Public Health England

NHS RightCare

Commissioning for Value
Mental health and dementia pack

NHS Leeds North CCG

January 2017

OFFICIAL

Gateway ref: 06288

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Foreword

“The Commissioning for Value packs and the RightCare programme place the NHS at the forefront of addressing unwarranted variation in care. I know that professionals - doctors, nurses, allied health professionals - and the managers who support their endeavours, all want to deliver the best possible care in the most effective way. We all assume we do so.

What Commissioning for Value does is shine an honest light on what we are doing. The RightCare approach then gives us a methodology for quality improvement, led by clinicians. It not only improves quality but also makes best use of the taxpayers’ pound ensuring the NHS continues to be one of the best value health and care systems in the world.”

Professor Sir Bruce Keogh
National Medical Director, NHS England

Foreword

“For many years, people with mental health problems have been largely neglected, with care provided by Cinderella services unable to meet their needs for mental and physical healthcare. People with severe mental illnesses, such as schizophrenia die between 15 and 20 years prematurely. Now, for the first time, mental healthcare for adults and children has become a major priority, with a growing evidence base about what works for whom. The RightCare approach and Commissioning for Value provide CCGs with the simple tools necessary to provide much needed improvement in the quality of care and quality of life for people with mental health problems.”

Professor Tim Kendall
National Clinical Director for Mental Health, NHS England

“Dementia is an illness that affects many people and is a priority for the NHS and social care. The beauty of the RightCare approach is that it will provide essential information for CCGs about indicators of good care for people with dementia, their families and carers, which is an essential prerequisite to drive up standards and improve the quality of care.”

Professor Alistair Burns
National Clinical Director for Dementia, NHS England

Your mental health and dementia pack

This pack contains data across a range of mental health and dementia services. It contains a number of new indicators not included in previous packs. These are shown as charts throughout the pack.

The information contained in this pack is personalised for your CCG and should be used to help support discussions about mental health care in your local health economy, to improve the value and utilisation of resources.

One of the main focuses for the Commissioning for Value series has always been reducing variation in outcomes. Commissioners should continue to use these packs and the supporting tools to drive local action to reduce inequalities in access to services and in the health outcomes achieved.

When commissioning services, CCGs should take into account the duties placed on them under the Equality Act 2010 and with regard to reducing health inequalities, duties under the Health and Social Care Act 2012. Service design and communications should be appropriate and accessible to meet the needs of diverse communities.

Previous Commissioning for Value packs and supporting information can be found on the NHS RightCare website at http://www.england.nhs.uk/rightcare

Mental health: A clinical perspective

One in four adults will be affected by a mental health problem in their lifetime. 50% of all lifetime mental illness will be established by age 14, and 75% by the time a person reaches their mid-twenties. The cost of mental ill health to the economy, NHS and society is over £100bn every year. For too long, people with mental health needs and dementia have struggled to get the support they need.

The 2016 Five Year Forward View (FYFV) for Mental Health sets ambitious targets for mental health and recommends significantly investing to improve care: crisis care, psychological therapies, liaison services in A&E departments, perinatal and children's services and suicide prevention. Sitting alongside the Prime Minister's challenge for dementia and the publication of *Future in Mind*, the trajectory for transforming mental health and dementia services is now clear. The detail of how this ambition is to be met over the next five years is set out in the MH FYFV Implementation Plan.

CCGs have a key role to play in achieving this change. There is now a wealth of data in mental health which can help CCGs develop a better understanding of both the needs of your local population and how services are currently meeting these needs, and the wider context within which services are commissioned.

The Mental Health and Dementia Intelligence Network contains a number of mental health profiles to support this. NHS England's MH FYFV dashboard includes measures for monitoring progress in transformation in mental health services in the coming years.

A link to both of these resources can be found at the end of this pack.

Mental health: Evidence based treatment pathways

Over the next five years NHS England will be working with arms' length body (ALB) partners to develop evidence-based treatment pathways and the supporting infrastructure to enable implementation. The pathways will be supported by self-assessment tools, which all local teams will be expected to complete, to enable localities to assess their provision against the model pathway. Each will span 'referral to recovery'.

Common activities:

- Establishment of a multi-stakeholder expert reference group;
- Pathway includes expectations for waiting times, interventions and outcomes;
- Specification of the dataset changes required to monitor and evaluate performance;
- Analysis of the gap between national baseline and ambitions in terms of cost, benefits, workforce;
- Development of a workforce strategy and planning tools to support implementation;
- Development of implementation guidance for the pathway.

Completed

- Early intervention in psychosis
- Community services for eating disorders in children and young people
- Crisis care: Urgent and emergency mental health liaison in acute hospitals
- Dementia

In development

- Generic children and young people's mental health
- Perinatal mental health
- Crisis care:
  - Urgent and emergency 'blue light' mental health response (all ages)
  - Urgent and emergency community-based mental health response
  - Urgent and emergency mental health response for CYP
- Acute mental health care
- Integrated psychological therapies

Planned for 2017/18 and 2018/19

- Community mental health care (psychosis, personality disorder, bipolar affective disorder and severe/complex common MH problems)
- Self-harm

The NHS RightCare programme

The NHS RightCare programme is about improving population-based healthcare, through focusing on value and reducing unwarranted variation. It includes the Commissioning for Value packs and tools, the NHS Atlas series, and the work of the Delivery Partners.

The approach has been tested and proven successful in recent years in a number of different health economies. As a programme it focuses relentlessly on value, increasing quality and releasing funds for reallocation to address future demand.

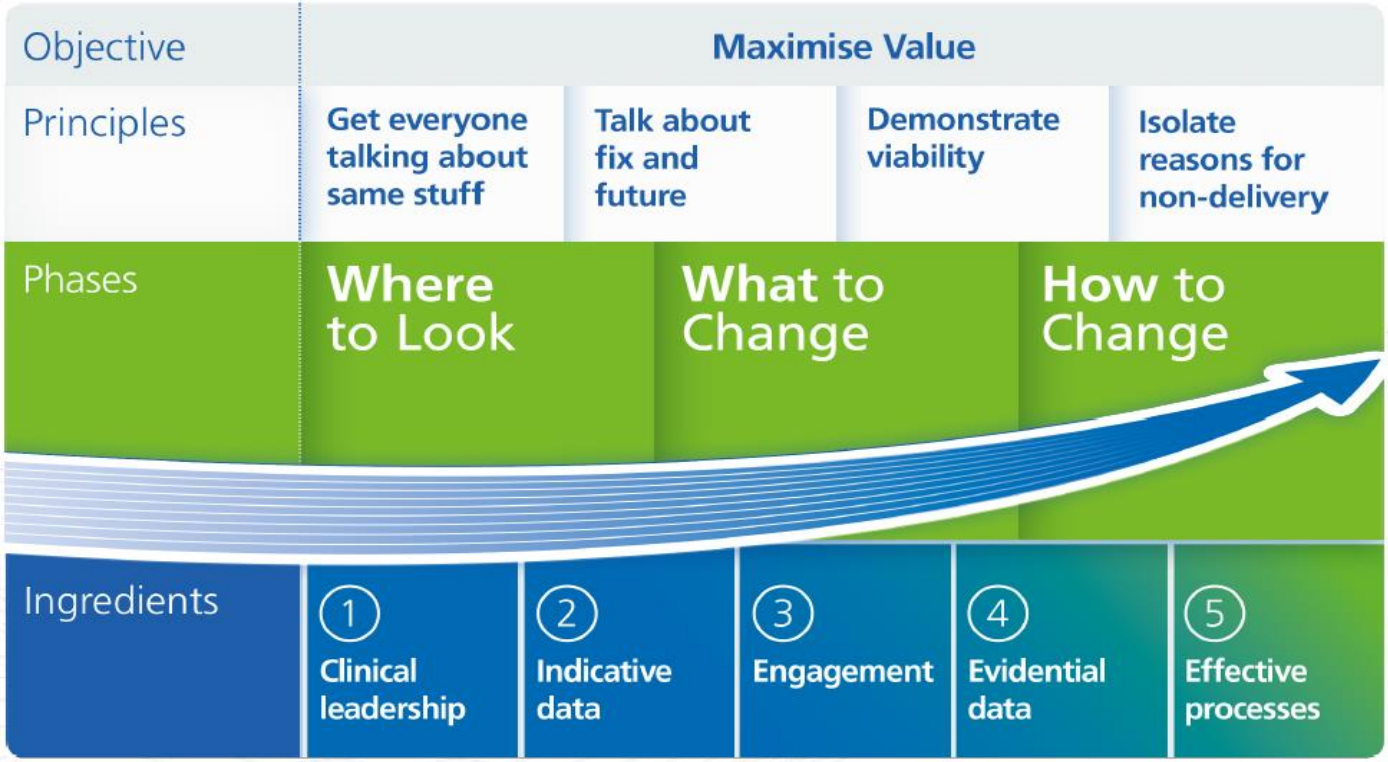
NHS England has committed significant funding to rolling out the RightCare approach. As of December 2016 all CCGs are now working with an NHS RightCare Delivery Partner.

NHS RightCare and Commissioning for Value

Commissioning for Value is a partnership between NHS RightCare and Public Health England. It provides the first phase of the NHS RightCare approach – *Where to Look*.

The approach begins with a review of indicative data to highlight the top priorities or opportunities for transformation and improvement. Value opportunities exist where a health economy is an outlier and will most likely yield the greatest improvement to clinical pathways and policies.

Phases two and three then move on to explore *What to Change* and *How to Change.*



Your most similar CCGs

Your CCG is compared to the 10 most demographically similar CCGs. This is used to identify realistic opportunities to improve health and healthcare for your population. The analysis in this pack is based on a comparison with your most similar CCGs which are:

- Leeds South and East
- West Essex
- Calderdale
- Greater Huddersfield
- Greater Preston
- North & West Reading
- Bury
- Airedale, Wharfedale and Craven
- Warwickshire North
- West Cheshire

To help you understand more about how your most similar 10 CCGs are calculated, the Similar 10 Explorer Tool is available on the NHS England website. This tool allows you to view similarity across all the individual demographics used to calculate your most similar 10 CCGs. You can also customise your similar 10 cluster group by weighting towards a desired demographic factor.

Pathways on a page

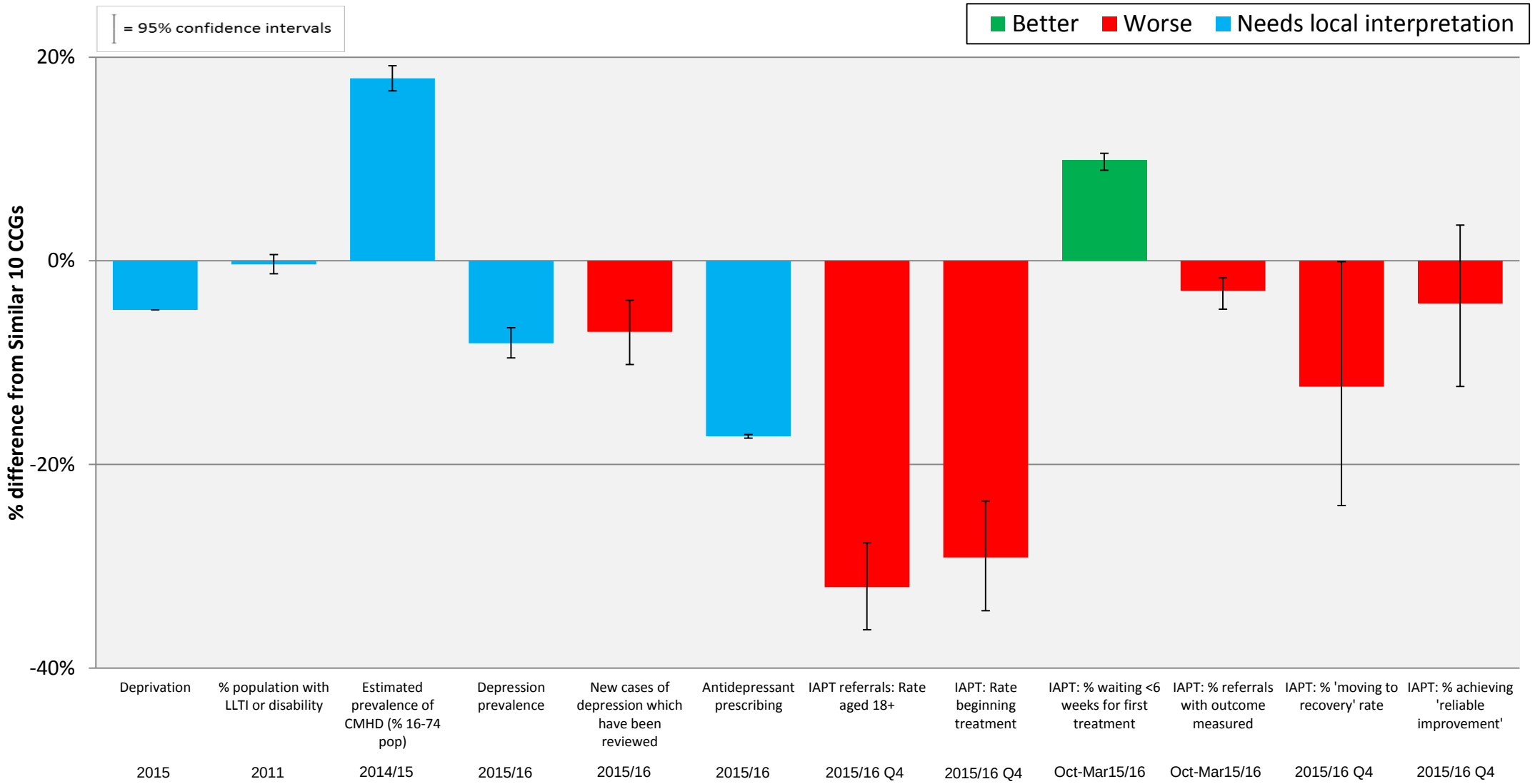
The following slides provide a detailed look at three 'Pathways on a page' by providing a wider range of key indicators for different conditions. The intention of these pathways is not to provide a definitive view of an optimal pathway, but to help commissioners explore potential opportunities by presenting key indicators along a patient pathway. These slides help to understand how performance in one part of the pathway may affect outcomes further along the pathway. Each indicator of these pathways is shown as the percentage difference from the average of the 10 CCGs most similar to you.

The indicators are colour coded to help you see if your CCG has 'better' (**green**) or 'worse' (**red**) values than your peers. This is not always clear-cut, so 'needs local interpretation' (**blue**) is used where it is not possible to make this judgement. For example, low prevalence may reflect that a CCG truly does have fewer patients with a certain condition, but it may reflect that other CCGs have better processes in place to identify and record prevalence in primary care.

Please note: The variation from the average of the similar 10 CCGs is statistically significant for those indicators where the confidence intervals do not cross the 0% axis.

Commissioners should work with local clinicians and public health colleagues to interpret these pathways. It is recommended that you look at packs for your similar CCG group. By doing so, it may be possible to identify those CCGs which appear to have much better pathways for populations with similar demographics.

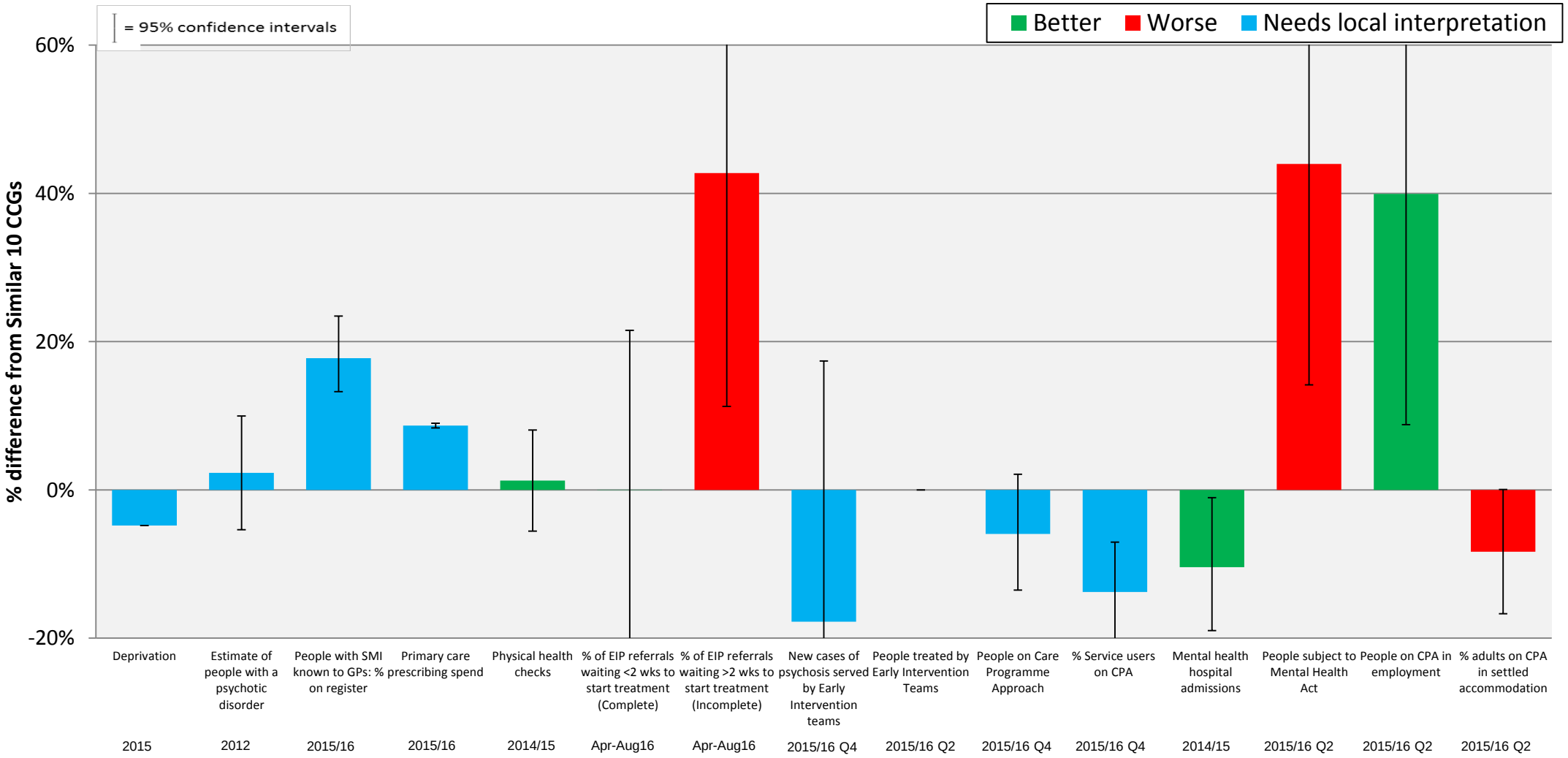
Common mental health conditions



NICE Guidance:

http://pathways.nice.org.uk/pathways/common-mental-health-disorders-in-primary-care

Severe mental health conditions



NICE Guidance:

http://pathways.nice.org.uk/pathways/psychosis-and-schizophrenia

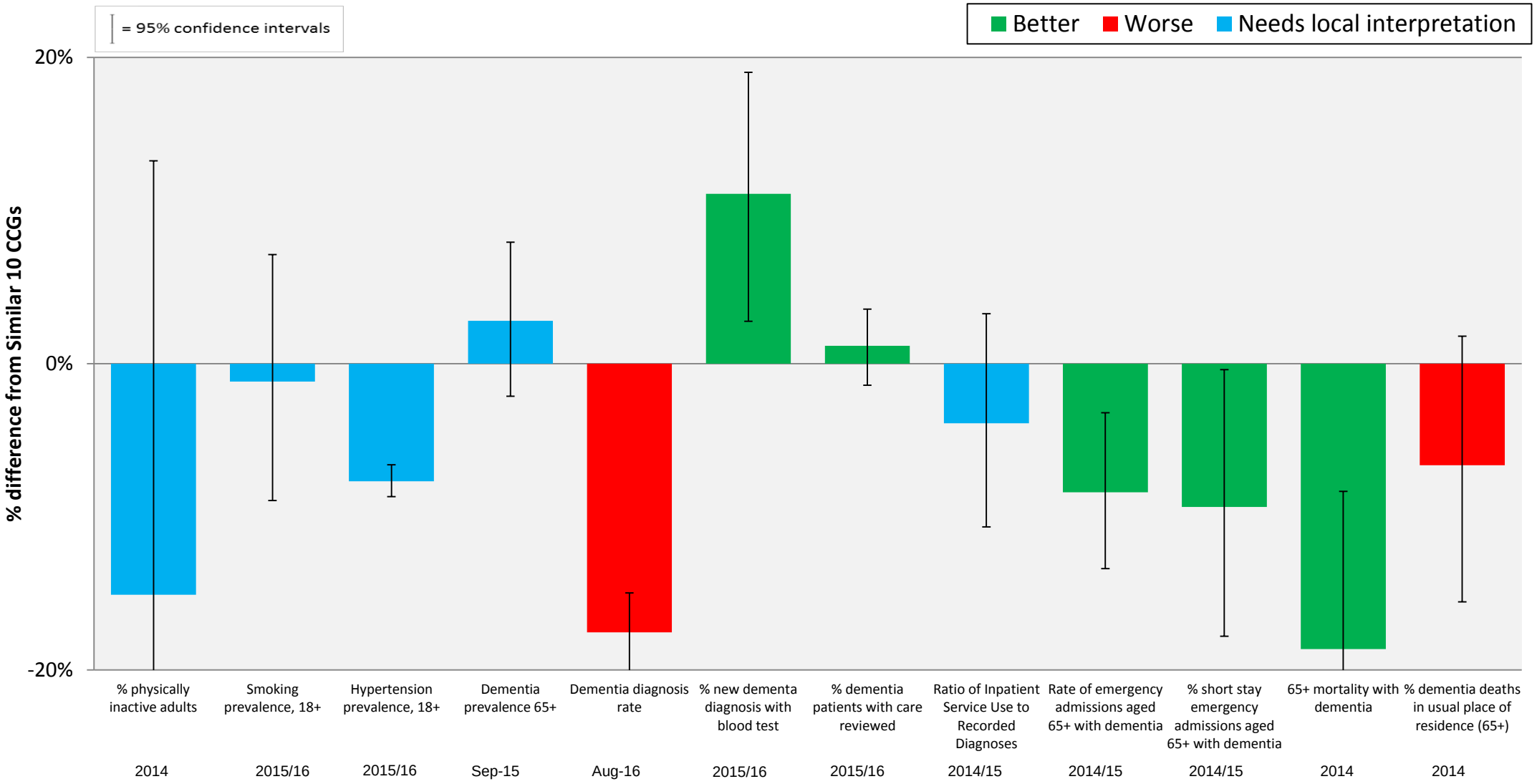
http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/

EIP (Early intervention in psychosis) Complete pathways- this shows the % of patients waiting less than 2 weeks to start treatment out of all those who have started treatment.

EIP Incomplete pathways – this shows the % of patients waiting more than 2 weeks out of all those who are yet to start treatment.

https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf

Dementia



NICE Guidance:

http://pathways.nice.org.uk/pathways/dementia

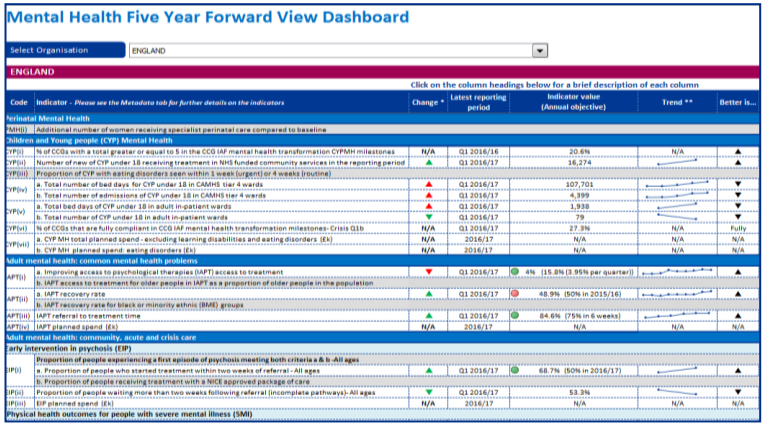
https://pathways.nice.org.uk/pathways/dementia-disability-and-frailty-in-later-life-mid-life-approaches-to-delay-or-prevent-onset

The mental health Five Year Forward View dashboard

The Mental Health Five Year Forward View Dashboard, published in October 2016, is a response to the recommendation in the Five Year Forward View (FYFV) for Mental Health that NHS England create a tool "*that will identify metrics for monitoring key performance and outcomes data and that will allow us to hold national and local bodies to account for implementing this strategy."*

It includes a suite of metrics based on the proposals in the FYFV Implementation Plan and is structured around the core elements of the mental health programme:

- children and young people's mental health
- perinatal mental health
- adult mental health: common mental health problems
- adult mental health: community, acute and crisis care
- secure care pathway
- health and justice
- suicide prevention



A key purpose of the dashboard is for NHS England and the Mental Health and Dementia Programme Board to be able to monitor progress on its commitments to transform mental health services. Additionally, by making the data publically available, NHS England aims to ensure that commissioners can use it to inform their work and that service users and their families and carers can see how local services are performing and understand where to look to make informed choices about their care.

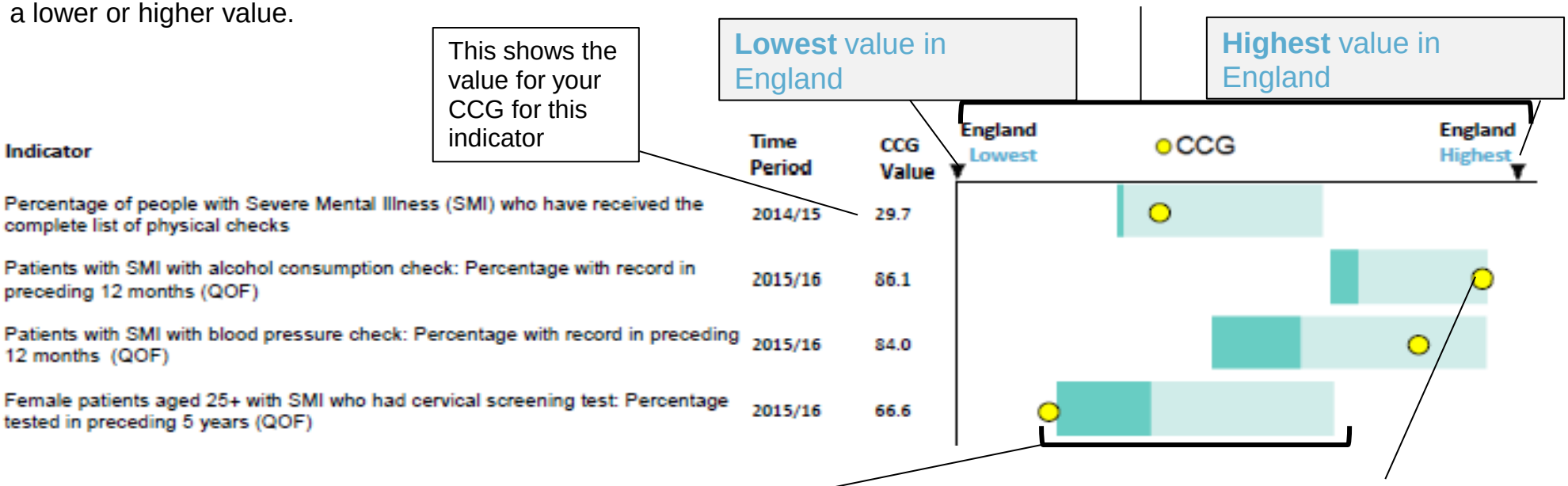
How to read the spine charts

These pages show where in the England range your CCG and your similar 10 CCGs sit. A yellow dot far to the right indicates your CCG has a high value compared to other CCGs in England. A yellow dot far to the left indicates your CCG has a low value across England. The positioning and size of the shaded area indicates the spread of values for the similar 10 CCGs across England and whether they are relatively higher or low. A large shaded area indicates a large spread of values. All indicators are presented from lowest to highest. Each indicator needs to be considered in turn as to whether it is better to have a lower or higher value.

This shows the value for your CCG for this indicator

Lowest value in England

Highest value in England



The shaded area is the range for your similar 10 group. Your CCG is the yellow circle and, as it is not part of the similar 10, it could appear anywhere from England lowest to highest. **The darker green shading shows the lowest quintile in the similar 10.**

Your CCG. If your CCG value is to the right of the similar 10 range, it means your CCG has a *higher* value than all the other similar 10 CCGs. If it is to the left, it means your CCG has a *lower* value than all the similar 10 CCGs.

Improving data quality

Every provider of NHS funded mental health care, for all ages, is required to flow data to the Mental Health Services Dataset (MHSDS). This is set out in an Information Standard and is part of the standard NHS contract. However we know that some areas are not flowing data, and others are submitting records of varying quality.

MHSDS is increasingly being used to assure local services and to demonstrate delivery through reporting, so commissioners need to ensure data is flowing and is robust. NHS Digital produces monthly reports which detail those providers who are flowing data.

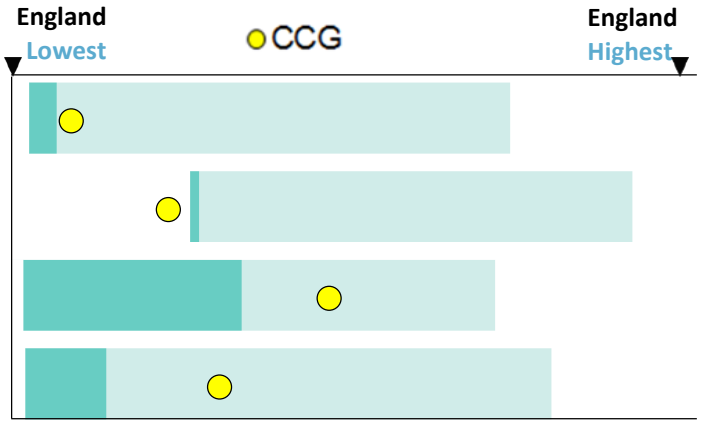
http://content.digital.nhs.uk/media/14816/Monthly-MHMDS-Reports---2014-15-Background-data-quality-report/pdf/Monthly_MHMDS_Reports_-_2014-15__Background_data_quality_report.pdf

The MHSDS provides data from provider organisations' patient administration systems. The primary purpose of such systems is to support the provision of patient care. The configuration of local systems may affect the accuracy of extracts used for MHSDS submissions and may contribute to the issues described above. Users of these packs and MHSDS data must therefore make their own assessment of the quality of the data for a particular purpose.

We know that the recording of some key information relating to a person's accommodation and employment status, ethnicity and diagnosis is not complete. For other information, there is likely to be variation in recording standards, such as information related to whether a person has a crisis plan in place or is on the Care Programme Approach. There is now a significant national drive to improve the quality of mental health data and CCGs should work with providers to improve data quality in order to better inform service improvements.

Improving data quality

Indicator	Time Period	CCG Value
Percentage of people in contact with mental health services with a diagnosis recorded (end of quarter snapshot)	2015/16 Q2	6.5
Percentage of cases where the ethnicity of the patient has been recorded	2014/15	70.3
Percentage of people in contact with mental health services with their accommodation status recorded (end of quarter snapshot)	2015/16 Q2	42.7
Percentage of people in contact with mental health services with their employment status recorded (end of quarter snapshot)	2015/16 Q2	26.1



Data recording for some key patient information is very low in some areas. These indicators highlight areas where the recording is low and where data recording improvement is needed in order for the information to be useful for service improvements. Where available, two time periods are shown - most recent quarter and the most recent full year - to allow CCGs to review whether recording quality has improved between the two time periods.

Priority groups

The Five Year Forward View for Mental Health identifies the need to commission the right mix of services to meet local needs. This will include targeting the groups of people we know are more likely to be at risk of developing mental health problems. The strategy stresses the need for key partners, including CCGs and Local Authorities to work together to achieve this.

By 2021 Health and Wellbeing Boards should have plans in place to promote good mental health, prevent problems arising and improve mental health services based on detailed local data for risk factors, protective factors and levels of unmet need.

The following pages include indicators for some of the groups identified as being at greater risk of developing mental health problems. The local Joint Strategic Needs Assessment (JSNA) may also provide further local context on priority groups.

Public Health England will publish a JSNA mental health toolkit in January 2017. The toolkit aims to present centrally available data and intelligence to help local areas identify need, understand which groups are at increased risk and which community assets can be built.

Case study: Positive Step for carers in North Somerset

Background

Research across North Somerset found that up to 30% of their 20,000 carers were struggling to cope.

The approach

A new programme aimed at supporting carers was commissioned in 2013. Run by Avon and Wiltshire Mental Health Partnership NHS Trust and charity Second Step, *Positive Step* provides psychological therapies for people with a range of issues including anxiety or panic, trauma, obsessions and depression aimed at building carers' resilience.

As much emphasis is given to how support is offered as the therapy itself. Those who need intensive help receive one-to-one support, by phone or face-to-face.

Group workshops are built upon principles of cognitive behavioural therapy and compassionate mind and organised around specific themes e.g managing stress, managing frustrations.

Workshops can be taken as a course or on an ad-hoc basis.

Referrals can be made through a GP, primary or secondary care or self-referral.

Outcomes

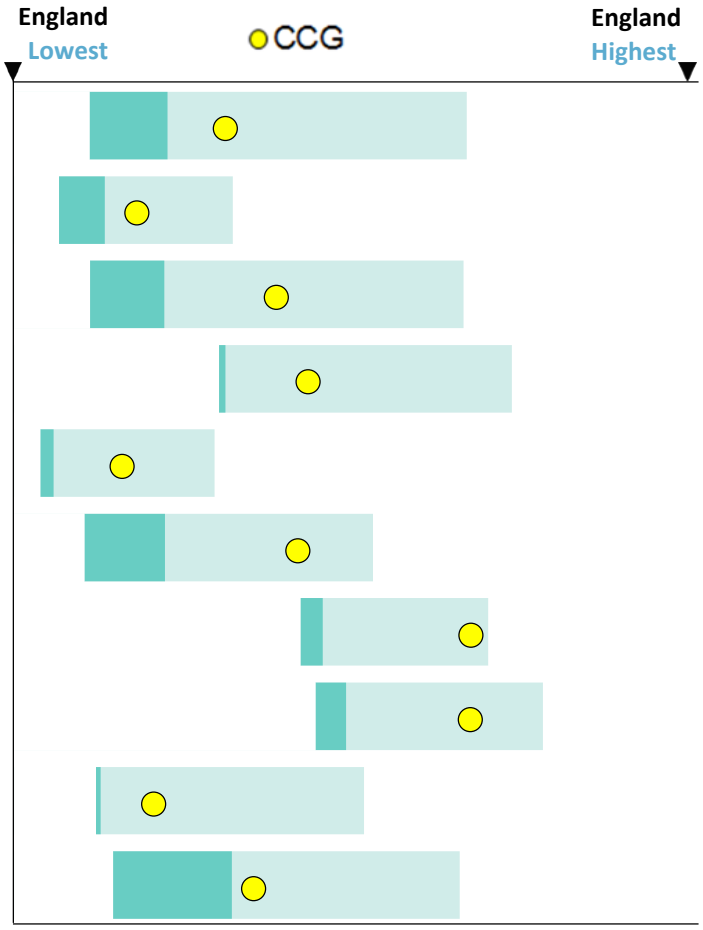
The psychological therapies (IAPT) service for Positive Step in North Somerset has helped more than 500 carers with therapy and support since launching three years ago.

Further information

More information about the Positive Step service can be found at: :
https://www.england.nhs.uk/mentalhealth/case-studies/positive-step/

Priority groups

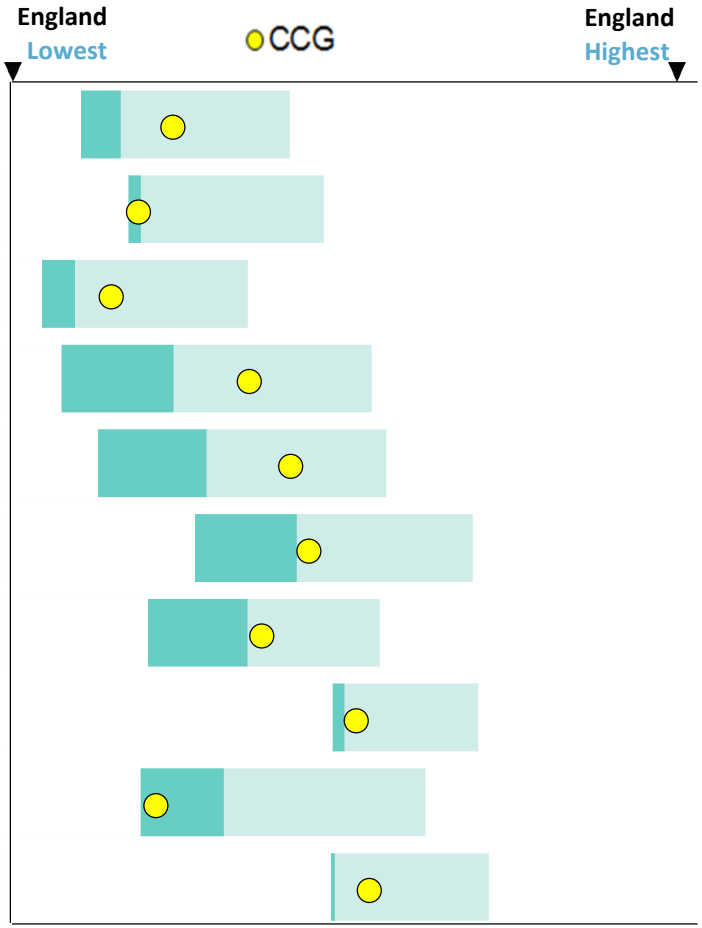
Indicator	Time Period	CCG Value
Socioeconomic deprivation: overall Index of Multiple Deprivation score (English Indices of Deprivation)	2015	20.0
Percentage of people aged 60+ living in income deprived households (English Indices of Deprivation)	2015	15.0
Employment deprivation - average score (English Indices of Deprivation)	2015	0.1
Crime deprivation - average score (English Indices of Deprivation)	2015	-0.1
Percentage of people in the CCG population who have never worked or are long term unemployed (Census 2011)	2011	5.6
Percentage of people in the CCG population who are living alone (Census 2011)	2011	32.4
Percentage of people in the CCG population aged 65 and over who are living alone (Census 2011)	2011	14.0
Percentage of people in the CCG population are providing unpaid care (Census 2011)	2011	10.9
% of households with dependent children and with no adults in employment	2011	3.5
Percentage of people with learning disabilities recorded on the GP patient register (QOF)	2015/16	0.4



Indicators on this page and the following page show groups of people in the population who may be at greater risk of developing mental ill health. CCGs should use these indicators as an opportunity to assess likely demand for services. CCGs should also consider how they can work with other organisations, such as local authorities, to prevent people in these groups from developing mental ill health. CCGs should be aware of the risk factors that contribute to health inequalities - by law these need to be considered. Commissioners should keep these risk factors and priority groups in mind when reading this pack. CCGs should also consider whether any of these groups are likely to access services or may be harder to reach than others.

Priority groups continued

Indicator	Time Period	CCG Value
Rate of emergency hospital spells where self harm was involved - all ages - per 100,000 (SUS)	2015/16	155.4
Rate of people admitted to hospital with alcohol specific conditions - per 100,000 (HSCIC)	2015 (Prov)	86.1
Rate of hospital admissions for mental and behavioural disorders due to use of alcohol (broad) - all ages - per 100,000	2014/15	327.4
Percentage of people in the CCG population of people who report being in bad or very bad health (Census 2011)	2011	5.2
Percentage of the total population with a limiting long term illness or disability (Census 2011)	2011	17.3
Percentage of people with CHD on GP register (QOF)	2015/16	3.0
Percentage of people with diabetes on GP register (QOF)	2015/16	6.2
Estimated prevalence of back pain (Health Survey for England and Arthriris Research UL)	2011	16.5
Percentage of people with COPD on GP register (QOF)	2015/16	1.4
Percentage of people with cancer recorded on GP register (QOF)	2015/16	2.4



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Perinatal mental illness

Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 20% of women, and covers a wide range of conditions. If left untreated, it can have significant and long lasting effects on the woman and her family.

Perinatal mental health problems can also have long-standing effects on children's emotional, social and cognitive development.

NHS England has committed to fulfilling the ambition in the Five Year Forward View for Mental Health, so that by 2020/21 there will be increased access to specialist perinatal mental health support in all areas of England, allowing at least an additional 30,000 women each year to receive evidence-based treatment, closer to home, when they need it. This includes the right range of specialist community and inpatient care. In November 2016 NHS England announced the first 20 areas which would receive funding to provide more support for pregnant women and new mothers with serious mental illness.

A phased, five-year transformation programme, backed by £365m in funding, is underway to build capacity and capability in specialist perinatal mental health services, focused on improving access to and experience of care, early diagnosis and intervention, and greater transparency and openness.

Perinatal mental illness case study: Warwickshire & Coventry

Background

Following the death of a mother who had experienced perinatal mental illness, an outcome which was considered potentially avoidable, in 2015 Coventry and Rugby CCG asked Arden and Greater East Midlands Commissioning Support Unit (Arden and GEM CSU) to review services. The immediate conclusion was that services were highly fragmented and needed to be redesigned.

The approach

Services across the whole of the Warwickshire footprint were redesigned. This included:

- Sharing resources and pooling funding making it possible to capitalise on economies of scale
- Recruiting a full-time multidisciplinary team, specialising in perinatal mental ill health operating across the region
- All members of the multidisciplinary team are specialists in perinatal mental ill health

The redesigned service has been operational since November 2015.

Continued on the next page…

Perinatal mental illness case study: Warwickshire & Coventry

Outcomes

- Any woman living in Coventry and Warwickshire who experiences perinatal mental ill health can be referred to the same range of support regardless of where they live
- All local staff now receive consistent training in perinatal mental illness, helping them to identify possible sufferers early and to make the right referrals at the right time
- In the first three months alone, the perinatal mental health team received 329 referrals and high levels of patient satisfaction

Critical success factors

- Clinical leadership
- The multidisciplinary clinical team helped design and now runs the perinatal mental health service

Further information

In September 2016 NHS Clinical Commissioners published the following report:

http://www.nhscc.org/policy-briefing/support-from-the-start/ which includes further detail on this case study.

Or contact Jo Dillon (Head of Joint Commissioning) Jo.dillon1@nhs.net.

Children and young people's mental health

Currently only one in four children with a diagnosable mental health condition access treatment and evidence based care. As stated in the Business Plan and Implementing the Five Year Forward View for Mental Health, NHS England has committed to increasing access to 70,000 more children per year by 2020/21.

An additional £1.4bn has been made available to accelerate improvements in the quality of services provided and access to those who need services. In terms of immediate priorities, CCGs are asked to:

- Refresh their Local Transformation Plans on an annual basis, detailing how children and young people's mental health services will be commissioned across all relevant local services, in line with the recommendations set out in Future in Mind
- Make sure that they are ready to deliver dedicated community eating disorder services for CYP as outlined in guidance published in 2015 by NHS England
- Work with the local Health Education England team with a view to improving workforce planning to build capacity
- Ensure that all financial returns, especially on the spending of additional funds, are accurate. These figures will be published in NHS England's Mental Health FYFV dashboard as a measure of local accountability.

Children and young people's mental health

The indicators included in this pack are drawn from the CCG Improvement and Assessment Framework (CCG IAF) and the recently published Mental Health FYFV dashboard.

Providers are now also required to flow data for children and young people through the mental health services dataset (MHSDS). However this is a relatively new dataset and there are issues related to data quality and completeness. There are also some providers who are not yet flowing data to the MHSDS. Although this is an issue across mental health pathways (see page 17), this problem is considered particularly acute for data relating to children and young people's mental health. Commissioners can access data from the MHSDS through the NHS Digital website.

It is expected that any future iteration of this pack will include CYP mental health data. However, commissioners should already be using this data for planning purposes and highlighting issues regarding reporting practices to providers. Commissioners should ensure that all services funded by the NHS can flow data as mandated in the standard NHS Contract.

The Mental Health and Dementia Intelligence Network public health profiles contain useful information on those factors known to increase the risk of the development of mental health conditions in children and young people. Evidence shows that around 60% of looked after children (72% for those in residential care) have some level of emotional and mental health problem.

Children and young people's mental health case study: County Durham CAMHS

Background

Before the County Durham CAMHS Crisis and Liaison Team became operational, a referral received out of hours for high risk individuals would be seen by the on-call psychiatrist. Routine on call referrals would be seen that day by the duty worker, with those received after 5pm admitted to a paediatric ward and seen the next day, with expected wait time for a psychiatric assessment in these cases typically 18+ hours.

Between May 2014 and December 2014, the Crisis and Liaison team conducted 434 assessments, with 83% of presentations assessed in fewer than 4 hours, greatly relieving the strain on front-line emergency services, and improving patient experience by offering faster access to necessary services.

The service provides:

- open access, with telephone support offered 8am –10pm, and liaison and consultation with other professionals and members of the children's workforce and including an out of hours response
- comprehensive mental Health and risk assessments, initial assessment appointment which aims to commence within one hour of referral being received by the service (four hours max)
- intensive support within the home/appropriate setting for up 72 hours post assessment or until the risks are contained
- training to other services and professionals.

Continued on the next page…

Children and young people's mental health case study: County Durham CAMHS

Outcomes

Initial evaluation for the period May to December 2014 showed key benefits as:

- Reduction in 204 overnight stays in paediatric beds
- Reduction in 109 attendances to A&E
- Reduction in time waited for young people and families (18+ hours reduced to average 1hr.36mins)
- Increase of 45% in community CAMHS crisis assessments

Further information

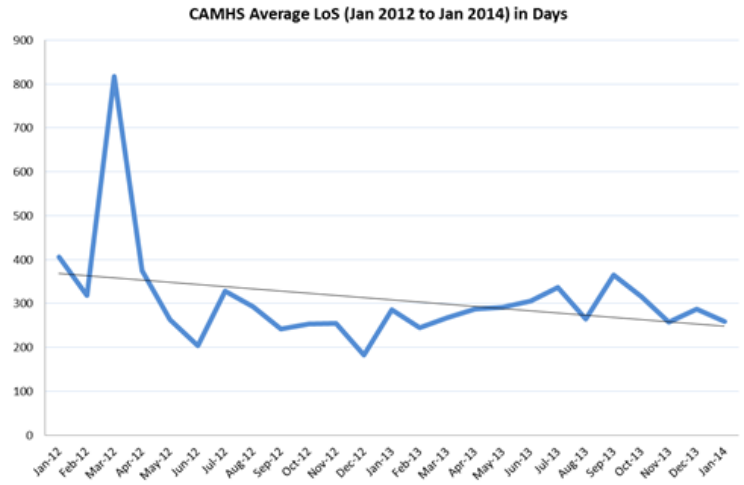
For more information about this case study please contact michelle.trainer@nhs.net

Children and young people's mental health case study: Derbyshire CAMHS Partnership

In 2014 Derbyshire CAMHS partnership introduced the use of Routine Outcome Measurements (ROMs) in CYP MH services. Consequently:

- Clinicians were encouraged to be more focused on the package of care through the use of 'Goal Based Outcomes'
- There was a 25% reduction in the average amount of time spent in services. The use of ROMs was believed to prevent therapeutic drift and allow the young person to have more control and say about the service being provided
- Improved evidence to commissioners the level of service being provided and how effective it is
- The parenting group used the outcomes to evidence changes in behaviour and parental mental health to feed into development of bespoke evidence-based interventions ensuring a high % of achieved patient outcomes. (e.g. Parenting Groups/ Dialectical behavioural)

For further information contact
scott.lunn@derbyshcft.nhs.uk



ROMs evidence that time in service is reducing

Children and young people's mental health case study: Sheffield Mental Health Services & School Link Pilot

Launched in October 2016 the Sheffield Mental Health Services and School Link Plot works with four secondary schools and six primary schools in the area. All participating schools use a framework model called 'Healthy Minds'.

