | **Substance Misuse** |
| **providers takes place** | **3. Adjust contractual arrangements for** | **Identify clearing referral pathways** | **services providers** |
| | **both pathways if necessary** | **between two services** | |

6. **Adult mental health services will work with**
**NHS and Local Authority commissioners to**
**explore pooled resources for best practice**
**activities as identified in “No health without**
**mental health” strategy**

| **6. Adult mental health services will work with** | **1. To have Joint commissioning strategy** | **April 2013 and** | **Head of Commissioning –** |
| **NHS and Local Authority commissioners to** | **in place** | **ongoing** | **BBC** |
| **explore pooled resources for best practice** | **2. To conduct joint service reviews as** | | **Head of Partnership** |
| **activities as identified in “No health without** | **required** | | **Commissioning - BCCG** |
| **mental health” strategy** | **3. To have mutual active participation in** | | |
| | **strategic commissioning projects of** | | |
| | **local authority and CCG** | | |

7. **Think family protocol will include emphasis**
**on evidence based family interventions**
**such as Multisystemic Therapy**

| **7. Think family protocol will include emphasis** | **1. Review local Think Family Protocol** | **April 2016** | **Think Family Protocol** |
| **on evidence based family interventions** | **2. Conduct feasibility of introducing** | | **Owner** |
| **such as Multisystemic Therapy** | **Multisystemic therapy locally** | | |
| | **3. Establish local providers of this service** | | |
| | **(if feasible)** | | |

8. **We will review eating disorders support**
**services and ensure they support young**
**people appropriately**

| **8. We will review eating disorders support** | **1. Review local eating disorder pathway** | **April 2017** | **Head of MH and LD** |
| **services and ensure they support young** | **2. Make recommendations on support for** | | **Commissioning BCCG** |
| **people appropriately** | **young people specifically** | | |
| | **3. Implement recommendations** | | |

9. **We will increase uptake of personal**
**budgets for physical, leisure and learning**
**activities as specified in BBC business**
**plan and provider’s personalisation plan**

| **9. We will increase uptake of personal** | **1. Establish baseline of personal budgets** | **April 2013** | **Commissioning Officer** |
| **budgets for physical, leisure and learning** | **for activities in question** | | **BBC** |
| **activities as specified in BBC business** | **2. Deliver effective awareness campaign** | **April 2014 and** | **Service Manager -BBC** |
| **plan and provider’s personalisation plan** | **to Care management teams to raise** | **ongoing** | **Clinical Manager - SEPT** |
| | **awareness of usage of personal budgets** | | |
| | **for activities in question.** | | |
| | **3. Commissioning team to adjust** | | |
| | **personalised services framework if** | | |
| | **additional changes required** | | |

10. **We will consider smoking cessation**
**services being integrated into common and**
**severe mental health problems care**
**pathway, including in reach programmes to**