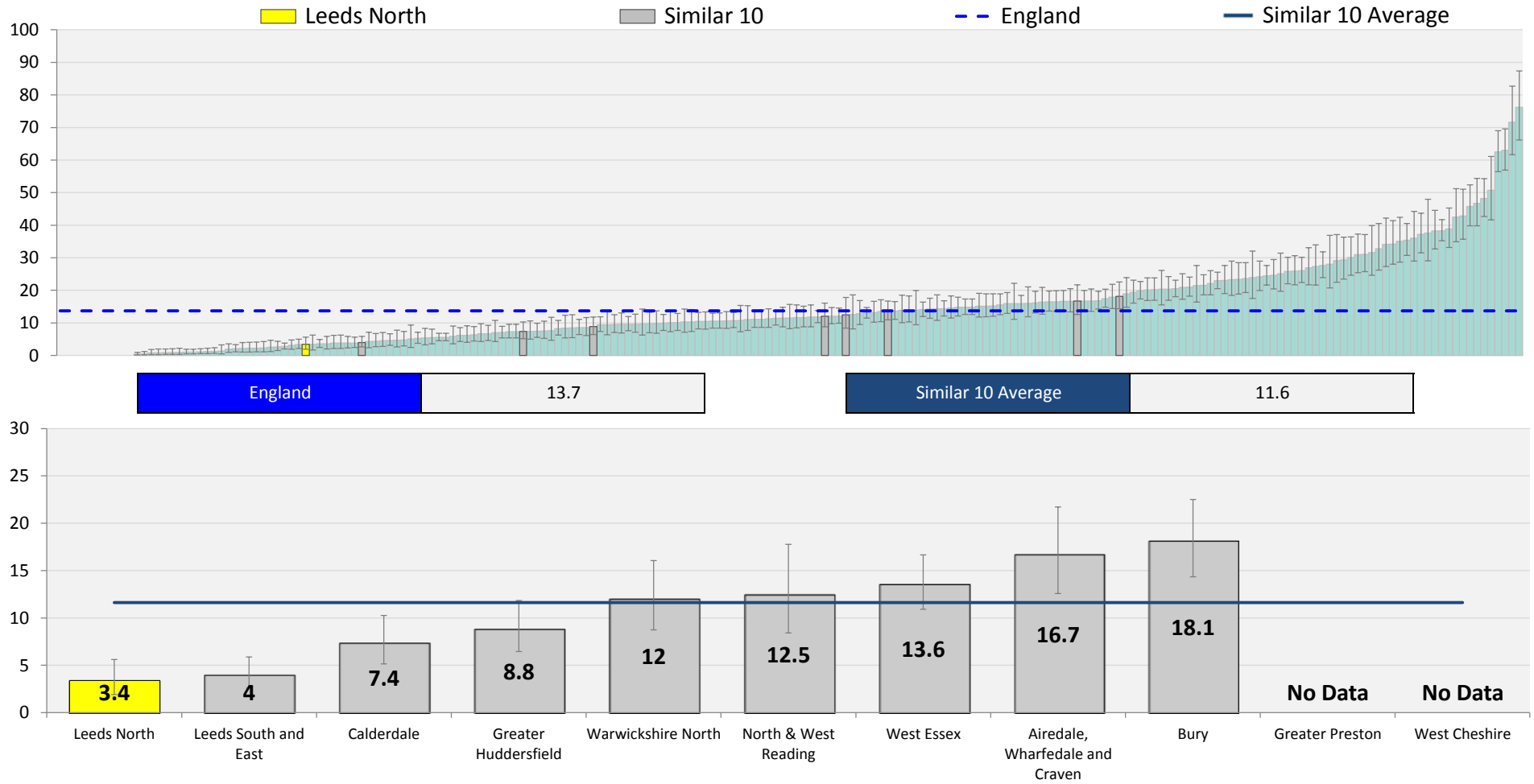
The key principles and approaches are as follows:

- A stepped Bronze, Silver and Gold approach
- Schools identifying their own emotional wellbeing and mental health priorities, based on the outcome of a comprehensive internal audit and the views of pupils
- Provides 'in reach' and clinical support from CAMHS, supporting school staff to be better able to respond to pupils emotional wellbeing and mental health needs
- Enhanced consultancy and support in school (individual one to one support with specific pupils can be available at Gold level with direct referral to CAMHS)
- A focus on improving communication and listening
- A training offer for schools
- A focus on staff health and wellbeing
- Promotion of Healthy Minds champions to support student voice
- Enablement of schools to establish effective evidence based interventions at a whole school level
- Inclusion of mental health within school policies such as behaviour, inclusion and self-harm

An initial review of the pilot has been undertaken and considered at the local Children's Joint Commissioning Group and Citywide Inclusion Board. Sheffield is looking to develop a integrated locality based model, potentially to be co-commissioned with schools linked to local Emotional Wellbeing and Family Support services.

For further information contact SHECCG.ChildrensCommissioning@nhs.net

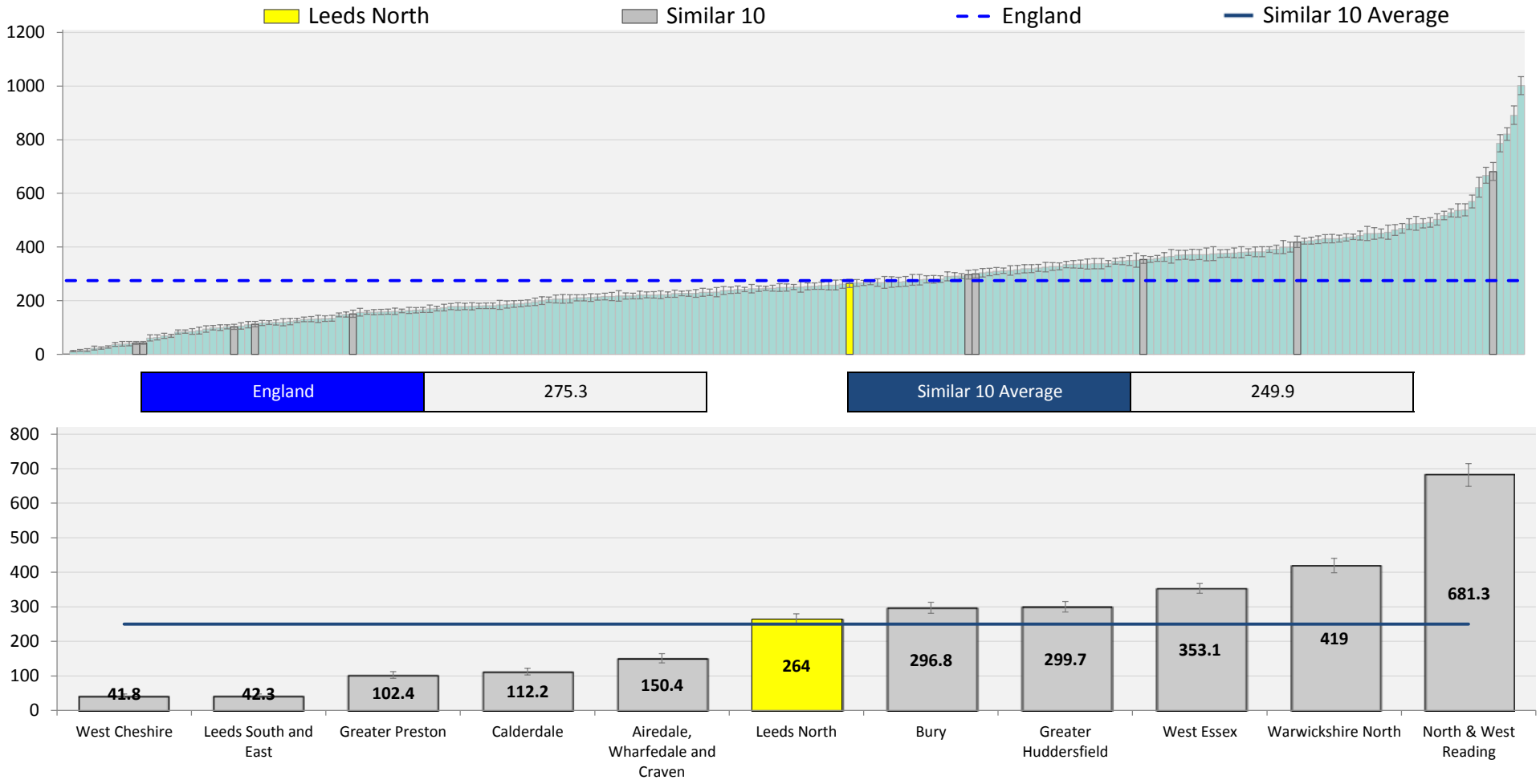
Rate of new children and young people aged under 18 receiving treatment in NHS funded community mental health services in the reporting period - per 10,000 population under 18s



CCGs should review whether low values are due to data quality or because they do not provide an adequate service.

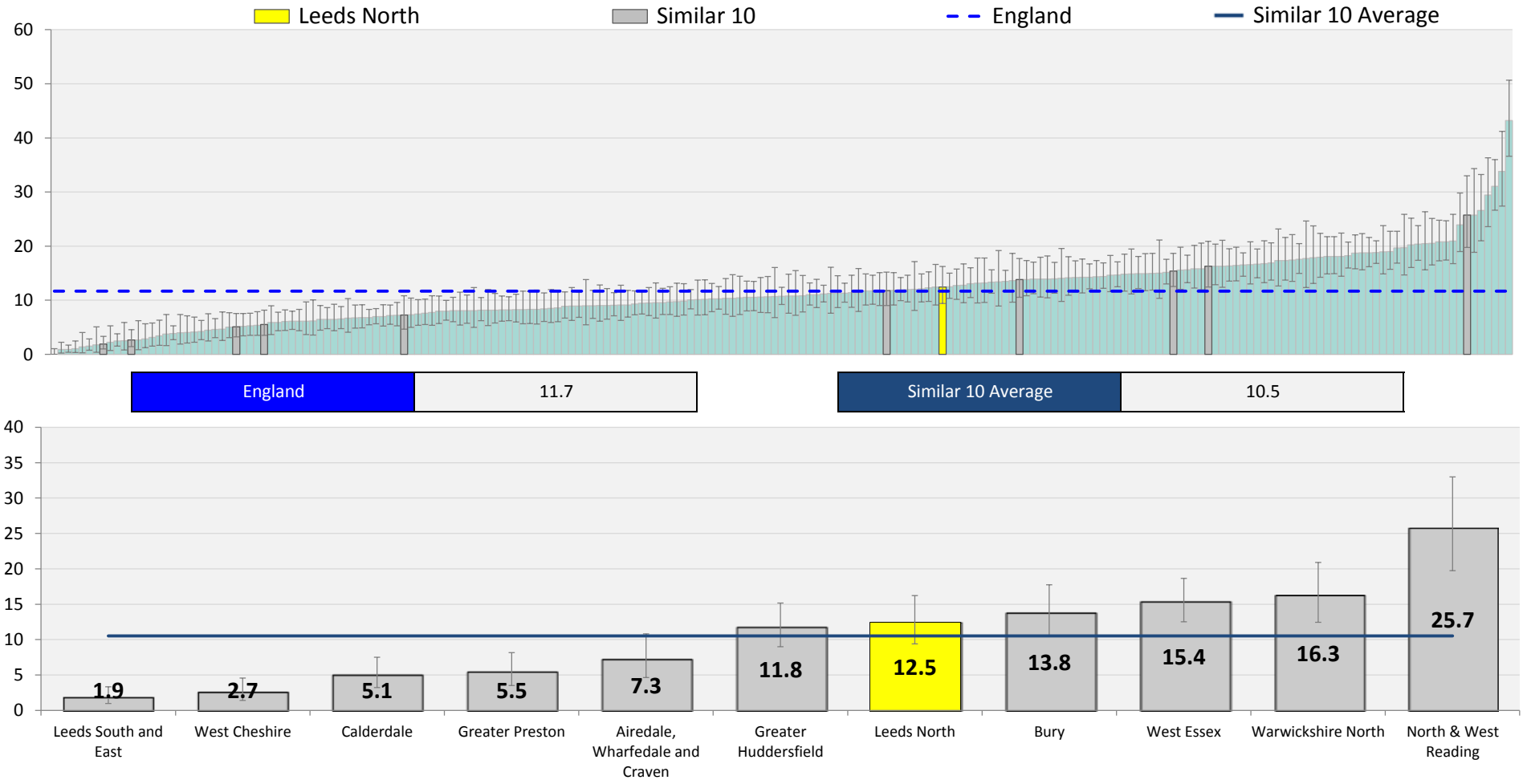
Definition: Rate of new children and young people aged under 18 receiving treatment in NHS funded community mental health services in the reporting period - per 10,000 population under 18s
Source: MHSDS, NHS Digital
Year: Q1 2016/17

Rate of bed days for children and young people aged under 18 in CAMHS tier 4 wards - per 10,000 under 18 population



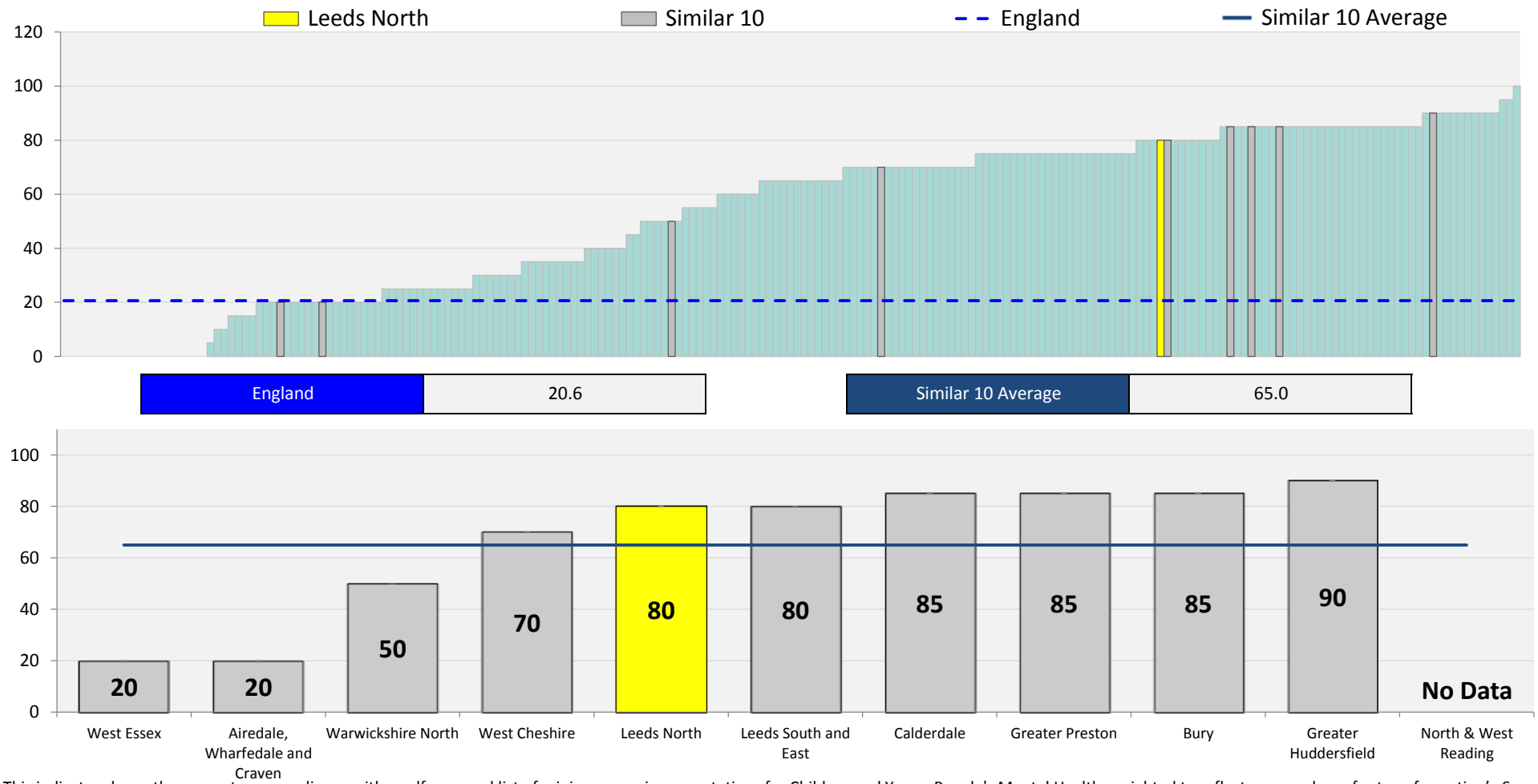
Definition: Rate of bed days for children and young people aged under 18 in CAMHS tier 4 wards - per 10,000 under 18 population
Source: Specialised commissioning dataset
Year: 2015/16

Rate of admissions for children and young people aged under 18 in CAMHS tier 4 wards - per 10,000 under 18 population



Definition: Rate of admissions for children and young people aged under 18 in CAMHS tier 4 wards - per 10,000 under 18 population
Source: Specialised commissioning dataset
Year: 2015/16

% Score against CCG IAF mental health transformation CYPMH milestones



This indicator shows the percentage compliance with a self-assessed list of minimum service expectations for Children and Young People's Mental Health, weighted to reflect preparedness for transformation' . Score is shown as a percentage compliance with a list of service expectations. A total score and percentage has been calculated by awarding points for each question - total possible score is 6.

Definition: % Score against CCG IAF mental health transformation CYPMH milestones
Source: Unify2
Year: 2016/17 Q1

Eating disorders

Eating disorders are serious mental health problems. They can have severe psychological, physical and social consequences. Children and young people with eating disorders often have other mental health problems (e.g. anxiety or depression) which also need to be treated in order to get the best outcomes.

It is vital that children and young people with eating disorders and their families and carers can access effective help quickly. Offering evidence-based, high-quality care and support as soon as possible can improve recovery rates, lead to fewer relapses and reduce the need for inpatient admissions. The availability of dedicated community eating disorder services (CEDS-CYP) has been shown to improve outcomes and cost effectiveness.

In 2014, the government announced an additional £30m funding a year to support the development of CEDS-CYP. These services will embed the CYP IAPT principles of improved access to collaborative, effective, evidence-based and outcome-focused treatment in participation with the young person and their family/carer.

The sooner someone with an eating disorder starts an evidence-based NICE approved treatment, the better the outcome. In partnership with the National Collaborating Centre for Mental Health Services (NCCMH), NHS England has developed the Evidence Based Treatment Pathway for Children and Young People with an Eating Disorder https://www.england.nhs.uk/wp-content/uploads/2015/07/cyp-eating-disorders-access-waiting-time-standard-comm-guid.pdf. The pathway is being extended to include episodes of care in inpatient or day patient settings from 2017.

Delivering the evidence-based treatment pathway for children and young people with eating disorders

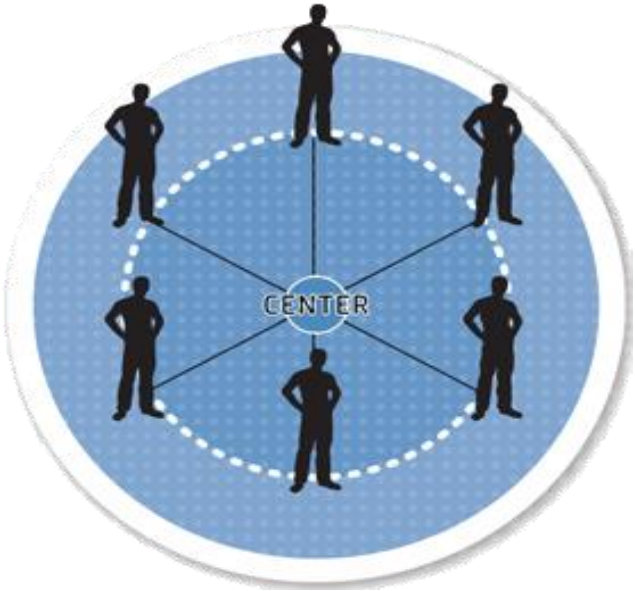
Referral to Treatment Standard

By 2020, 95% of those referred are to start NICE concordant treatment with four weeks if case is routine and one week if urgent.

A viable community eating disorder service (CEDS) for children and young people

Should be resourced to:

- Receive a minimum of 50 new eating disorder referrals a year
- Cover a minimum general population of 500,000 (all ages)
- Use up to date evidence-based interventions to treat the most common types of coexisting mental health problems (for example, depression and anxiety disorders) alongside the eating disorder
- Enable direct access to community eating disorder treatment through self-referral or from primary care services (for example, GPs, schools, colleges and voluntary sector services)
- Include medical and non-medical staff with significant eating disorder experience
- Have an appropriately trained, supported and supervised team
- Use information technology for teamwork from different geographical locations, eg following a ‘hub and spoke’ model

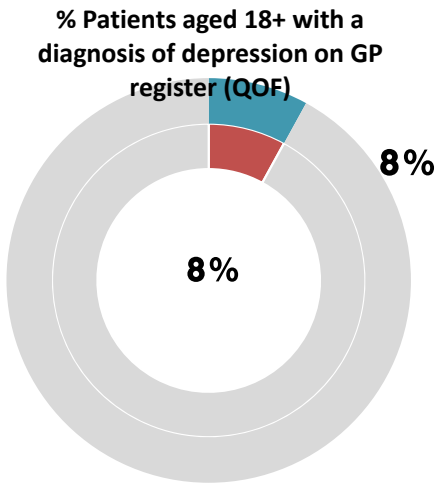


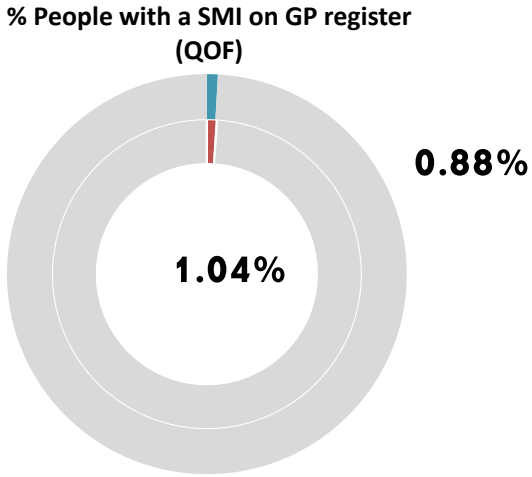
Adult mental health

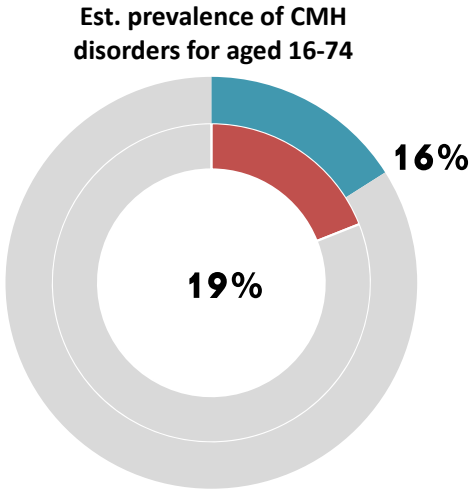
Mental health problems present the largest single cause of disability in the UK, and co-morbid mental and physical health problems are common. One in four British adults experience at least one diagnosable mental health problem in any one year and one in six experiences this at any given time.

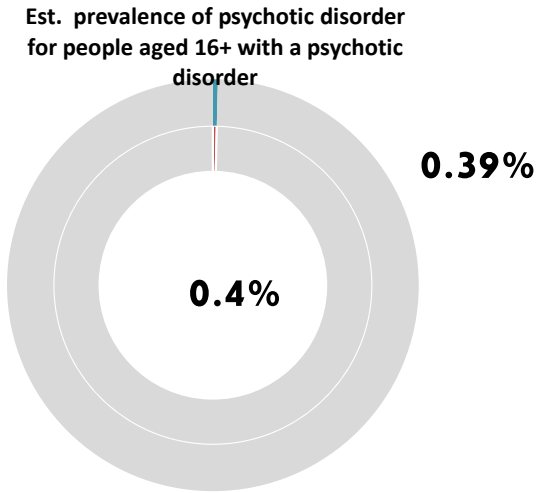
There is a very significant treatment gap in mental healthcare in England, with about 75% of people with mental illness receiving no treatment at all. Around 16% of adults with common mental health conditions are accessing treatment each year.

NHS Leeds North CCG - Adult Mental Health Prevalence Profile









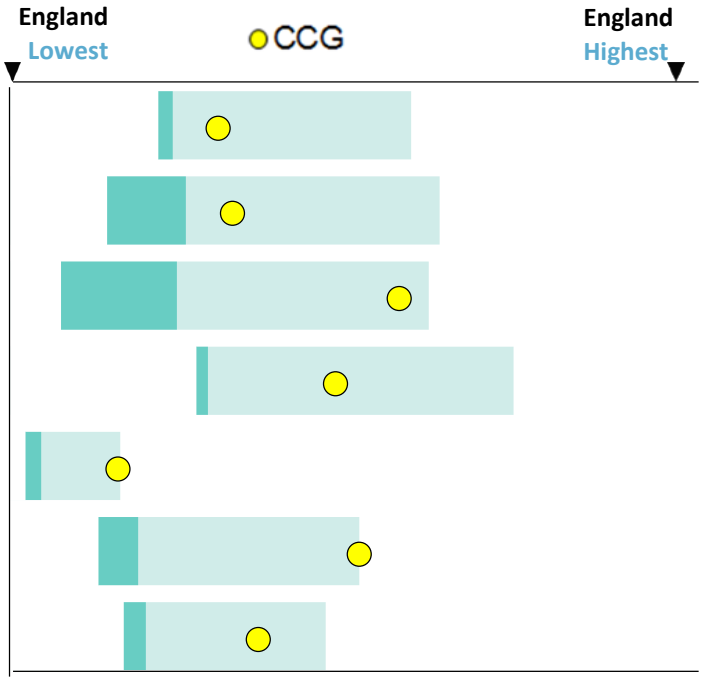
CCG

Average of similar 10 CCGs

Please note that this is a summary of key indicators in this section.
Summary slides are included in those sections for which they are most useful.

Prevalence of mental illness

Indicator	Time Period	CCG Value
Percentage of people who reported feeling moderately/extremely/severely anxious or depressed (GP Patient Survey)	2015/16	11.4
Percentage of patients aged 18+ with a diagnosis of depression on GP register (QOF)	2015/16	7.7
Estimated prevalence of common mental health disorders: estimated percentage of population aged 16-74 with any common mental health disorder	2014/15	19.2
Percentage of people completing the GP patient survey who reported long-term mental health problem	2015/16	5.4
New cases of psychosis: estimated incidence rate of psychosis per 100,000 aged 16-64	2011	24.4
Percentage of people with a Severe Mental Illness on GP register (QOF)	2015/16	1.0
Estimated prevalence of psychotic disorder: estimated percentage of population aged 16+ with a psychotic disorder	2012	0.4



These indicators show the estimated and reported prevalence of common mental health disorders and severe mental illness in the CCG population. Low reported prevalence in primary care (through QOF) may reflect true prevalence rates, or it may indicate that some cases in the population are not being picked up. Prevalence rates should therefore be considered alongside estimates for those in the community who may be at risk, or prone to developing mental ill health

Primary Care

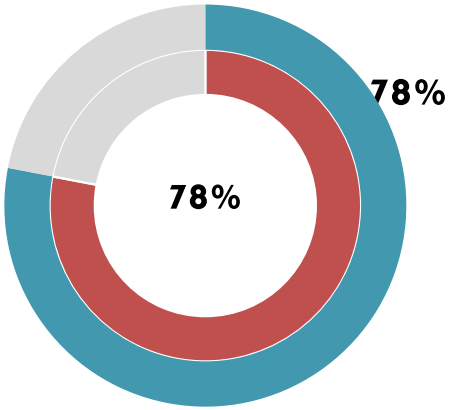
The vast majority of people receiving treatment for mental health problems are seen within primary care:

- 81% first come into contact with mental health services via their GP and continue to receive support from their GP throughout the period they are in contact with secondary care services;
- 90% of people receive treatment and care for their mental health problem solely in primary care settings;
- it is estimated that one third of GP appointments involve a mental health component.

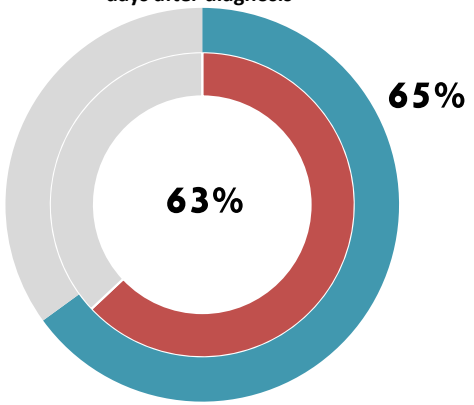
However, models of primary mental health care are currently under-developed, and people with mental health problems are not always well supported in primary care with either their mental or physical health care needs. Integrated models of primary mental health care are being developed that can deliver effective support to prevent a greater number of people from requiring secondary mental health care, ensure that people have targeted access to relevant physical healthcare interventions and support them to maintain recovery following discharge from secondary mental health care. As part of this expansion, the General Practice Forward View committed to the introduction of 3,000 new mental health therapists co-located in primary care.

NHS Leeds North CCG - Primary Care Profile

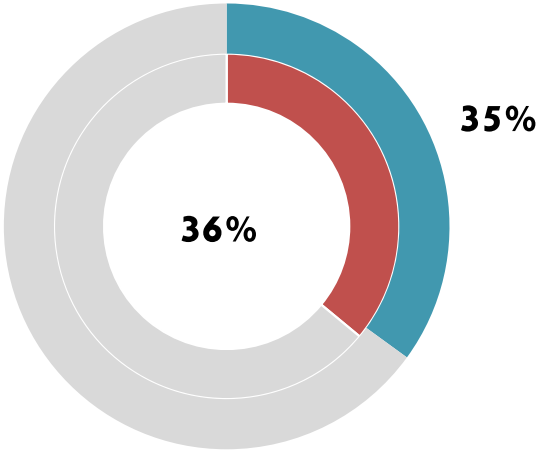
% Patients with SMI who have comprehensive care plan

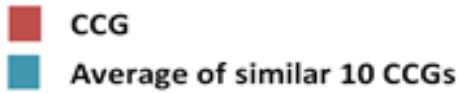


% Newly diagnosed patients with depression who had a review 10-56 days after diagnosis



% People with SMI who have received the complete list of physical checks





Primary Care

Indicator	Time Period	CCG Value
Patients with SMI who have comprehensive care plan: Percentage with plan (QOF)	2015/16	78.1
Exceptions from SMI checks: Percentage of people on SMI registers excluded from checks (QOF)	2015/16	11.2
Percentage of people aged 18+ with SMI who are recorded as current smokers on GP systems	2014/15	36.0
Percentage of adults with a new diagnosis of depression who had a bio-psychosocial assessment on diagnosis (QOF)	2013/14	82.0
Review of depression: Percentage of newly diagnosed patients with depression who had a review 10-56 days after diagnosis (QOF)	2015/16	63.2
Exception rate for depression: % of patients on depression register excluded from quality indicators (QOF)	2015/16	23.0

The indicators on this page show how CCGs are performing on GP QOF indicators related to mental illness. Where available, indicators use the latest published data from 2015/16. Also included are indicators from previous versions of QOF which are not included in the 2015/16 publication. Exception rates show rates where patients on a specific clinical register have been removed from individual QOF indicators - for example, if a patient is unsuitable for treatment, is newly registered with the practice, is newly diagnosed with a condition, or in the event of informed dissent. Where applicable, exceptions from QOF are included in the denominator of the indicator.

Primary Care prescribing

Indicators on prescribing within primary care should always be considered in the context of other data on mental ill health prevalence, activity and outcomes. Data should be discussed with mental health colleagues at a local level through area prescribing or other similar forums.

Patients, their carers and supporters need to be fully informed about their medication. Adherence for patients with mental illness can often be significantly lower than 100%. Where appropriate, the patient should be offered a choice of medication so that they feel involved in decision making. Any side effects of the medication should be explained to the patient and routinely monitored in order to address adverse impacts such as interactions with smoking, weight gain, sedation, impact on relationships and sexual function. Accessible information on drugs prescribed and advice on adherence should be readily available to patients and their carers and in every prescriber's toolkit.

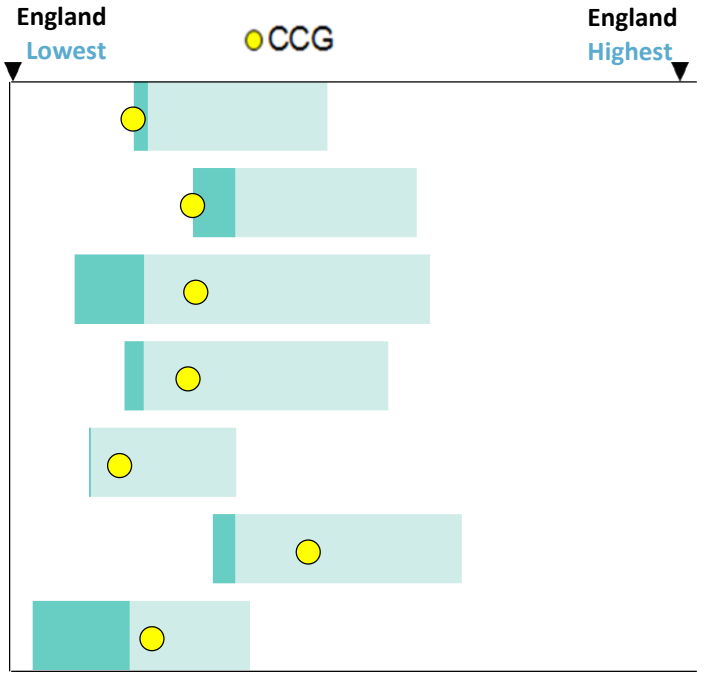
Best value medication is where:

- the patient is a full partner in the decision about their medication, feels supported to reduce side effects and feels so engaged that adherence is 100%
- the patient's drug treatment is individualised and delivered in a supportive way
- prescribers have ensured medicines reconciliation so that there is not duplication of medications between primary and secondary care prescribers, and that primary care prescribers are supported to continue the prescribing/administration of long term medicines when safe and appropriate for the individual patient
- optimal procurement contracts with the local mental health trusts and retail and primary care prescribing have been negotiated

https://www.nice.org.uk/guidance/cg178/chapter/1-recommendations

Prescribing

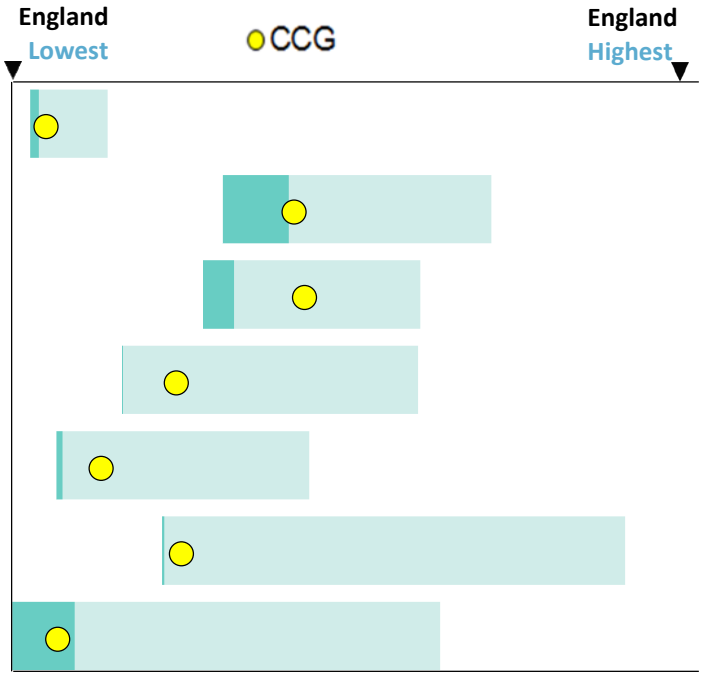
Indicator	Time Period	CCG Value
Mental Health - Total primary care prescribing spend per 1000 ASTRO-PU population	2015/16	8971.5
Antidepressant primary care prescribing cost per 1,000 ASTRO-PU population	2015/16	4144.1
Hypnotics prescribing: Average daily quantities (ADQs) per STAR-PU	2015/16	0.9
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Venlafaxine (CMHD)	2015/16	732.1
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Nortriptyline (CMHD)	2015/16	451.6
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Sertraline Hydrochloride (CMHD)	2015/16	357.4
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Trazodone Hydrochloride (CMHD)	2015/16	526.1



The hypnotics indicator represents the number of average daily quantities (ADQs) for benzodiazepines (indicated for use as hypnotics) and “Z” drugs per Hypnotics (BNF 4.1.1 sub-set) ADQ based STAR-PU. Average daily quantity represents the assumed average maintenance dose per day for a drug used for its main indication in adults. STAR PU includes weighting for age and sex. The other indicators on this page show the primary care prescribing rates for individual antidepressant drugs for common mental health disorders. The figures show Net Ingredient Cost (NIC) and have been standardised using ASTRO-PU weightings. Prescribing data is from epact.net and provided by the NHS Business Services Authority. Prescribing data requires local interpretation and rates should be considered alongside prevalence, quality and outcomes indicators.

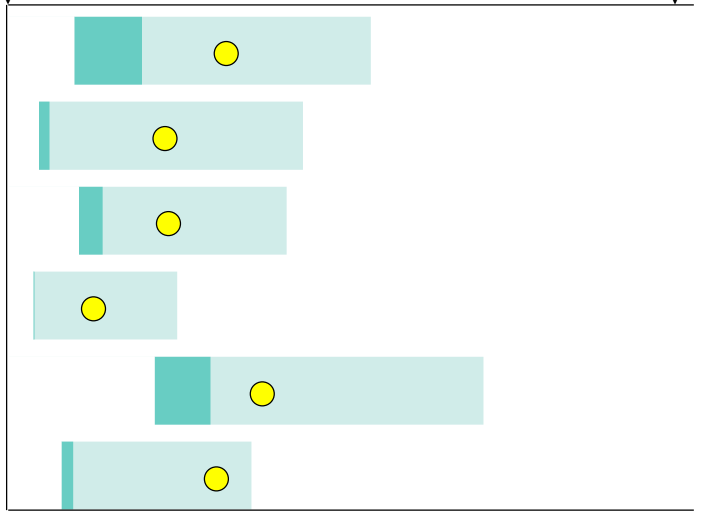
Prescribing continued

Indicator	Time Period	CCG Value
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Escitalopram (CMHD)	2015/16	21.8
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Citalopram Hydrobromide (CMHD)	2015/16	261.6
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Fluoxetine Hydrochloride (CMHD)	2015/16	211.6
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Mirtazapine (CMHD)	2015/16	153.2
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Trimipramine Maleate (CMHD)	2015/16	138.2
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Paroxetine Hydrochloride (CMHD)	2015/16	113.0
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Tranylcypromine Sulfate (CMHD)	2015/16	25.5



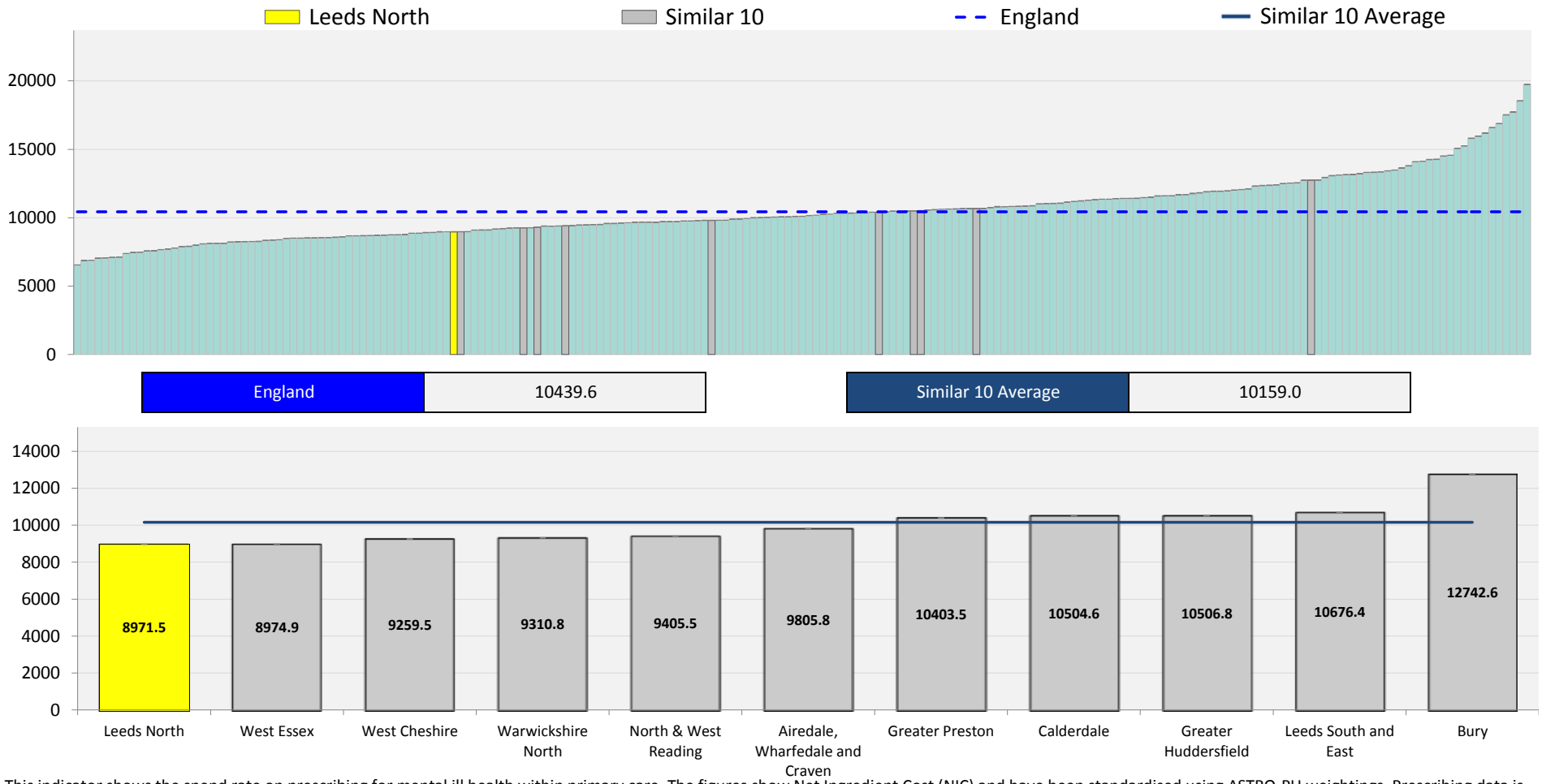
The indicators on this page show the primary care prescribing rates for individual antidepressant drugs for common mental health disorders. The figures show Net Ingredient Cost (NIC) and have been standardised using ASTRO-PU weightings. Prescribing data is from epact.net and provided by the NHS Business Services Authority. Prescribing data requires local interpretation and rates should be considered alongside prevalence, quality and outcomes indicators.

Prescribing continued

Indicator	Time Period	CCG Value	England Lowest – CCG – England Highest
Psychoses primary care prescribing per 1,000 ASTRO-PU population	2015/16	2200.7	
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Aripiprazole (SMI)	2015/16	618.0	
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Quetiapine (SMI)	2015/16	523.7	
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Risperidone (SMI)	2015/16	177.6	
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Valproic Acid (SMI)	2015/16	149.1	
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Olanzapine (SMI)	2015/16	106.7	

The indicators on this page show the primary care prescribing rates for individual drugs for psychoses and related disorders. The figures show Net Ingredient Cost (NIC) and have been standardised using ASTRO-PU weightings. Prescribing data is from epact.net and provided by the NHS Business Services Authority. Prescribing data requires local interpretation and rates should be considered alongside prevalence, quality and outcomes indicators.

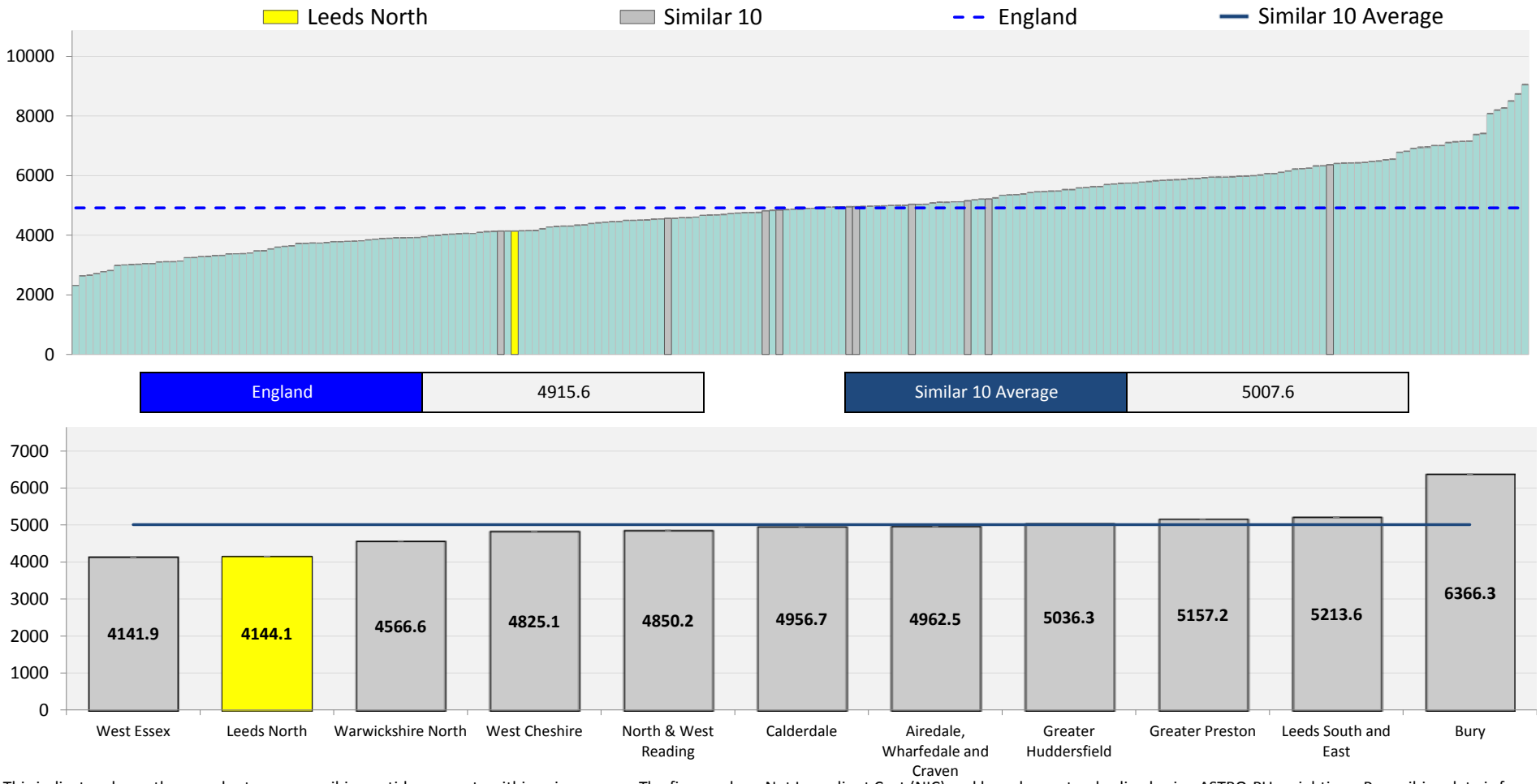
Mental Health - Total primary care prescribing spend per 1000 ASTRO-PU population



This indicator shows the spend rate on prescribing for mental ill health within primary care. The figures show Net Ingredient Cost (NIC) and have been standardised using ASTRO-PU weightings. Prescribing data is from epact.net and provided by the NHS Business Services Authority. Prescribing data requires local interpretation and rates should be considered alongside prevalence, quality and outcomes indicators. This indicator is a grouping of select BNF chemical substances and their aggregated total Net Ingredient Cost.

Definition: Mental Health - Total primary care prescribing spend per 1000 ASTRO-PU population
Source: ePACT.net – data provided by the NHS Business Services Authority
Year: 2015/16

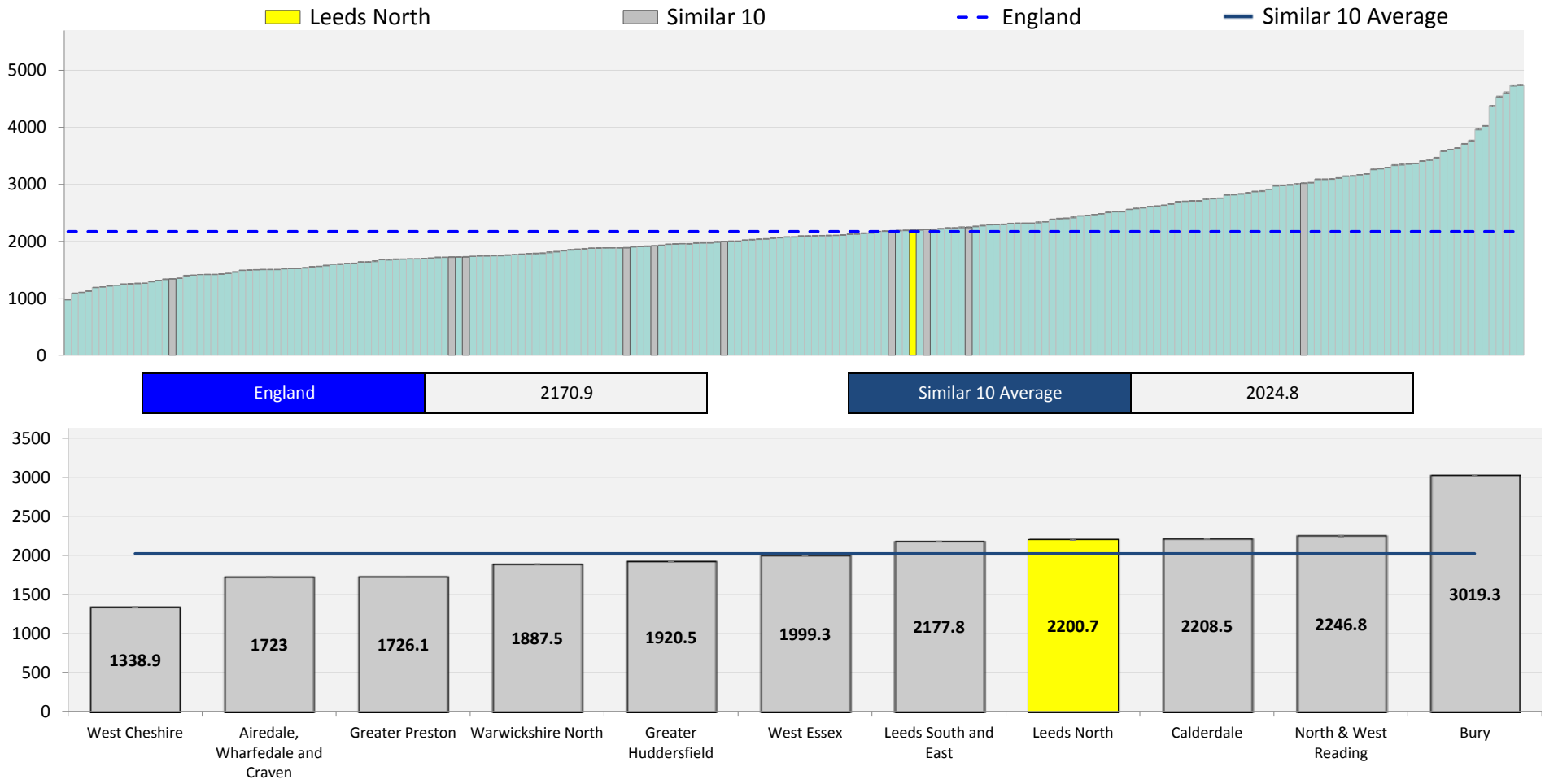
Antidepressant primary care prescribing cost per 1,000 ASTRO-PU population



This indicator shows the spend rate on prescribing antidepressants within primary care. The figures show Net Ingredient Cost (NIC) and have been standardised using ASTRO-PU weightings. Prescribing data is from epact.net and provided by the NHS Business Services Authority. Prescribing data requires local interpretation and rates should be considered alongside prevalence, quality and outcomes indicators. This indicator is a grouping of select BNF chemical substances and their aggregated total Net Ingredient Cost.

Definition: Antidepressant primary care prescribing cost per 1,000 ASTRO-PU population
Source: ePACT.net – data provided by the NHS Business Services Authority
Year: 2015/16

Psychoses primary care prescribing per 1,000 ASTRO-PU population



This indicator shows the spend rate on prescribing for psychoses and related disorders within primary care. The figures show Net Ingredient Cost (NIC) and have been standardised using ASTRO-PU weightings. Prescribing data is from epact.net and provided by the NHS Business Services Authority. This indicator is a grouping of select BNF chemical substances and their aggregated total Net Ingredient Cost.

Definition: Psychoses primary care prescribing per 1,000 ASTRO-PU population
Source: ePACT.net – data provided by the NHS Business Services Authority
Year: 2015/16

Primary Care: Improving physical health care of people with severe mental illness

The life expectancy of people with severe mental illness (SMI), such as schizophrenia and bipolar is reduced by an average of 15–20 years mainly due to preventable physical illness.

Individuals living with mental ill health have three times more A&E attendances and five times more unplanned inpatient admissions than the general population with significantly higher length of stays.

There is a lack of access to physical healthcare for people with SMI. Less than a third of people with schizophrenia in hospital have received the recommended assessment of cardiovascular disease (CVD) risk in previous 12 months

The Five Year Forward View for Mental Health states that NHS England should ensure 280,000 more people with SMI have their physical needs met by 2020/2021.

Continued on the next page…

Primary Care: Improving physical health care of people with severe mental illness

By 2018/19 an additional 280,000 people living with SMI (60% of the SMI register) will be able to access a comprehensive annual physical check and follow up support to meet their needs.

The current position for your CCG in relation to physical checks for people with SMI in primary care is shown on page 54.

Although these indicators asses performance in primary care only, both primary and secondary care providers have shared care responsibilities for physical health, and data should be shared between these providers.

Data on physical health assessments in secondary care are being measured through the delivery of NHS England's CQUIN on improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI).

Improving physical health care of people with severe mental illness case study: Bradford

The approach

Using a collaborative model between specialist mental health and primary care, Bradford developed a standardised physical health template and a shared care protocol across primary and secondary care.

- Five severe mental illness (SMI) specific wellbeing clinics delivered by the Mental Health Trust for people in inpatient, Community Mental Health Team and Early Intervention in Psychosis services
- A consistent template to prompt clinicians to undertake all the NICE recommended elements of a physical health check which is in use across primary and secondary care
- Has been rolled out to 80 GP practices in Bradford and Airedale
- There is a consistent framework of training across primary and secondary care
- Quarterly reports are provided to review data in primary care

Outcomes

Doubled the detection rate of cardiovascular disease (CVD) for patients with SMI

Success factors

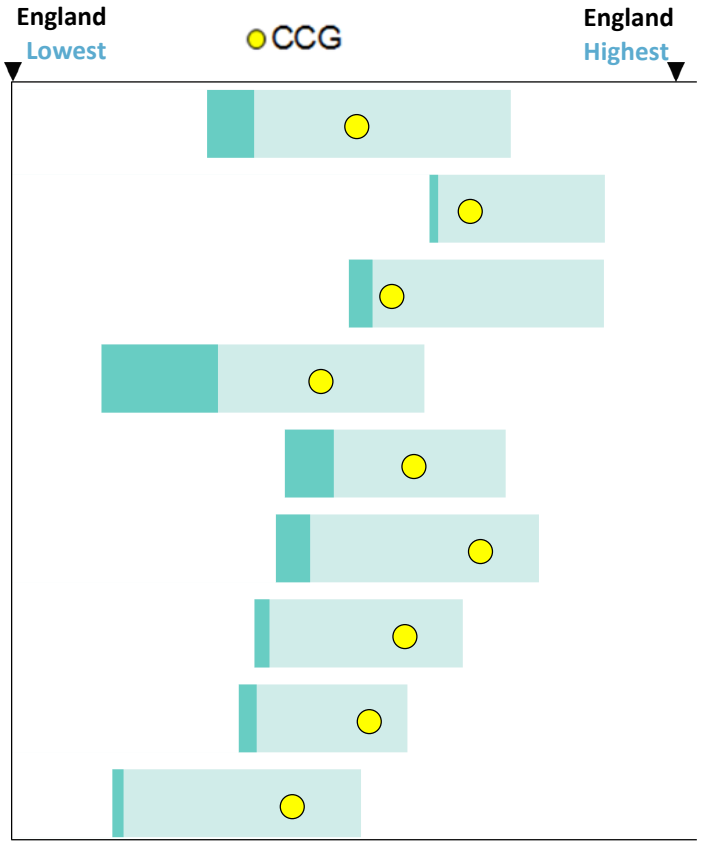
- Training among practice nurses helped the delivery of comprehensive physical health checks
- GP championing and engagement was key to success
- Clear agreed shared care guidance with clarity on who is responsible for what in follow up of test results
- Sharing information to reduce risk of overlap and duplication

Further information

For more information please contact Kate Dale, Physical Health Project Lead, Bradford District Care NHS Foundation Trust, kate.dale@bdct.nhs.uk

Physical Health for people with Severe Mental Illness

Indicator	Time Period	CCG Value
Percentage of people with Severe Mental Illness (SMI) who have received the complete list of physical checks (QOF)	2014/15	35.6
Patients with SMI with alcohol consumption check: Percentage with record in preceding 12 months (QOF)	2015/16	77.2
Patients with SMI with blood pressure check: Percentage with record in preceding 12 months (QOF)	2015/16	79.5
Female patients aged 25+ with SMI who had cervical screening test: Percentage tested in preceding 5 years (QOF)	2015/16	72.2
Patients on lithium therapy with record of serum creatinine and TSH (Thyroid-Stimulating Hormone): % with record in the preceding 9 months (QOF)	2015/16	93.5
Patients on lithium therapy with levels in therapeutic range: % within preceding 4 months (QOF)	2015/16	84.6
Patients with SMI with BMI check: percentage with record in preceding 12 months (QOF)	2013/14	80.2
Patients with SMI with cholesterol check: Percentage with record in preceding 12 months (QOF)	2013/14	69.6
Patients with SMI with blood glucose or HbA1c check: percentage with record in preceding 12 months (QOF)	2013/14	76.1



Where applicable, exceptions from QOF are included in the denominator.Although indicators related to physical health for patients in SMI assess performance in primary care only, both primary and secondary care providers have shared care responsibilities for physical health.Data related to physical health assessments, results and followup interventions should be shared between primary and secondary care providers. Guidance to support CCGs investment in physical health care for people with SMI will be published by NHS England in early 2017.

Improving access to psychological therapies (IAPT)

The Improving Access to Psychological Therapies (IAPT) programme began in 2008 and has transformed treatment of adult anxiety disorders and depression in England. Over 900,000 people now access IAPT services each year, and the Five Year Forward View for Mental Health committed to expanding services further, alongside improving quality.

IAPT services provide evidence based treatments for people with anxiety and depression (implementing NICE guidelines).

IAPT services are characterised by three things:

- **Evidenced based psychological therapies**: with the therapy delivered by fully trained and accredited practitioners, matched to the mental health problem and its intensity and duration designed to optimize outcomes.
- **Routine outcome monitoring**: so that the person having therapy and the clinician offering it have up-to-date information on an individual's progress. This supports the development of a positive and shared approach to the goals of therapy and as this data is anonymized and published this promotes transparency in service performance encouraging improvement.
- **Regular and outcomes focused supervision** so practitioners are supported to continuously improve and deliver high quality care.

More recent quarterly IAPT data is available and can be found here: http://content.digital.nhs.uk/iaptreports

Improving access to psychological therapies (IAPT)

Key messages

- From the current levels, the Five Year Forward View for Mental Health committed to an increase of 600,000 people per year accessing services for common mental health conditions – so that 1.5m people in total access them a year. The majority of this increase will be integrated with physical healthcare. As part of this expansion, 3,000 new mental health therapists will be co-located in primary care, as set out in the General Practice Forward View.
- The NHS Operational and Planning Guidance 2017-2019 indicated that in 2018/19 services should be commissioned to provide psychological therapies so that at least 19% of people with anxiety and depression access treatment each year, with the majority of the increase from the baseline of 15% to be integrated with physical health care.

Improving access to psychological therapies (IAPT) case study: Talking Shop, Doncaster

Background

Doncaster mental health patients were finding it difficult to get access to mental health services and GPs were becoming increasingly frustrated with long waits for treatment for their patients. The poor service resulted in an increase in complaints from patients and GPs. In response to these issues Rotherham, Doncaster and South Humber NHS Trust put forward the idea of the 'Talking Shop'.

The approach

Talking Shop opened in 2010 as a public information centre and the headquarters for the psychological therapies service in the town. It had the full backing of commissioners and Involved a local patient support group whose members came up with its name, and helped design key materials.

The 'shop' run by Rotherham, Doncaster and South Humber NHS Foundation Trust allows members of the public to walk in off the street if they need help for problems such as depression, panic or phobias, or simply to access free information or advice.

Outcomes

In its first year the IAPT service received 3,995 referrals, with a self-referral rate of just 0.3 per cent. By 2014/15, referrals had soared to 10,250, with a self-referral rate of 23 per cent.

Further information

A link to more information on the Talking Shop can be found here:
http://www.talkingsense.org/how-we-can-help/the-talking-shop/

Improving access to psychological therapies (IAPT) case study: Bath and North East Somerset

Background

Bath and North East Somerset (BANES) recommissioned their IAPT service in August 2013. After a year the service was not meeting the national 50% recovery standard. The service experienced high levels of drop outs which are synonymous with poorer recovery rates.

The approach

Drawing inspiration from the way other services had improved recovery, the service used a PDSA (Plan, Do, Study, Act) approach. This enabled them to identify themes in the data affecting recovery. These included clients being discharged having achieved good improvement but not meeting recovery; clients not being offered the full range of NICE approved treatments; clients not being offered a trial at step 2 of the IAPT stepped care approach if appropriate; staff not attending to scores from measures; and failure to repeat ADSMs (Anxiety Disorder Specific Measures). Attending to staff supervision and continuing development whilst instigating new procedures was of great importance.

Outcomes

Within six months the recovery rates had improved to 60%+. Drop out rates were reduced and clients reported greater satisfaction on the Patient Experience Questionnaires. In the 2015/16 IAPT Annual Report, BANES Talking Therapies Service demonstrated the highest national recovery rate overall.

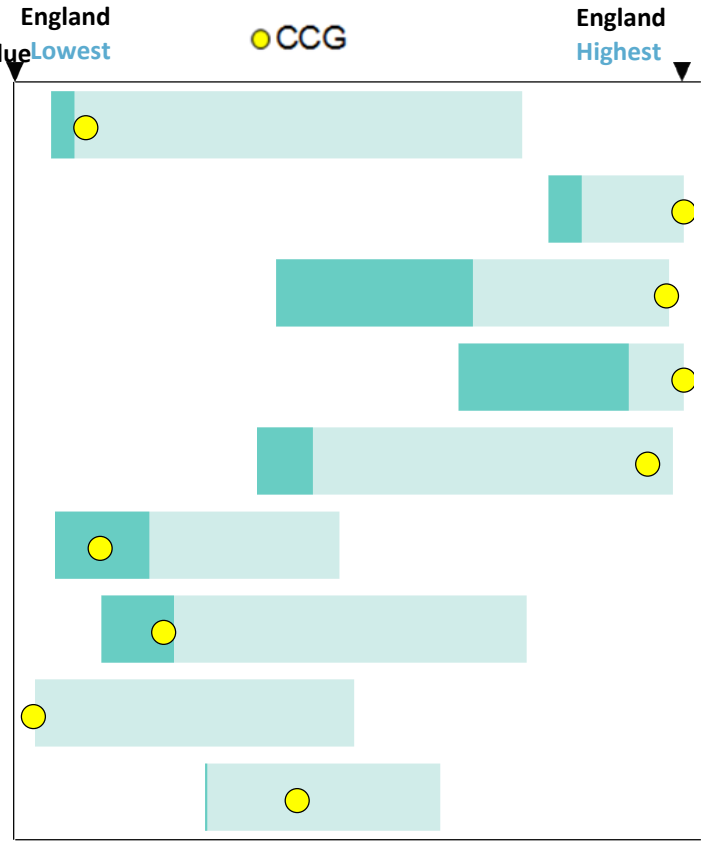
Further information

For more information contact valerieclark2@nhs.net

NHS Leeds North CCG - IAPT Profile

Improving access to psychological therapies (IAPT)

Indicator	Time Period	CCG Value
IAPT: Rate of referrals for people aged 18+ - per 100,000 (quarterly)	2015/16 Q4	630.4
Percentage of IAPT referrals entering treatment waiting <18 weeks for first treatment	Oct-Mar1516	100.0
Percentage of IAPT referrals entering treatment waiting <6 weeks for first treatment	Oct-Mar1516	98.1
Percentage of IAPT referrals that have finished course of treatment waiting <18 weeks for first treatment	Oct-Mar1516	100.0
Percentage of IAPT referrals that have finished course of treatment waiting <6 weeks for first treatment	Oct-Mar1516	95.7
People entering IAPT as percentage of those estimated to have anxiety/depression	Oct-Mar1516	0.8
IAPT: Rate of people aged 18+ beginning IAPT treatment per 100,000 (quarterly)	2015/16 Q4	429.8
Average wait to enter IAPT treatment: Mean wait for first treatment (days)	2015/16	7.7
IAPT: Average treatment wait between first and second appointments	2015/16	37.9



The national target is for 95% to begin IAPT treatment within 18 weeks and for 75% to begin IAPT treatment within 6 weeks. The entered treatment date for a referral is the date of the first, attended treatment appointment. To finish a course of treatment, a referral must have ended with at least 2 treatment apts having been attended in the course of the referral. The data reflects the most recent available at the time. As IAPT data is published on a regular basis CCGs should also make use of the most recent data alongside these packs, to inform decision making.

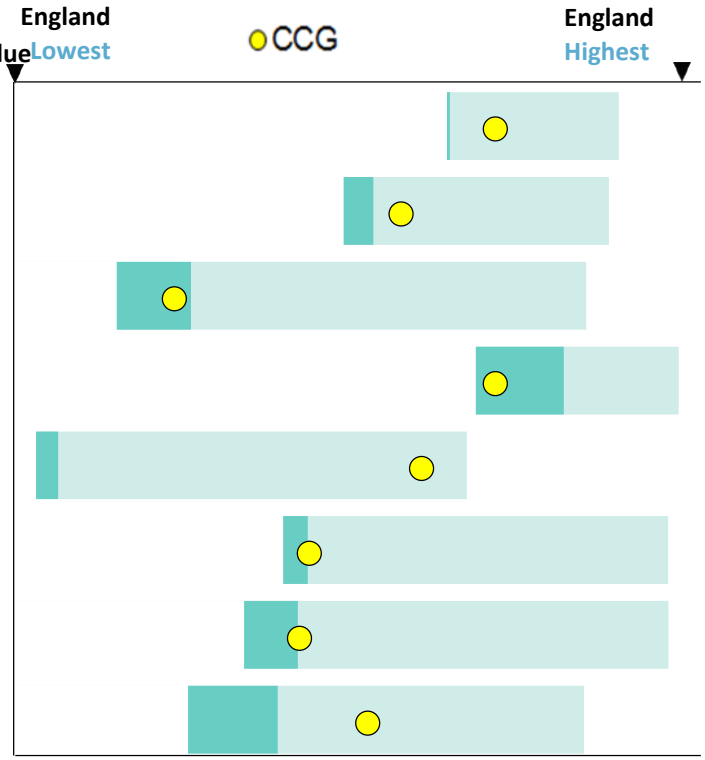
IAPT continued

Indicator	Time Period	CCG Value
Rate of IAPT referrals aged 65+ per 1,000 65+ population	2015/16	6.1
IAPT: Percentage of referrals into IAPT which are for people aged 65 and over	2014/15	5.4
Rate of IAPT referrals aged 18-35 per 1,000 18-35 population	2015/16	33.4
Rate of IAPT referrals aged 36-64 per 1,000 35-64 population	2015/16	21.2
Percentage of IAPT referrals (in quarter) which are for people of black and minority ethnic groups	2015/16 Q4	28.8
IAPT: Percentage of patients who have been given a provisional diagnosis	2014/15 Q4	68.3
Percentage of IAPT referrals (in quarter) with a valid ethnic group code	2015/16 Q4	92.9
Percentage of IAPT appointments where patient did not attend and gave no advance warning	Oct-Mar1516	9.7

These indicators show IAPT referrals and use by different ages in the population as well as other quality indicators. More detail on other IAPT indicators are available on charts for these indicators further on in this section. The data reflects the most recent available at the time. As IAPT data is published on a regular basis CCGs should also make use of the most recent data alongside these packs, to inform decision making.

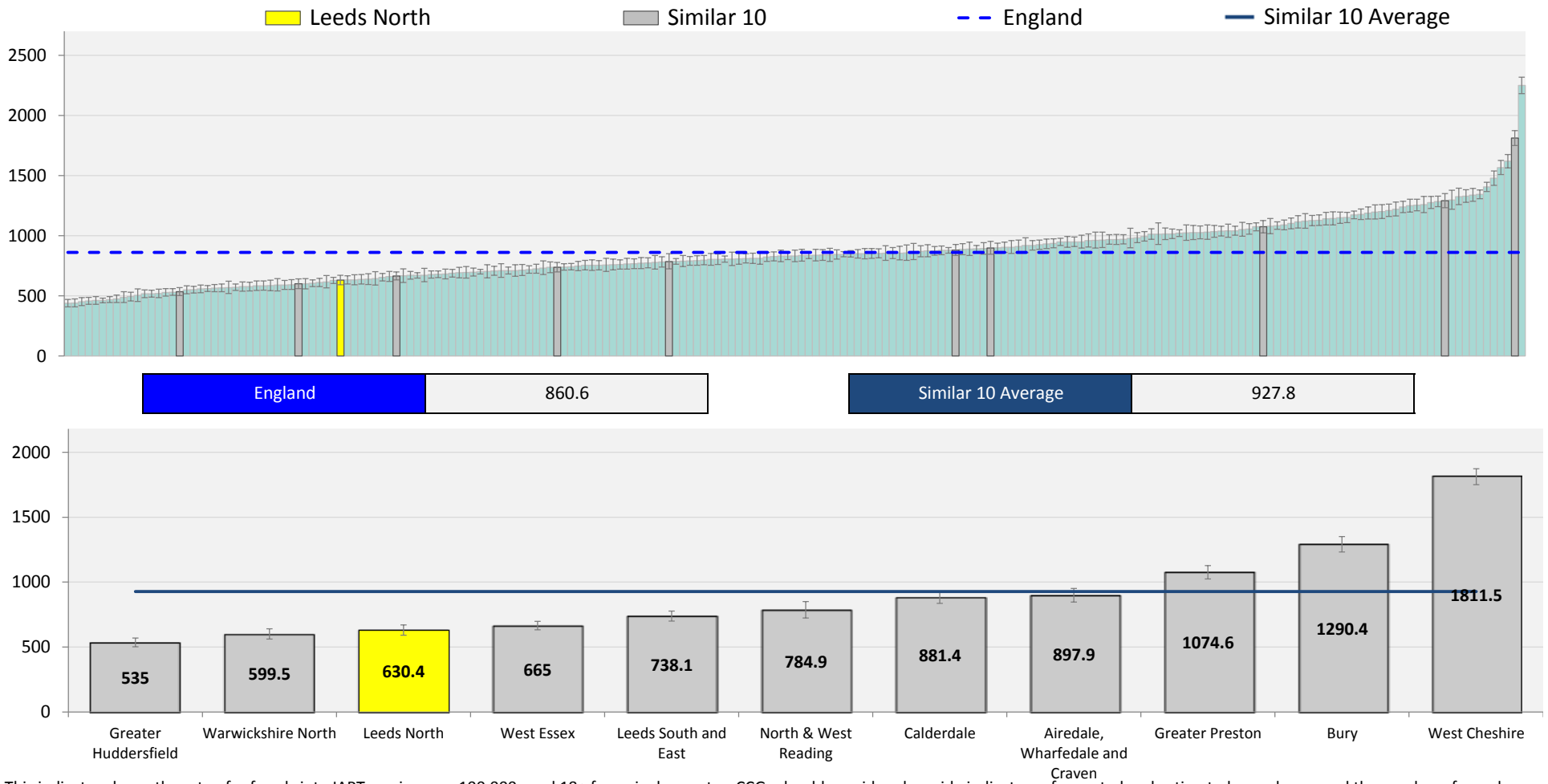
IAPT continued

Indicator	Time Period	CCG Value
IAPT: Percentage of people who have finished IAPT treatment who achieved "reliable improvement" (quarterly)	2015/16 Q4	63.1
IAPT: Percentage of people who have completed IAPT treatment who are "moving to recovery"	2015/16 Q4	38.5
IAPT: Rate of people aged 18+ completing IAPT treatment per 100,000 (quarterly)	2015/16 Q4	206.9
Percentage of IAPT referrals with treatment outcome measured - paired data completeness: % of finished treatments with paired PHQ9 and ADSM scores	Oct-Mar1516	95.7
IAPT: Percentage of people who have finished a course of treatment who have a Long Term Condition	2015/16	28.4
IAPT: Percentage of patients with a long term condition finishing a course of treatment who are moving to recovery	2015/16	36.4
IAPT: Percentage of patients with a long term condition finishing a course of treatment who are achieving reliable recovery	2015/16	35.4
IAPT: Percentage of patients with a long term condition finishing a course of treatment who are achieving reliable improvement	2015/16	59.4



The three indicators at the bottom relate to people receiving IAPT treatment who have a long term physical health condition when they are referred. To finish a course of treatment, a referral must have ended with at least two treatment appointments. A referral has shown reliable improvement if their scores on one or both PHQ-9 and GAD7 (or other ADSM) reliably decreases whilst the other shows no reliable increase. A referral has moved to recovery if classified as a clinical case when they enter treatment but not when they have completed a course of treatment. Recovery is measured in terms of the anxiety and depression scores: the patient needs to score below the clinical threshold on BOTH scores at the end of treatment. Recovery is measured by looking at the welfare of the individual rather than one specific symptom. A referral has shown reliable recovery if they have both reliably improved and also recovered. For more information, see Appendix 3 of the IAPT 2015/16 report.

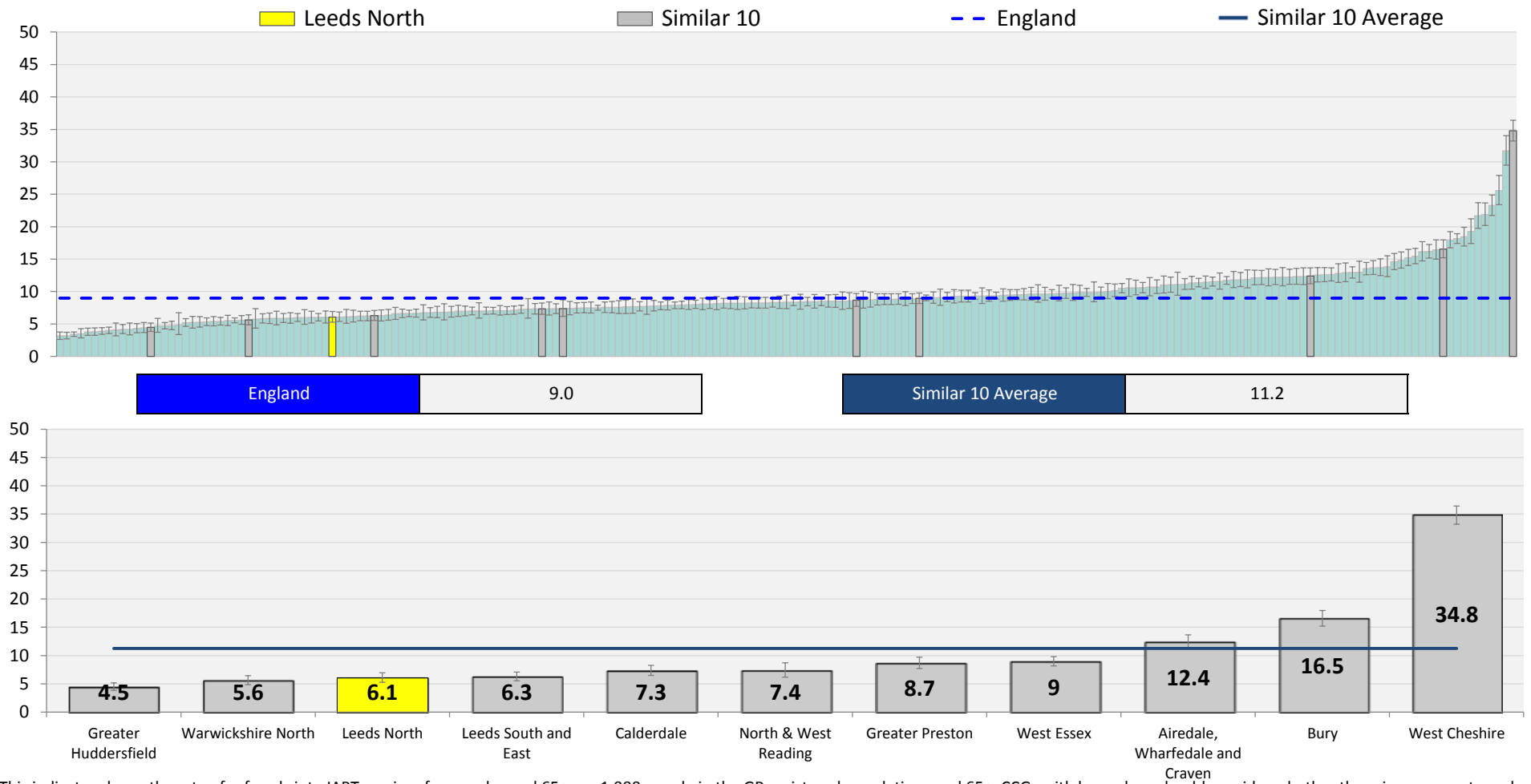
IAPT: Rate of referrals for people aged 18+ - per 100,000 (quarterly)



This indicator shows the rate of referrals into IAPT services per 100,000 aged 18+ for a single quarter. CCGs should consider alongside indicators of reported and estimated prevalence, and the number of people entering IAPT as a percentage of those estimated to have anxiety or depression. CCGs with low values should consider whether there is any unmet need or an inadequate service.

Definition: IAPT: Rate of referrals for people aged 18+ - per 100,000 (quarterly)
Source: IAPT, PHE Fingertips Common Mental Health Disorders Profile
Year: 2015/16 Q4

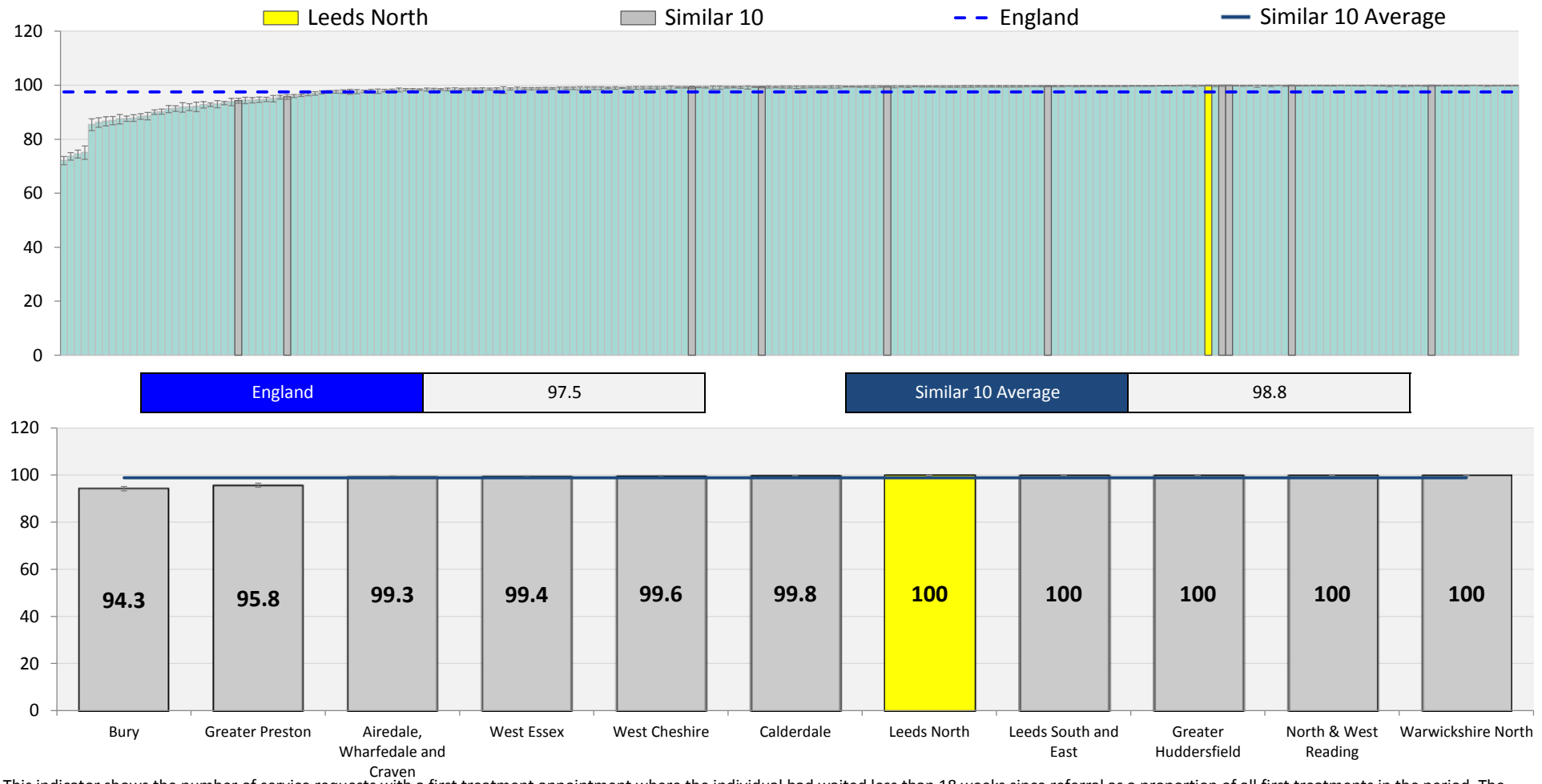
Rate of IAPT referrals aged 65+ per 1,000 65+ population



This indicator shows the rate of referrals into IAPT services for people aged 65+ per 1,000 people in the GP registered population aged 65+. CCGs with low values should consider whether there is any unmet need or an inadequate service.

Definition: Rate of IAPT referrals aged 65+ per 1,000 65+ population
Source: Improving Access to Psychological Therapies (IAPT) dataset, NHS Digital
Year: 2015/16

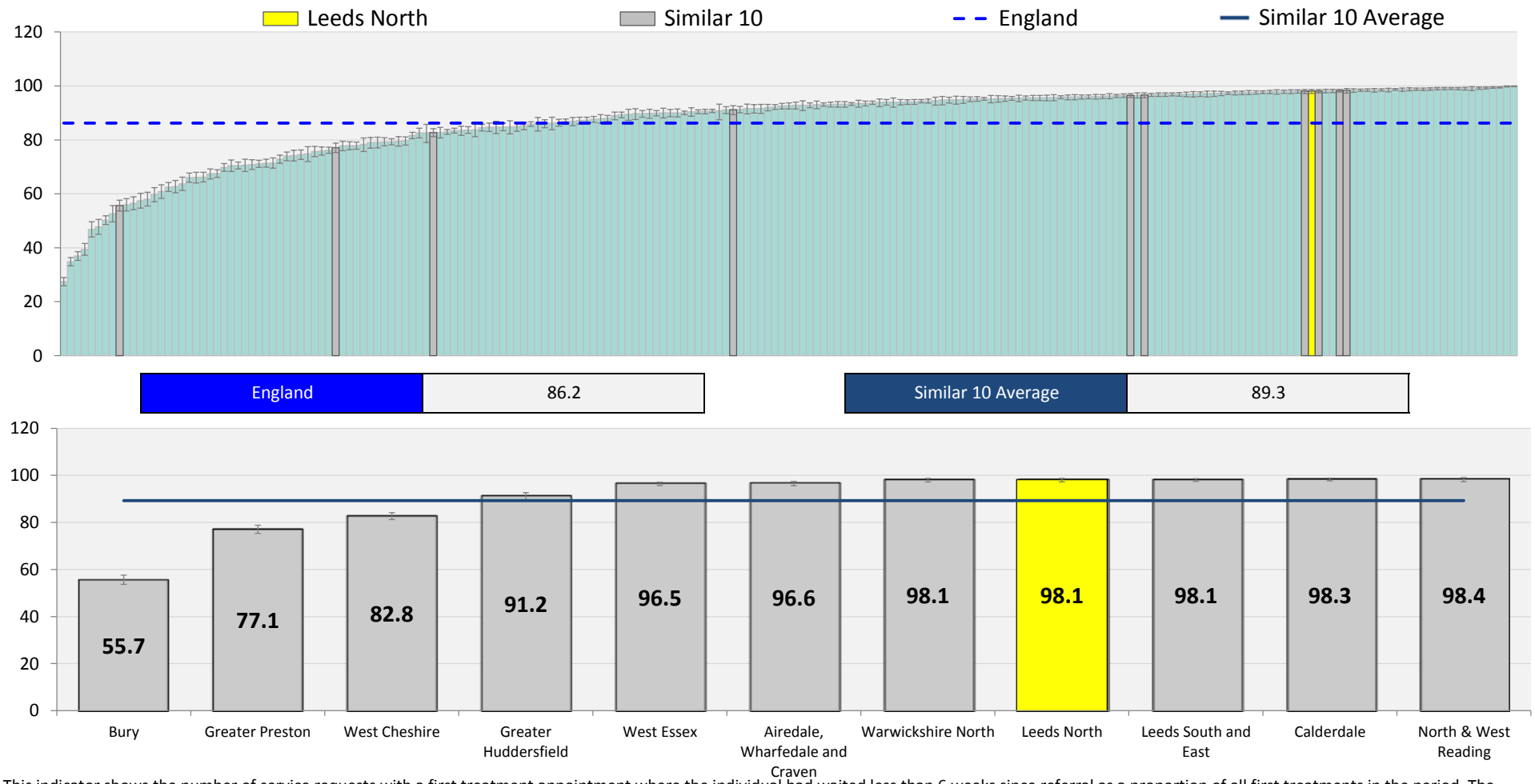
Percentage of IAPT referrals entering treatment waiting <18 weeks for first treatment



This indicator shows the number of service requests with a first treatment appointment where the individual had waited less than 18 weeks since referral as a proportion of all first treatments in the period. The entered treatment date for a referral is the date of the first, attended treatment appointment. The national target is for 95% to begin IAPT treatment within 18 weeks.

Definition: Percentage of IAPT referrals entering treatment waiting <18 weeks for first treatment
Source: IAPT, PHE Fingertips Common Mental Health Disorders Profile
Year: Oct-Mar1516

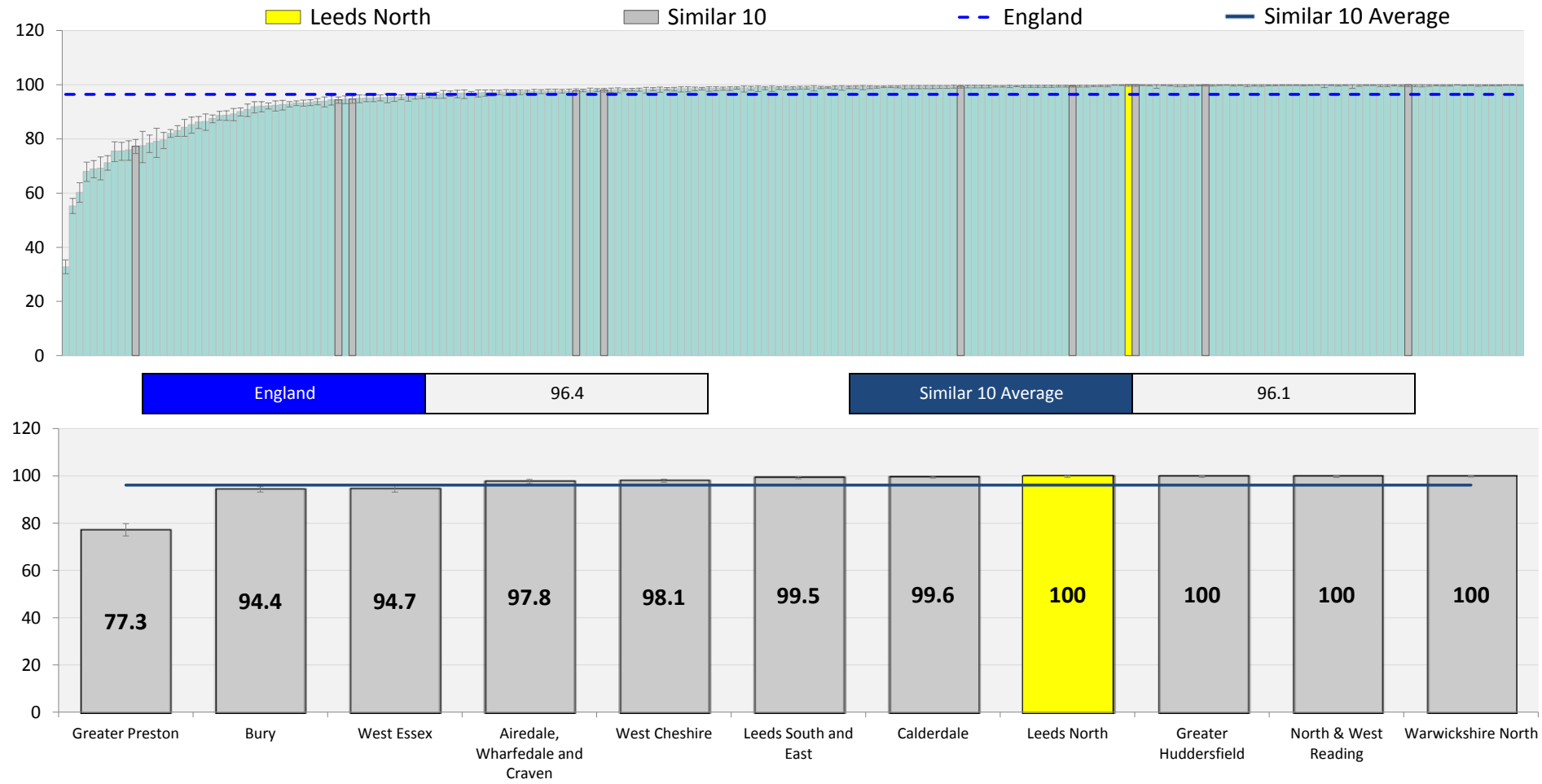
Percentage of IAPT referrals entering treatment waiting <6 weeks for first treatment



This indicator shows the number of service requests with a first treatment appointment where the individual had waited less than 6 weeks since referral as a proportion of all first treatments in the period. The entered treatment date for a referral is the date of the first, attended treatment appointment. The national target is for 75% to begin IAPT treatment within 6 weeks.

Definition: Percentage of IAPT referrals entering treatment waiting <6 weeks for first treatment
Source: IAPT, PHE Fingertips Common Mental Health Disorders Profile
Year: Oct-Mar1516

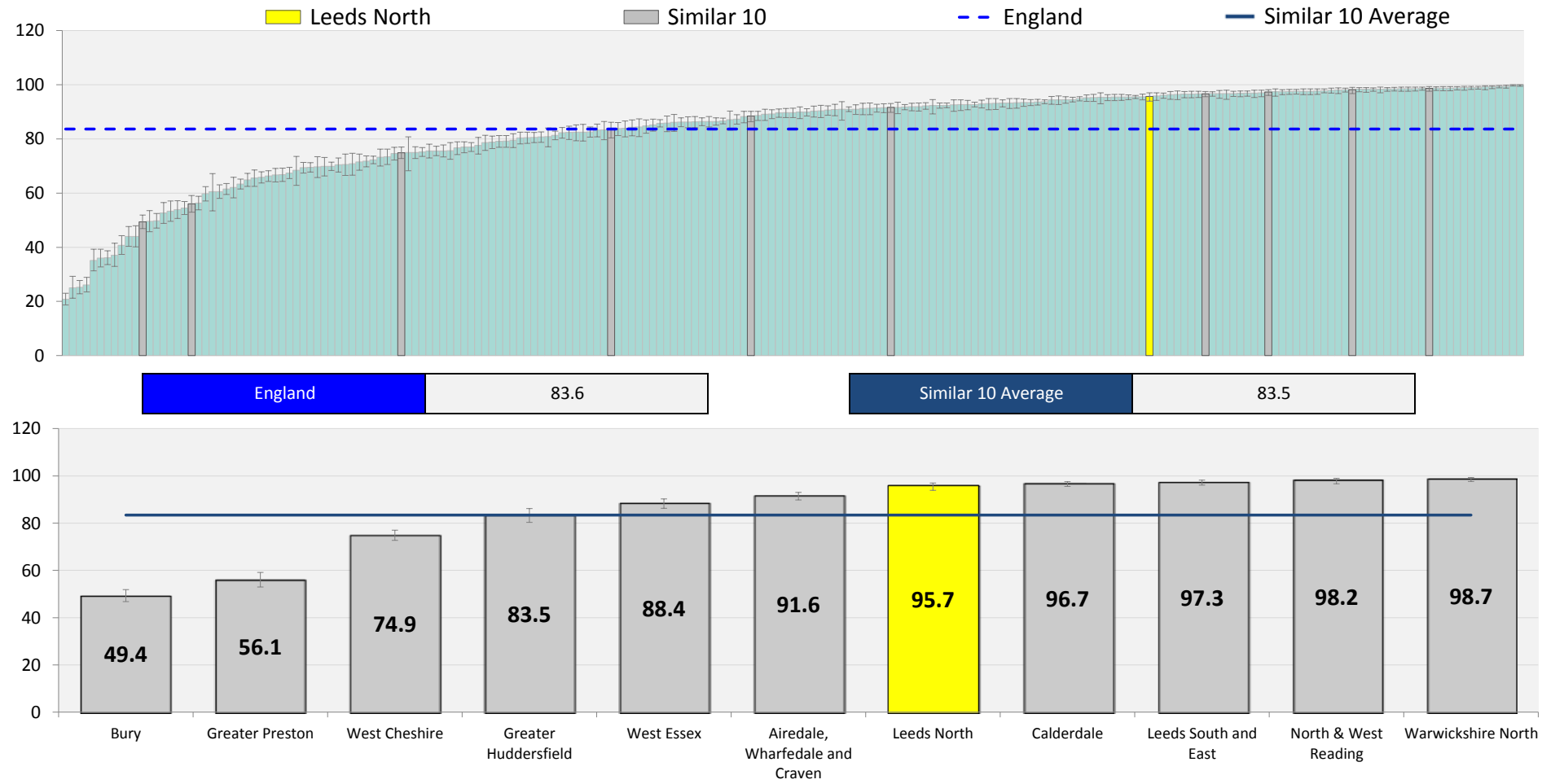
Percentage of IAPT referrals that have finished course of treatment waiting <18 weeks for first treatment



The no. of service requests that finished a course of treatment where the individual waited <18weeks for 1st treatment as a proportion of all those that had finished a course of treatment in the period. To finish a course of treatment, a referral must have ended with at least 2 treatment apts having been attended in the course of the referral. Target: 95% to begin treatment <18wks.

Definition: Percentage of IAPT referrals that have finished course of treatment waiting <18 weeks for first treatment
Source: IAPT, PHE Fingertips Common Mental Health Disorders Profile
Year: Oct-Mar1516

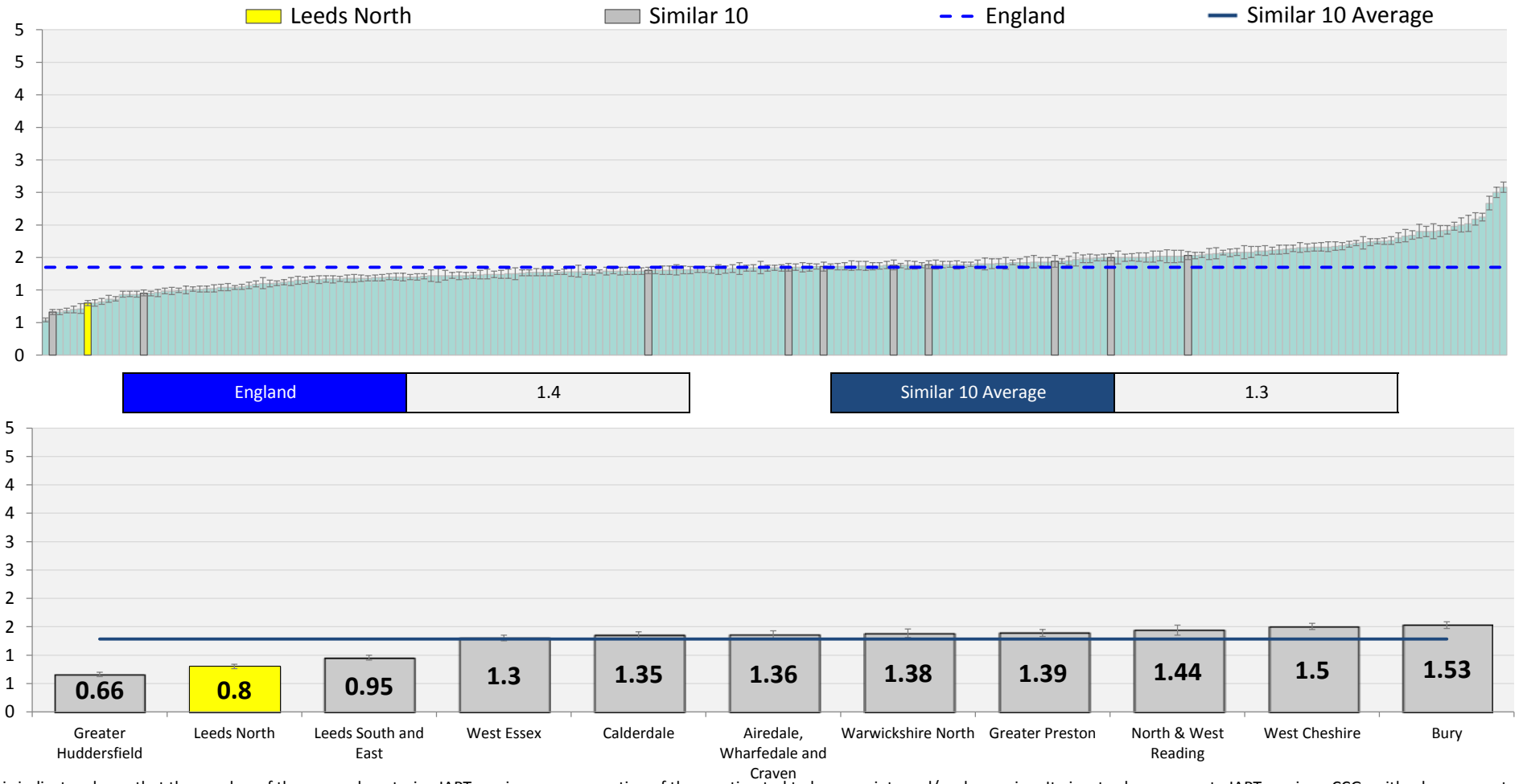
Percentage of IAPT referrals that have finished course of treatment waiting <6 weeks for first treatment



The no. of service requests that finished a course of treatment where the individual waited <6 weeks for 1st treatment as a proportion of all those that had finished a course of treatment in the period. To finish a course of treatment, a referral must have ended with at least 2 treatment apts having been attended in the course of the referral. Target: 75% to begin treatment <6wks.