<p>| <strong>10. We will consider smoking cessation</strong> | <strong>1. Conduct MH pathway review</strong> | <strong>April 2014</strong> | <strong>Head of MH and LD</strong> |
| <strong>services being integrated into common and</strong> | <strong>2. Ensure smoking cessation services</strong> | | <strong>commissioning BCCG</strong> |
| <strong>severe mental health problems care</strong> | <strong>are considered fully in the scope of the</strong> | | <strong>SEPT Clinical Leads</strong> |
| <strong>pathway, including in reach programmes to</strong> | <strong>review</strong> | | |</p>
<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
<th>Timeframes</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td>We will promote debt advising local services such as Citizens Advice Bureau and Moneymadeclear service via care management team and Wellbeing centre</td>
<td>April 2015</td>
<td>Commissioning Officer – BBC, Operational manager – Mind, Clinical CMHTs manager - SEPT</td>
</tr>
<tr>
<td></td>
<td>1. Conduct local and national review of most effective financial advising services for people with MH problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Make strategic commissioning adjustments if necessary, including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Wellbeing Centre in Bedford will have established financial advice services in their portfolio</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Raise awareness of financial advising services among care management teams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Clinical and social services will be aware and refer appropriately to moneyadvice.service.org.uk – independent organisation to help people to understand and manage their finances</td>
<td>April 2015</td>
<td>Commissioning Officer – BBC, Service manager BBC, Clinical CMHTs manager SEPT</td>
</tr>
<tr>
<td></td>
<td>1. Raise awareness of money advice service among local care management teams</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Monitor referrals and outcomes of this service for local population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>We will increase number of people with mental health problems in employment</td>
<td>April 2013 and ongoing</td>
<td>Partnership Manager – Job Centre Plus</td>
</tr>
<tr>
<td></td>
<td>1. Establish MHPB employment subgroup with all main MH stakeholders with clear action plan</td>
<td>Aprl 2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Adopt the Individual Placement and Support (IPS) locally</td>
<td>Aprl 2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Complete local day services review and ensure that supported employment is fully considered</td>
<td>Aprl 2014</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>We will reduce isolation and increase social networks and opportunities for community engagement, including peer support programmes</td>
<td>April 2014</td>
<td>Commissioning Officer BBC, Head of MH and LD commissioning BCCG</td>
</tr>
<tr>
<td></td>
<td>1. Complete local day services review</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Ensure that Local Information and Advice website is fit for purpose for people with MH problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Work with local volunteer sector providers on specific projects</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 15. We will improve support for informal carers, including support for carers of people with schizophrenia and psychosis | 1. Review with Carers in Bedfordshire support for carers for people with mental health problems  
2. Produce recommendations  
3. Carers contract holders to implement recommendations | April 2014 | Carers in Bedfordshire Head of MH and LD Commissioning BCCG Commissioning Officer BBC |
|---|---|---|---|
| 16. We will promote physical activities and physical health | 1. Work with public health and sports development department on increasing opportunities for physical activities  
2. Encourage use of personal budgets for physical activities  
3. Work with public health and local volunteer providers on expansion of volunteer lead health walk schemes. | April 2014 | Public Health Manager  
Sports development team BBC  
Clinical CMHTs manager - SEPT |