Definition: Percentage of IAPT referrals that have finished course of treatment waiting <6 weeks for first treatment
Source: IAPT, PHE Fingertips Common Mental Health Disorders Profile
Year: Oct-Mar1516

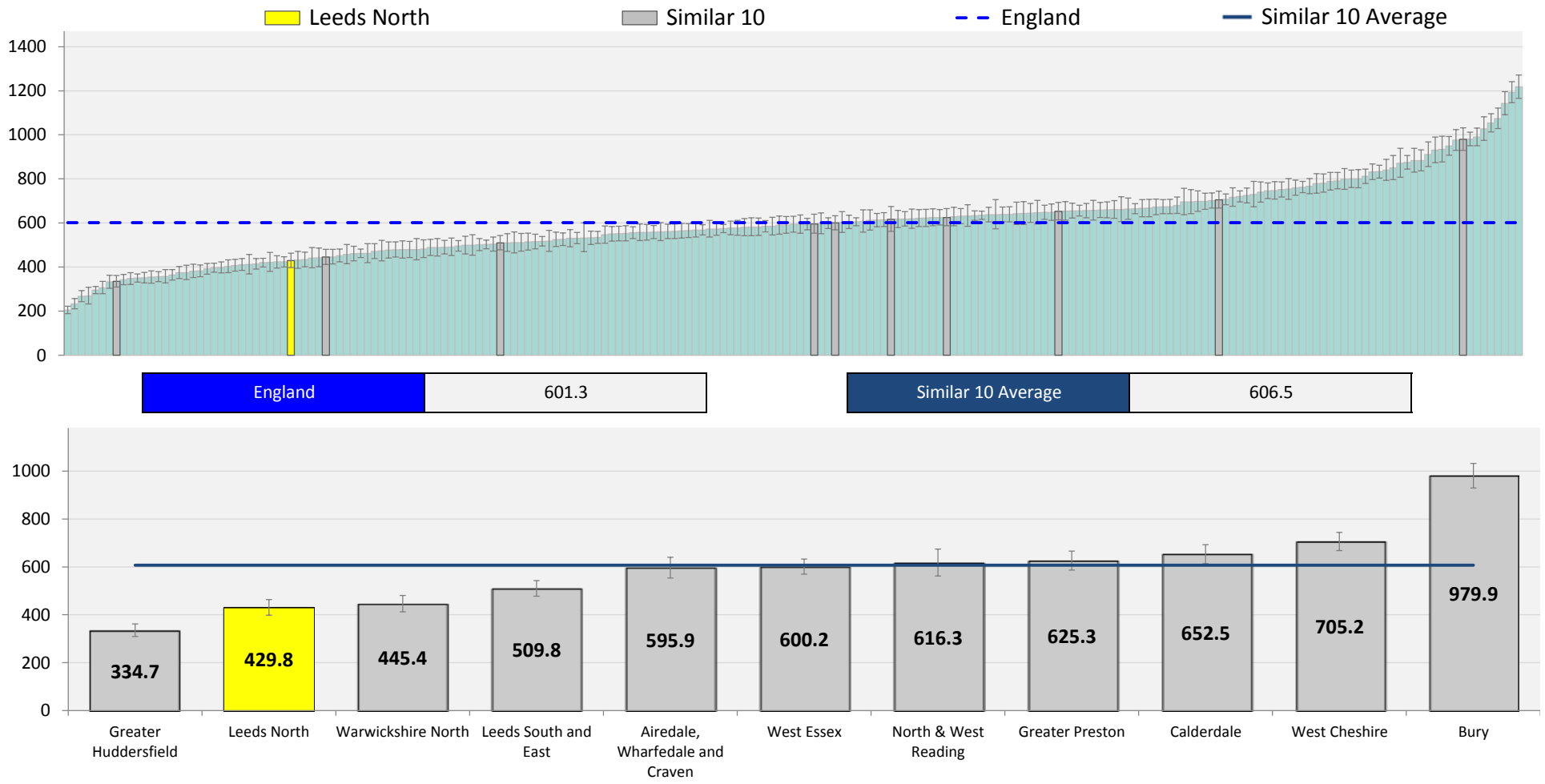
People entering IAPT as percentage of those estimated to have anxiety/depression



This indicator shows that the number of those people entering IAPT services as a proportion of those estimated to have anxiety and/or depression. It aims to show access to IAPT services. CCGs with a low percentage compared to similar CCGs should explore local reasons for this - for example, hard to reach groups in the population.

Definition: People entering IAPT as percentage of those estimated to have anxiety/depression
Source: IAPT, PHE Fingertips Common Mental Health Disorders Profile
Year: Oct-Mar1516

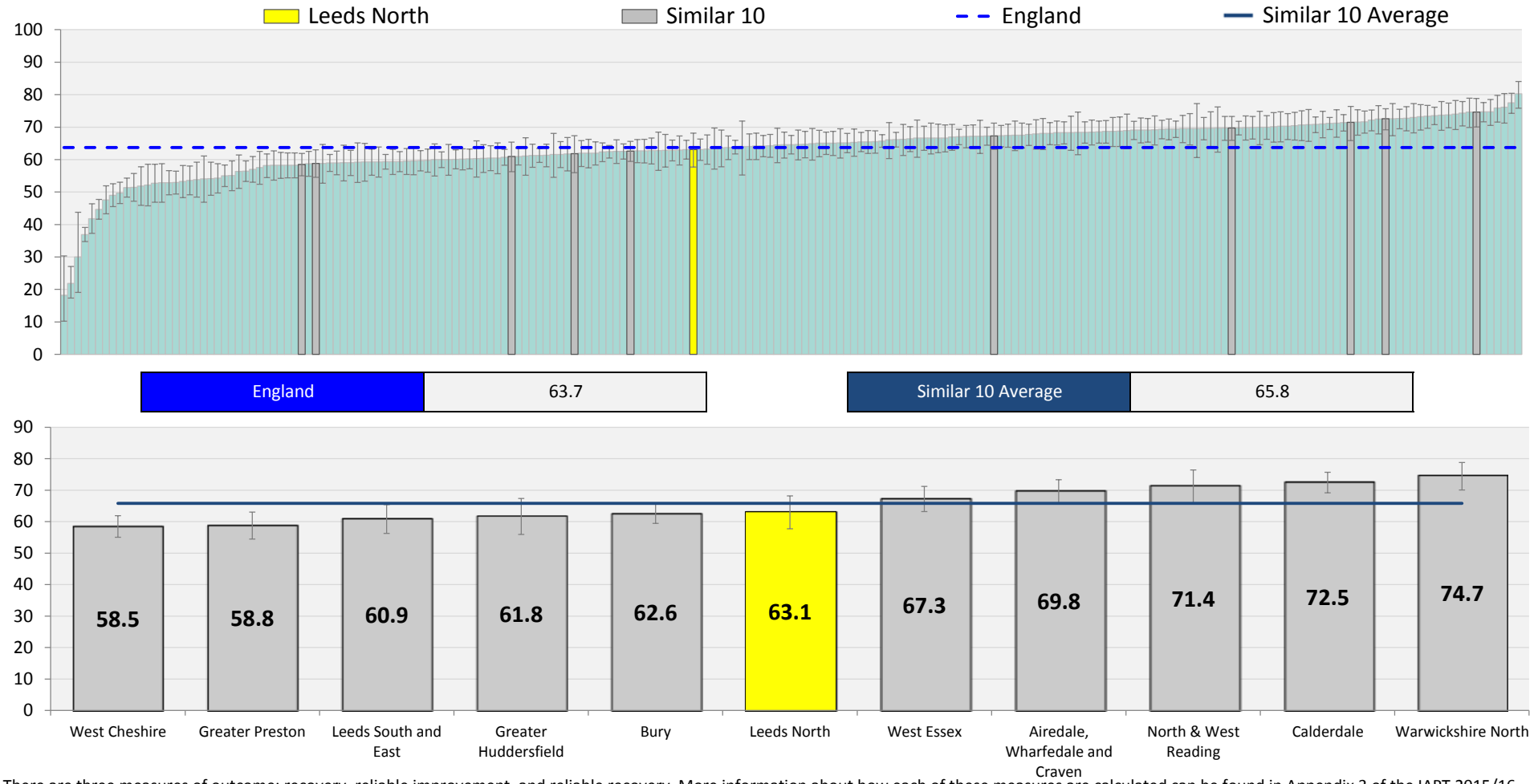
IAPT: Rate of people aged 18+ beginning IAPT treatment per 100,000 (quarterly)



This indicator shows the number of first IAPT treatments in the quarter expressed as a rate per resident population aged 18+

Definition: IAPT: Rate of people aged 18+ beginning IAPT treatment per 100,000 (quarterly)
Source: IAPT, PHE Fingertips Common Mental Health Disorders Profile
Year: 2015/16 Q4

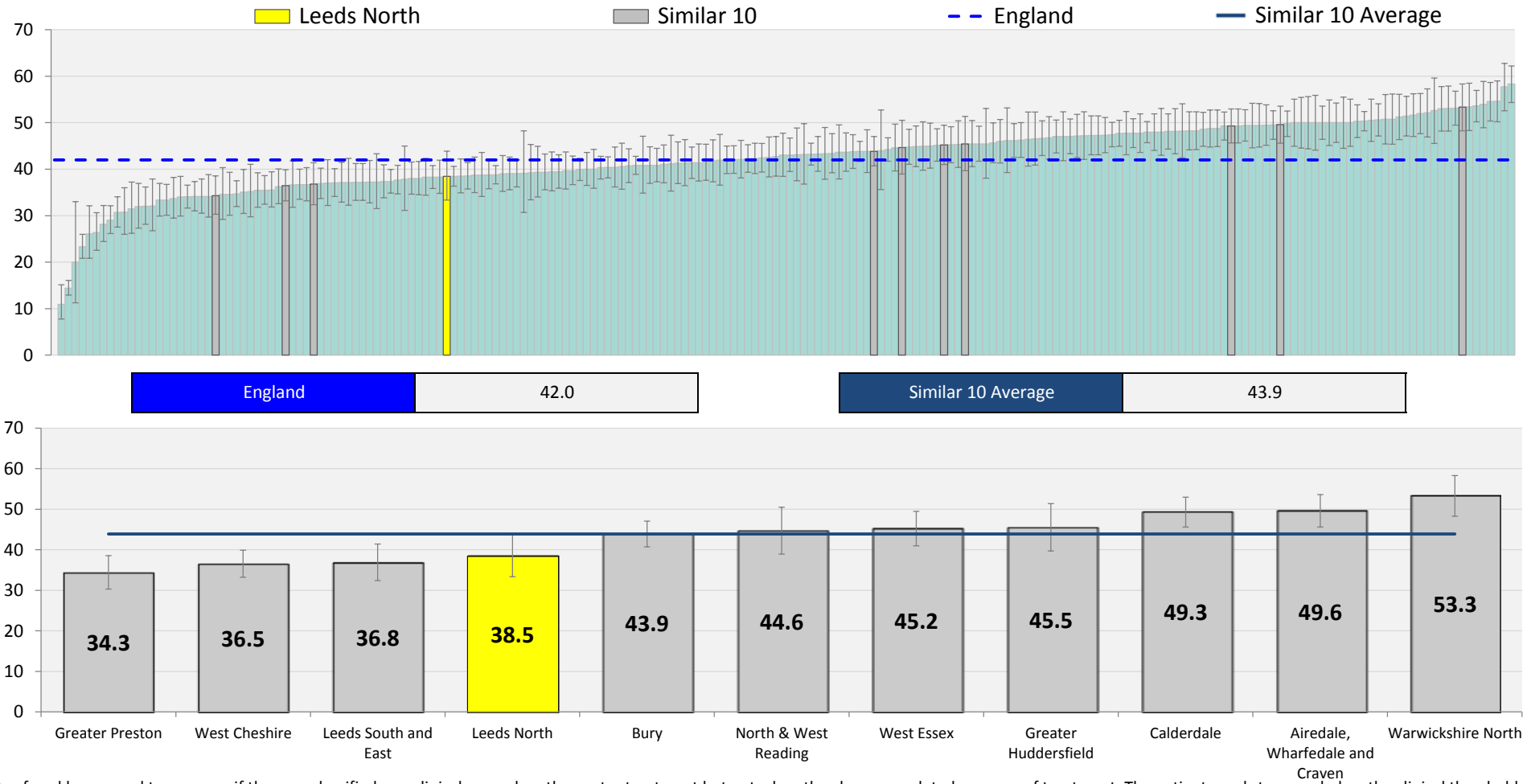
IAPT: Percentage of people who have finished IAPT treatment who achieved "reliable improvement" (quarterly)



There are three measures of outcome: recovery, reliable improvement, and reliable recovery. More information about how each of these measures are calculated can be found in Appendix 3 of the IAPT 2015/16 annual report. A referral has shown reliable improvement if their scores on one or both PHQ9 and GAD7 (or other ADSM) - reliably decreases whilst the other shows no reliable increase.

Definition: IAPT: Percentage of people who have finished IAPT treatment who achieved "reliable improvement" (quarterly)
Source: IAPT, PHE Fingertips Common Mental Health Disorders Profile
Year: 2015/16 Q4

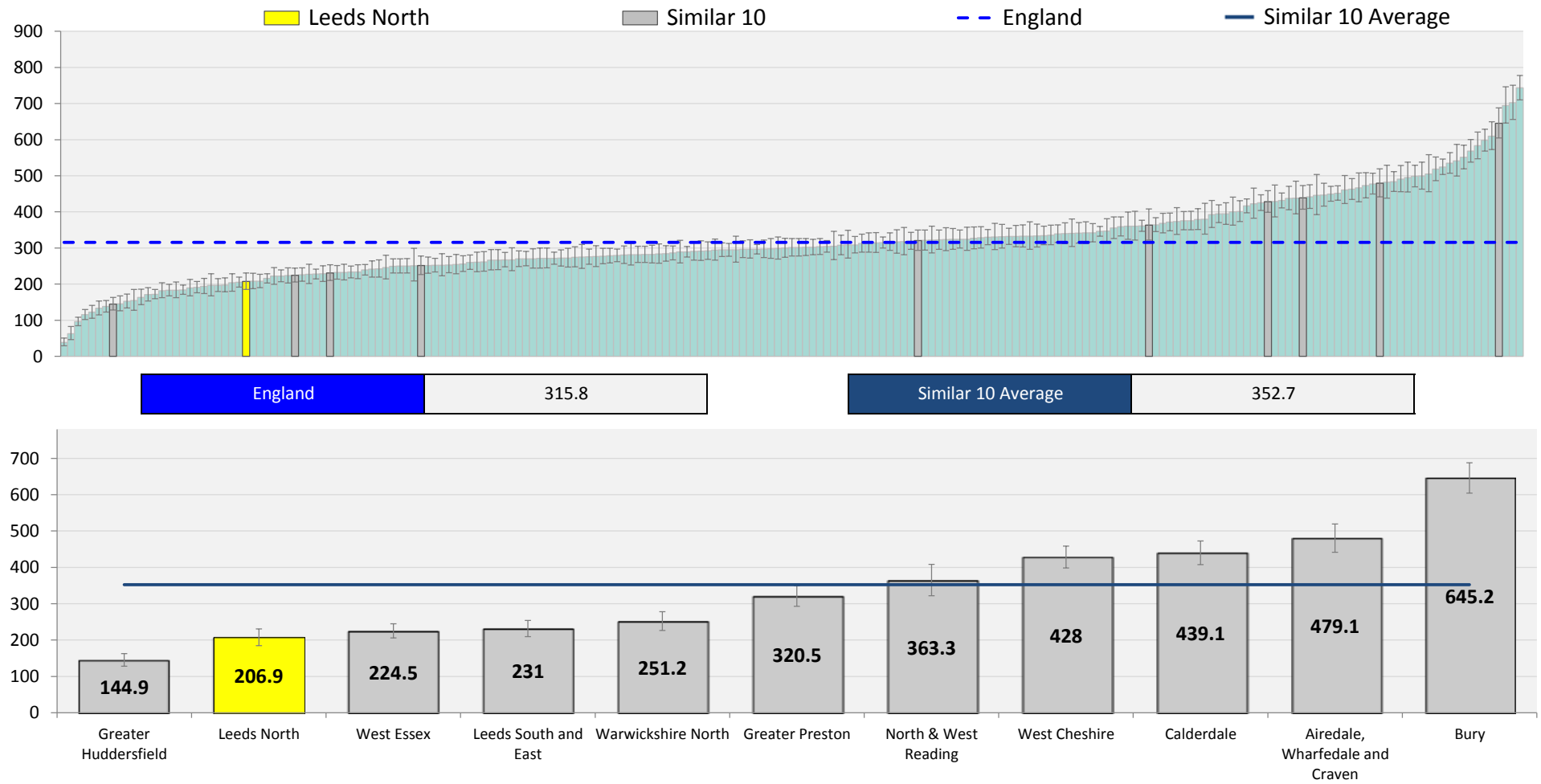
IAPT: Percentage of people who have completed IAPT treatment who are "moving to recovery"



A referral has moved to recovery if they are classified as a clinical case when they enter treatment but not when they have completed a course of treatment. The patient needs to score below the clinical threshold on both scores (anxiety and depression) at end of treatment, to ensure that recovery is measured by looking at welfare of the individual rather than one specific symptom.

Definition: IAPT: Percentage of people who have completed IAPT treatment who are "moving to recovery"
Source: IAPT, PHE Fingertips Common Mental Health Disorders Profile
Year: 2015/16 Q4

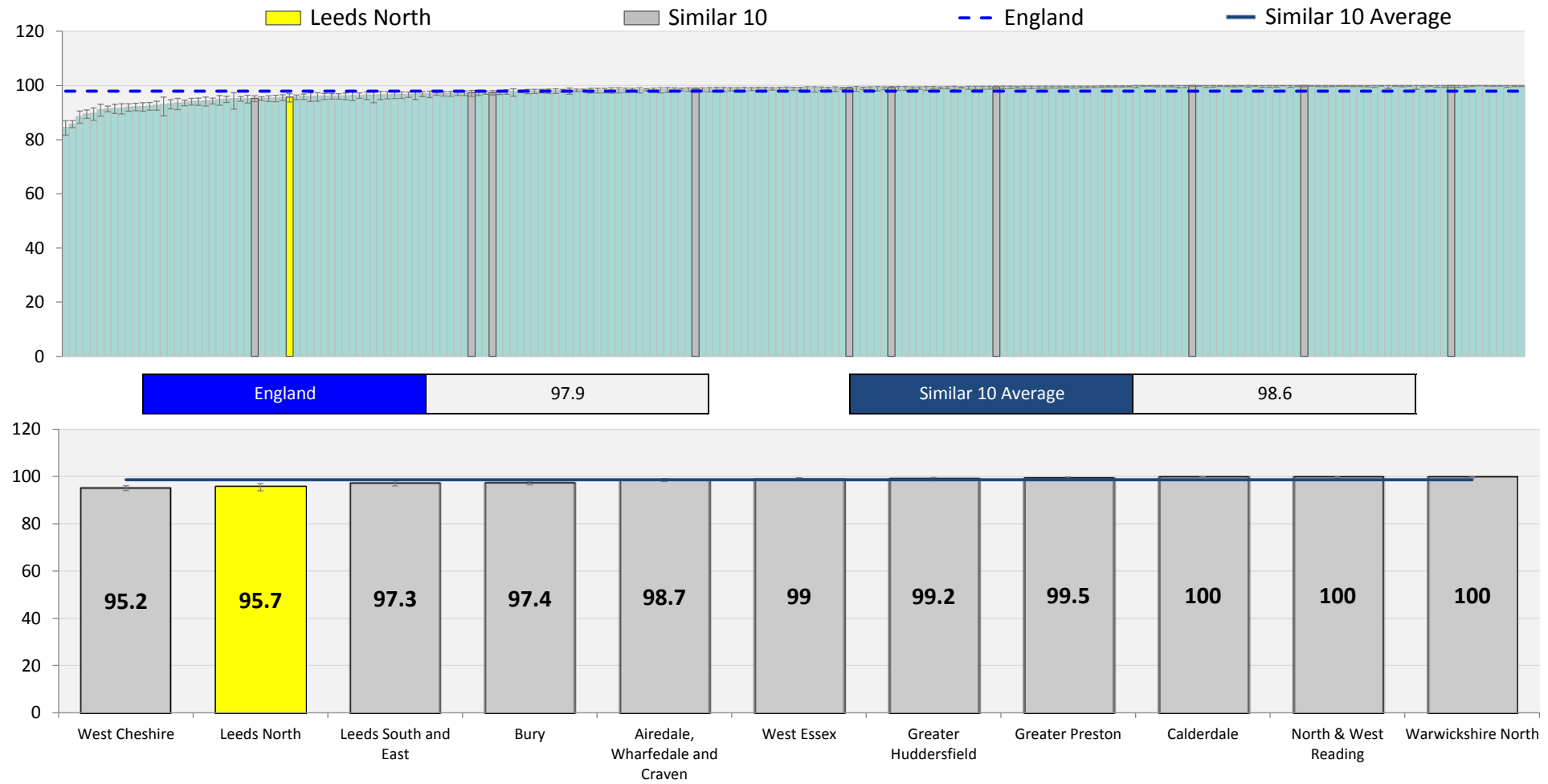
IAPT: Rate of people aged 18+ completing IAPT treatment per 100,000 (quarterly)



In order to finish a course of treatment, a referral must have ended with at least two treatment appointments having been attended in the course of the referral.

Definition: IAPT: Rate of people aged 18+ completing IAPT treatment per 100,000 (quarterly)
Source: IAPT, PHE Fingertips Common Mental Health Disorders Profile
Year: 2015/16 Q4

Percentage of IAPT referrals with treatment outcome measured - paired data completeness: % of finished treatments with paired PHQ9 and ADSM scores



The proportion of service requests that finished a course of treatment where there were paired PHQ9 and ADSM scores

Definition: Percentage of IAPT referrals with treatment outcome measured - paired data completeness: % of finished treatments with paired PHQ9 and ADSM scores
Source: Monthly Improving Access to Psychological Therapies Dataset Reports, PHE Fingertips Common Mental Health Disorders Profile
Year: Oct-Mar1516

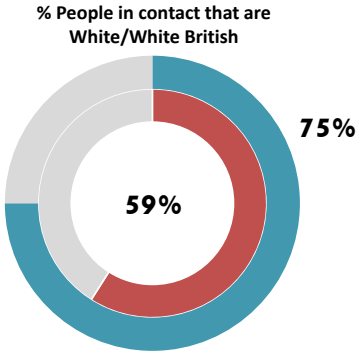
Contact with secondary mental health services

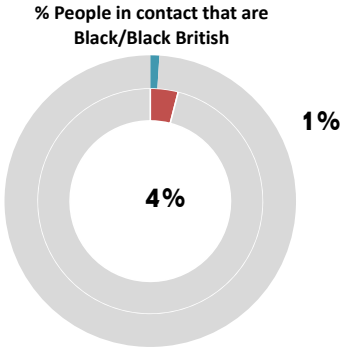
Secondary services are those which patients are referred to by their GP, A&E or other organisations and offer more specialist support. Secondary care can include community mental health teams, hospital care or support from other mental health service providers.

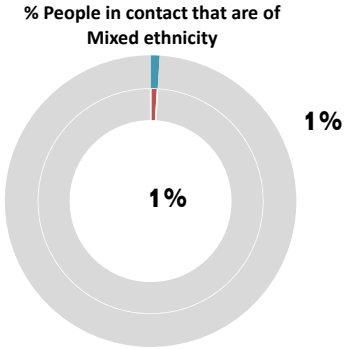
Nearly two million adults were in contact with specialist mental health and learning disability services at some point in 2014/15 and there has been a similar level of activity in 2015/16.

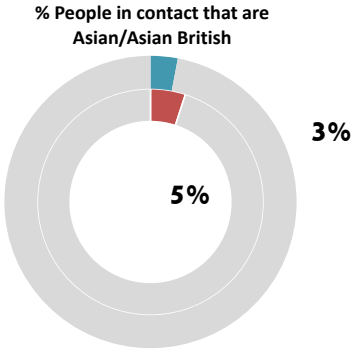
The data included in this section provides a detailed breakdown of referrals to and contact with secondary services for your CCG. This data can be used to help you to understand more about the rates of contact with and the characteristics of those accessing services. It can be used to explore whether there is evidence of unmet need for some population groups and whether the services accessed indicate appropriate care.

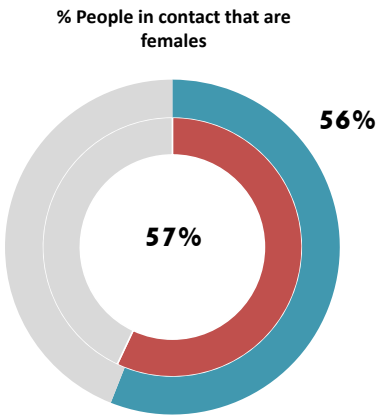
NHS Leeds North CCG - Contact Profile

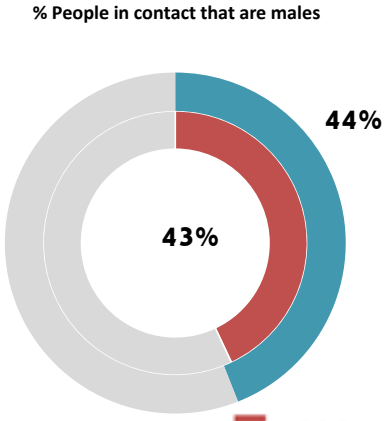


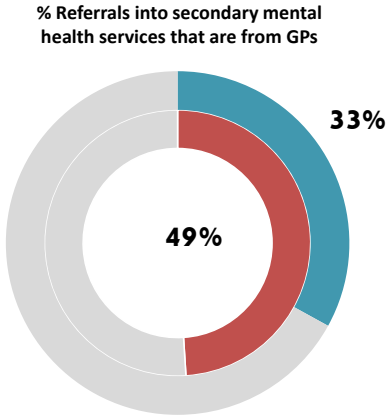


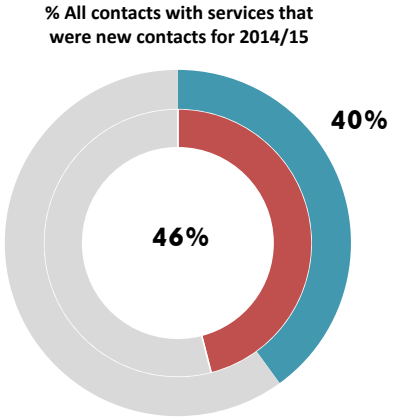












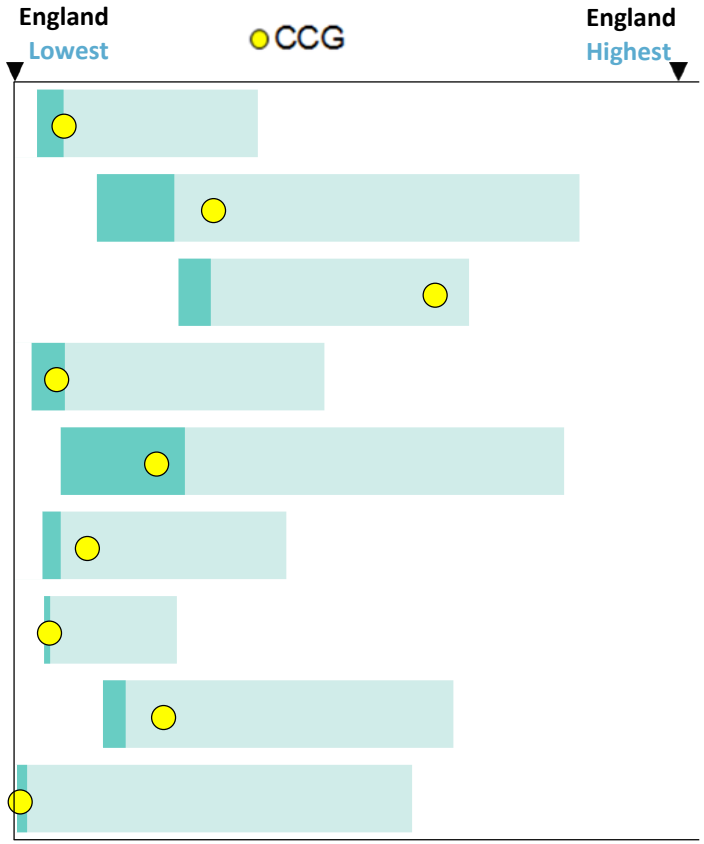
CCG

Average of similar 10 CCGs

These summary slides help CCGs understand to what extent the profile of people in contact with services differs from their similar CCG cluster.

Contact with secondary mental health services

Indicator	Time Period	CCG Value
Rate of referrals 18+ into secondary mental health services - per 100,000	2014/15	4665.1
Rate of people referred into secondary mental health services by GPs during 2014/15 – per 100,000	2014/15	978.9
Percentage of people referred into secondary mental health services that are referred by GPs	2014/15	49.1
Rate of people aged 18+ who are referred into secondary mental health services more than once within 2014/15 - per 100,000	2014/15	672.4
Rate of referrals of White people to secondary mental health services by GPs - per 100,000 White population	2014/15	550.1
Rate of referrals of Black/Black British people to secondary mental health services by GPs - per 100,000 Black/Black British population	2014/15	459.8
Rate of referrals of people of mixed ethnicity to secondary mental health services by GPs - per 100,000 people of mixed ethnicity	2014/15	276.7
Rate of referrals of Asian/Asian British people to secondary mental health services by GPs - per 100,000 Asian/Asian British population	2014/15	324.5
Rate of referrals of people of Other ethnicity to secondary mental health services by GPs - per 100,000 people of Other ethnicity	2014/15	377.9



These indicators show rates of referrals of people of different ethnicities by GPs into secondary mental health services. Note that the first indicator presents overall rates of referrals; all other indicators on this page present rate of unique people referred. Where applicable, indicators have been standardised against the relative population group within the community. Rates therefore take account of the differing sizes of different ethnic groups in a CCG and its similar ten CCGs' populations. Referral rates should be considered alongside indicators that present possible need for services amongst at risk groups. Where referral rates are low, CCGs may wish to consider whether certain groups are harder to reach in their community. Indicators are indirectly age/sex standardised per 100,000 people in the relevant GP registered population.

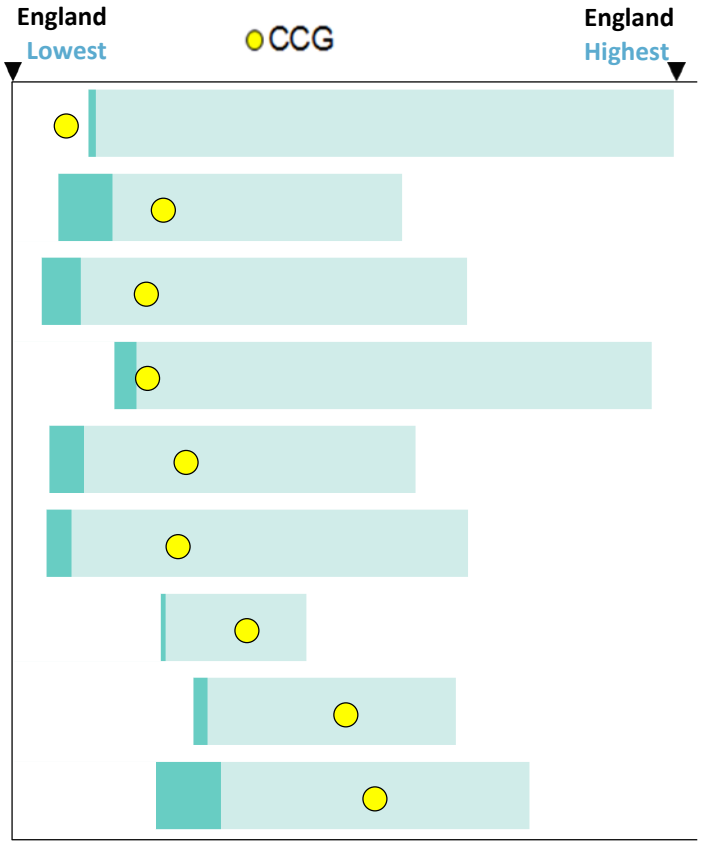
Contact with secondary mental health services continued

Indicator	Time Period	CCG Value
Rate of people in contact with secondary mental health services - per 100,000 (end of quarter snapshot)	2015/16 Q4	2464.1
Rate of people in contact with secondary mental health/learning disabilities services in 2014/15 - per 100,000	2014/15	3044.4
Rate of contact with secondary mental health services by people with open spells from the previous year - per 100,000	Before 1415	1659.8
Rate of people in contact with secondary mental health services per 100,000 - Apr-Aug 14/15	Apr-Aug2014	605.7
Rate of people in contact with secondary mental health and learning disabilities services per 100,000 - Sep-Mar 1415	Sep-Mar1415	780.6
Percentage of all contacts with services that were new contacts for 2014/15	2014/15	45.6
Average contacts with a healthcare professional per patient	2014/15	10.0
Rate of attended contacts and day care attendances by people aged 18+ - per 100,000	2014/15	39488.5

Rates of contact should be considered alongside indicators that present possible need for services amongst at risk groups. Where contact rates are low, CCGs may wish to consider whether certain groups are harder to reach in their community. Where applicable, indicators are indirectly age/sex standardised per 100,000 people in the relevant GP registered population.

Contact with secondary mental health services continued

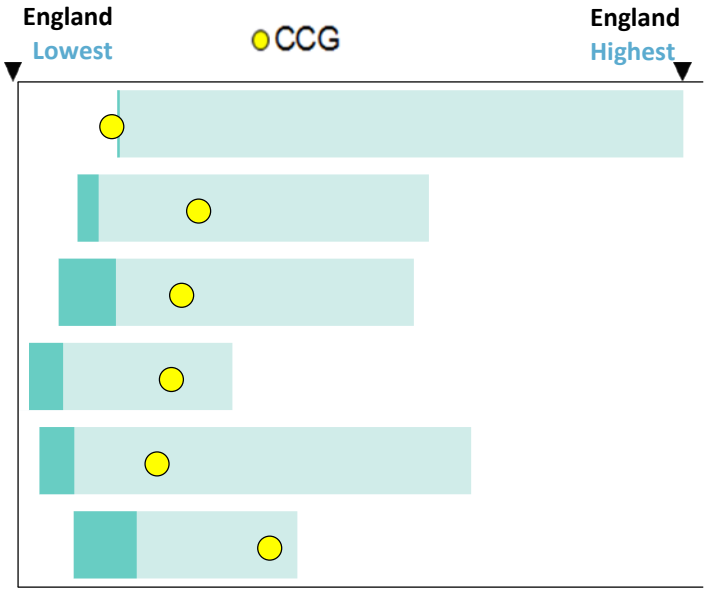
Indicator	Time Period	CCG Value
Rate of people aged 18 - 35 in contact with secondary mental health services - those with open spells from the previous year - per 100,000	2014/15	1079.8
Rate of people aged 18-35 in contact with secondary mental health services - per 100,000 population aged 18-35	Apr-Aug2014	746.7
Rate of people aged 18-35 in contact with secondary mental health/learning disabilities services - per 100,000 population aged 18-35	Sep-Mar1415	977.7
Rate of people aged 36-64 in contact with secondary mental health services - those with open spells from the previous year - per 100,000	Before 1415	1579.6
Rate of people aged 36-64 in contact with secondary mental health services - per 100,000 population aged 36-64	Apr-Aug2014	572.7
Rate of people aged 36-64 in contact with secondary mental health/learning disabilities services - per 100,000 population aged 36-64	Sep-Mar1415	701.8
Rate of people aged 65+ in contact with secondary mental health services - those with open spells from the previous year - per 100,000	Before 1415	4736.1
Rate of people aged 65+ in contact with secondary mental health services - per 100,000 population aged 65+	Apr-Aug2014	1166.8
Rate of people aged 65+ in contact with secondary mental health/learning disabilities services - per 100,000 population aged 65+	Sep-Mar1415	1557.0



These indicators show contact with secondary mental health services by 3 age groups.Indicators are split into 3 time periods; those that were in contact with services prior to 1st April 2014 and had continued contact within 2014/15 (shown as "Before April 1415"); those that had their first contact with services between April and August 2014; and those that had their first contact with services between September and March. 2 time periods for 2014/15 are shown to reflect the inclusion of people accessing Learning Disabilities services in the data from September onwards. Relatively higher rates in the September 2014 - April 2015 period compared to other CCGs may indicate a greater caseload for people accessing learning disabilities services.CCGs should also consider whether they have particularly high or low rates of access for a particular age group. Lower rates may suggest a harder to reach group in the population. Indicators are standardised against the relative population.

Contact with secondary mental health services continued

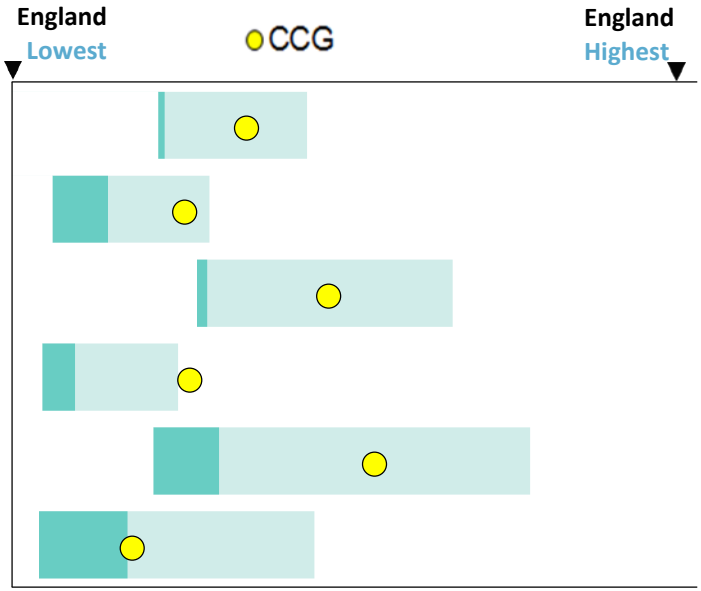
Indicator	Time Period	CCG Value
Rate of contact with secondary MH services by people aged 18-64 per 100,000 - referred before April 2014 - no inpatient stay	Before 1415	1238.6
Rate of contact with secondary mental health services by people aged 18-64 per 100,000 18-64 population - referred before April 2014 - had an inpatient stay	Before 1415	133.5
Rate of people aged 18-64 in contact with secondary MH services per 100,000 - referred Apr-Aug 2014 - no inpatient stay	Apr-Aug2014	610.8
Rate of people aged 18-64 in contact with secondary mental health services per 100,000 18-64 population - referred Apr-Aug 2014 - had an inpatient stay	Apr-Aug2014	33.4
Rate of people aged 18-64 in contact with secondary MH /learning disabilities services per 100,000 - referred Sept 14-Mar 15 - no inpatient stay	Sep-Mar1415	761.7
Rate of people aged 18-64 in contact with secondary mental health /learning disabilities services per 100,000 18-64 population - referred Sept 14-Mar 15 - had an inpatient stay	Sep-Mar1415	48.4



These indicators show rates of contact with services for those who didn't have an inpatient stay during the year separated out from those who did. The 'had an inpatient stay' category identifies people that spent time in hospital in the year. They may also have used community mental health services. The 'no inpatient stay' category identifies people who were only in contact with community mental health services. CCGs should consider whether they have relatively higher rates of contact by those who did have an inpatient stay compared to those who did not, compared to similar CCGs. The indicators show the point at which the patient was referred at the start of their continuous spell of care; these time periods reflect the inclusion of patients accessing learning disabilities from September 2014 onwards. Equivalent indicators for people aged 65+ are published on the following page. Indicators are indirectly age/sex standardised against the relevant age GP registered population.

Contact with secondary mental health services continued

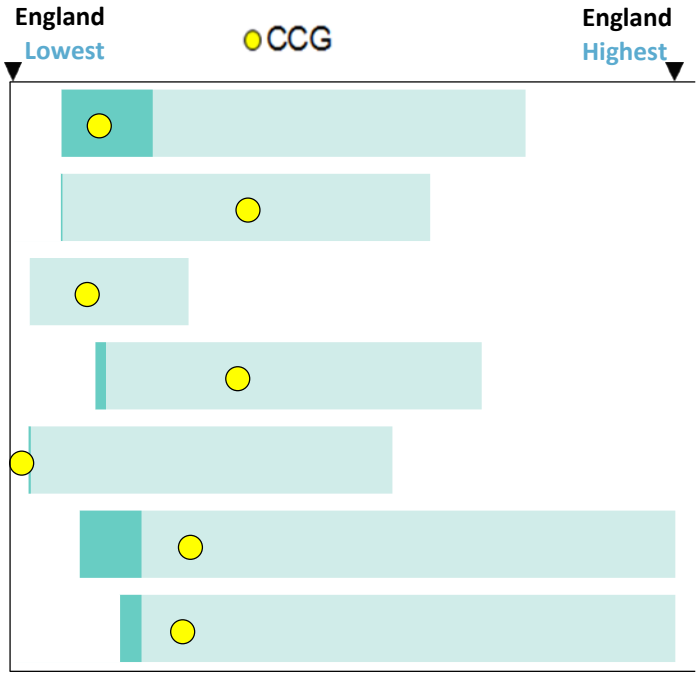
Indicator	Time Period	CCG Value
Rate of contact with secondary MH services by people aged 65+ per 100,000 - referred before April 2014 - no inpatient stay	Before 1415	4587.8
Rate of contact with secondary mental health services by people aged 65+ per 100,000 65+ population - referred before April 2014 - had an inpatient stay	Before 1415	162.5
Rate of people aged 65+ in contact with secondary MH services per 100,000 - referred Apr-Aug 2014 - no inpatient stay	Apr-Aug2014	1094.1
Rate of people aged 65+ in contact with secondary mental health services per 100,000 65+ population - referred Apr-Aug 2014 - had an inpatient stay	Apr-Aug2014	58.7
Rate of people aged 65+ in contact with secondary MH /learning disabilities services per 100,000 - referred Sept 14-Mar 15 - no inpatient stay	Sep-Mar1415	1557.0
Rate of people aged 65+ in contact with secondary mental health /learning disabilities services per 100,000 65+ population - referred Sept 14-Mar 15 - had an inpatient stay	Sep-Mar1415	29.4



These indicators show rates of contact with services for those who didn't have an inpatient stay during the year separated out from those who did. The 'had an inpatient stay' category identifies people that spent time in hospital in the year. They may also have used community mental health services. The 'no inpatient stay' category identifies people who were only in contact with community mental health services. CCGs should consider whether they have relatively higher rates of contact by those who did have an inpatient stay compared to those who did not, compared to similar CCGs. The indicators show the point at which the patient was referred at the start of their continuous spell of care; these time periods reflect the inclusion of patients accessing learning disabilities from September 2014 onwards. Equivalent indicators for people aged 18-64 are published on the previous page. Indicators are indirectly age/sex standardised against the relevant age GP registered population.

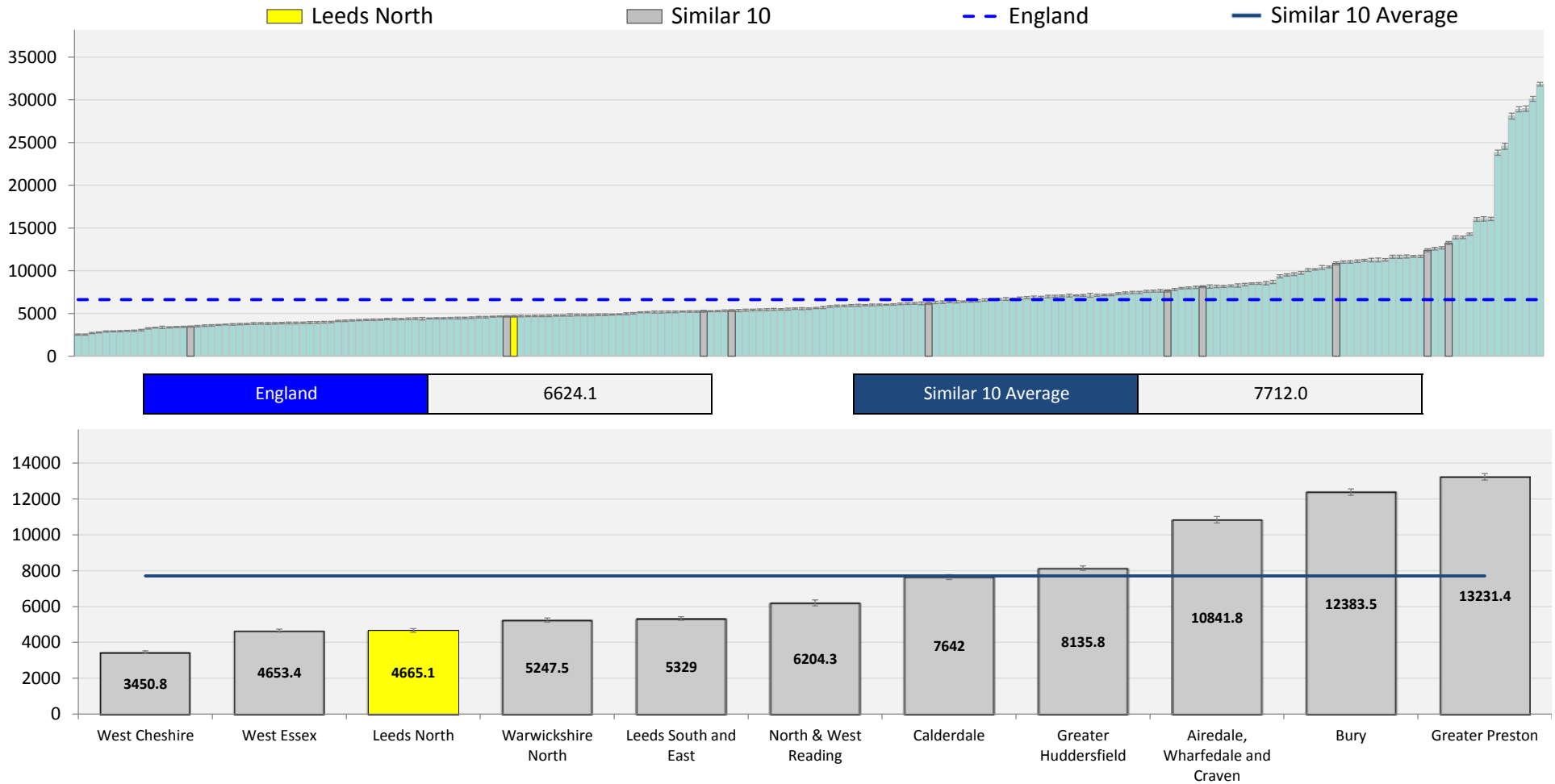
Contact with secondary mental health services continued

Indicator	Time Period	CCG Value
Rate of White people in contact with secondary mental health/learning disabilities services per 100,000 White population	2014/15	2230.0
Rate of Black/Black British people in contact with secondary mental health/learning disabilities services per 100,000 Black/Black British population	2014/15	2616.5
Rate of Mixed ethnic group in contact with secondary mental health/learning disabilities services per 100,000 Mixed ethnic group population	2014/15	1646.4
Rate of Asian/Asian British people in contact with secondary mental health/learning disabilities services per 100,000 Asian/Asian British population	2014/15	1602.2
Rate of people of Other ethnicity in contact with secondary mental health/learning disabilities services per 100,000 population of Other ethnicity	2014/15	1699.2
Rate of people of females in contact with secondary mental health/learning disabilities services per 100,000 female population	2014/15	3487.6
Rate of people of males in contact with secondary mental health/learning disabilities services per 100,000 male population	2014/15	2599.2



These indicators show the relative rates of contact with services by different ethnicities. Indicators are age/sex standardised against the relative equivalent population - this means that differences in population sizes of different ethnicities between CCGs have been taken into account. Where rates are low compared to similar CCGs, a CCG should consider whether these individuals may be harder to reach.

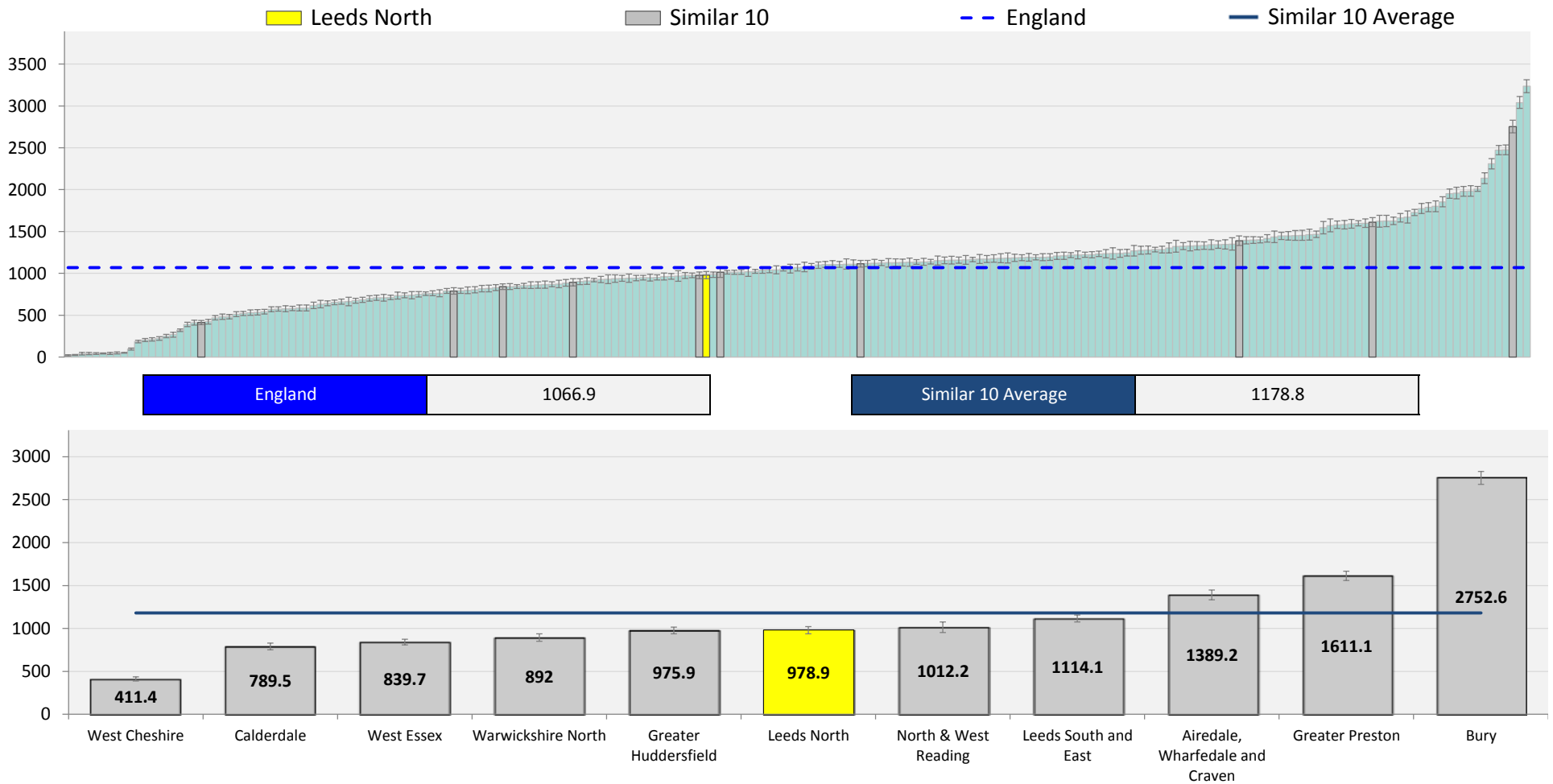
Rate of referrals 18+ into secondary mental health services - per 100,000



Local interpretation of whether high or low rates of referrals is good or bad is needed by CCGs. Low referral rates may indicate unmet need in the population - CCGs should consider referral rates alongside indicators related to prevalence and at risk groups.

Definition: Rate of referrals 18+ into secondary mental health services - per 100,000
Source: MHLDDS
Year: 2014/15

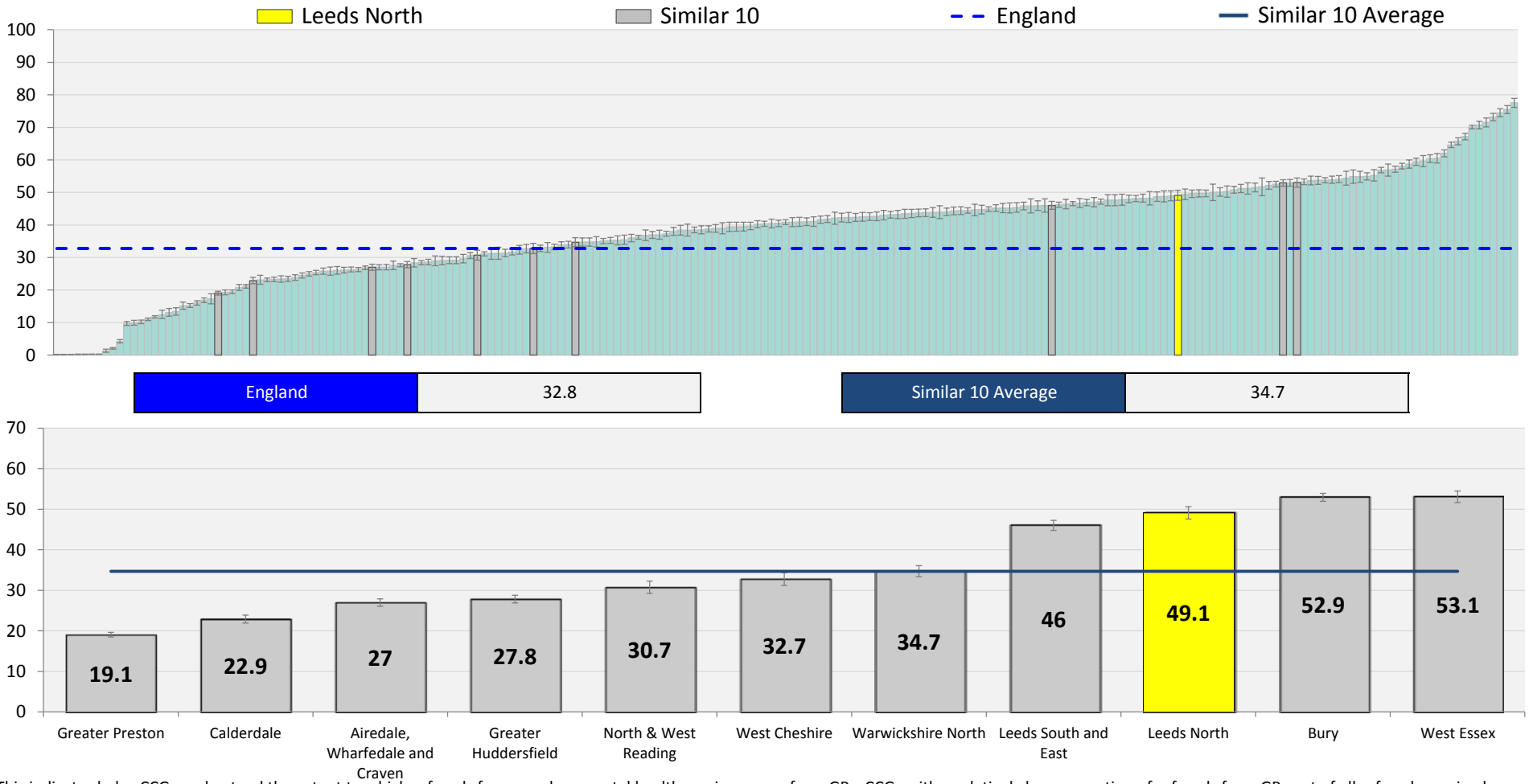
Rate of people referred into secondary mental health services by GPs during 2014/15 – per 100,000



GPs are the single biggest source of referrals into secondary mental health services in England. This indicator shows the age and sex standardised rate of referrals from GPs for all ages, and may give an indication to CCGs of the current and likely demand for services in their area. Referral rates should be considered alongside indicators showing at risk groups in the population.

Definition: Rate of people referred into secondary mental health services by GPs during 2014/15 – per 100,000
Source: MHLDDS
Year: 2014/15

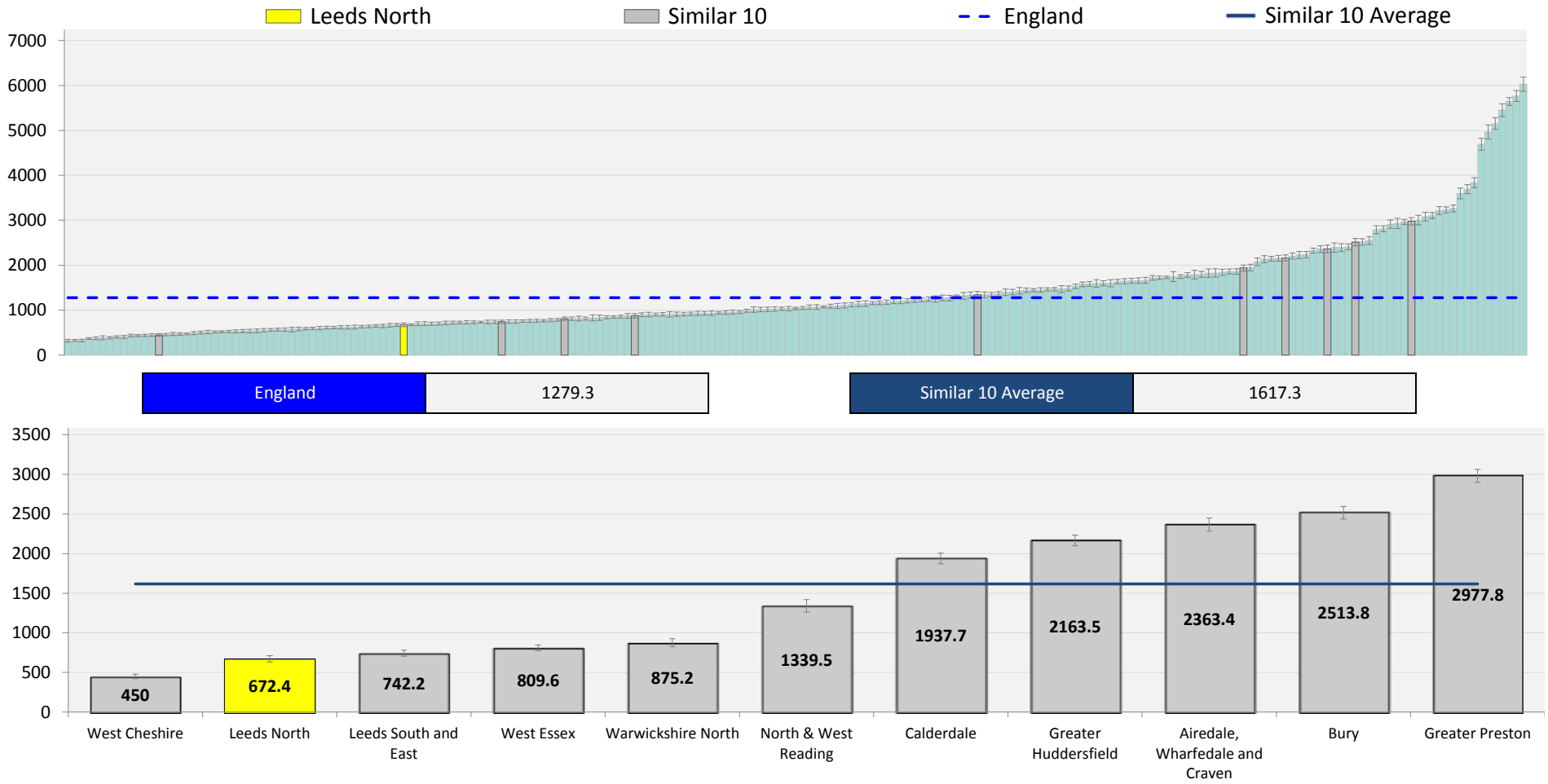
Percentage of people referred into secondary mental health services that are referred by GPs



This indicator helps CCGs understand the extent to which referrals for secondary mental health services come from GPs. CCGs with a relatively low proportion of referrals from GPs out of all referrals received may wish to explore their own data to understand where else referrals are being received from or whether there are data recording issues.

Definition: Percentage of people referred into secondary mental health services that are referred by GPs
Source: MHLDDS
Year: 2014/15

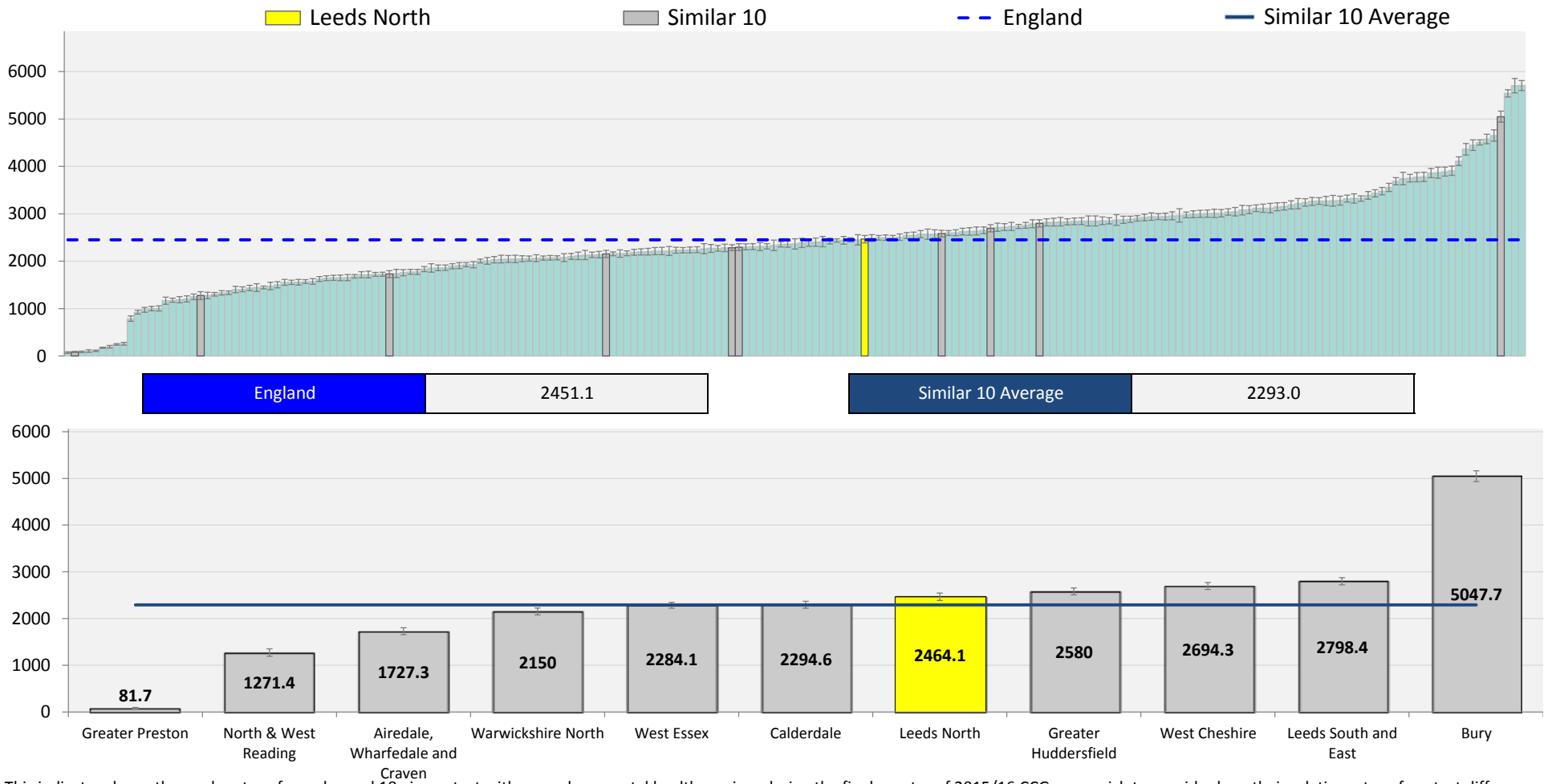
Rate of people aged 18+ who are referred into secondary mental health services more than once within 2014/15 - per 100,000



This indicator shows the rates of people who were referred into secondary mental health services more than once within 2014/15. It may help CCGs understand whether they have high numbers of patients who require re-referral into services. CCGs should consider whether there is appropriate post discharge support. It is indirectly age/sex standardised per 100,000

Definition: Rate of people aged 18+ who are referred into secondary mental health services more than once within 2014/15 - per 100,000
Source: MHLDDS
Year: 2014/15

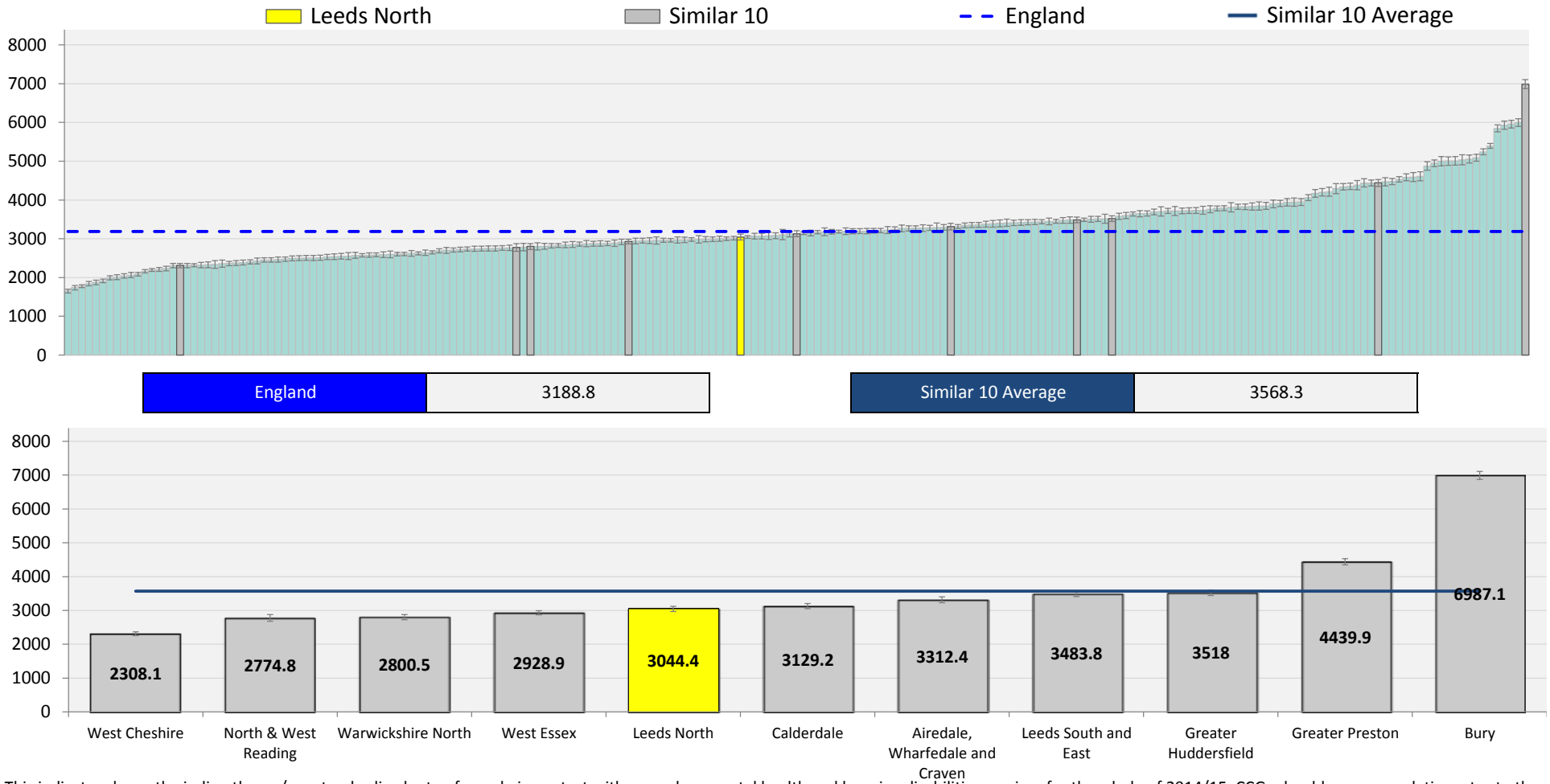
Rate of people in contact with secondary mental health services - per 100,000 (end of quarter snapshot)



This indicator shows the crude rates of people aged 18+ in contact with secondary mental health services during the final quarter of 2015/16.CCGs may wish to consider how their relative rates of contact differ compared to rates for the whole of 2014/15.This is a crude rate, so does not take into account the age/sex mix of people accessing services and within the wider CCG population.

Definition: Rate of people in contact with secondary mental health services - per 100,000 (end of quarter snapshot)
Source: Health & Social Care Information Centre, PHE Fingertips Severe Mental Illness Profile
Year: 2015/16 Q4

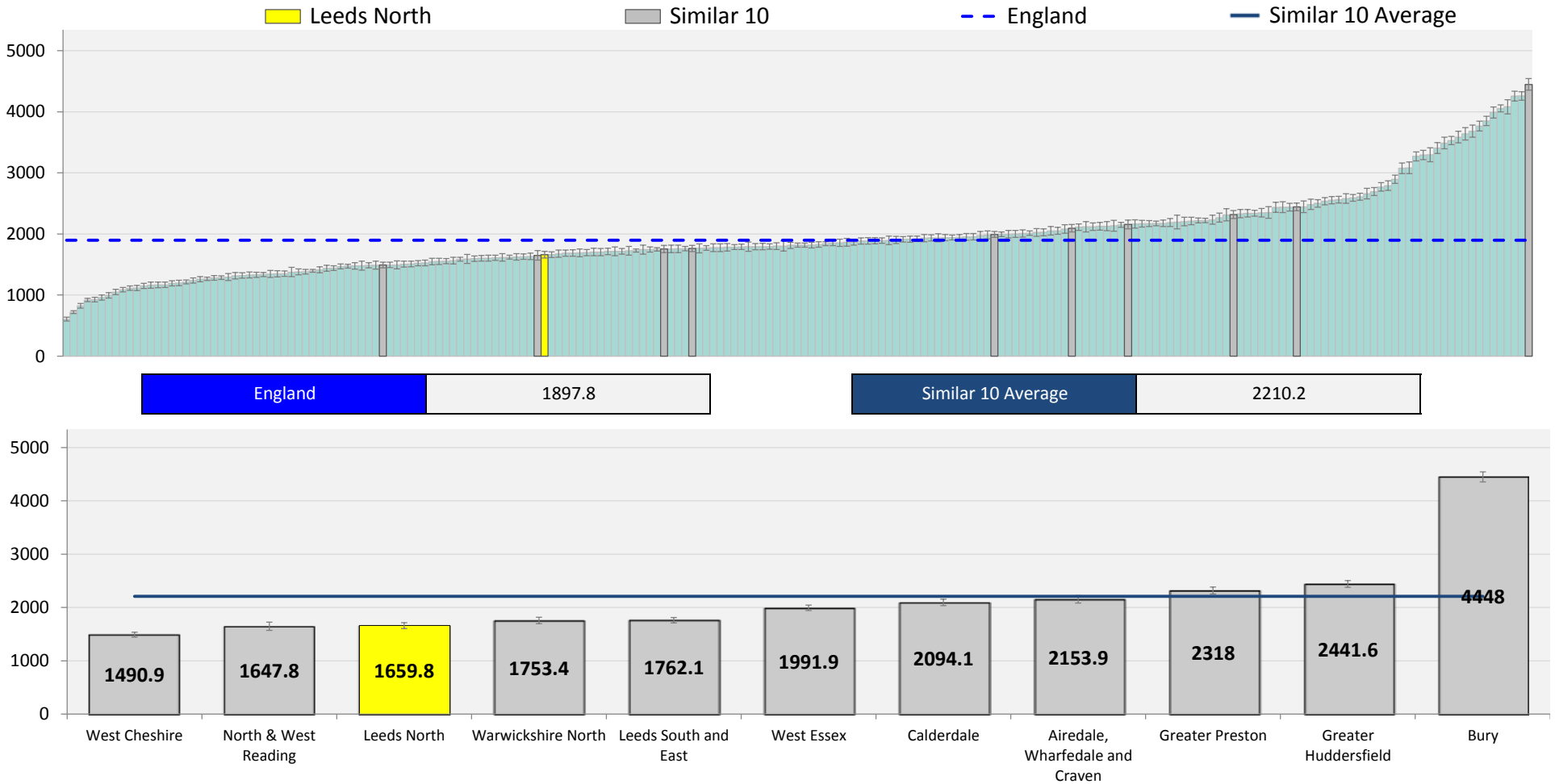
Rate of people in contact with secondary mental health/learning disabilities services in 2014/15 - per 100,000



This indicator shows the indirectly age/sex standardised rate of people in contact with secondary mental health and learning disabilities services for the whole of 2014/15. CCGs should compare relative rates to the most recent quarter. Where a person was recorded against more than one CCG during the year, they are only counted once for the CCG against their highest level of care.

Definition: Rate of people in contact with secondary mental health/learning disabilities services in 2014/15 - per 100,000
Source: MHLDDS
Year: 2014/15

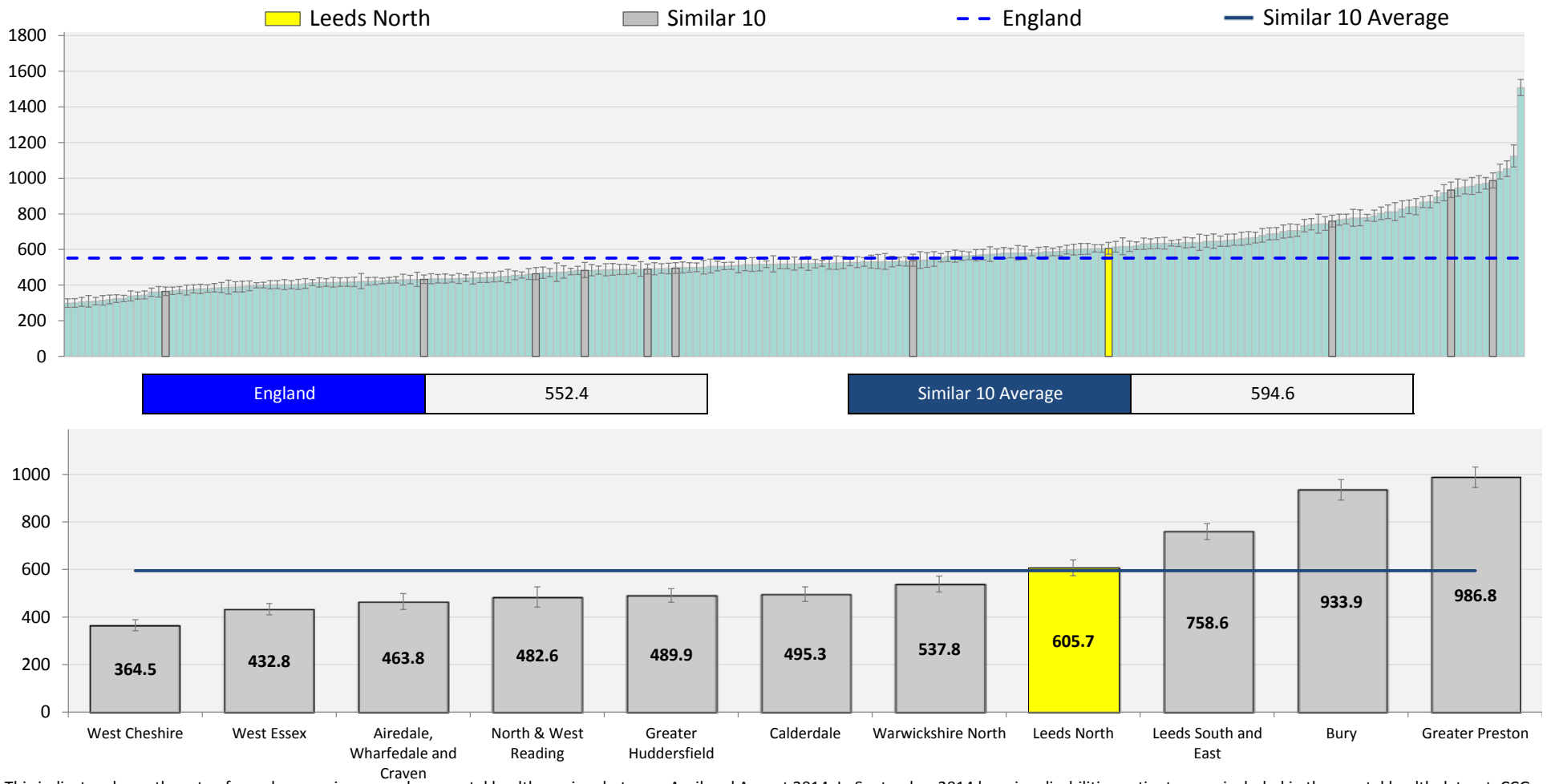
Rate of contact with secondary mental health services by people with open spells from the previous year - per 100,000



This indicator shows the rate of contact with services in 2014/15 for patients who had an open continuing spell of contact with a provider that started before April 2014. It should be considered alongside other indicators in this section to help CCGs understand whether they have high rates of people accessing services who were in contact before the start of 2014/15, or whether their patients are new patients for 2014/15.

Definition: Rate of contact with secondary mental health services by people with open spells from the previous year - per 100,000
Source: MHLDDS
Year: Before 1415

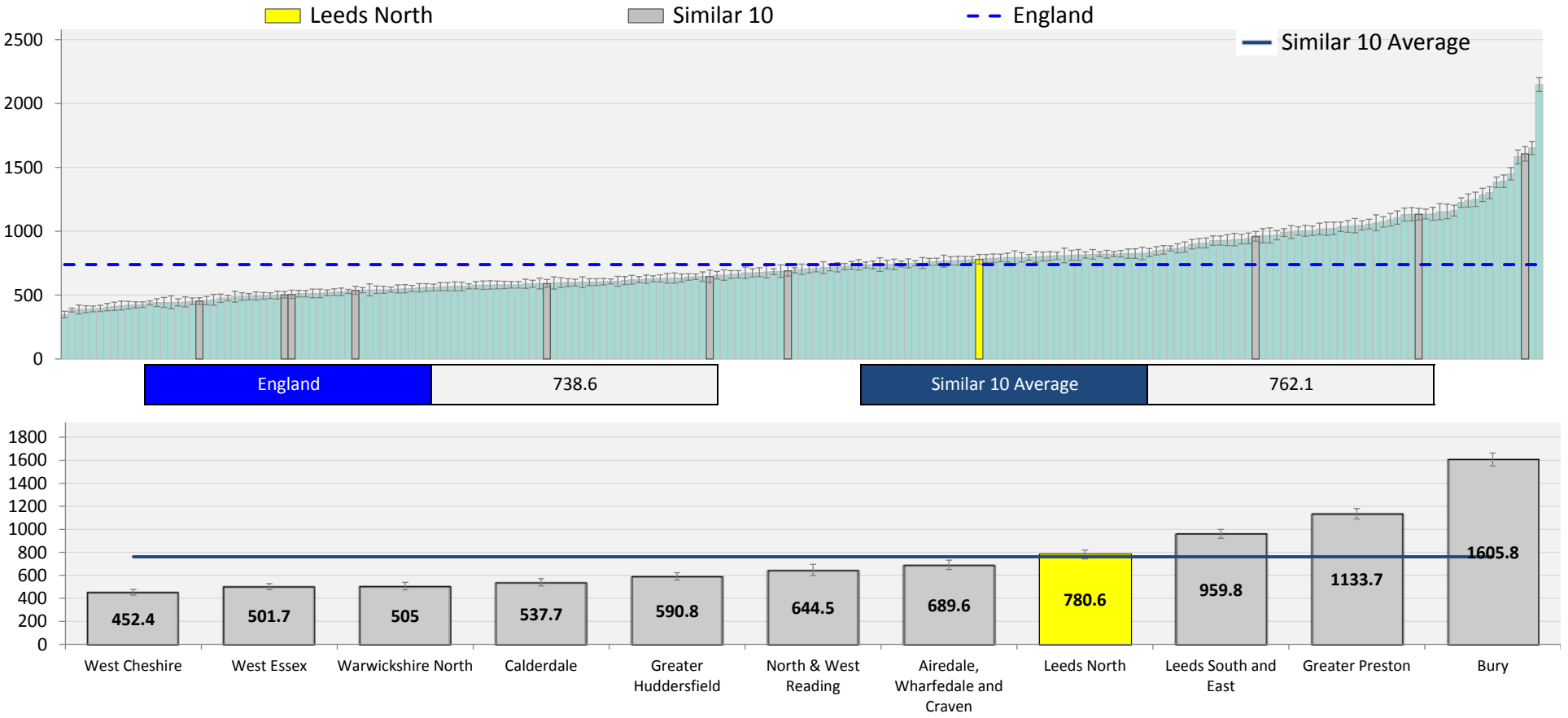
Rate of people in contact with secondary mental health services per 100,000 - Apr-Aug 14/15



This indicator shows the rate of people accessing secondary mental health services between April and August 2014. In September 2014 learning disabilities patients were included in the mental health dataset. CCGs should look for any significant change in rate compared to similar CCGs between this indicator and the indicator on the following page.

Definition: Rate of people in contact with secondary mental health services per 100,000 - Apr-Aug 14/15
Source: MHLDDS
Year: Apr-Aug2014

Rate of people in contact with secondary mental health and learning disabilities services per 100,000 - Sep-Mar 1415



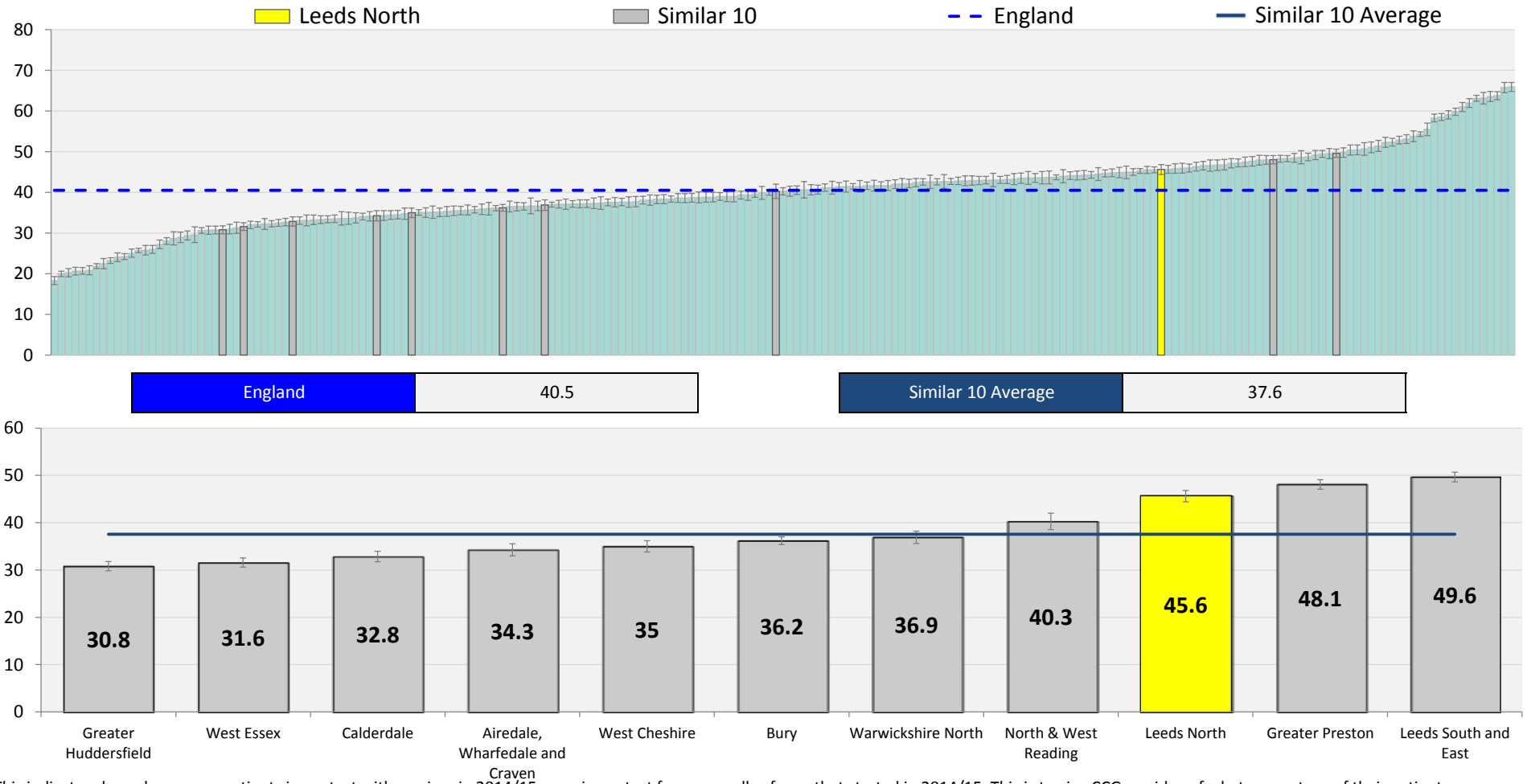
This indicator shows the rate of patients accessing mental health or learning disabilities services between September 2014 and March 2015. From September 2014 patients accessing learning disabilities services were included in the dataset. Many people who have a learning disability use mental health services and people in learning disability services may have a mental health problem. Therefore activity cannot be distinctly divided into mental health or learning disability spells of care – a single spell of care may include inputs from either of both types of service. CCGs should consider the extent to which relative rates of contact increased in this period compared to similar CCGs.

Definition: Rate of people in contact with secondary mental health and learning disabilities services per 100,000 - Sep-Mar 1415

Source: MHLDDS

Year: Sep-Mar1415

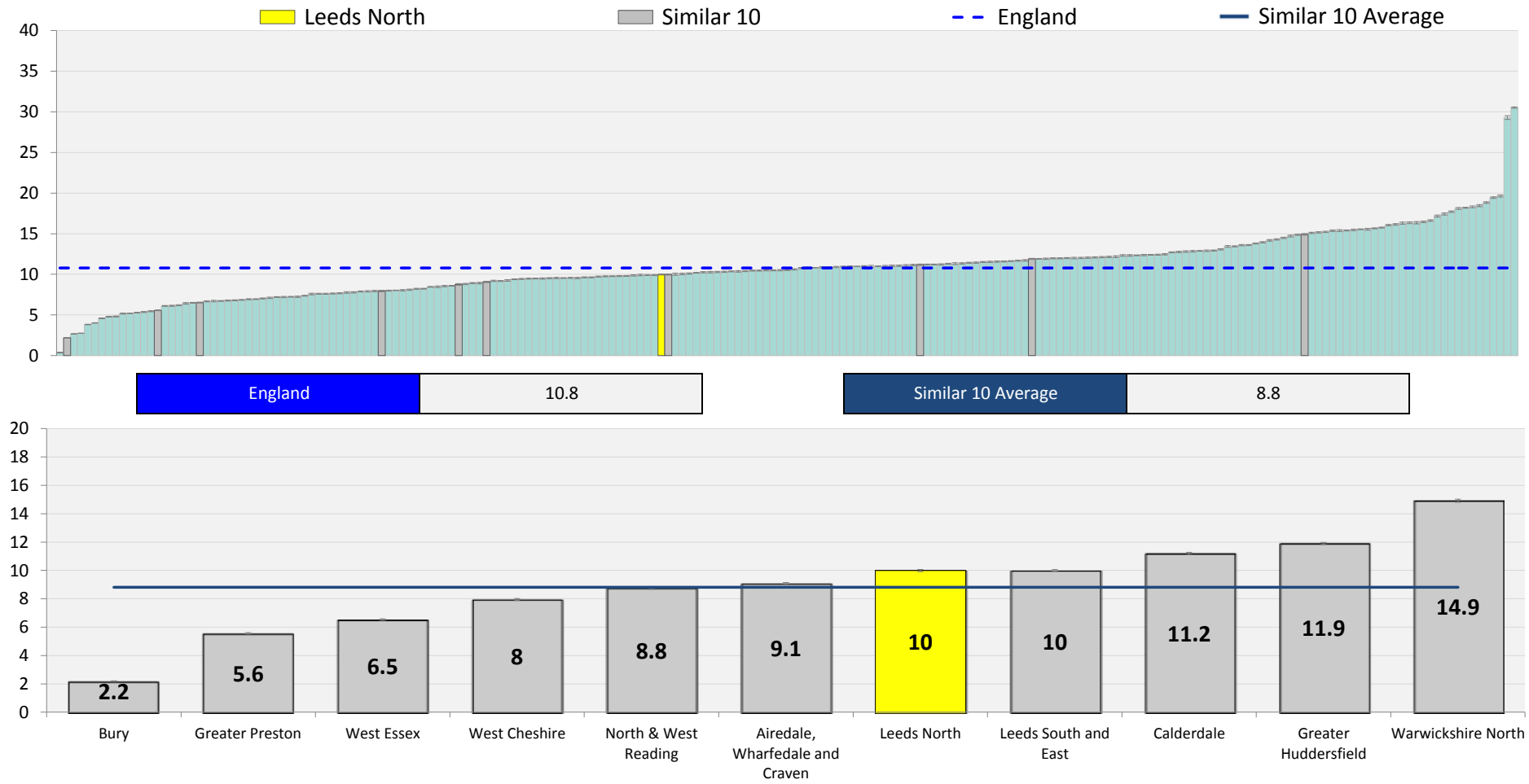
Percentage of all contacts with services that were new contacts for 2014/15



This indicator shows how many patients in contact with services in 2014/15 were in contact for new spells of care that started in 2014/15. This is to give CCGs an idea of what percentage of their patients were new in 2014/15 vs those who had accessed services prior to 2014/15 and were continuing to do so.

Definition: Percentage of all contacts with services that were new contacts for 2014/15
Source: MHLDDS
Year: 2014/15

Average contacts with a healthcare professional per patient



This indicator shows the average number of contacts a patient had with a healthcare professional during 2014/15. This needs local interpretation by CCGs to consider whether high or low average contacts are good or bad; CCGs should consider other indicators related to contacts, clustering and admissions to understand the case mix of people in contact and the complexity of their needs.

Definition: Average contacts with a healthcare professional per patient
Source: MHLDDS
Year: 2014/15

Cluster assignments

Mental Health clustering is used to cluster groups of people with similar characteristics, identified from a holistic assessment, and then rated using the Mental Health Clustering Tool. Patients should be assessed and clustered at the end of an initial assessment, at all planned CPA or other formal care reviews, and at other points where a significant change in planned care is deemed necessary.

In the absence of complete diagnostic information in the mental health data set, information related to clusters of patients is presented to help CCGs understand the types of patients accessing their services and their possible service needs.

There are three core groups of clusters:

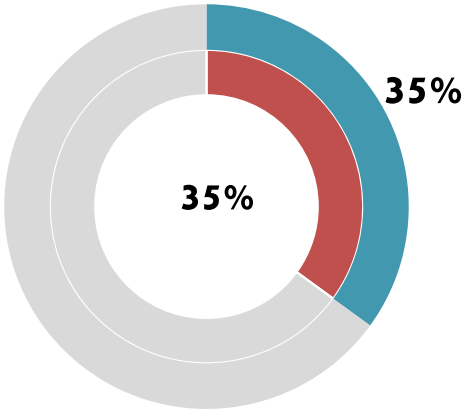
- Non-psychotic - common mental health problems, problems involving depressed mood, severe mood disturbance, anxiety or other disorders, chaotic and challenging disorders -not including psychosis.
- Psychosis - psychotic symptoms
- Organic - organic brain disorders, cognitive impairments, dementia

Information is presented at the Super Class level (Non-psychotic, Psychosis, Organic) rather than at the individual cluster level to ensure robustness of data presented as far as possible. Not all patients are allocated to a mental health cluster. CCGs should explore locally reasons for this.

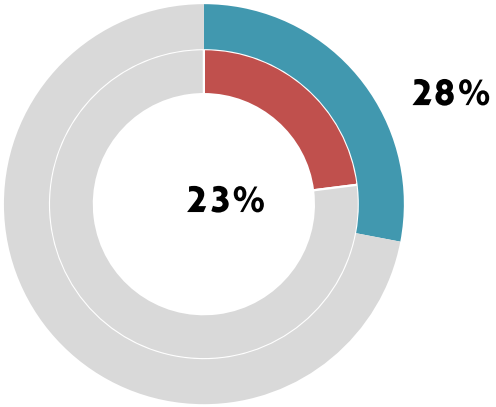
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499475/Annex_B4_Mental_health_clustering_booklet.pdf

NHS Leeds North CCG - Clusters Profile

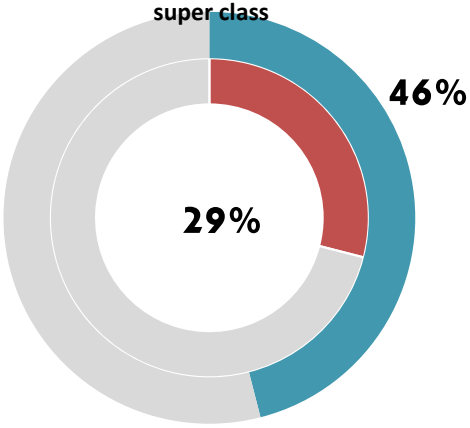
% All patients who have been assigned to a mental health cluster



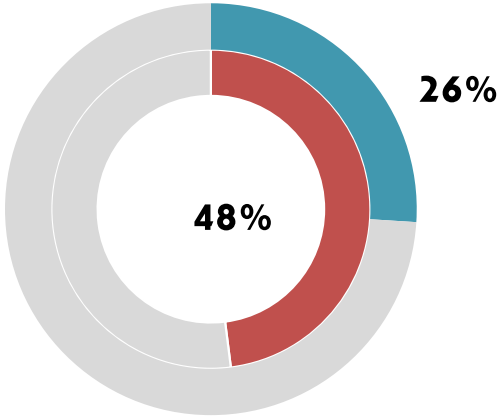
% People allocated to a cluster that are in the Psychotic super class



% People allocated to a cluster that are in the Non-psychotic super class



% People allocated to a cluster that are in the Organic super class

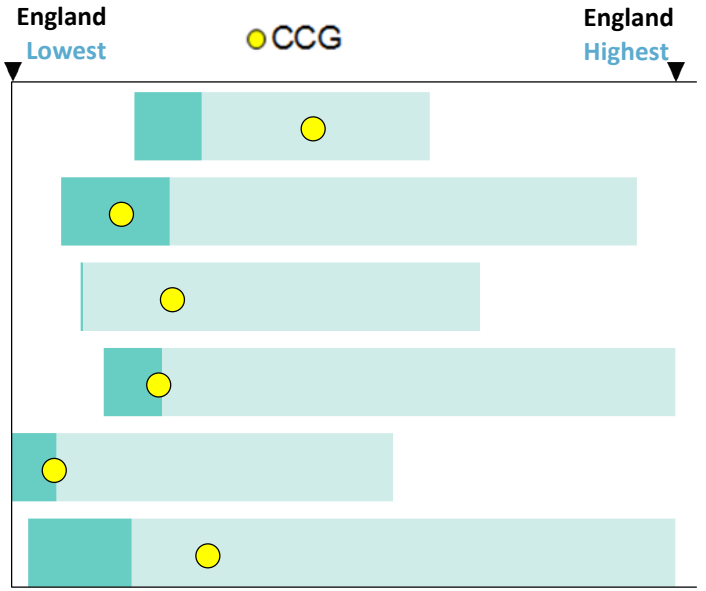


CCG

Average of similar 10 CCGs

Mental Health Clustering

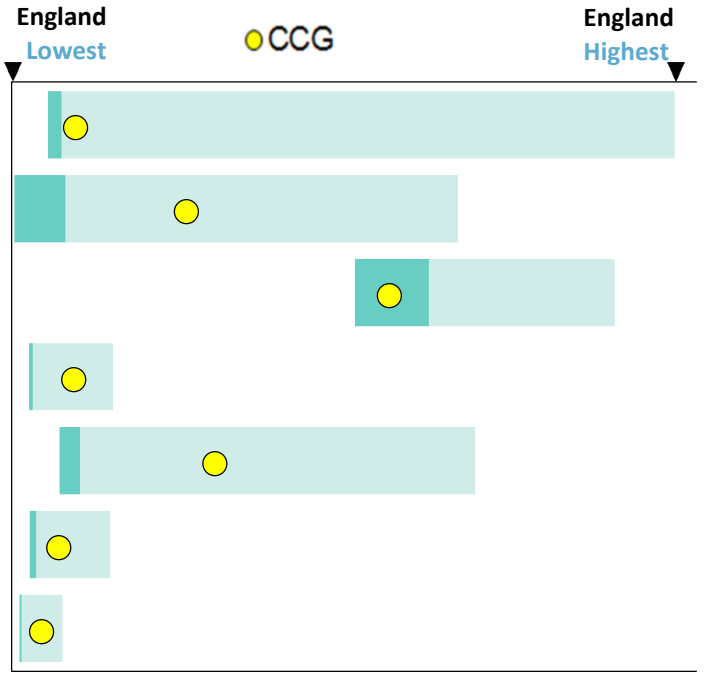
Indicator	Time Period	CCG Value
Percentage of all patients in contact with secondary mental health/learning disabilities services who have been assigned to a mental health cluster	2014/15	35.4
Percentage of people allocated to a cluster that are in the Non-psychotic super class (1-8)	2014/15	29.5
Percentage of people allocated to a cluster that are in the Common mental health problems clusters (1-2)	2014/15	3.0
Percentage of people allocated to a cluster that are in the Non-psychotic clusters (3-7)	2014/15	24.1
Percentage of people allocated to a cluster that are in the Chaotic and challenging behaviours cluster (8)	2014/15	2.2
Percentage of people allocated to a cluster that are in the Psychotic super class (10-17)	2014/15	23.0



These indicators show what percentage of all patients allocated to a cluster are in specific cluster groups. They do not include patients that are not allocated to a cluster group; percentage of all patients allocated to a cluster is shown in the first indicator. Individual clusters included in each group are shown in brackets. Common mental health conditions (1-2), non-psychotic (3-7) and chaotic and challenging behaviours (8) indicators are a sub-set of the overall Non-psychotic super class (1-8). Percentage of patients in the Organic super class is shown in the Dementia section of this pack. The Common Mental Health conditions cluster is often used as a holding cluster and assignment to it can be poor. CCGs should use local information to inform understanding of patients in this cluster.

Mental Health Clustering continued

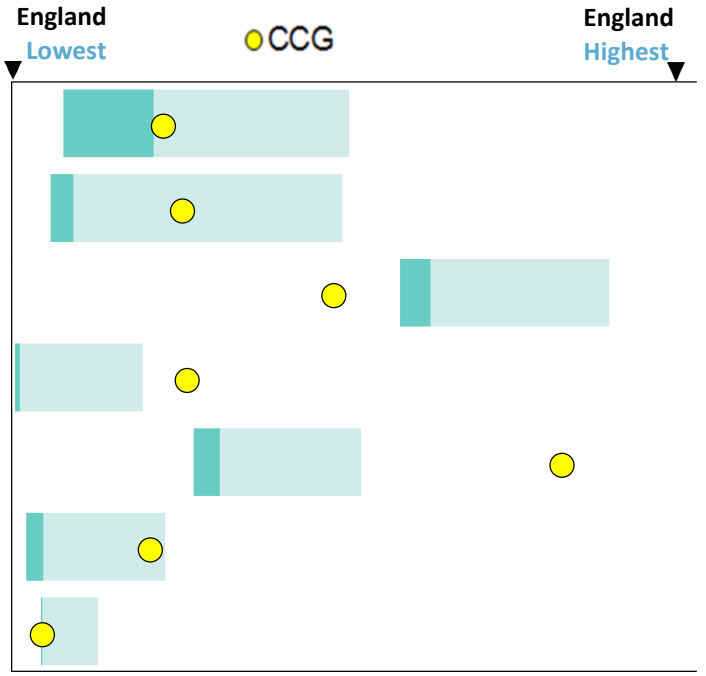
Indicator	Time Period	CCG Value
Rate of people aged 18-64 assigned to the Non-Psychotic super class (1-8) per 100,000 18-64 population	2014/15	391.4
Rate of people aged 65+ assigned to the Non-Psychotic super class (1-8) per 100,000 65+ population	2014/15	475.8
Percentage of people in the Non-psychosis super class who are of White ethnicity	2014/15	73.7
Percentage of people in the Non-psychosis super class who are of Black/Black British ethnicity	2014/15	1.5
Percentage of people in the Non-psychosis super class who are of Mixed ethnicity	2014/15	1.5
Percentage of people in the Non-psychosis super class who are of Asian/Asian British ethnicity	2014/15	3.0
Percentage of people in the Non-psychosis super class who are of Other ethnicity	2014/15	1.5



These indicators show the percentage of patients within the Non-psychosis super class that are from different ethnicities. Figures may not sum to totals for other super class indicators as some patients do not have an ethnicity or valid ethnicity recorded. Note that figures are not standardised against the relevant population so CCGs should consider whether they have higher or lower percentages of people from each different ethnicity in their overall population compared to their similar CCGs.