### Strategic priority 2: more people with mental health problems will recover

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Responsible</th>
</tr>
</thead>
</table>
| 1. We will review our common and severe mental health pathways according to best practice  
1. Develop care pathway  
2. Consult on care pathway  
3. Prepare business case to deliver accepted service pathway  
4. Modify service specification  
5. Award contract/or contract variation | April 2014  
Head of MH and LD commissioning BCCG |
| 2. We will increase availability of talking therapies interventions – IAPT  
1. Increase access to IAPT to 10% of prevailing population  
2. Increase access to IAPT to 15% of prevailing population  
3. Monitor access to IAPT and review targets | April 2014  
April 2015  
April 2016 | Head of MH and LD commissioning BCCG |
| 3. We will consider evidence for early interventions in psychosis and review local | 1. Evaluate effectiveness of changes made to service specification in 2012 | April 2014 | Head of MH and LD Commissioning BCCG |
| 4. | We will ensure that recommendations of “No health without mental health” for support of offenders’ mental health needs are considered locally | 1. Ensure effective link with prison partnership board  
2. Review prison mental health provision according to “No health without mental health” recommendations  
3. Adjust the care pathway based on recommendations | Head of MH and LD  
Commissioning BCCG  
Commissioning Manager, Offender Health and Military Health |
|---|---|---|---|
| 5. | We will improve access to mental health services for people with personality disorders through effective engagement and interventions by appropriate secondary care services, and through multidisciplinary specialist services | 1. Establish local baseline for access to services  
2. Review barriers  
3. Adjust relevant services as required | April 2014  
Head of MH and LD  
Commissioning BCCG |
| 6. | We will ensure that Offender Personality Disorder strategy owned by NOMS (National Offender Management Service) links effectively with mental health services | 1. Establish task and finish group with NOMS services  
2. Review NOMS based on the Offender Personality Disorder strategy  
3. Delivery recommendations in partnership with Mental Health Partnership Board | April 2017  
Head of MH and LD  
Commissioning BCCG  
Commissioning Manager, Offender Health and Military Health |
| 7. | We will ensure that recommendations of “Triangle of Care – Carers Included” are considered in care planning process | 1. Review carers assessment process for carers of people with mental health problems  
2. Produce local recommendations based on Triangle of Care  
3. Agree and adjust local protocols | April 2014  
Service Manager BBC  
Clinical CMHTs lead SEPT  
Carers in Beds |
| 8. | We will incorporate recommendations of MIND’s inquiry into acute and crisis mental health care into local services | 1. Review local acute and crisis mental health care based on the report  
2. Produce recommendations  
3. Agree and Adjust service delivery | April 2014  
Locality Director – SEPT |
<p>| | | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9. We will ensure that mental health services do not discharge patients from hospital with nowhere to go</td>
<td>1. Ensure that discharge planning form acute hospital fully considers housing needs and capability of care admission environment to support individual post discharge</td>
<td>April 2014</td>
<td>Commissioning Officer BBC</td>
<td>Head of MH and LD Commissioning BCCG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Ensure that local rehabilitation pathway review considers housing needs</td>
<td></td>
<td>Clinical Lead – Acute Care SEPT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Ensure local capacity is in place not to delay discharge due to housing needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. We will seek innovative approaches, in cooperation with vulnerable communities' commissioners to improve access to acute and primary care for vulnerable communities</td>
<td>1. Work with volunteer sector to support vulnerable communities and commission specific projects if necessary</td>
<td>April 2014</td>
<td>Head of Commissioning BBC</td>
<td>Head of MH and LD Commissioning BCCG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Ensure that each commissioned provider of mental health services along local pathway has explicit targets about vulnerable communities</td>
<td></td>
<td>Volunteer sector organisations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. We will ensure that recommendations of mental needs HNA review and recommendations of Military Veterans forum are implemented by mental health services</td>
<td>1. MH Partnership board to Support Military Covenant wellbeing subgroup in delivery of adjustments for mental health services via separate action plan.</td>
<td>April 2013 and on-going</td>
<td>Lead of Health and Wellbeing Subgroup of Military Covenant work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. We will ensure that recommendations of autism strategy in relation to mental health are incorporated with mental health pathways</td>
<td>1. MH Partnership board to autism partnership in delivery of adjustments for mental health services via separate action plan</td>
<td>April 2013 and on-going</td>
<td>Commissioning Officer BBC</td>
<td>Head of MH and LD Commissioning BCCG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. We will consider results of “organisation recovery challenge” pilot conducted Centre for Mental Health and NHS confederation to shape our mental health services.</td>
<td>1. Ensure “recovery perspective” of mental health pathway redesign work</td>
<td>April 2014</td>
<td>Head of MH and LD commissioning BCCG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Produce local recommendations mapped against lessons learned from national pilot sites</td>
<td></td>
<td>Commissioning Officer BBC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Deliver recommendations across the whole pathway</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 14. We will increase profile of supported employment with CMHTs to encourage service users to consider employment options where appropriate | 1. Plan and run local information campaign on supported employment within CMHTS to clarify:  
- Availability of local support  
- Referral process | April 2015 | Partnership Manager – Job Centre Plus  
Supported employment service managers BBC, SEPT |
|---|---|---|---|
| 15. We will review our local housing provision, map local demand and commission or decommission accordingly in order to maximise community based provision | 1. Design data collection templates to map offer and demand  
2. Analyse data  
3. Produce recommendations to inform commissioning of social care, supporting people and general needs housing  
4. Shape local housing provision based on recommendations | June 2013  
October 2013  
January 2014  
April 2014 and on-going | Commissioning Officer BBC  
Head of Supporting People  
Housing needs Manager |
| 16. We will take into account and work on implementation of housing review recommendations from 2012 | 1. Support delivery of 10 recommendations from supporting people housing review by  
- Establishing housing task and finish group and smart action plan  
- Linking with supporting people partnership, strategic and operational housing colleagues | April 2013  
April 2013 | Head of Supporting People |
| 17. We will create an effective system of information exchange between care management, housing department and commissioning team in order to have reliable data to inform local commissioning | 1. Map local information on housing across care management, supporting people and general needs housing databases  
2. Establish what information on housing needs could be shared among relevant stakeholders to inform commissioning more fully  
3. Define protocols and logistics of information sharing | April 2015 | Commissioning Officer BBC  
Head of Supporting People  
Housing needs Manager  
Clinical CMHTs lead SEPT |
| 18. We will include the needs of people with schizophrenia and psychosis who are | 1. Ensure local homelessness services are able to provide required data | April 2015 | Public Health JSNA Manager |
### Strategic priority 3: more people with Mental Health problems will have good physical health

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Due date</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Work with public health on local smoking cessation campaigns</td>
<td>April 2016</td>
<td>Clinical CMHTs lead SEPT</td>
</tr>
<tr>
<td>2. Ensure that local mental health care pathway model incorporates this as one of the priorities</td>
<td></td>
<td>Public Health Manager GPs representative</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Due date</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Review all physical care pathways for accessibility of talking therapies</td>
<td>April 2014</td>
<td>Head of MH and LD commissioning BCCG</td>
</tr>
<tr>
<td>2. Produce recommendations and adjust pathways</td>
<td></td>
<td>Head of Acute and Chronic Care Pathways Commissioning BCCG</td>
</tr>
</tbody>
</table>