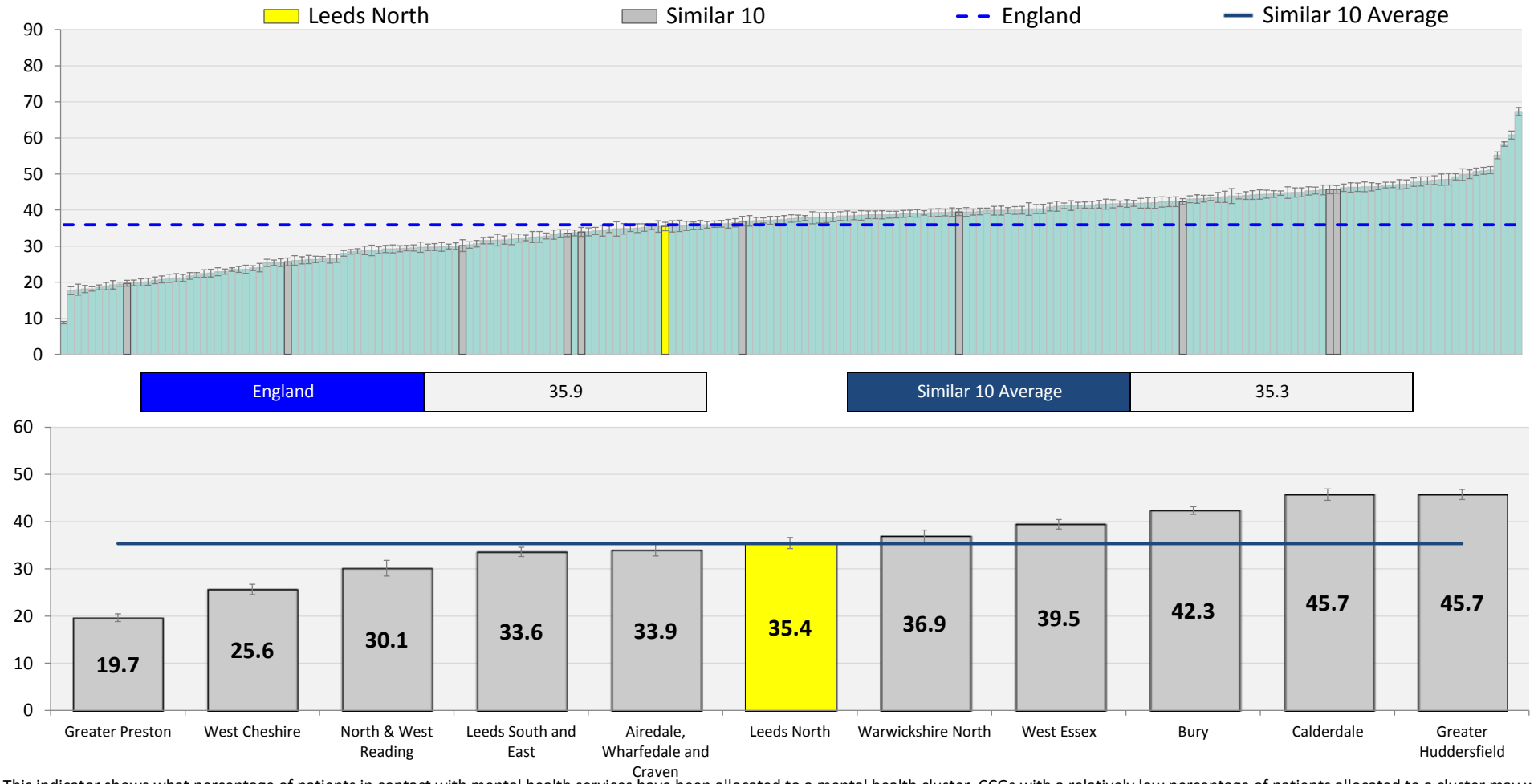
Mental Health Clustering continued

Indicator	Time Period	CCG Value
Rate of people aged 18-64 assigned to the Psychosis super class (10-17) per 100,000 18-64 population	2014/15	326.5
Rate of people aged 65+ assigned to the Psychosis super class (10-17) per 100,000 65+ population	2014/15	301.1
Percentage of people in the Psychosis cluster who are of White ethnicity	2014/15	61.5
Percentage of people in the Psychosis cluster who are of Black/Black British ethnicity	2014/15	13.5
Percentage of people in the Psychosis cluster who are of Mixed ethnicity	2014/15	4.8
Percentage of people in the Psychosis cluster who are of Asian/Asian British ethnicity	2014/15	12.5
Percentage of people in the Psychosis cluster who are of Other ethnicity	2014/15	1.0



These indicators show the percentage of patients within the Psychosis super class that are from different ethnicities. Figures may not sum to totals for other super class indicators as some patients do not have an ethnicity or valid ethnicity recorded. Note that figures are not standardised against the relevant population so CCGs should consider whether they have higher or lower percentages of people from each different ethnicity in their overall population compared to their similar CCGs.

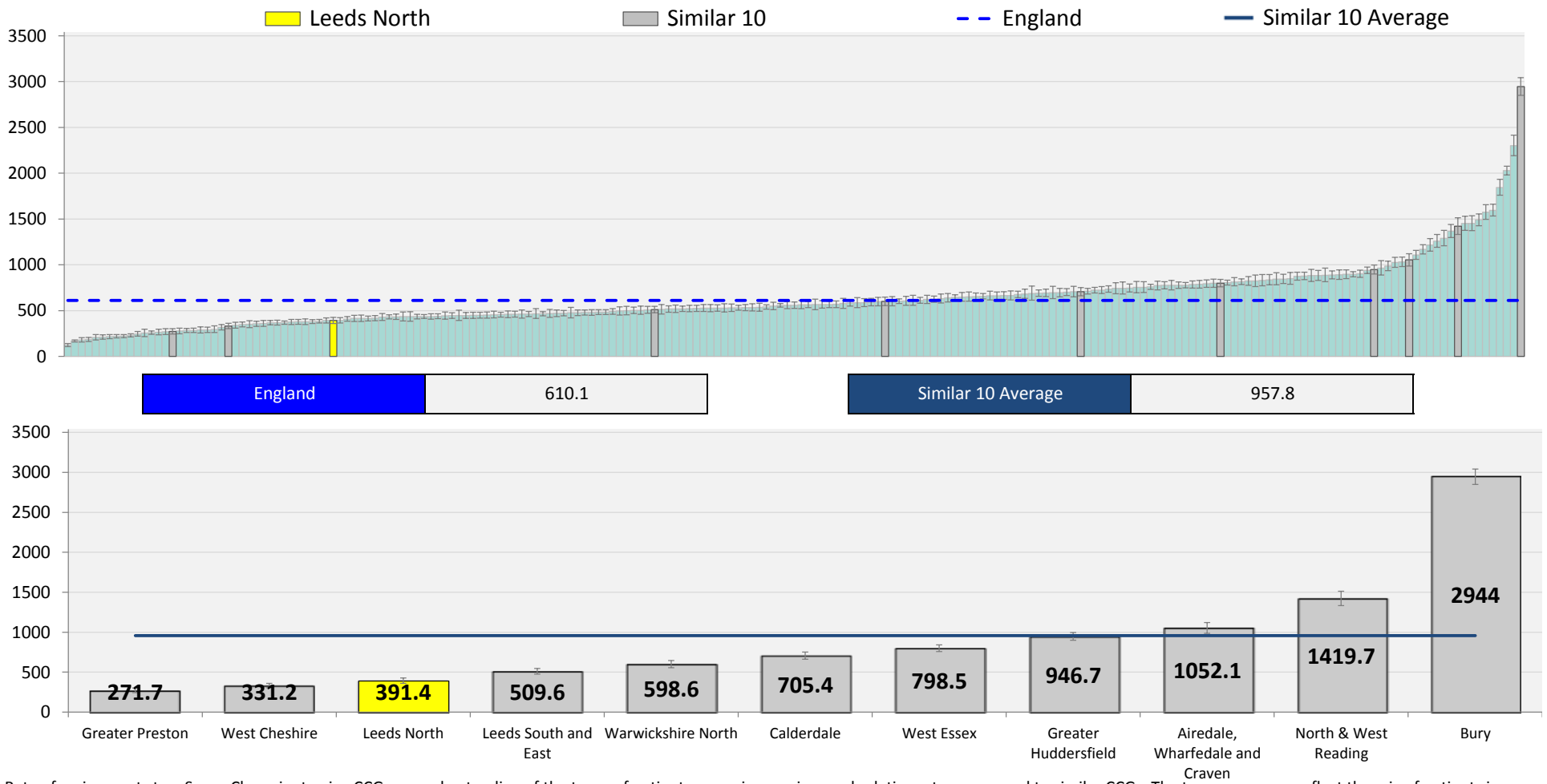
Percentage of all patients in contact with secondary mental health/learning disabilities services who have been assigned to a mental health cluster



This indicator shows what percentage of patients in contact with mental health services have been allocated to a mental health cluster. CCGs with a relatively low percentage of patients allocated to a cluster may wish to explore reasons for this locally.

Definition: Percentage of all patients in contact with secondary mental health/learning disabilities services who have been assigned to a mental health cluster
Source: MHLDDS
Year: 2014/15

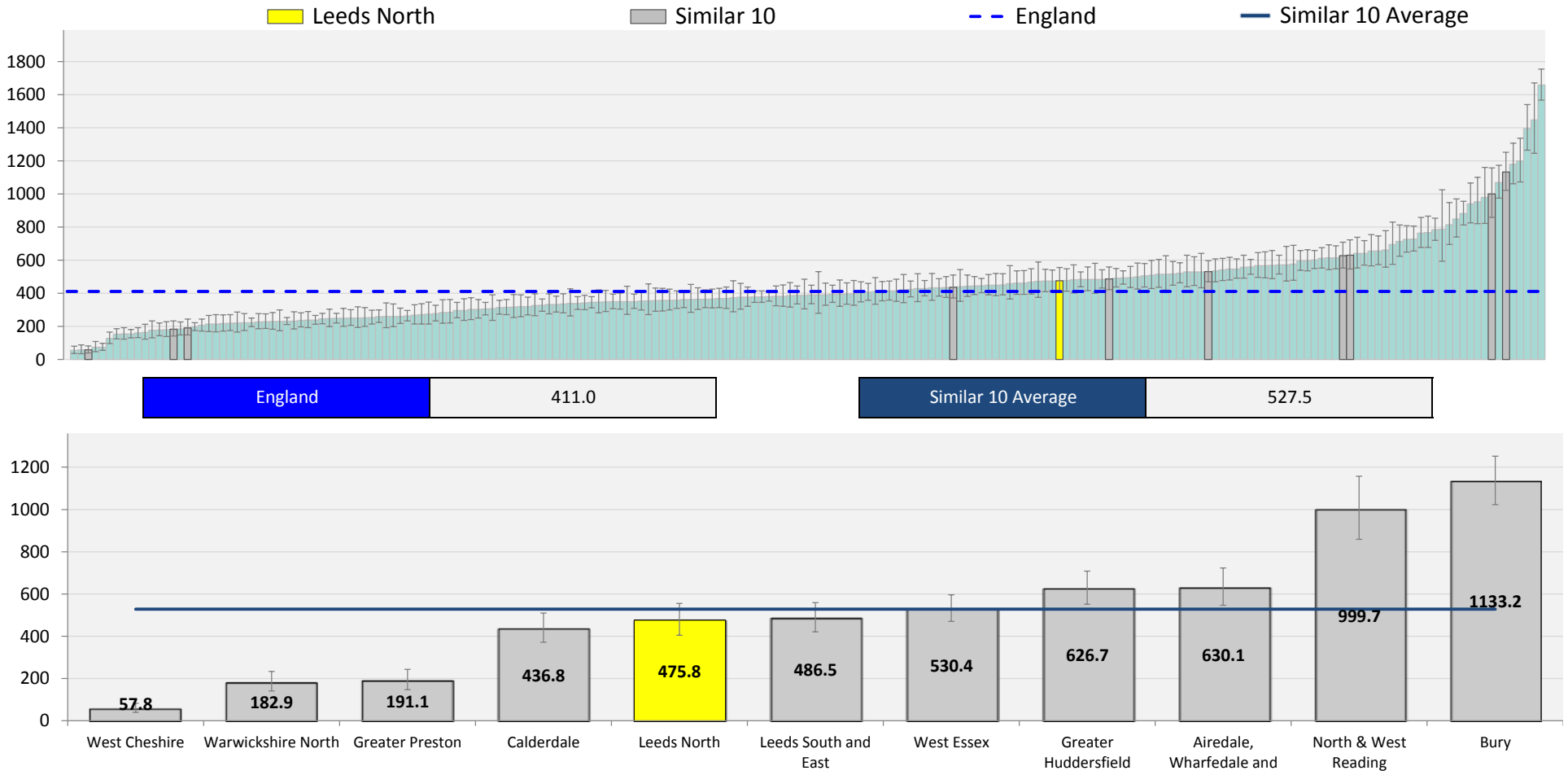
Rate of people aged 18-64 assigned to the Non-Psychotic super class (1-8) per 100,000 18-64 population



Rate of assignments to a Super Class aim to give CCGs an understanding of the types of patients accessing services and relative rates compared to similar CCGs. The two age groups reflect the mix of patients in different clusters. CCGs with a high % age of patients allocated to a cluster may have higher rates; indicators should be considered together. Rates are age/sex standardised.

Definition: Rate of people aged 18-64 assigned to the Non-Psychotic super class (1-8) per 100,000 18-64 population
Source: MHLDDS
Year: 2014/15

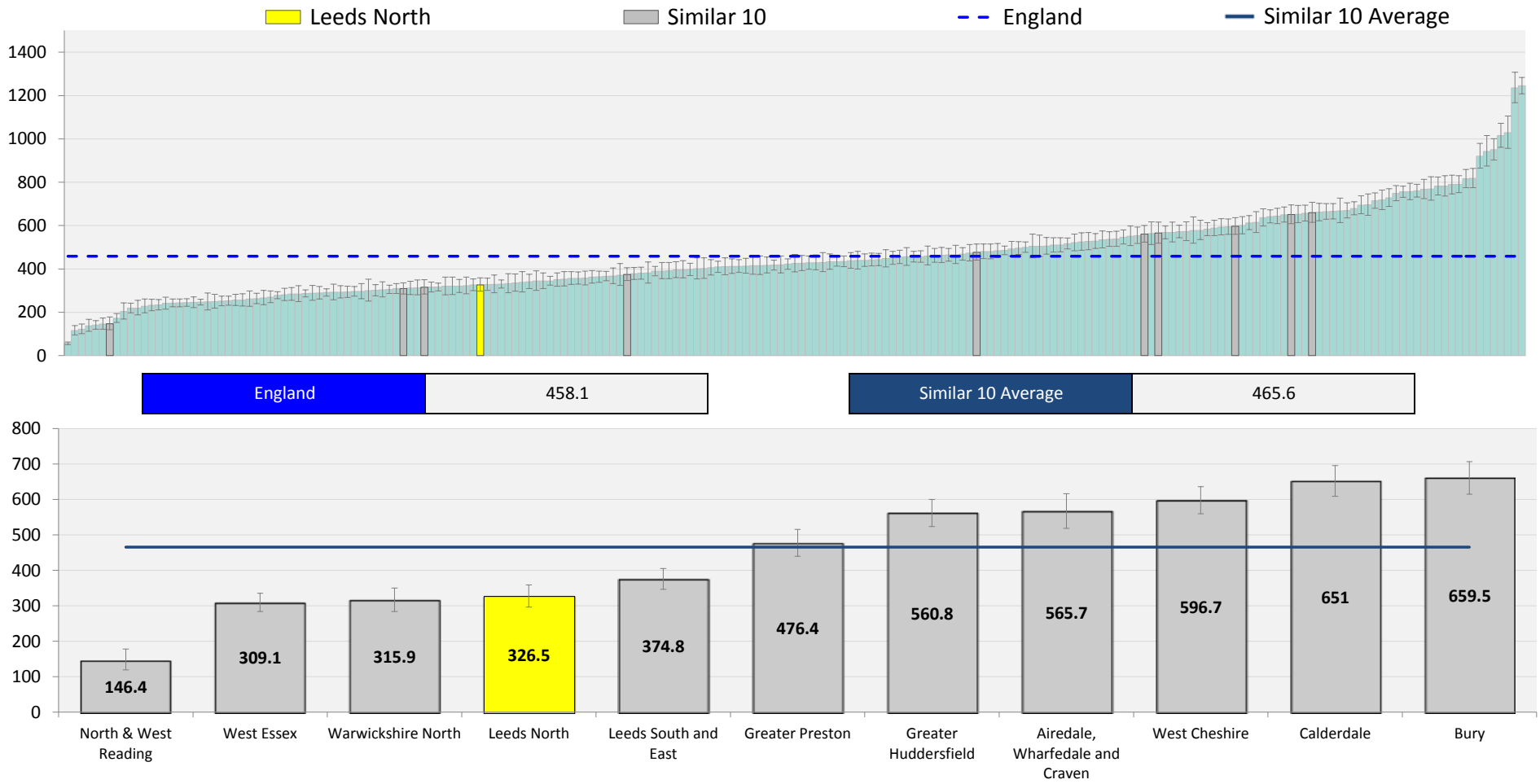
Rate of people aged 65+ assigned to the Non-Psychotic super class (1-8) per 100,000 65+ population



Rate of assignments to a Super Class aim to give CCGs an understanding of the types of patients accessing services and relative rates compared to similar CCGs. The two age groups reflect the mix of patients in different clusters. CCGs with a high % age of patients allocated to a cluster may have higher rates; indicators should be considered together. Rates are age/sex standardised.

Definition: Rate of people aged 65+ assigned to the Non-Psychotic super class (1-8) per 100,000 65+ population
Source: MHLDDS
Year: 2014/15

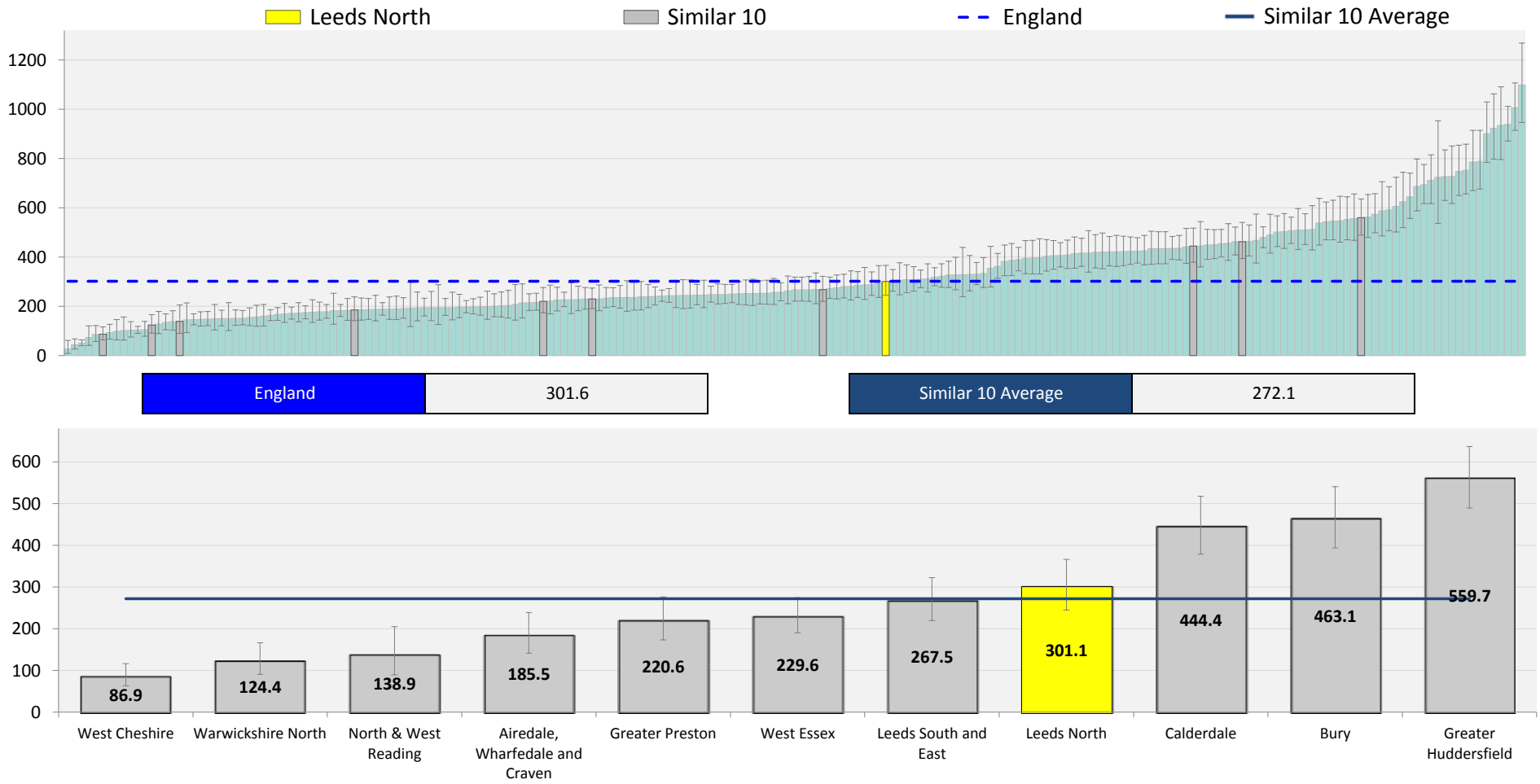
Rate of people aged 18-64 assigned to the Psychosis super class (10-17) per 100,000 18-64 population



Rate of assignments to a Super Class aim to give CCGs an understanding of the types of patients accessing services and relative rates compared to similar CCGs. The two age groups reflect the mix of patients in different clusters. CCGs with a high % age of patients allocated to a cluster may have higher rates; indicators should be considered together. Rates are age/sex standardised.

Definition: Rate of people aged 18-64 assigned to the Psychosis super class (10-17) per 100,000 18-64 population
Source: MHLDDS
Year: 2014/15

Rate of people aged 65+ assigned to the Psychosis super class (10-17) per 100,000 65+ population



Rate of assignments to a Super Class aim to give CCGs an understanding of the types of patients accessing services and relative rates compared to similar CCGs. The two age groups reflect the mix of patients in different clusters. CCGs with a high % age of patients allocated to a cluster may have higher rates; indicators should be considered together. Rates are age/sex standardised.

Definition: Rate of people aged 65+ assigned to the Psychosis super class (10-17) per 100,000 65+ population
Source: MHLDDS
Year: 2014/15

Early intervention in psychosis

An Early Intervention in Psychosis (EIP) service is a multidisciplinary community mental health service that provides treatment and support to people experiencing or at high risk of developing psychosis. This support typically continues for three years.

The defining characteristic of an EIP service is its strong ethos of hope and whole-team commitment to enabling recovery through the provision of individually tailored, evidence-based interventions and support to service users and their families / carers.

Psychosis is characterised by hallucinations, delusions and a disturbed relationship with reality, and can cause considerable distress and disability for the person and their family or carers. A diagnosis of schizophrenia, bipolar disorder, psychotic depression or other less common psychotic disorder will usually be made, although it can take months or even years for a final diagnosis.

Treatment can begin as soon as a provisional diagnosis of first episode psychosis is made – it does not have to wait for a final diagnosis. EIP services are evidence-based, cost-saving and preferred by service users and carers over generic services.

People who experience psychosis can and do recover. The time from onset of psychosis to the provision of evidence-based treatment has a significant influence on long-term outcomes. The sooner treatment is started the better the outcome and the lower the overall cost of care.

To improve access to EIP services, NHS England has introduced an access and waiting time standard: https://www.england.nhs.uk/mentalhealth/resources/access-waiting-time/

Early intervention in psychosis case studies

Berkshire

A digital dashboard showing daily updates of progress against the new access and waiting time standard for early intervention in psychosis is helping improve outcomes in Berkshire. The tool was created at Berkshire Healthcare NHS Foundation Trust so clinicians could make sure people receive the early help they need and to evaluate performance against each NICE standard. A video

A video is available here: https://www.youtube.com/watch?v=xcqvTqgWkw8

Salford

In September 2016 NHS Clinical Commissioners published the *Support from the Start* report, Included is a case study of an early intervention initiative introduced in Salford which introduced support workers to help people access activities, engage with job centres, or help with their physical health. The report can be found at: http://445oon4dhpii7gjvs2jih81q.wpengine.netdna-cdn.com/wp-content/uploads/2016/09/NHSCC_Support-from-the-start_final.pd

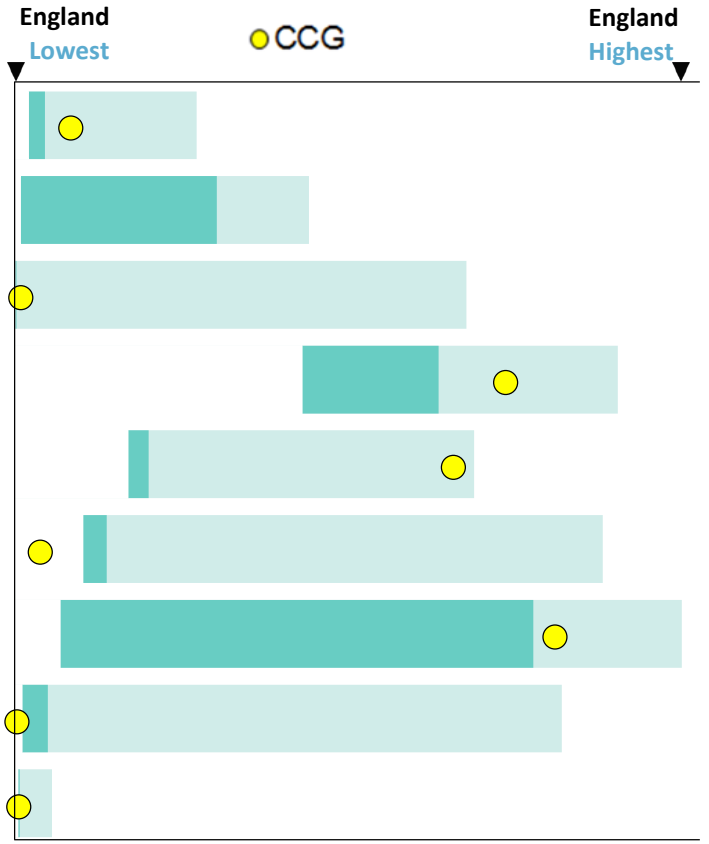
Cornwall

This YouTube video provides details of an early intervention initiative in Cornwall where an employment support scheme for people receiving treatment for first episode psychosis helped more than half into full-time education, jobs or work placements and improved self-esteem.

https://www.youtube.com/watch?v=G9xsEpAKM88

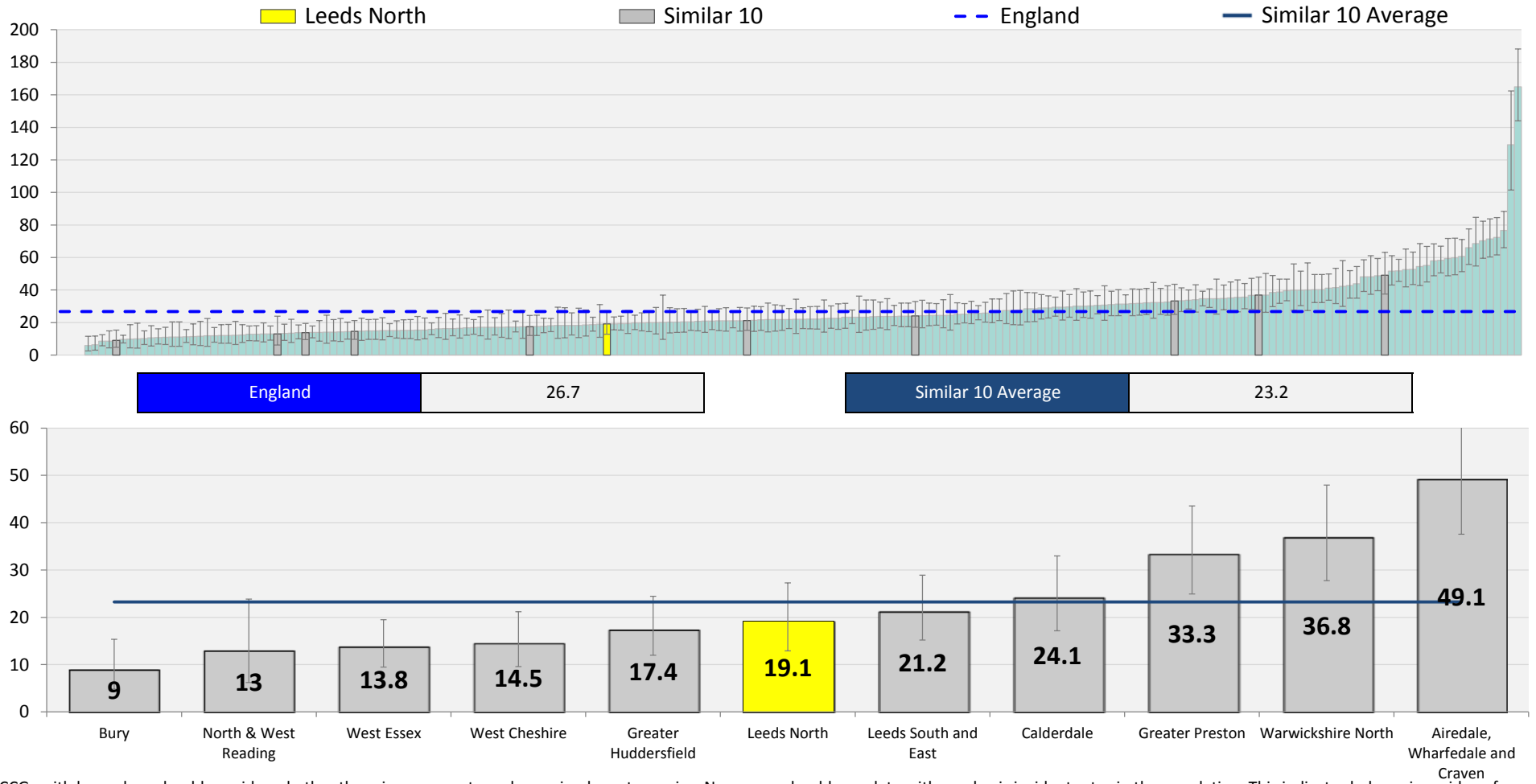
Early Intervention in Psychosis Service

Indicator	Time Period	CCG Value
Rate of new cases of psychosis served by Early Intervention Teams - per 100,000	2015/16 Q4	19.1
Rate of people being treated by Early Intervention Teams - per 100,000 (end of quarter snapshot)	2015/16 Q2	No Data
Early Intervention in Psychosis - Rate of appointments by people aged 18+ - per 100,000	2014/15	45.7
Early Intervention in Psychosis - Percentage of patients waiting less than 2 weeks to start EIP treatment – Percentage of all complete pathways	Apr-Aug2016	75.0
Early Intervention in Psychosis - Percentage of patients waiting more than 2 weeks to start EIP treatment – Percentage of all Incomplete pathways	Apr-Aug2016	70.0
Early Intervention in Psychosis- Rates of referral to services for people aged 18+ - per 100,000	2014/15	5.8
Early Intervention in Psychosis - Percentage of appointments that were attended	2014/15	81.3
Early Intervention in Psychosis - Rate of appointments where the patient did not attend and gave no advance warning - per 100,000 - 18+	2014/15	2.9
Early Intervention in Psychosis - Rate of appointments for people aged 18+ that were cancelled by the provider - per 100,000	2014/15	2.9



EIP waiting indicators are currently collected on UNIFY2. Data quality and completeness issues exist with the UNIFY collection, meaning some caution should be exercised when interpreting this data.NHS England is working with NHS Digital and others to determine criteria for a switch from UNIFY to MHSDS data as the source for RTT reporting, planned for 2017/18.

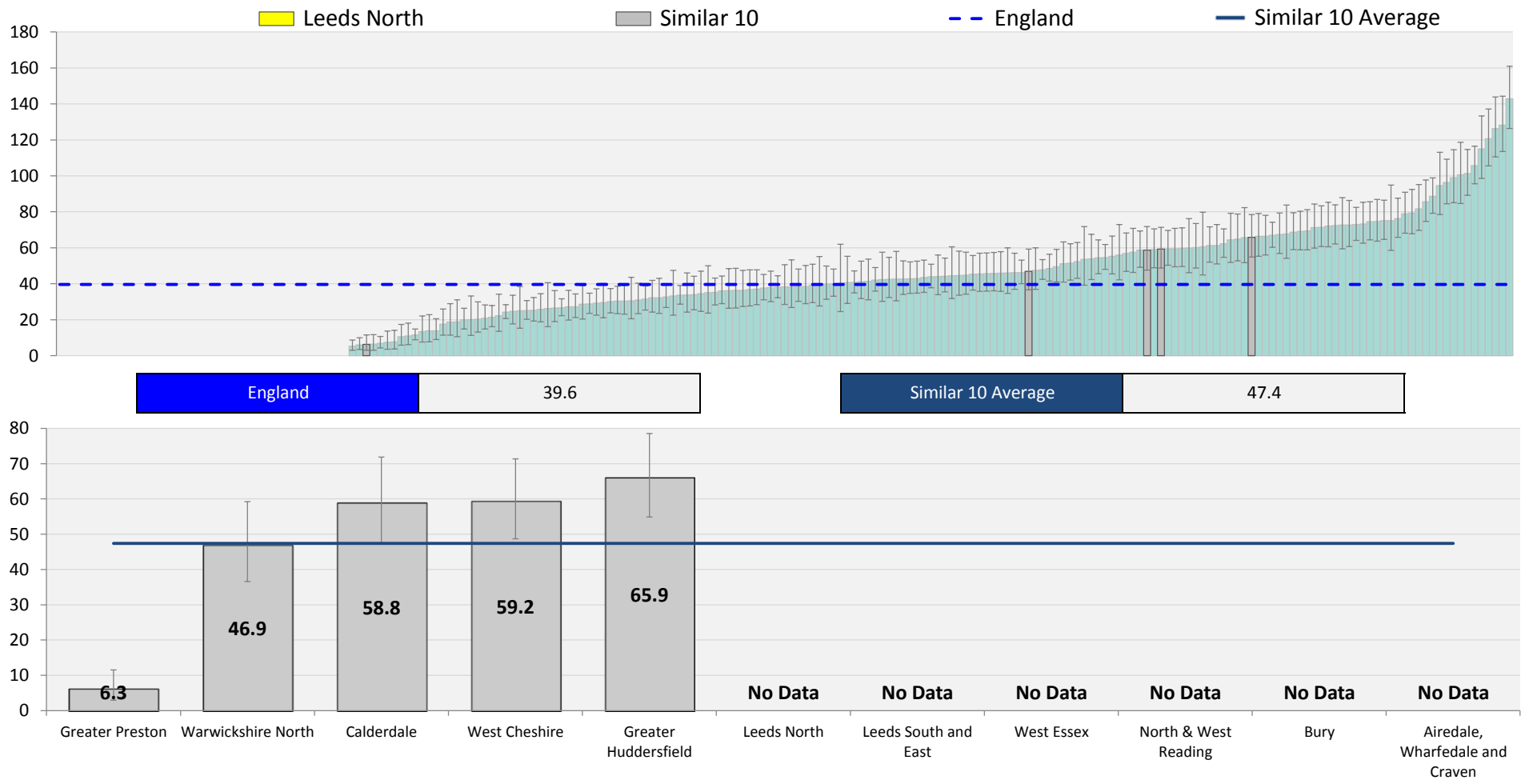
Rate of new cases of psychosis served by Early Intervention Teams - per 100,000



CCGs with low values should consider whether there is any unmet need or an inadequate service. New cases should correlate with psychosis incident rates in the population. This indicator helps gain an idea of coverage of Early Intervention Programmes (which will also include bipolar disorder and people assessed but not confirmed with psychosis).

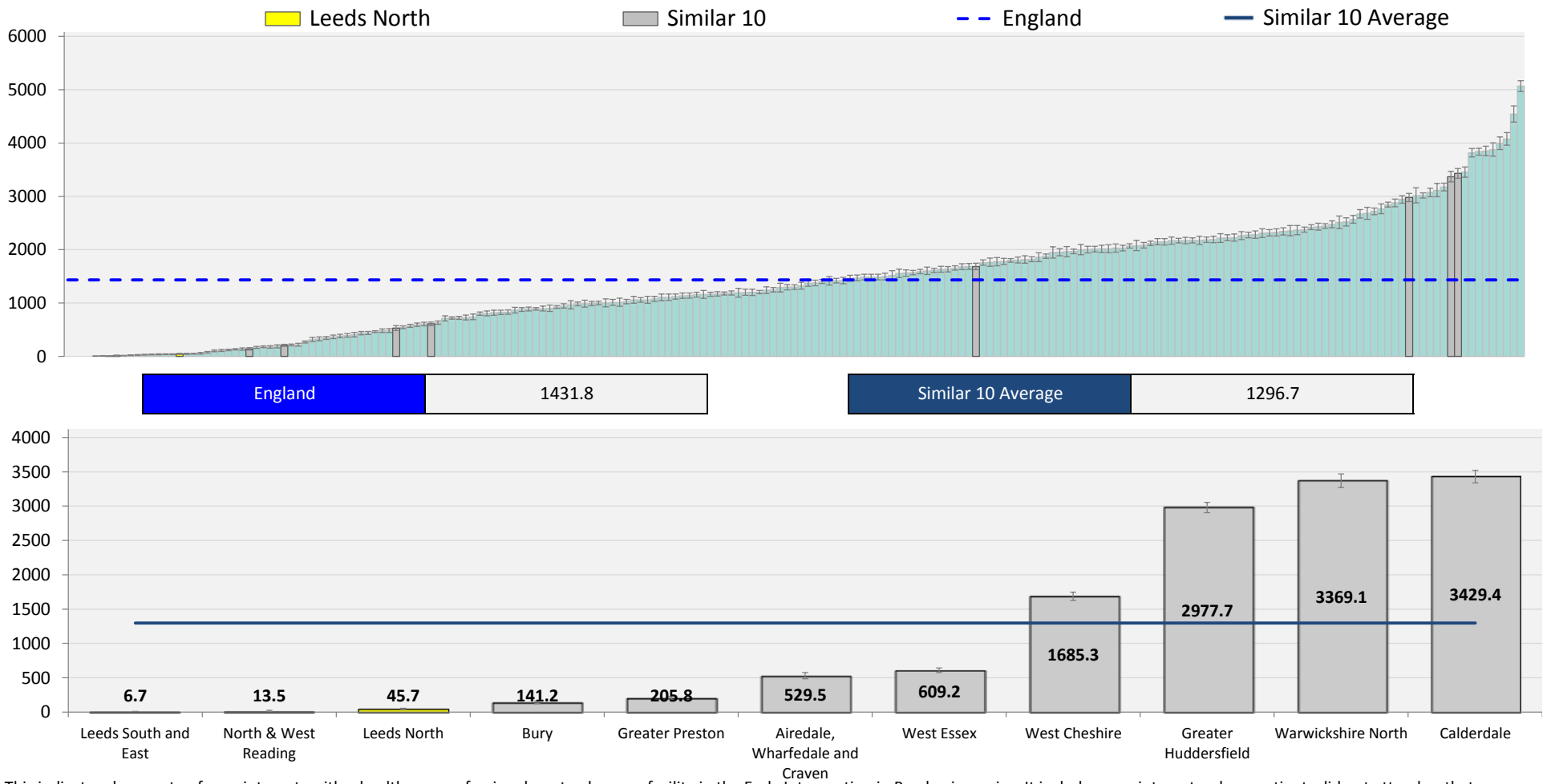
Definition: Rate of new cases of psychosis served by Early Intervention Teams - per 100,000
Source: Mental Health Community Teams Activity, PHE Fingertips Severe Mental Illness Profile
Year: 2015/16 Q4

Rate of people being treated by Early Intervention Teams - per 100,000 (end of quarter snapshot)



Definition: Rate of people being treated by Early Intervention Teams - per 100,000 (end of quarter snapshot)
Source: Health & Social Care Information Centre (NHS Digital), PHE Fingertips Severe Mental Illness Profile
Year: 2015/16 Q2

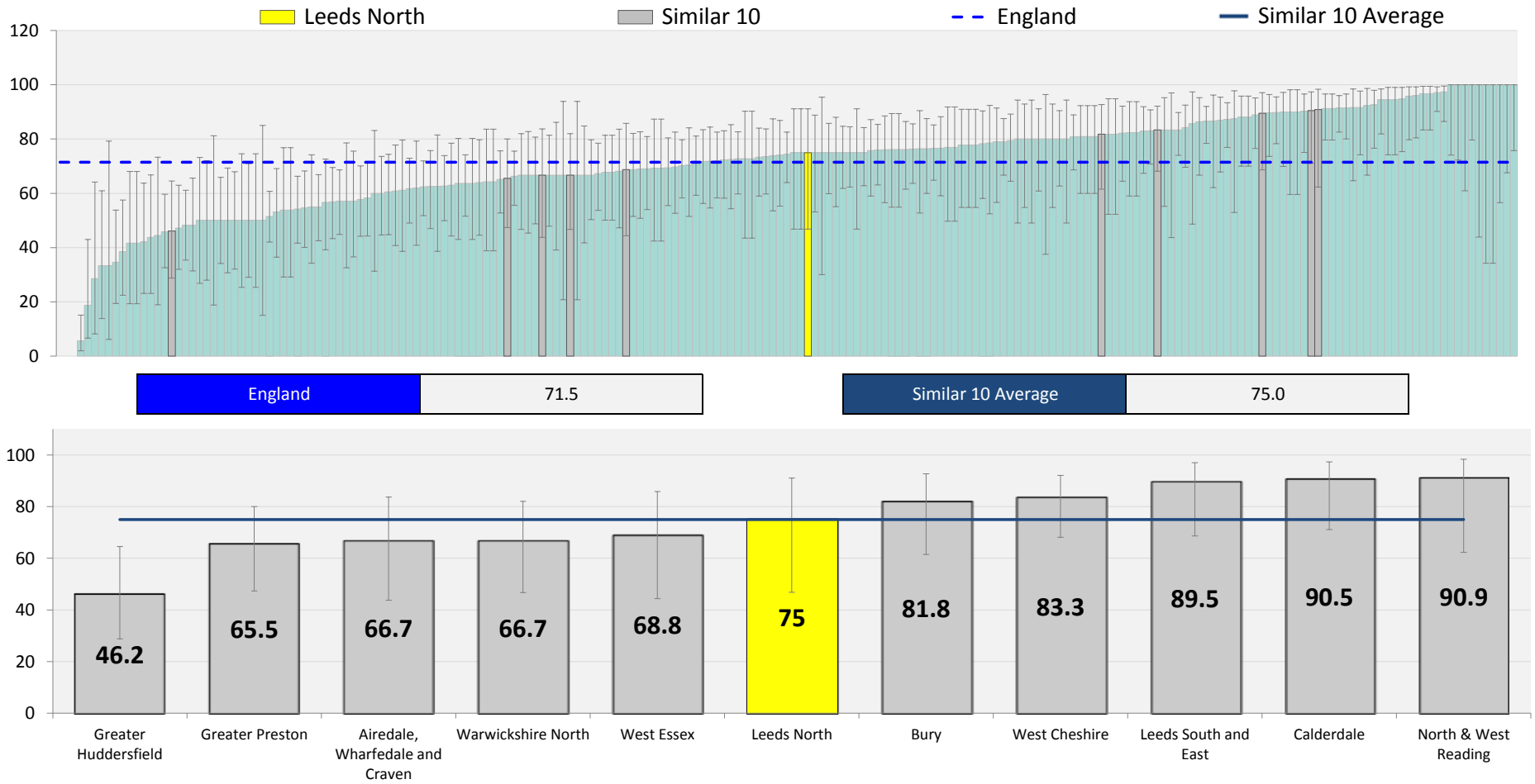
Early Intervention in Psychosis - Rate of appointments by people aged 18+ - per 100,000



This indicator shows rate of appointments with a healthcare professional or at a day care facility in the Early Intervention in Psychosis service. It includes appointments where patients did not attend or that were subsequently cancelled by the patient or the provider. It should therefore be considered alongside the indicator showing what proportion of appointments were attended.

Definition: Early Intervention in Psychosis - Rate of appointments by people aged 18+ - per 100,000
Source: MHLDDS
Year: 2014/15

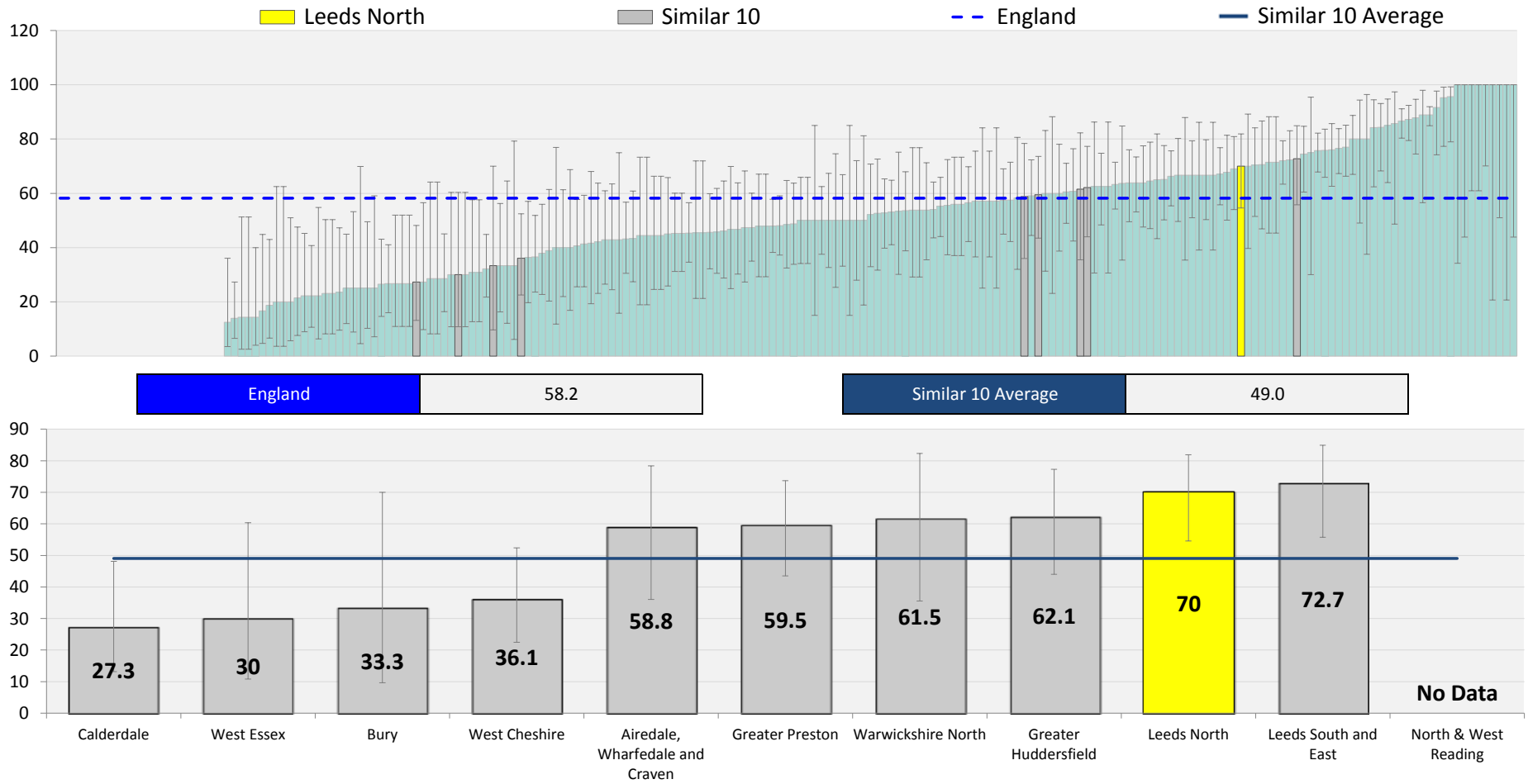
Early Intervention in Psychosis - Percentage of patients waiting less than 2 weeks to start EIP treatment – Percentage of all complete pathways



This indicator shows the percentage of patients who started EIP treatment in less than 2 weeks out of all patients who have started treatment.The waiting time standard requires that, from 1 Apr 2016 more than 50% of people experiencing first episode psychosis will be treated with a NICE-approved care package within two weeks of referral. The standard is targeted at people aged 14-65. Data quality and completeness issues exist with the UNIFY collection, meaning some caution should be exercised when interpreting this data.NHS England is working with NHS Digital and others to determine criteria for a switch from UNIFY to MHSDS data as the source for RTT reporting, planned for 2017/18.