### Strategic priority 4: more people will have a positive experience of care and support

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Due date</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish baseline for access to talking therapies for people 65+</td>
<td>April 2014</td>
<td>Head of MH and LD commissioning BCCG</td>
</tr>
<tr>
<td>2. Review barriers and produce recommendations</td>
<td>April 2015 and on-going</td>
<td></td>
</tr>
<tr>
<td>3. Implement recommendations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Monitor effectiveness of adjustments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Due date</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. SEPT to produce annual organisational reflections on CQC community survey results to MHPB</td>
<td>June 2013 and on-going annually</td>
<td>Locality Director SEPT</td>
</tr>
<tr>
<td>2. SEPT to implement identified recommendations based on annual CQC surveys</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Due date</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish baseline for personal budgets uptake</td>
<td>April 2013</td>
<td>Commissioning Officer BBC</td>
</tr>
</tbody>
</table>
via personalisation action plan until measured patient experience tells us that people are happy with personalised support they are receiving

| via personalisation action plan until measured patient experience tells us that people are happy with personalised support they are receiving |
| 2. Establish on-going annual feedback of usage and accessibility of personal budgets |
| 3. Produce and implement recommendations based on on-going feedback |
| 4. Actively promote personal budgets, where appropriate, for people with schizophrenia and psychosis |

| April 2014 and on-going |
| Continuously |

| Service Manager BBC |
| Clinical CMHTs lead SEPT |

| Strategic priority 5: fewer people will suffer avoidable harm |
| Objectives |
| Due date |
| Responsible |

| 1. We will raise awareness of dignity in care campaign among staff in acute settings |
| 1. Establish dignity champions across acute setting |
| 2. Dignity champions network to report regularly to MHPB on activities to raise and support the campaign |
| April 2014 |
| April 2014 and on-going |

| Locality Director SEPT |

| 2. Mental health services will consider recommendations of government suicide prevention strategy when published |
| 1. Establish local suicide prevention group |
| 2. Ensure national suicide prevention strategy informs local action plan |
| 3. Ensure that MHPB support local suicide prevention action plan |
| April 2013 |
| April 2013 |
| April 2013 and ongoing |

| Public Health Manager |

| 3. We will ensure that best practice principles of Risk management guidance are fully incorporated in mental health pathways locally |
| 1. Review risk management according to the developing best practice |
| 2. Flexibly Adjust local mental health pathway based on on-going review of best practice |
| 3. Flexibly Adjust local mental health pathway based on annual Multiagency Safeguarding Board Priorities |
| April 2014 and on-going |

| Locality Director SEPT |

| 4. We will ensure that “Think Family” practice guide principles are included in mental |
| 1. Raise awareness of local “Think Family” protocol |
| April 2014 and on-going |