Definition: Early Intervention in Psychosis - Percentage of patients waiting less than 2 weeks to start EIP treatment – Percentage of all complete pathways
Source: Unify2 data collection - First Episode Psychosis
Year: Apr-Aug2016

Early Intervention in Psychosis - Percentage of patients waiting more than 2 weeks to start EIP treatment – Percentage of all Incomplete pathways



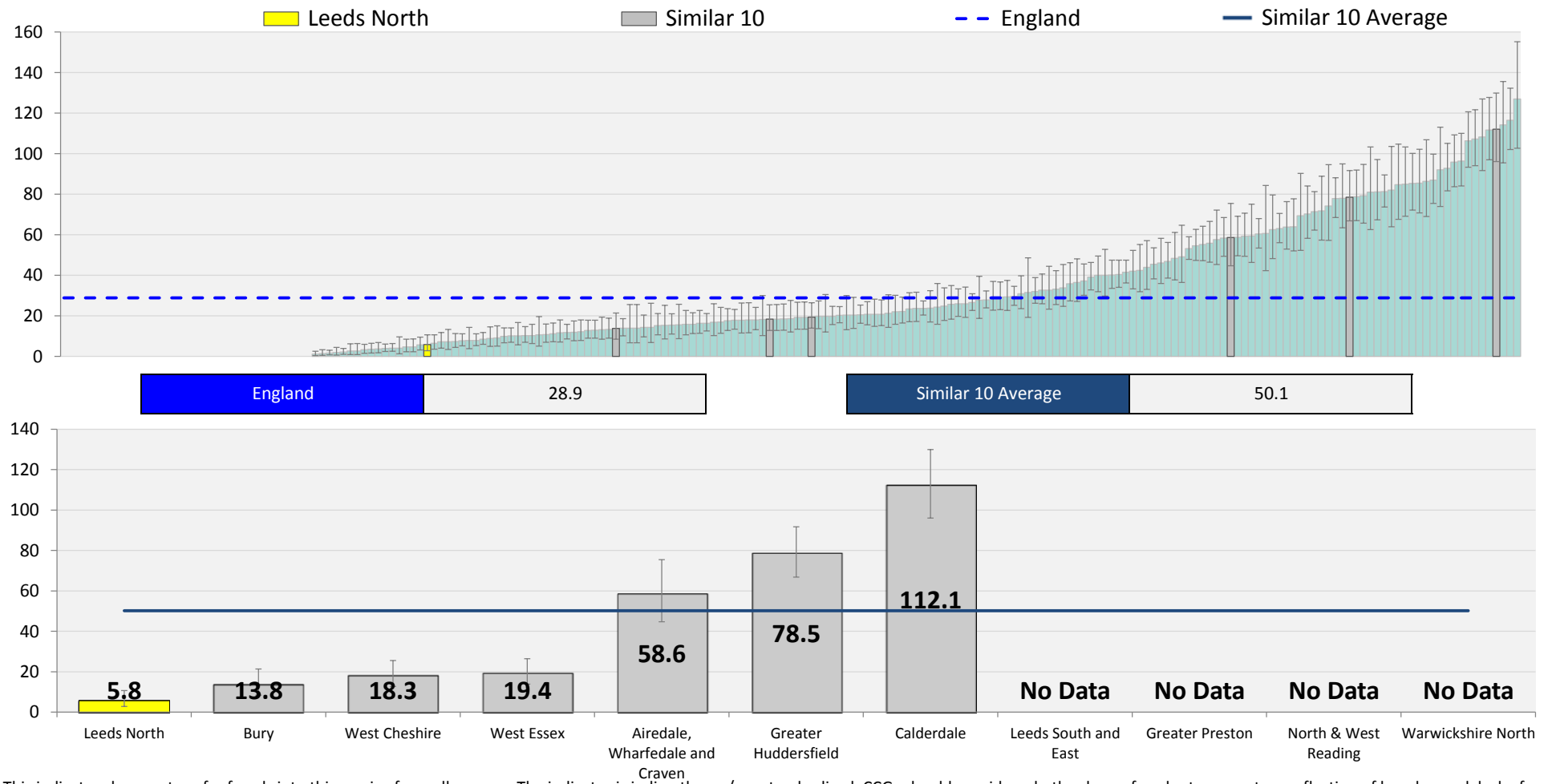
This indicator shows the percentage of patients who started EIP treatment in more than 2 weeks out of all patients who have not yet started treatment.The waiting time standard requires that,from 1 Apr 2016 more than 50% of people experiencing first episode psychosis will be treated with a NICE-approved care package within two weeks of referral.The standard is targeted at people aged 14-65. Data quality and completeness issues exist with the UNIFY collection, meaning some caution should be exercised when interpreting this data.NHS England is working with NHS Digital and others to determine criteria for a switch from UNIFY to MHSDS data as the source for RTT reporting, planned for 2017/18.

Definition: Early Intervention in Psychosis - Percentage of patients waiting more than 2 weeks to start EIP treatment – Percentage of all Incomplete pathways

Source: Unify2 data collection - First Episode Psychosis

Year: Apr-Aug2016

Early Intervention in Psychosis- Rates of referral to services for people aged 18+ - per 100,000



This indicator shows rates of referrals into this service from all sources. The indicator is indirectly age/sex standardised. CCGs should consider whether low referral rates are a true reflection of low demand, lack of adequate service availability, or potential unmet need in the population.

Definition: Early Intervention in Psychosis- Rates of referral to services for people aged 18+ - per 100,000
Source: MHLDDS
Year: 2014/15

Care Programme Approach (CPA)

The Care Programme Approach (CPA) is the national framework for mental health services assessment, care planning, review, care co-ordination, and service user and carer involvement focused on recovery.

The CPA framework includes arrangements for two types of support:

- CPA for people who have more complex needs, are at most risk or have mental health problems compounded by disadvantage, and need support from multiple agencies
- Lead Professional Care (LPC) for people who need secondary mental health services but have more straightforward needs involving contact with only one professional or one agency

Patients might be offered CPA support if they:

- are diagnosed as having a severe mental condition
- are at risk of suicide, self-harm, or harm to others
- are vulnerable; this could be for various reasons, such as physical or emotional abuse, financial difficulties because of mental illness or cognitive impairment
- have misused drugs or alcohol
- have learning disabilities
- rely significantly on the support of a carer, or have their own caring responsibilities
- have recently been detained under the Mental Health Act
- have parenting responsibilities
- have a history of violence or self-harm

Care Programme Approach (CPA)

Key messages

The overarching aim of CPA is to ensure that people with high levels of needs, who are likely to be receiving support from more than one agency, are supported by an allocated care-coordinator in the planning, coordination and review of their care and recovery.

High levels of variation in the proportion of people in contact with MH services who are placed on to CPA may be indicative of variation in relation to the quality of care co-ordination, planning and review for patients with complex needs.

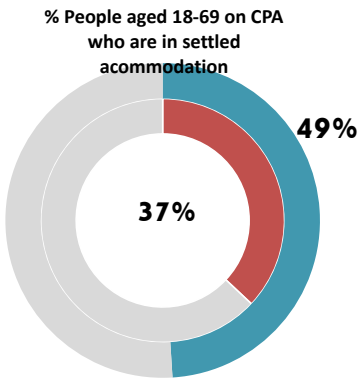
A review of the CPA framework will start in 2017/18 to ensure that it can better support:

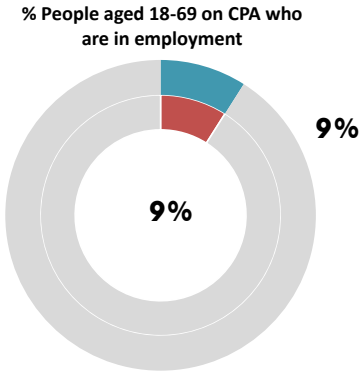
- Co-production with people who use services and shared decision-making
- Integration of health and social care, and implementation of the Care Act
- Integrated working with primary care with a specific focus on improved access to physical health checks and interventions
- Improved access to NICE interventions
- Recovery and values based care

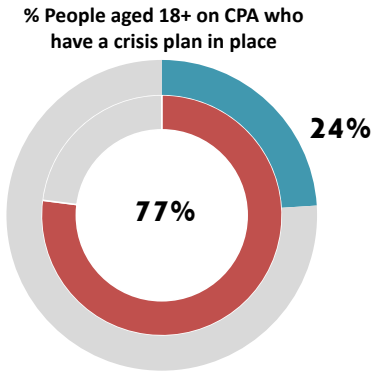
The review will also seek to reduce the administrative burden sometimes associated with the CPA.

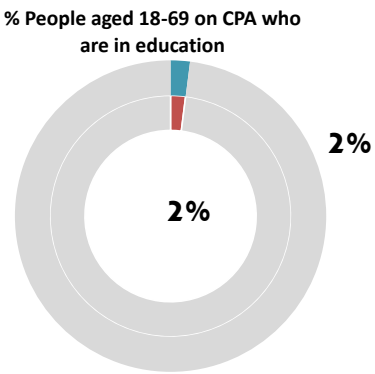
The Five Year Forward View for Mental Health committed the NHS to doubling access to evidence based employment support in the form of Individual Placement and Support (IPS) for patients with severe mental illness. An audit of existing IPS provision will be carried out in early 2017. The audit results will inform the strategy for expansion and development of new services, and the targeting of investment into STP areas to support this, from 2018/19. Areas with persistent low levels of employment for people on CPA will want to consider the role of IPS as part of a holistic, recovery focussed package of care.

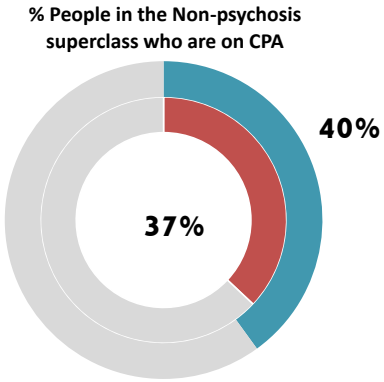
NHS Leeds North CCG - CPA Profile

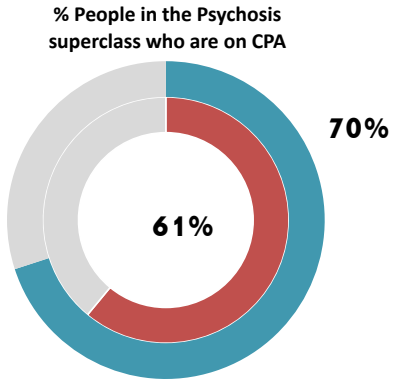


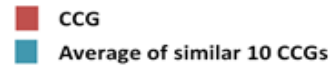






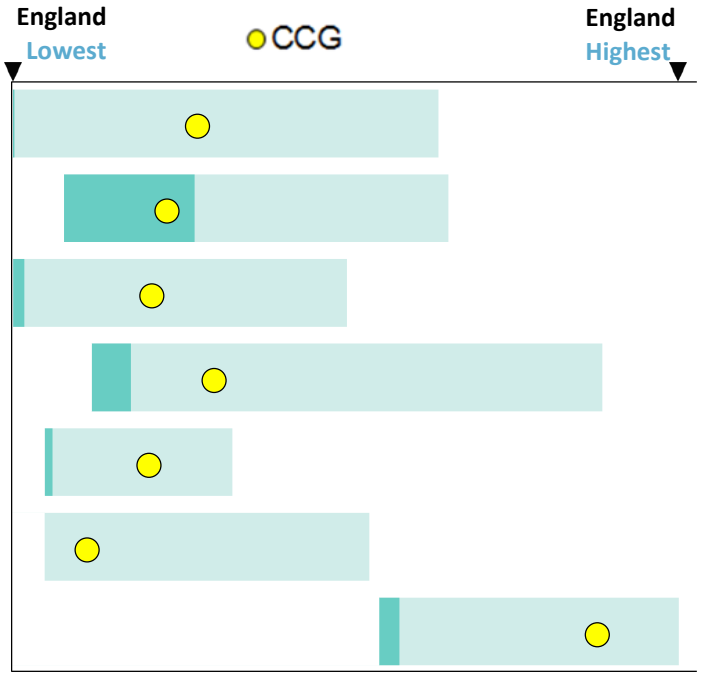






The Care Programme Approach

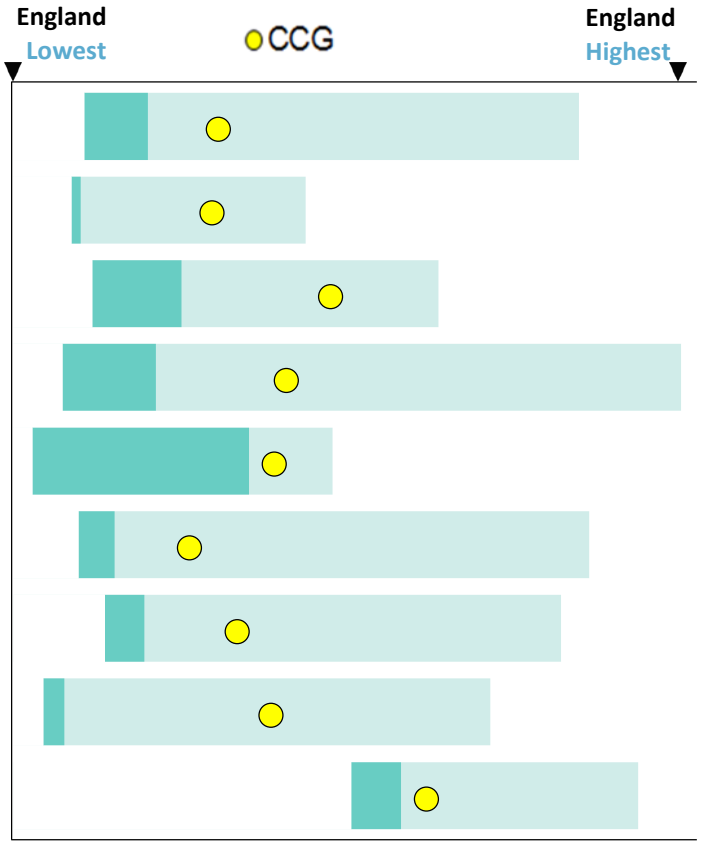
Indicator	Time Period	CCG Value
Rate of people aged 18+ on CPA - per 100,000 (end of quarter snapshot)	2015/16 Q4	362.9
Rate of people aged 18+ on CPA - per 100,000	2014/15	605.8
Percentage of people in contact with mental health services who are on CPA (end of quarter snapshot)	2015/16 Q4	14.7
Percentage of people in contact with mental health services who are on CPA	2014/15	15.3
Rate of admissions to hospital for people aged 18+ who are on CPA - per 100,000	2014/15	177.8
Rate of admissions to hospital for people aged 18+ who are not on CPA - per 100,000	2014/15	41.4
Percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care (end of quarter snapshot)	2015/16 Q4	98.0



These indicators show rates and percentages of people on CPA for the most recent quarter available and for the most recent full year available. High levels of variation in the proportion of people in contact with MH services who are placed on to CPA may be indicative of variation in relation to the quality of care co-ordination, planning and review for patients with complex needs. Quality of care coordination for patients on CPA should be considered locally when reviewing these indicators.

The Care Programme Approach continued

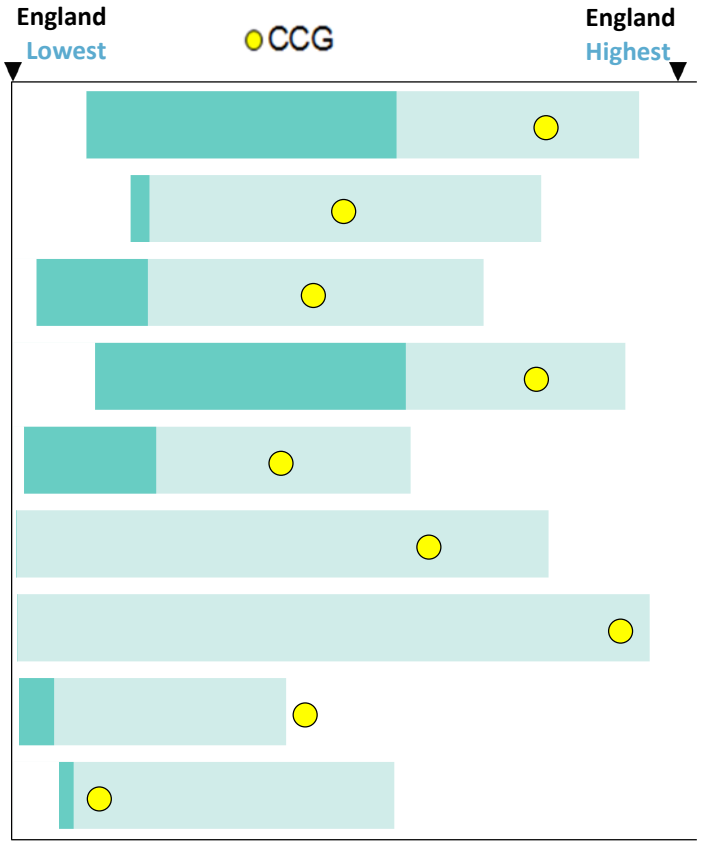
Indicator	Time Period	CCG Value
White people on CPA as a percentage of all White people in contact with secondary mental health services	2014/15	18.0
Black/Black British people on CPA as a percentage of all Black/Black British people in contact with secondary mental health services	2014/15	37.5
People of a mixed ethnicity on CPA as a percentage of all people of a mixed ethnicity in contact with secondary mental health services	2014/15	38.9
Asian/Asian British people on CPA as a percentage of all Asian/Asian British people in contact with secondary mental health services	2014/15	30.5
People of Other ethnic groups on CPA as a percentage of all people of Other ethnic groups in contact with secondary mental health services	2014/15	33.3
Females on CPA as a percentage of all females in contact with secondary mental health services	2014/15	14.1
Males on CPA as a percentage of all males in contact with secondary mental health services	2014/15	18.1
Percentage of patients in the Non-psychosis superclass who are on CPA	2014/15	36.5
Percentage of patients in the Psychosis superclass who are on CPA	2014/15	60.8



These indicators show the percentage of people from different ethnicities on CPA as a percentage of those from that ethnicity who are accessing mental health services. These indicators therefore control for rates of access to services varying by ethnicity (for example, due to different population sizes). The indicators related to gender take the same format. CCGs with very low percentages of patients on CPA relatively may wish to explore reasons for this locally. High levels of variation in the proportion of people in contact with MH services who are placed on to CPA may be indicative of variation in relation to the quality of care co-ordination, planning and review for patients with complex needs. Quality of care coordination for patients on CPA should be considered locally when reviewing these indicators.

The Care Programme Approach continued

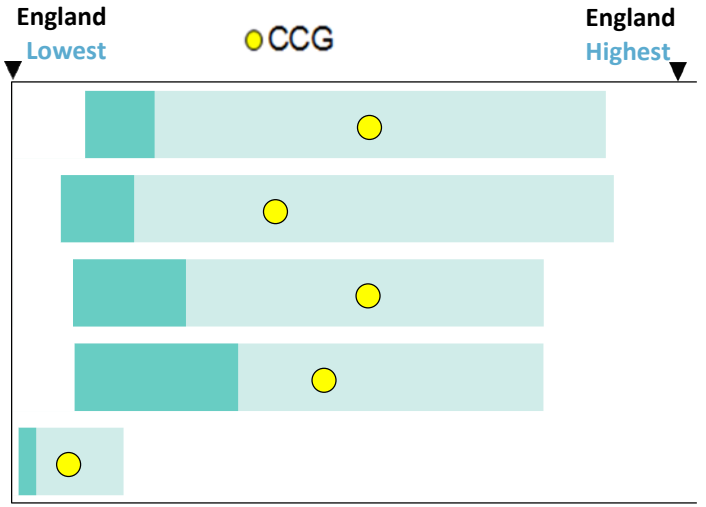
Indicator	Time Period	CCG Value
Percentage of people on CPA with a HoNOS assessment recorded (end of quarter snapshot)	2015/16 Q2	84.9
Percentage of people on CPA for 12 months who have a HoNOS score recorded out of all patients on CPA	2014/15	62.4
Percentage of people on CPA for 12 months out of all patients on CPA	2014/15	33.7
Percentage of people on CPA for more than 12 months who have had a review (end of quarter snapshot)	2015/16 Q2	81.3
Percentage of people on CPA for 12 months who have had a review out of all patients on CPA	2014/15	28.7
Rate of people aged 18+ who are on CPA and have a crisis plan in place per 100,000	2014/15	466.3
Percentage of people aged 18+ on CPA who have a crisis plan in place	2014/15	77.2
Percentage of people aged 18+ who are on CPA that are admitted to hospital	2014/15	24.8
Percentage of people aged 18+ who are not on CPA that are admitted to hospital	2014/15	0.8



These indicators present different services and quality measures related to patients on CPA. For all CPA indicators, high levels of variation in the proportion of people in contact with MH services who are placed on to CPA may be indicative of variation in relation to the quality of care co-ordination, planning and review for patients with complex needs. Quality of care coordination for patients on CPA should be considered locally when reviewing these indicators. CCGs with higher percentages of patients with crisis plans should look at indicators related to outcomes - such as admission rates - as evidence of whether the crisis plans are working effectively. Quality of crisis plans can vary enormously. CCGs should ensure they consider locally the quality of crisis plans and how well they are used as well as the number of people for whom it is appropriate who are recorded as having them.

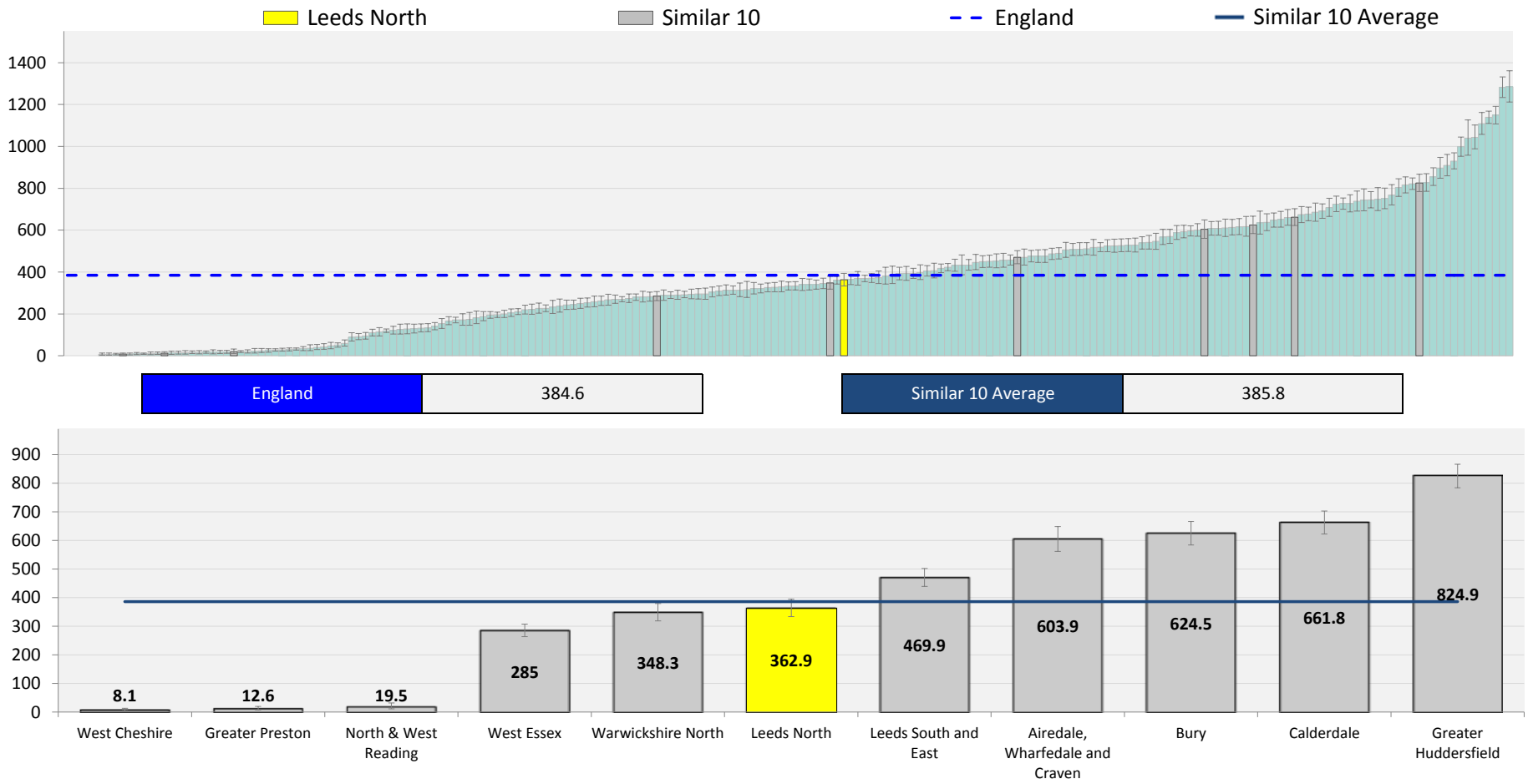
The Care Programme Approach continued

Indicator	Time Period	CCG Value
Percentage of people aged 18-69 on CPA who are in settled accommodation (end of quarter snapshot)	2015/16 Q2	49.5
Percentage of people aged 18-69 on CPA who are in settled accommodation	2014/15	37.1
Percentage of people aged 18-69 on CPA who are in employment (end of quarter snapshot)	2015/16 Q2	11.8
Percentage of people aged 18-69 on CPA who are in employment	2014/15	8.8
Percentage of people aged 18-69 on CPA who are in education	2014/15	1.8



These indicators present different services and quality measures related to patients on CPA. For all CPA indicators, high levels of variation in the proportion of people in contact with MH services who are placed on to CPA may be indicative of variation in relation to the quality of care co-ordination, planning and review for patients with complex needs. Quality of care coordination for patients on CPA should be considered locally when reviewing these indicators. Some of these indicators reflect two different time periods, one of which is quarterly, the other of which is annual; any significant changes should be considered locally. Quality of recording of employment and accommodation status varies by CCG; more information can be found in the "Improving data quality" section of this pack.

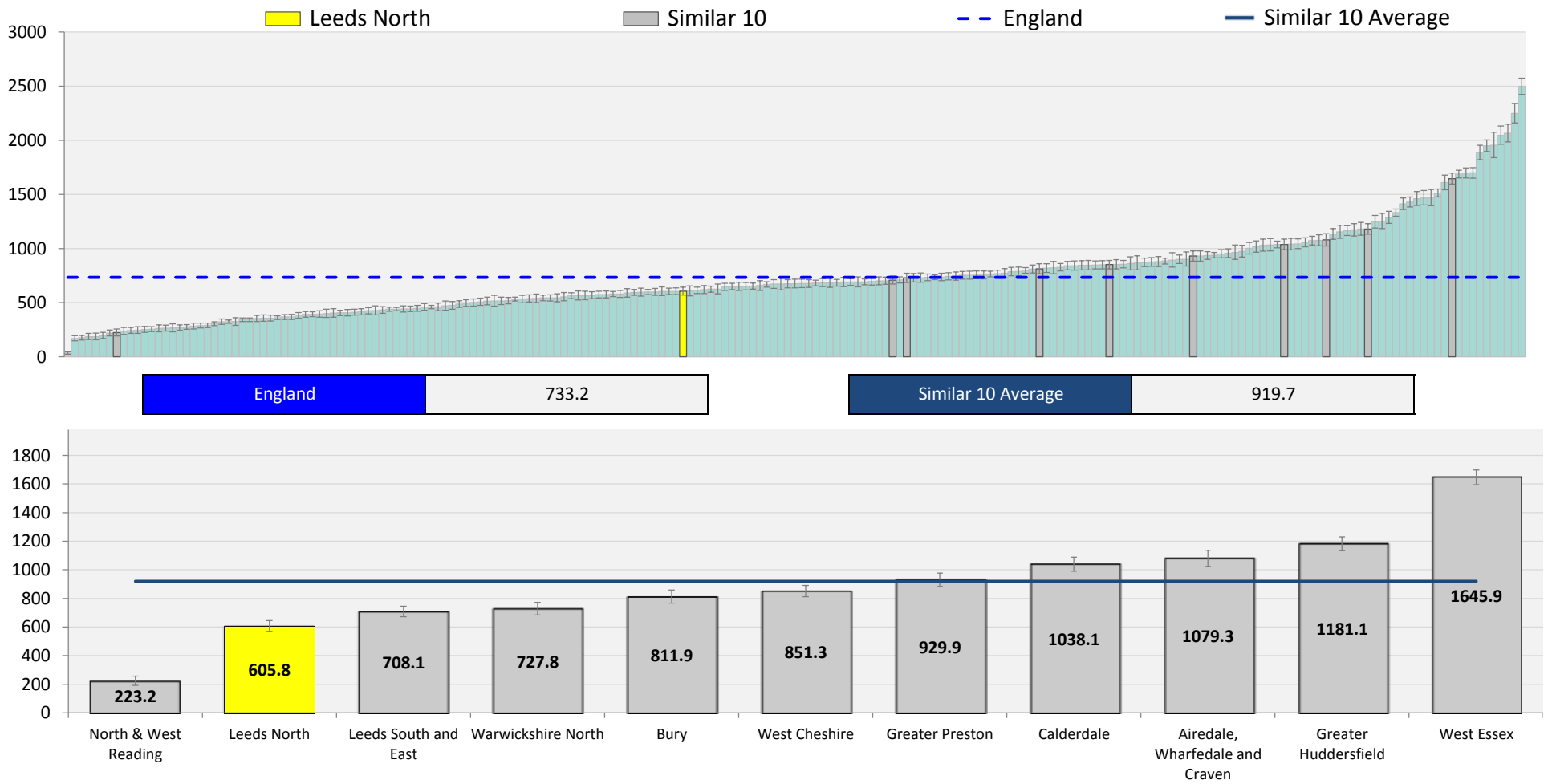
Rate of people aged 18+ on CPA - per 100,000 (end of quarter snapshot)



This shows the rate of people in contact with mental health services who are on CPA for the most recent quarter available. The overarching aim of CPA is to ensure that people with high levels of needs, who are likely to be receiving support from more than one team, have their recovery focussed care planned, co-ordinated and reviewed by an allocated care co-ordinator. High rates of people on CPA may therefore be positive but CCGs should consider alongside other indicators of quality and outcomes, as there may be variation across CCGs in how CPA is interpreted and applied.

Definition: Rate of people aged 18+ on CPA - per 100,000 (end of quarter snapshot)
Source: Health & Social Care Information Centre (NHS Digital), PHE Fingertips Severe Mental Illness Profile
Year: 2015/16 Q4

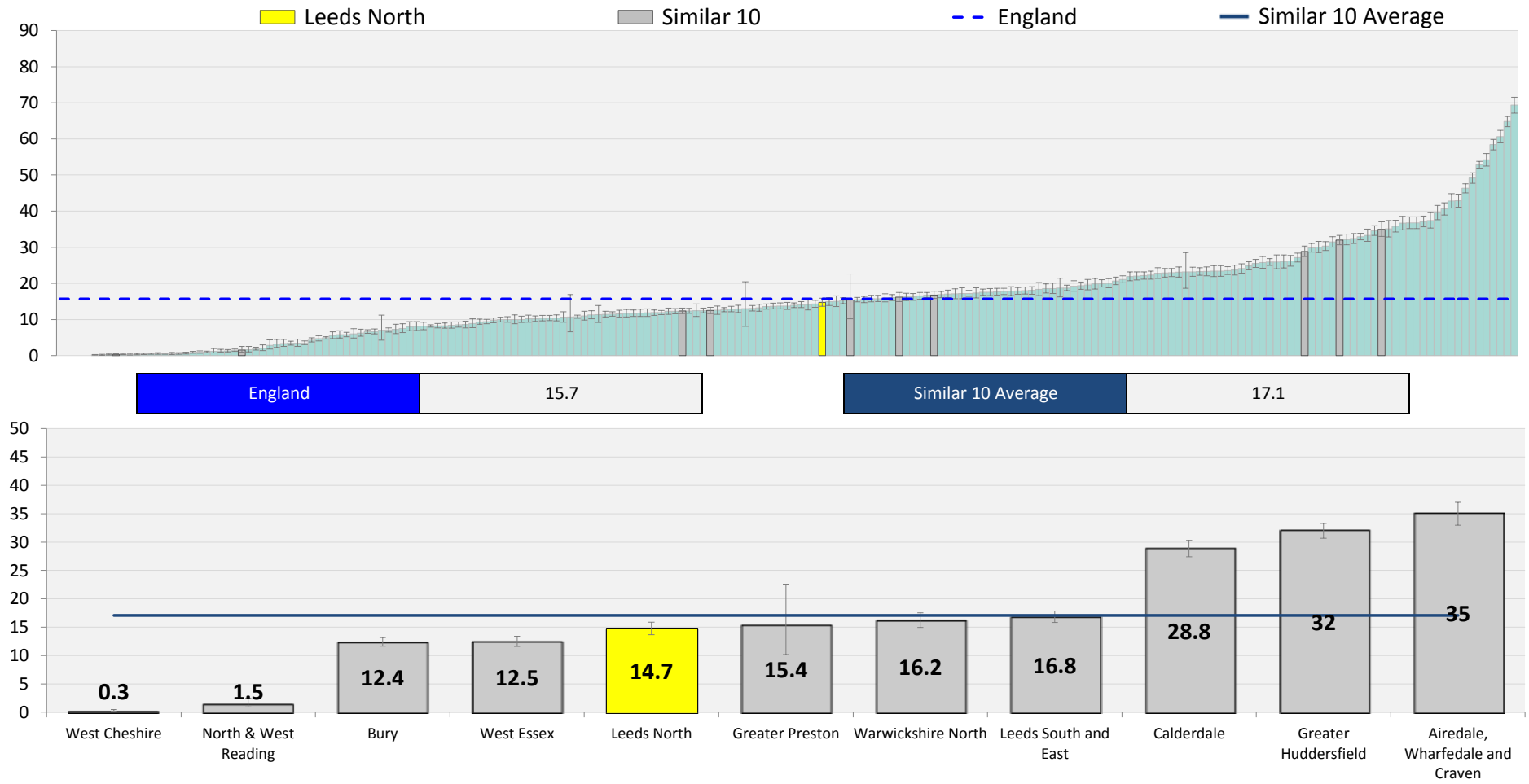
Rate of people aged 18+ on CPA - per 100,000



This shows the rate of people in contact with mental health services who are on CPA for the whole of 2014/15.

Definition: Rate of people aged 18+ on CPA - per 100,000
Source: MHLDDS
Year: 2014/15

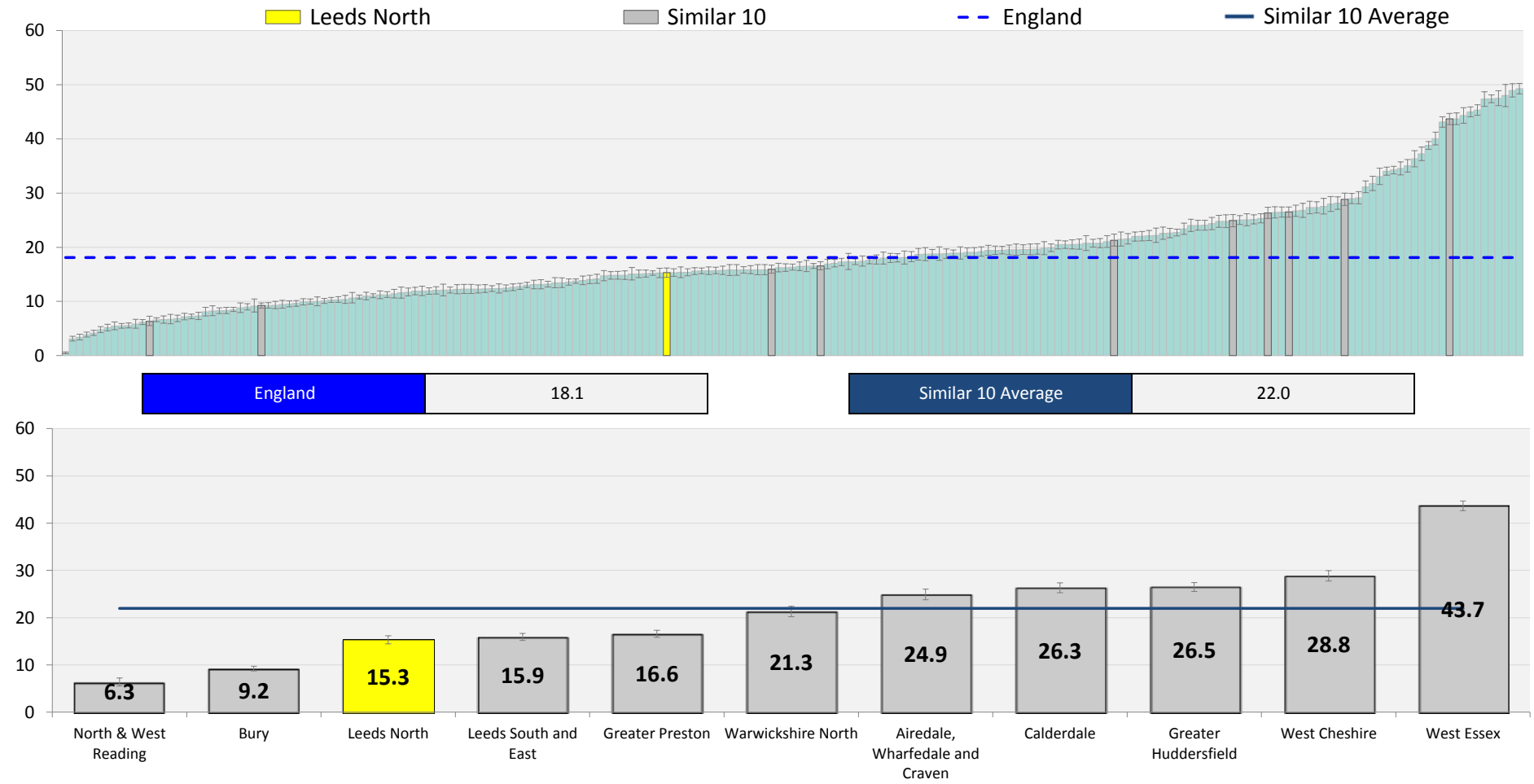
Percentage of people in contact with mental health services who are on CPA (end of quarter snapshot)



This indicator shows the percentage of people in contact with mental health services who are placed on CPA for the most recent quarter available. High levels of variation in the proportion of people in contact with MH services who are placed on to CPA may be indicative of variation in relation to the quality of care co-ordination, planning and review for patients with complex needs.

Definition: Percentage of people in contact with mental health services who are on CPA (end of quarter snapshot)
Source: Health & Social Care Information Centre (NHS Digital), PHE Fingertips Severe Mental Illness Profile
Year: 2015/16 Q4

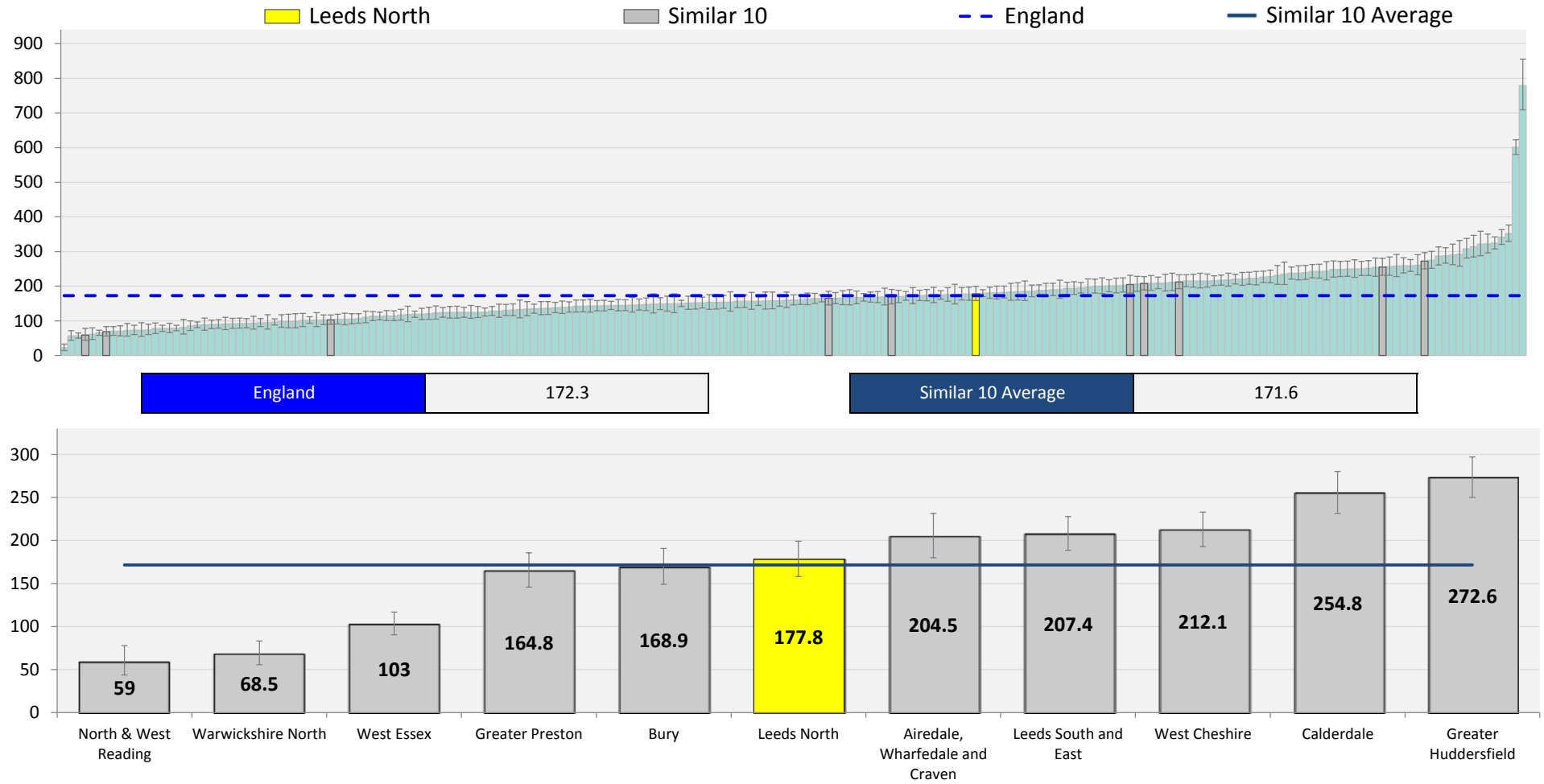
Percentage of people in contact with mental health services who are on CPA



This indicator shows the percentage of people in contact with mental health services who are placed on CPA for the most recent full year available. High levels of variation in the proportion of people in contact with MH services who are placed on to CPA may be indicative of variation in relation to the quality of care co-ordination, planning and review for patients with complex needs.

Definition: Percentage of people in contact with mental health services who are on CPA
Source: MHLDDS
Year: 2014/15

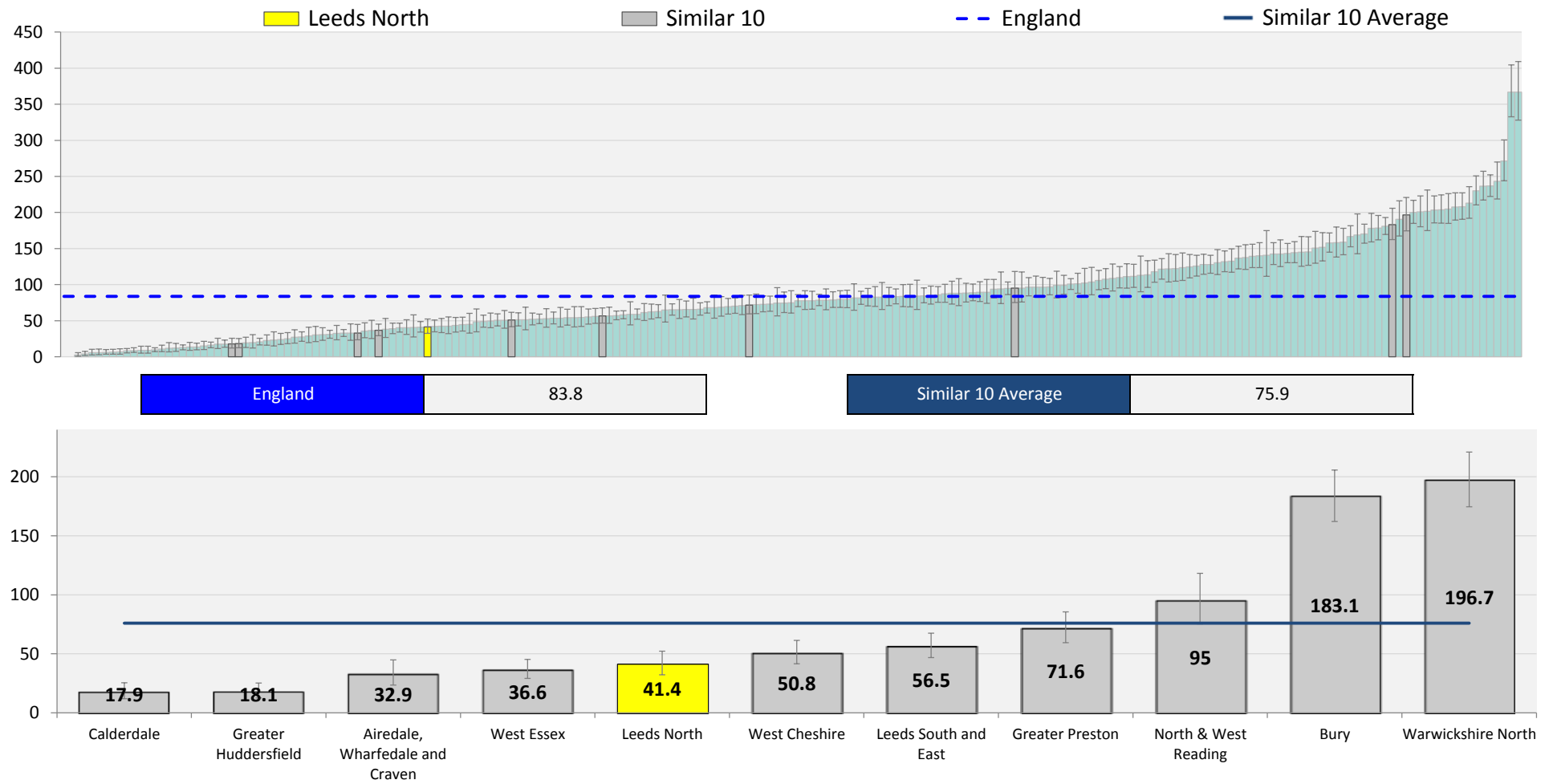
Rate of admissions to hospital for people aged 18+ who are on CPA - per 100,000



This indicator shows the rate of admissions to hospital only by those who are recorded as being on CPA. CCGs should therefore consider relative rates of admissions compared to other CCGs.

Definition: Rate of admissions to hospital for people aged 18+ who are on CPA - per 100,000
Source: MHLDDS
Year: 2014/15

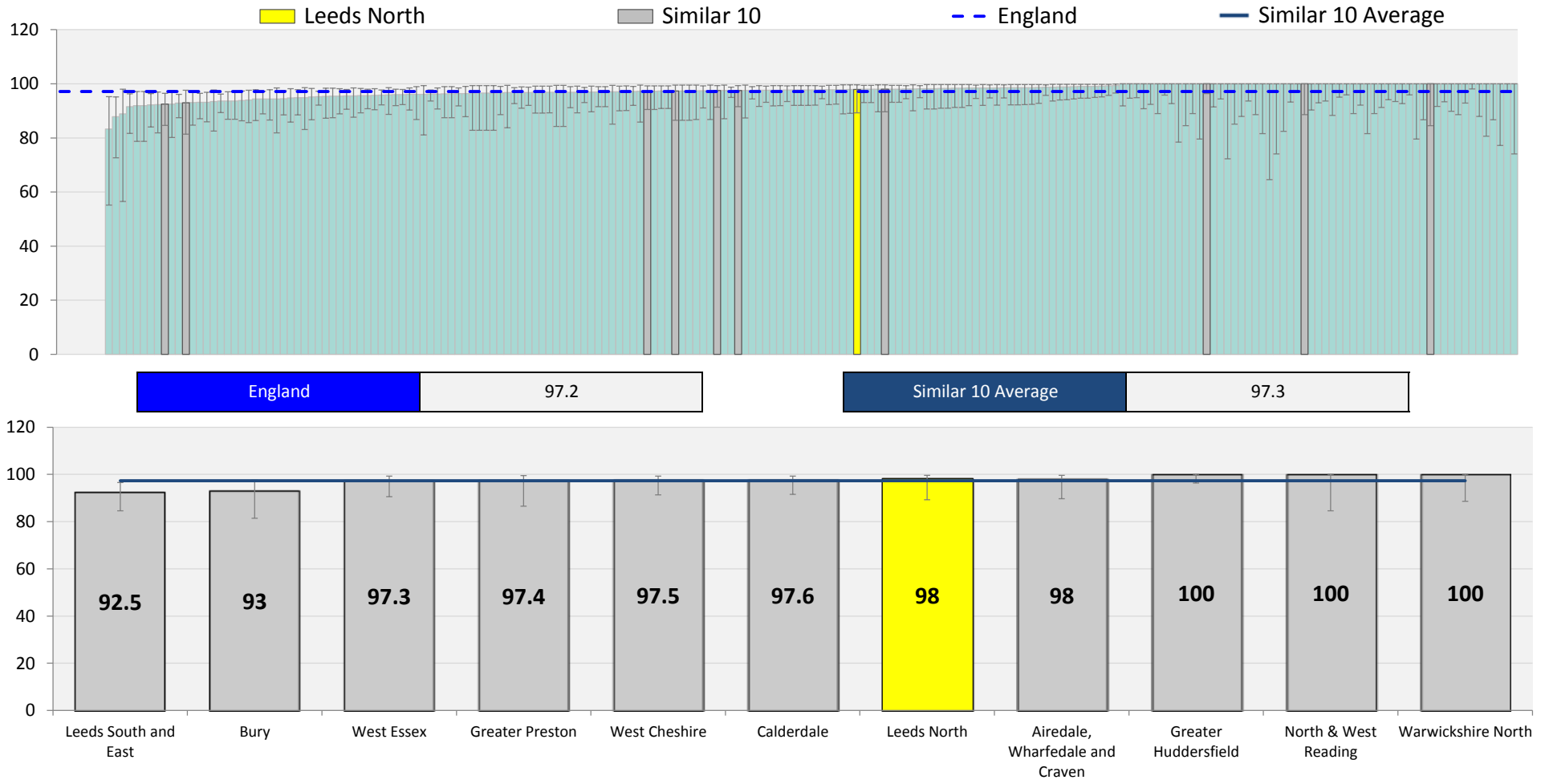
Rate of admissions to hospital for people aged 18+ who are not on CPA - per 100,000



This indicator shows the rate of admissions to hospital only by those who are recorded as not being on CPA. CCGs should therefore consider relative rates of admissions compared to other CCGs.