<p>| Think Family protocol owner |</p>
<table>
<thead>
<tr>
<th>Strategic priority 6: fewer people will experience stigma and discrimination</th>
<th>Objectives</th>
<th>Due date</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. We will ensure that the Wellbeing Centre provides education and information on reducing stigma to general public</td>
<td>1. Extend activities portfolio of local Wellbeing Centre to tackle stigma and discrimination</td>
<td>April 2013 and ongoing</td>
<td>Commissioning Officer BBC, Operational Manager Mind</td>
</tr>
<tr>
<td>2. We will ensure increased local awareness of “Time to Change” initiative supported by all local statutory and volunteer organisations.</td>
<td>1. Create task and finish group to run local Time to Change campaign 2. Consider signing up to “Time to Change” addition to local MH contracts</td>
<td>April 2015</td>
<td>Operational Manager Mind, Commissioning Officer BBC, Head of MH and LD commissioning BCCG</td>
</tr>
<tr>
<td>3. All mental health providers should ensure that people with schizophrenia and psychosis (in hospital and the community) are aware of their right to request a review of their medication including, where appropriate, access to a specialist pharmacist, and are encouraged to exercise it in practice.</td>
<td>1. Review local support and advocacy provision for the group in question 2. Local advocacy and engagement service provider to have support activities in place to support people with schizophrenia and psychosis</td>
<td>April 2014</td>
<td>POhWER Locality Manager, Commissioning Officer BBC, Head of MH and LD commissioning BCCG</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategic priority 7: Equality</th>
<th>Objectives</th>
<th>Due date</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All Local Authority and BCCG contractual arrangements and service level agreements for mental health services will set specific targets to enable people from ethnic minorities to access the services.</td>
<td>1. Continuously update contracts, as they are scheduled for review, with specific targets in this area</td>
<td>April 2015</td>
<td>Head of MH and LD commissioning BCCG, Head of Commissioning BBC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **2.** Local Authority, BCCG and providers will work together to deliver preventative, secondary and acute care services underpinned by cultural competency principles to meet the needs of diverse local population. | **1.** Establish task and finish group to review cultural sensitivity of local mental health services  
2. The group to establish baseline for access  
3. The group to produce recommendations and agree with MHPB acceptable targets to inform commissioning and contracts |
| April 2015 | Head of MH and LD commissioning BCCG  
Head of Commissioning BBC |
<table>
<thead>
<tr>
<th>Glossary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy</td>
<td>Support for people in making their own decisions and ensuring that their views are properly represented</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group, newly established commissioning organisation led by local GPs, which will take over the responsibilities of the PCT. In Bedford it is Bedfordshire Clinical Commissioning Group (BCCG)</td>
</tr>
<tr>
<td>Commissioning</td>
<td>Planning, buying and reviewing of health and social care services</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission - checks whether hospitals, care homes and care services are meeting national standards</td>
</tr>
<tr>
<td>Direct payments</td>
<td>Money paid to you by your local Council so that you can buy your own care and support</td>
</tr>
<tr>
<td>Fuel poverty</td>
<td>This is a where a household cannot afford to keep adequately warm at a reasonable cost given their income. A fuel poor household is one that needs to spend more than 10% of its income on fuel use in order to heat the home to an adequate standard of warmth</td>
</tr>
<tr>
<td>Health Inequalities</td>
<td>Refer to gaps in the quality of health and health care across, racial, ethic, sexual orientation and socio-economic groups. These inequalities mean poorer health, reduced quality of life and early death for many people</td>
</tr>
<tr>
<td>Incidence</td>
<td>A measure of the risk of developing some new condition within a specified period of time e.g. within a year</td>
</tr>
<tr>
<td>Joint Strategic Needs Assessment (JSNA)</td>
<td>Bedfordshire Clinical Commissioning Group and Bedford Borough Council working together to understand the future health, care and well-being needs of the community</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>Provides important safeguards to protect families, carers, health and social care staff, and other people who act and make decisions on behalf of people who lack the mental capacity to make the decision for themselves</td>
</tr>
<tr>
<td>Payment by Result (PBR)</td>
<td>Payment system in England under which commissioners (BCCG and BBC) pay healthcare providers (e.g. SEPT) for each patient seen or treated</td>
</tr>
<tr>
<td><strong>PCT</strong></td>
<td>Primary Care Trust, known locally as NHS Bedfordshire/Bedfordshire Clinical Commissioning Group and responsible for the health of all people living in Bedfordshire. NHS Bedfordshire/Bedfordshire Clinical Commissioning Group assesses needs, plans services, funds care, delivers patient satisfaction and assures quality. The overall aim is to secure a real improvement in the health of local people.</td>
</tr>
<tr>
<td><strong>Person centred planning</strong></td>
<td>Putting you at the centre of planning for your life. Family, friends, professionals and services listening to and learning about what you want from your life and working together with you to make this happen.</td>
</tr>
<tr>
<td><strong>Personal budget</strong></td>
<td>A Personal Budget is a sum of money allocated to you as a result of an assessment of need. The amount of money is based on your eligible needs which the Council has a duty to support you with.</td>
</tr>
<tr>
<td><strong>Personal health budget</strong></td>
<td>A personal health budget makes it clear to someone getting support from the NHS and the people who support them how much money is available for their care and lets them agree the best way to spend it.</td>
</tr>
<tr>
<td><strong>Personal health plan</strong></td>
<td>Designed to look at your health needs, make plans for better health, tell people who need to know about your health to enable them to look after you.</td>
</tr>
<tr>
<td><strong>Prevalence</strong></td>
<td>The proportion of a population found to have a condition.</td>
</tr>
<tr>
<td><strong>Stakeholder</strong></td>
<td>Any individual or organisation with an interest in health and social care services.</td>
</tr>
<tr>
<td><strong>Strategy</strong></td>
<td>Describes the services we have now and how we will develop these services over the coming years.</td>
</tr>
</tbody>
</table>