Definition: Rate of admissions to hospital for people aged 18+ who are not on CPA - per 100,000
Source: MHLDDS
Year: 2014/15

Percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care (end of quarter snapshot)



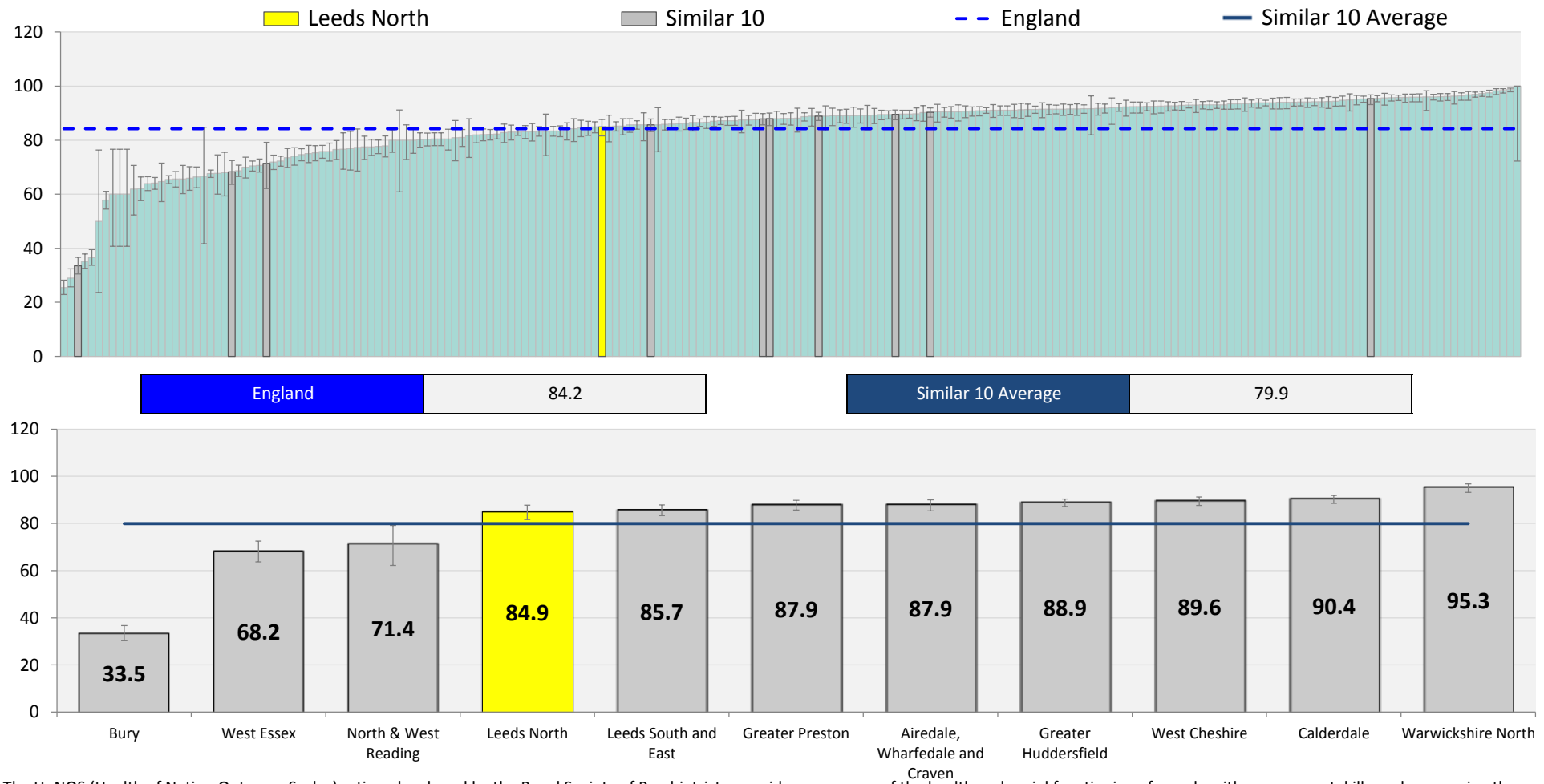
All patients on CPA discharged from psychiatric inpatient care are to be followed up either by face to face contact or by phone within 7 days of discharge to reduce risk of suicide and social exclusion and improve care pathways. The national threshold is to follow up 95% of patients within 7 days.

Definition: Percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care (end of quarter snapshot)

Source: Mental Health Community Teams Activity, NHS England http://www.england.nhs.uk/statistics/category/statistics/mental-health-community/, PHE Fingertips Severe Mental Illness Profile

Year: 2015/16 Q4

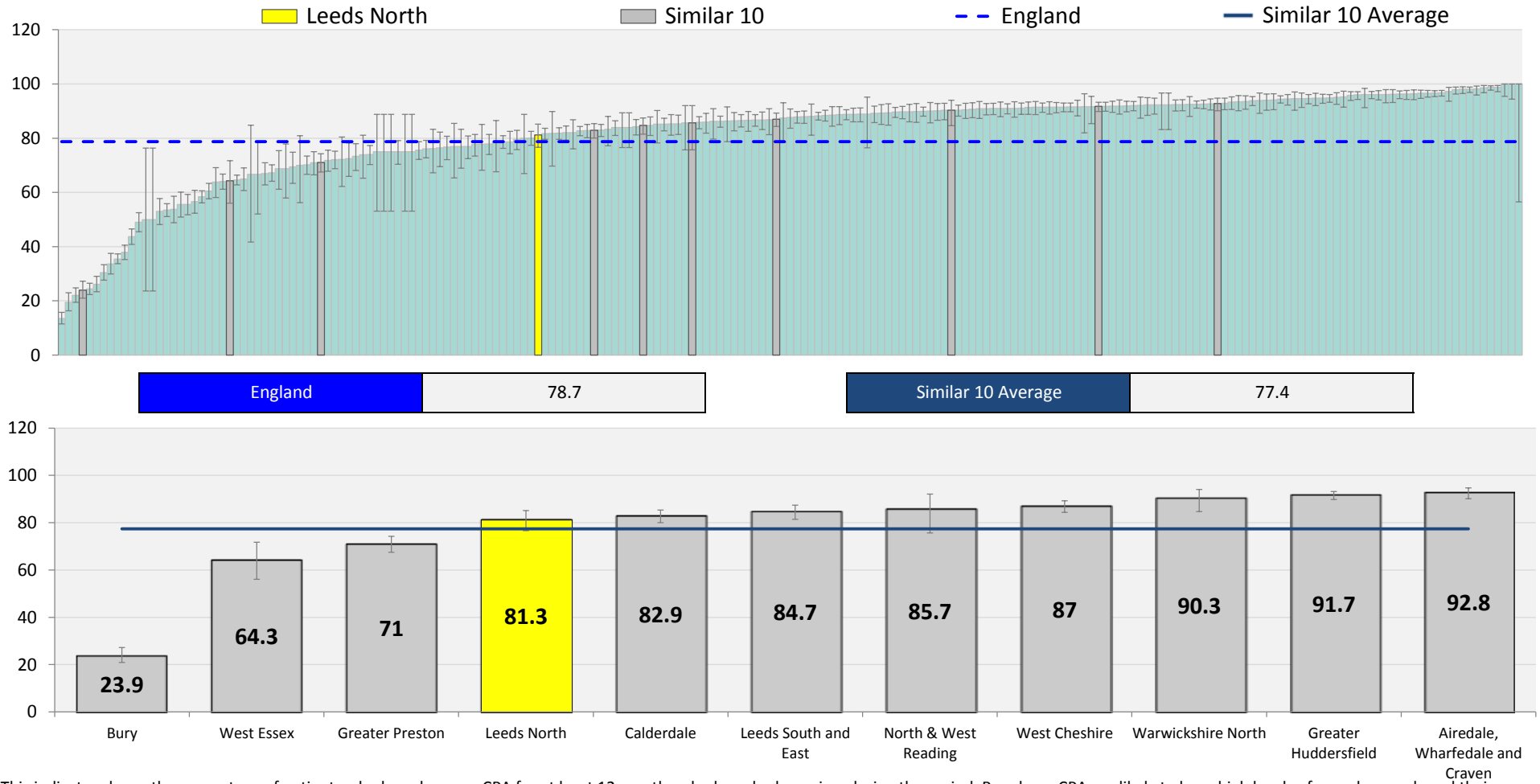
Percentage of people on CPA with a HoNOS assessment recorded (end of quarter snapshot)



The HoNOS (Health of Nation Outcome Scales) rating, developed by the Royal Society of Psychiatrists, provides a measure of the health and social functioning of people with severe mental illness by assessing the patient's state in each the twelve scales.

Definition: Percentage of people on CPA with a HoNOS assessment recorded (end of quarter snapshot)
Source: Health & Social Care Information Centre (NHS Digital), PHE Fingertips Severe Mental Illness Profile
Year: 2015/16 Q2

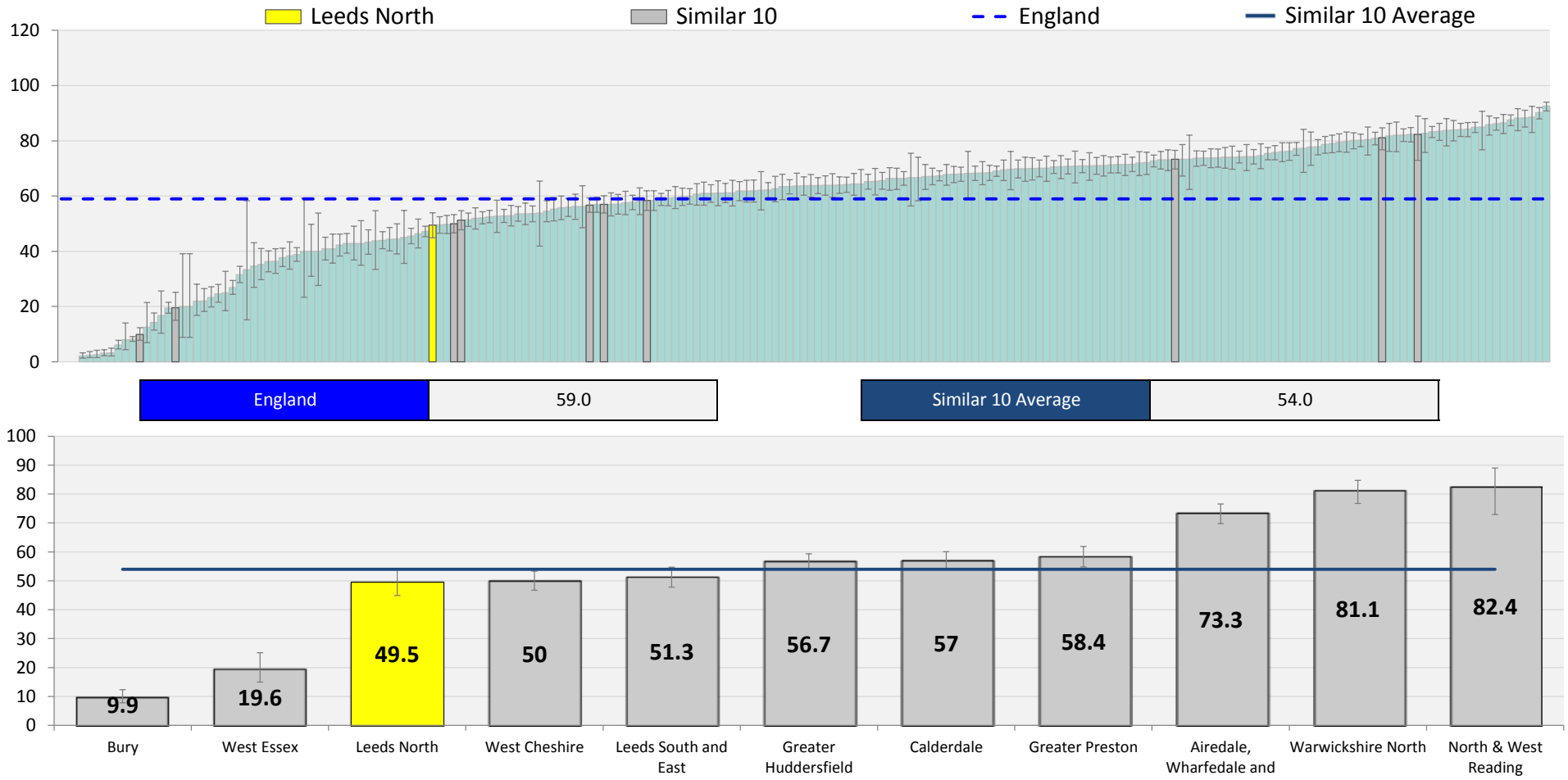
Percentage of people on CPA for more than 12 months who have had a review (end of quarter snapshot)



This indicator shows the percentage of patients who have been on CPA for at least 12 months who have had a review during the period. People on CPA are likely to have high levels of complex needs and their care should be reviewed at regular intervals.

Definition: Percentage of people on CPA for more than 12 months who have had a review (end of quarter snapshot)
Source: Health & Social Care Information Centre (NHS Digital), PHE Fingertips Severe Mental Illness Profile
Year: 2015/16 Q2

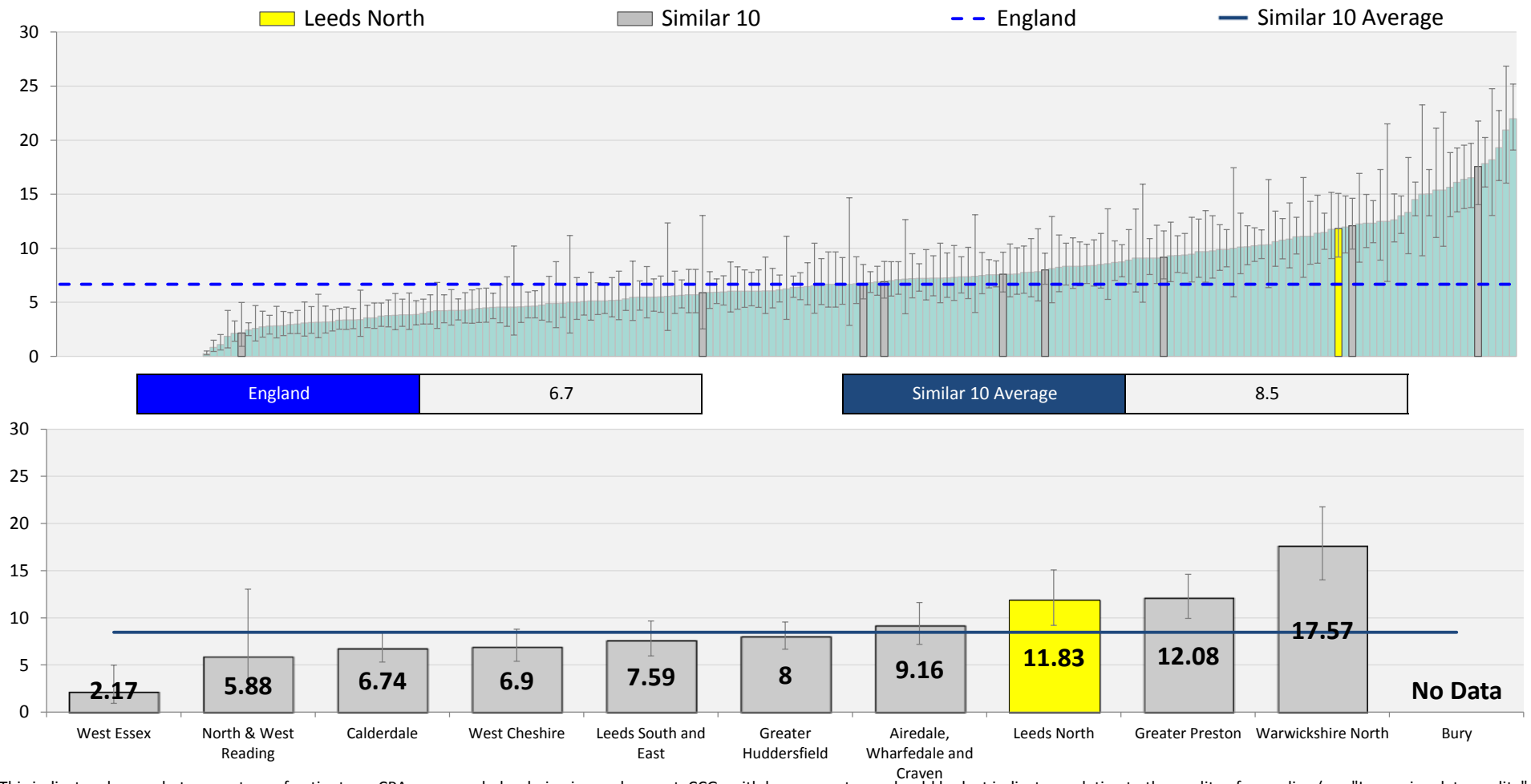
Percentage of people aged 18-69 on CPA who are in settled accommodation (end of quarter snapshot)



This indicator shows what percentage of patients on CPA are recorded as being in settled accommodation. CCGs with low percentages should look at indicators relating to the quality of recording (see "Improving data quality" section in this pack) as CCGs have a high proportion of patients without an accommodation status recorded.

Definition: Percentage of people aged 18-69 on CPA who are in settled accommodation (end of quarter snapshot)
Source: Health & Social Care Information Centre (NHS Digital), PHE Fingertips Severe Mental Illness Profile
Year: 2015/16 Q2

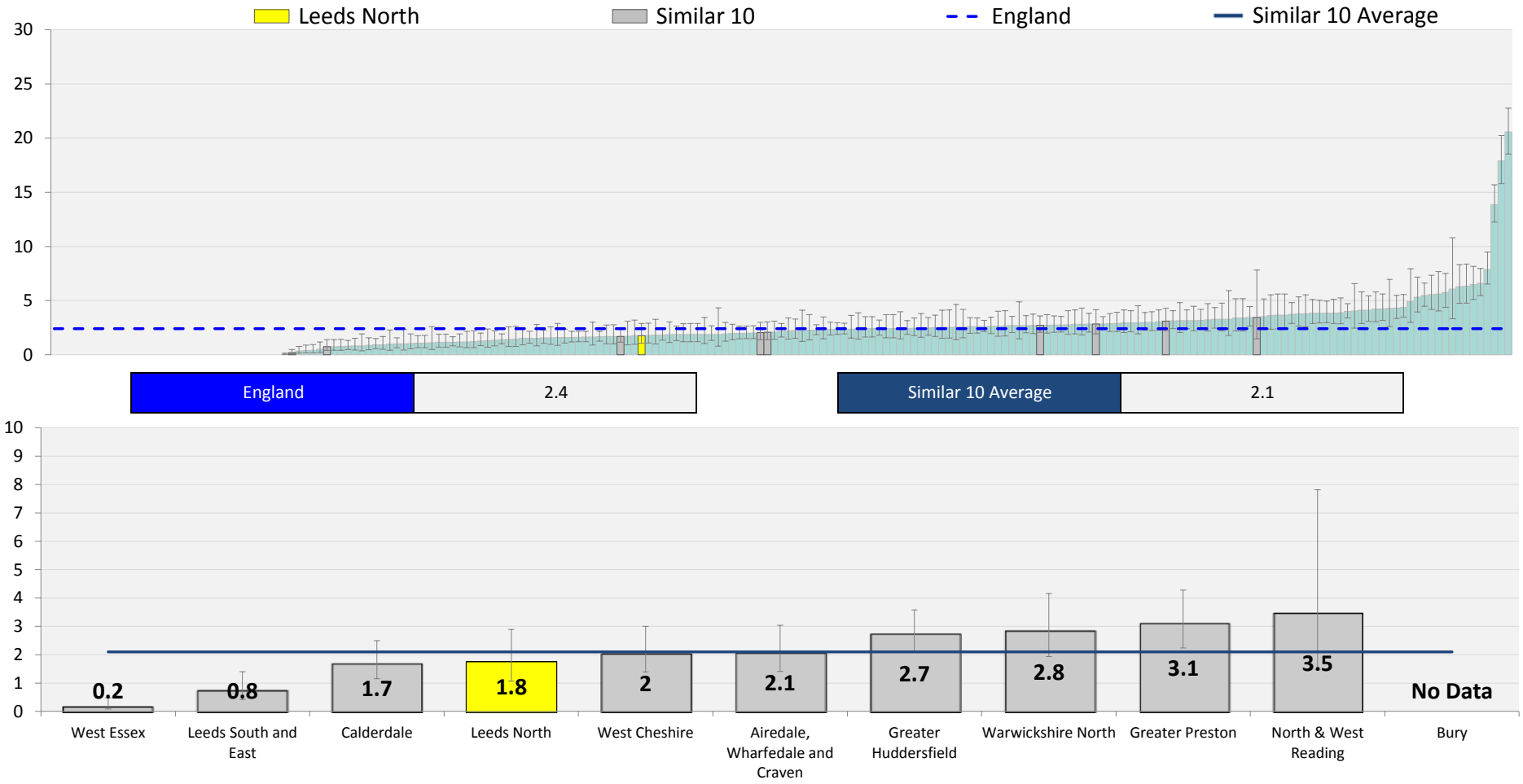
Percentage of people aged 18-69 on CPA who are in employment (end of quarter snapshot)



This indicator shows what percentage of patients on CPA are recorded as being in employment. CCGs with low percentages should look at indicators relating to the quality of recording (see "Improving data quality" section in this pack) as CCGs have a high proportion of patients without an employment status recorded. Should be considered alongside indicator on % people on CPA in education.

Definition: Percentage of people aged 18-69 on CPA who are in employment (end of quarter snapshot)
Source: Health & Social Care Information Centre, PHE Fingertips Severe Mental Illness Profile
Year: 2015/16 Q2

Percentage of people aged 18-69 on CPA who are in education



This indicator shows what percentage of patients aged 18-69 on CPA are recorded as being in education. CCGs with low percentages should look at indicators relating to the quality of recording (see "Improving data quality" section in this pack) as many have a high proportion without an education/employment status recorded. Should be considered alongside indicator of % people on CPA in employment.

Definition: Percentage of people aged 18-69 on CPA who are in education
Source: MHLDDS
Year: 2014/15

Crisis care

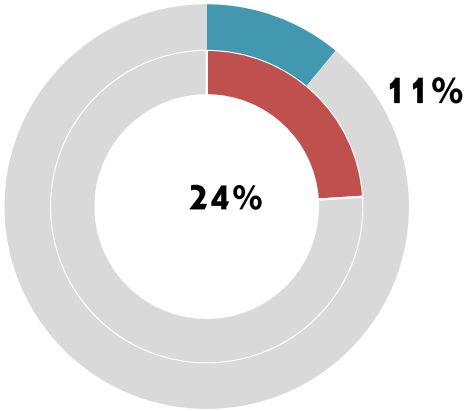
Crisis care is improving, but there is still further work to do to match standards in urgent and emergency care for physical health. Evidence based treatment pathways for crisis care are being developed for all ages across the crisis pathway. In order to deliver a '7 day NHS for mental health' NHS England has set out that:

- By 2020/21, a 24/7 community-based mental health crisis response will be available across England, with Crisis Resolution and Home Treatment Teams (CRHTTs) adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission;
- By 2020/21 all age mental health liaison will be available in all acute hospitals. For adults (including older adults) at least 50% will be operating at the core 24 standard as a minimum, with the rest making progress towards 24/7 provision - and equivalent models of community crisis response and acute hospital liaison will be developed for children and young people;
- By 2020/21, people will no longer have to travel out of area inappropriately for non-specialist acute inpatient mental health care;
- From April 2017, children and young people will no longer be detained in police cells as a Place of Safety, and they will be used only in exceptional circumstances for adults.

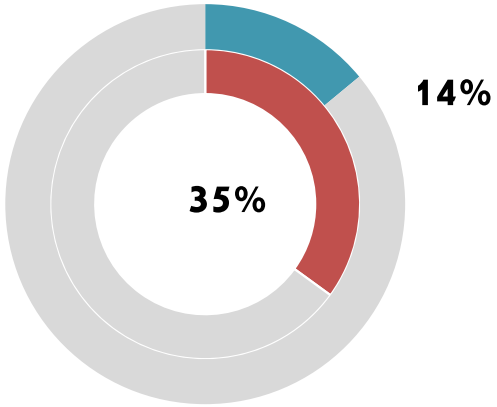
There are a number of changes in the reporting of crisis, liaison and acute care (including out of area placements) which are due to come on line in the coming year and will be available on the NHS Digital website and in NHS England's MH FYFV dashboard.

NHS Leeds North CCG - Crisis Care Plans Profile

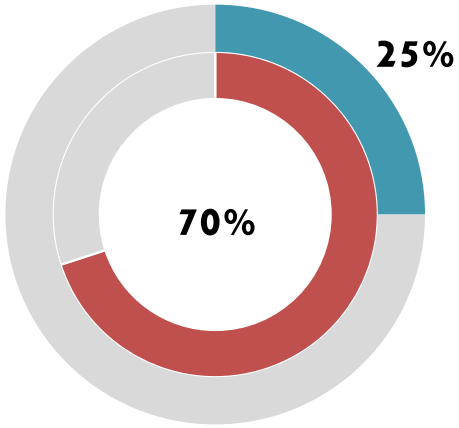
% Patients with crisis plan in place



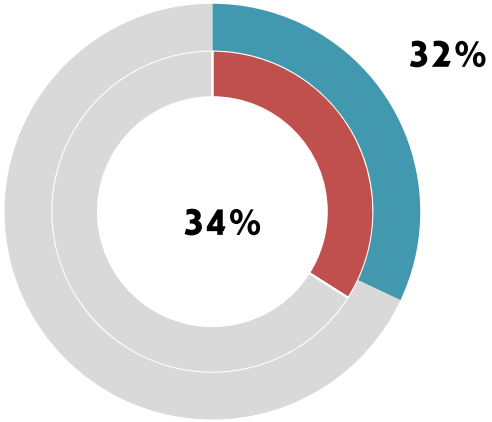
% Patients in the Non Psychosis super class with a crisis plan



% Patients in the Psychosis super class with a crisis plan



% Patients with crisis plan in place, who are in settled accommodation

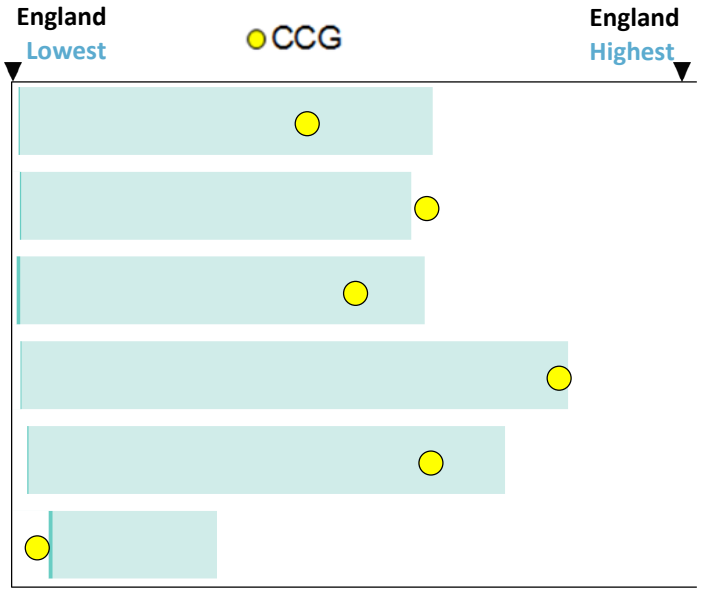


CCG

Average of similar 10 CCGs

Crisis planning

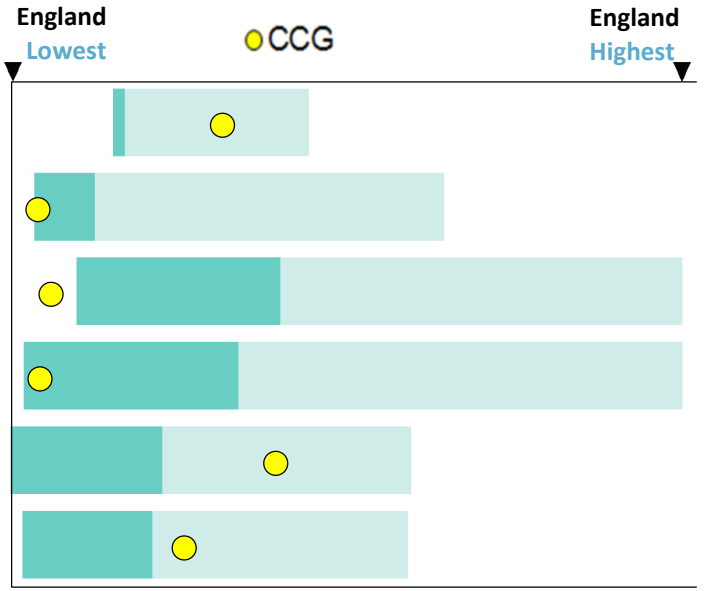
Indicator	Time Period	CCG Value
Percentage of people in contact with mental health services with a crisis plan in place (end of quarter snapshot)	2015/16 Q2	24.1
Percentage of people in contact with mental health services with a crisis plan in place	2014/15	20.6
Percentage of people in the Non-psychosis superclass with a crisis plan in place	2014/15	34.6
Percentage of people in the Psychosis superclass with a crisis plan in place	2014/15	70.2
Rate of admissions to hospital for people aged 18+ who have a crisis plan in place per 100,000	2014/15	165.7
Rate of admissions to hospital for people aged 18+ who do not have a crisis plan in place per 100,000	2014/15	68.0



These indicators show the percentage of people with crisis plans in place and rates of admissions to hospital. Indicator values should be considered relative to peers; rates of admissions to hospital for those without a crisis plan are likely to be higher than those with a crisis plan because there are more people without a crisis plan. % of people with a crisis plan for the whole of 2014/15 in some cases may be lower as the total numbers of people in contact with services is greater for an entire year than for a single quarter. CCGs with higher % of patients with crisis plans should look at indicators related to outcomes - such as admission rates - as evidence of whether the crisis plans are working effectively.There may be variation across CCGs in the quality of crisis plans in place and there is evidence that many crisis plans are very poor quality; CCGs should ensure they consider locally the quality of crisis plans and how well they are used as well as the number of people for whom it is appropriate who are recorded as having them.

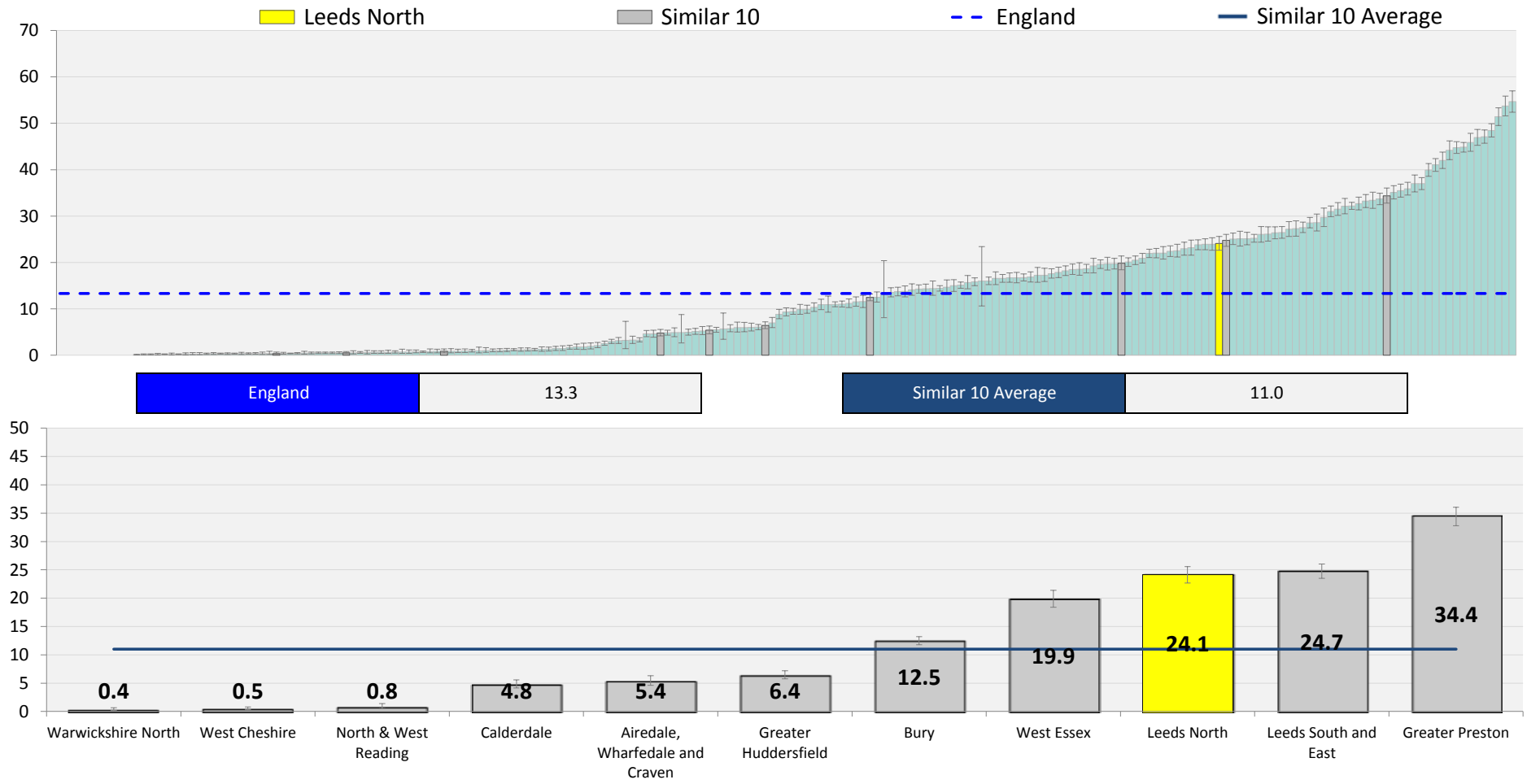
Crisis planning continued

Indicator	Time Period	CCG Value
Percentage of people aged 18+ with a crisis plan that are admitted to hospital	2014/15	16.9
Percentage of people aged 18+ without a crisis plan that are admitted to hospital	2014/15	1.6
Percentage of patients in the Non-psychosis superclass (1-8) who were admitted to hospital without a crisis plan	2014/15	14.3
Percentage of patients in the Psychosis superclass (10-17) who were admitted to hospital without a crisis plan	2014/15	9.5
Percentage of people with crisis plan that are in settled accommodation	2014/15	34.5
Percentage of people without crisis plan that are in settled accommodation	2014/15	19.5



These indicators show admissions and outcomes by whether a patient had a crisis plan. These should be considered in context of overall rates and proportions of people with a crisis plan and wider outcomes. There may be variation across CCGs in the quality of those crisis plans in place and there is evidence that many crisis plans are very poor quality; CCGs should ensure they consider locally the quality of crisis plans and how well they are used as well as the number of people for whom it is appropriate who are recorded as having them. CCGs should consider the full range of crisis and outcomes indicators and use local information to inform decision making on crisis planning and service improvements. Percentage of admissions to hospital for those with crisis plans may also be higher than those without crisis plans due to the differing nature of illnesses and needs of people with crisis plans. Recording of accommodation status is low in many CCGs;there is more information in the "Improving Data Quality" section of this pack.

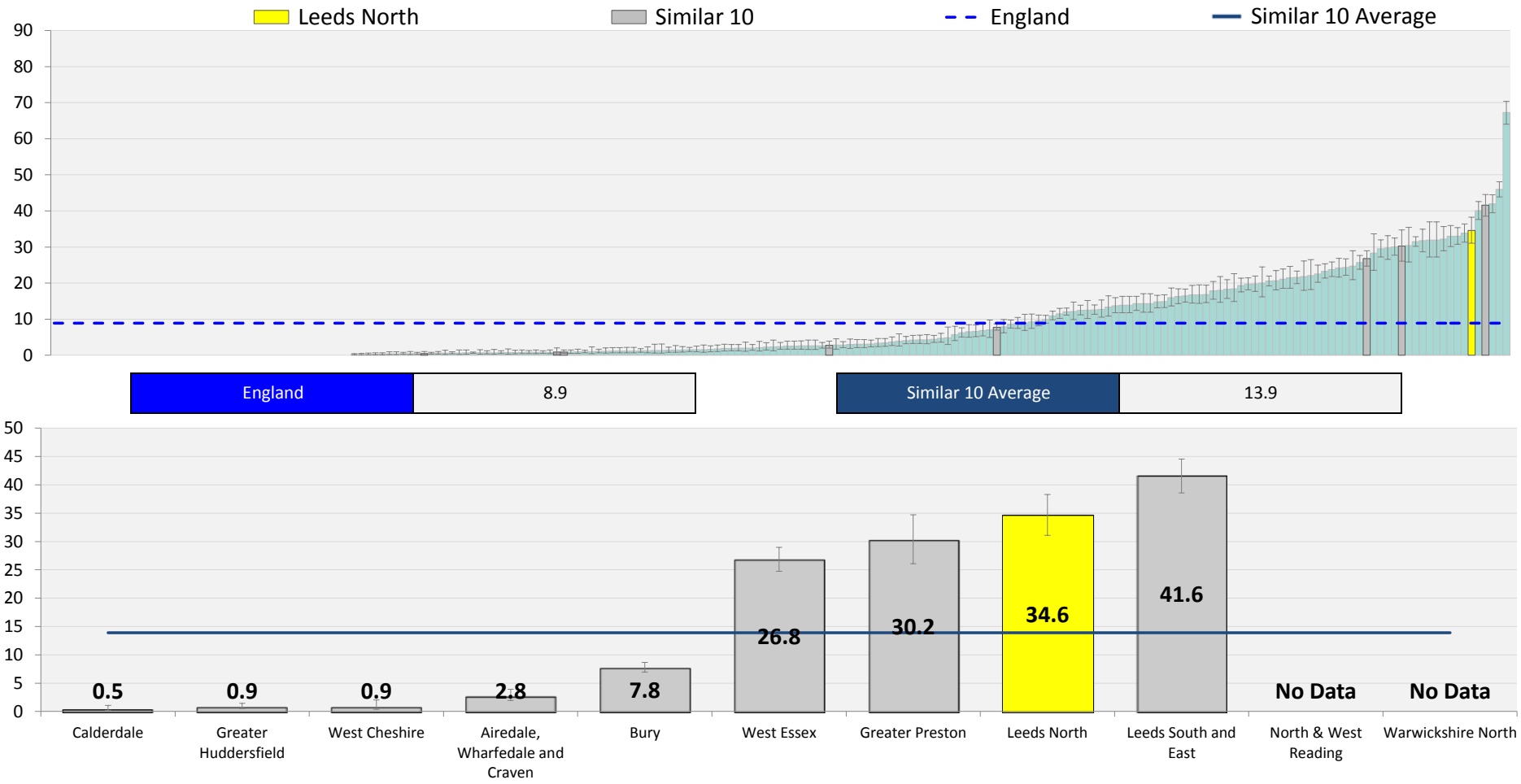
Percentage of people in contact with mental health services with a crisis plan in place (end of quarter snapshot)



This indicator shows the percentage of patients in contact with mental health services who have a crisis plan in place for the most recent quarter available. CCGs with higher percentages of patients with crisis plans should look at indicators related to outcomes - such as admission rates - as evidence of whether the crisis plans are working effectively.

Definition: Percentage of people in contact with mental health services with a crisis plan in place (end of quarter snapshot)
Source: Health & Social Care Information Centre (NHS Digital), PHE Fingertips Severe Mental Illness Profile
Year: 2015/16 Q2

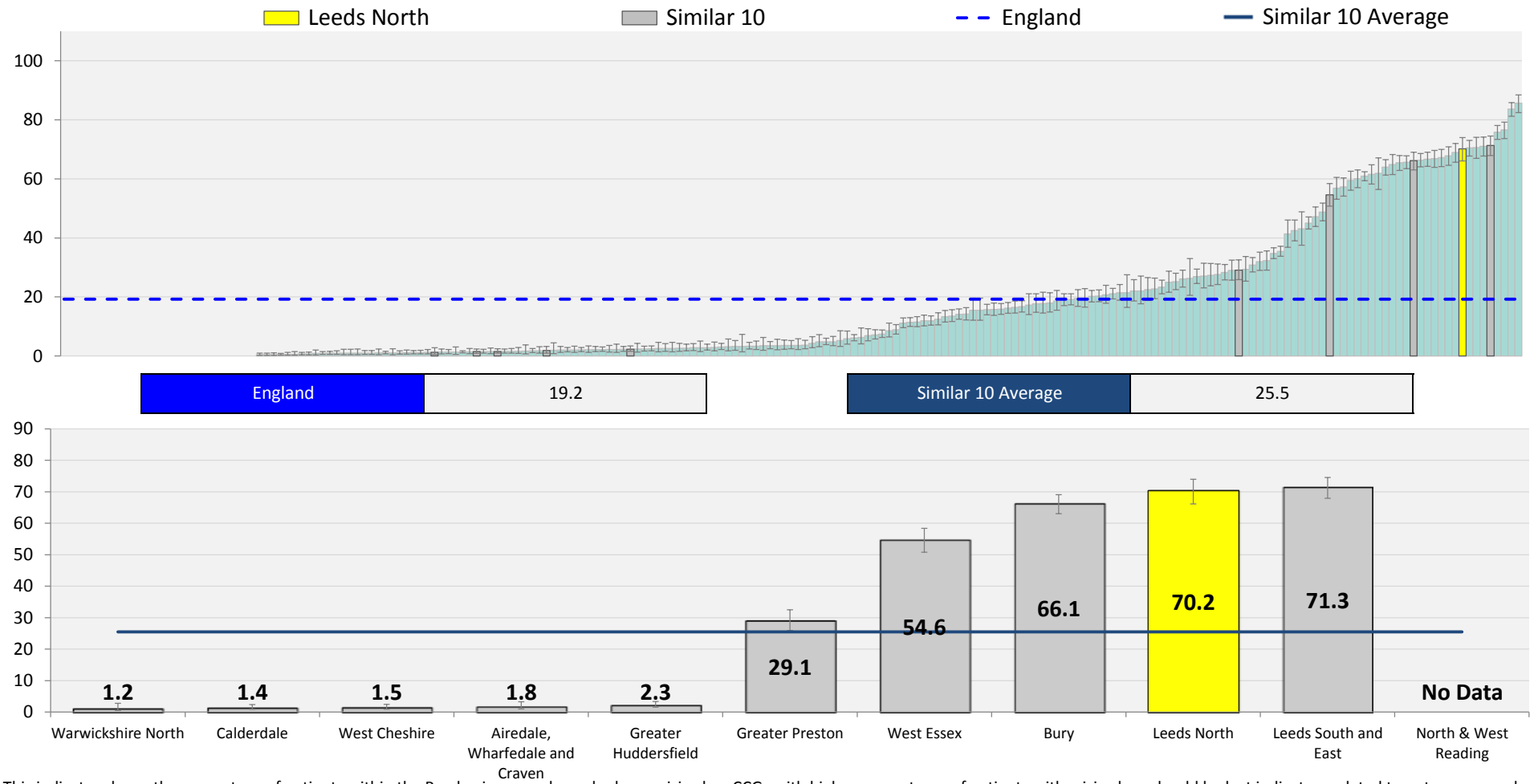
Percentage of people in the Non-psychosis superclass with a crisis plan in place



This indicator shows the percentage of patients within the Non-Psychosis super class who have crisis plan. CCGs with higher percentages of patients with crisis plans should look at indicators related to outcomes - such as admission rates - as evidence of whether the crisis plans are working effectively.

Definition: Percentage of people in the Non-psychosis superclass with a crisis plan in place
Source: MHLDDS
Year: 2014/15

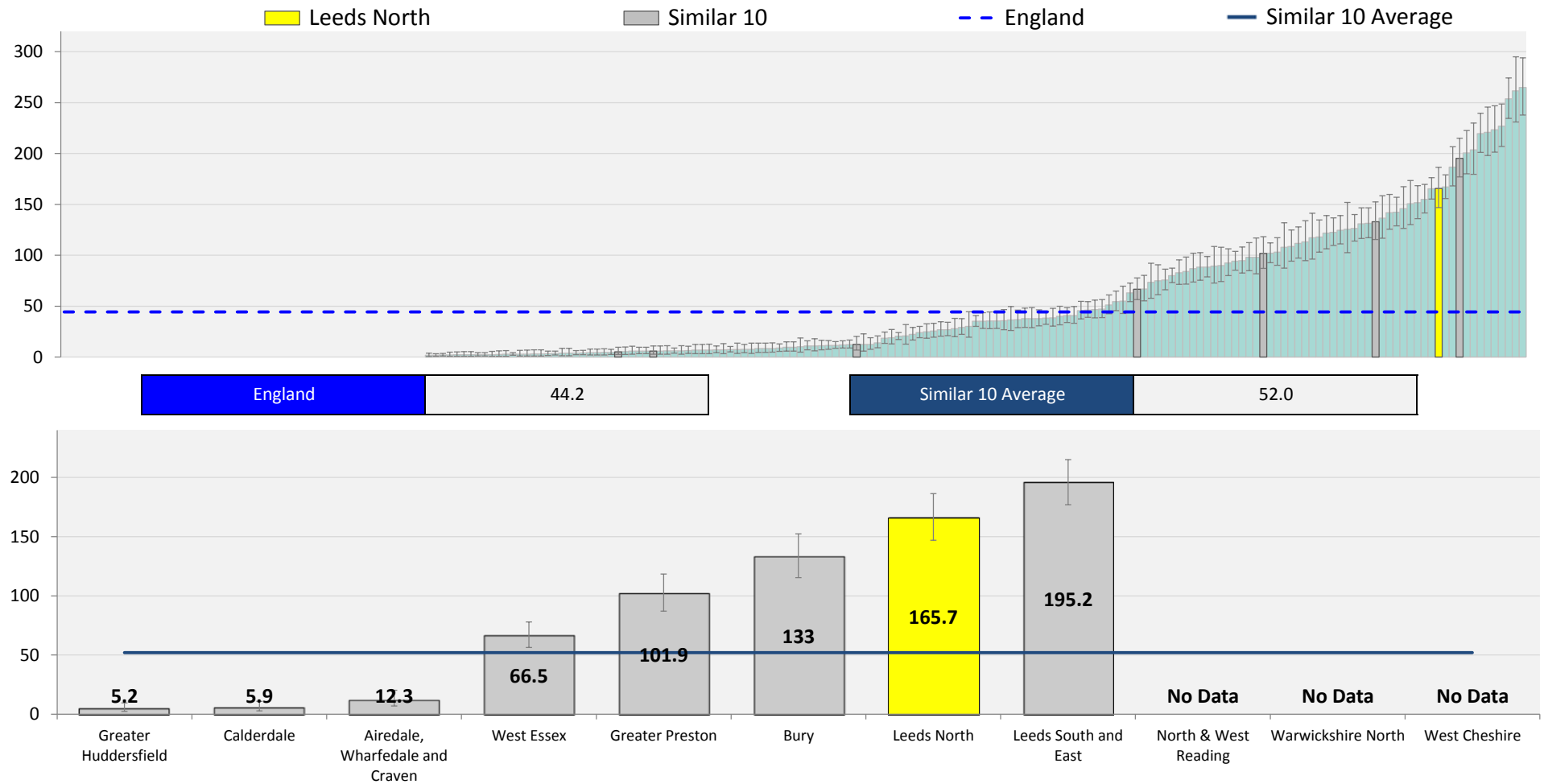
Percentage of people in the Psychosis superclass with a crisis plan in place



This indicator shows the percentage of patients within the Psychosis super class who have crisis plan. CCGs with higher percentages of patients with crisis plans should look at indicators related to outcomes - such as admission rates - as evidence of whether the crisis plans are working effectively.

Definition: Percentage of people in the Psychosis superclass with a crisis plan in place
Source: MHLDDS
Year: 2014/15

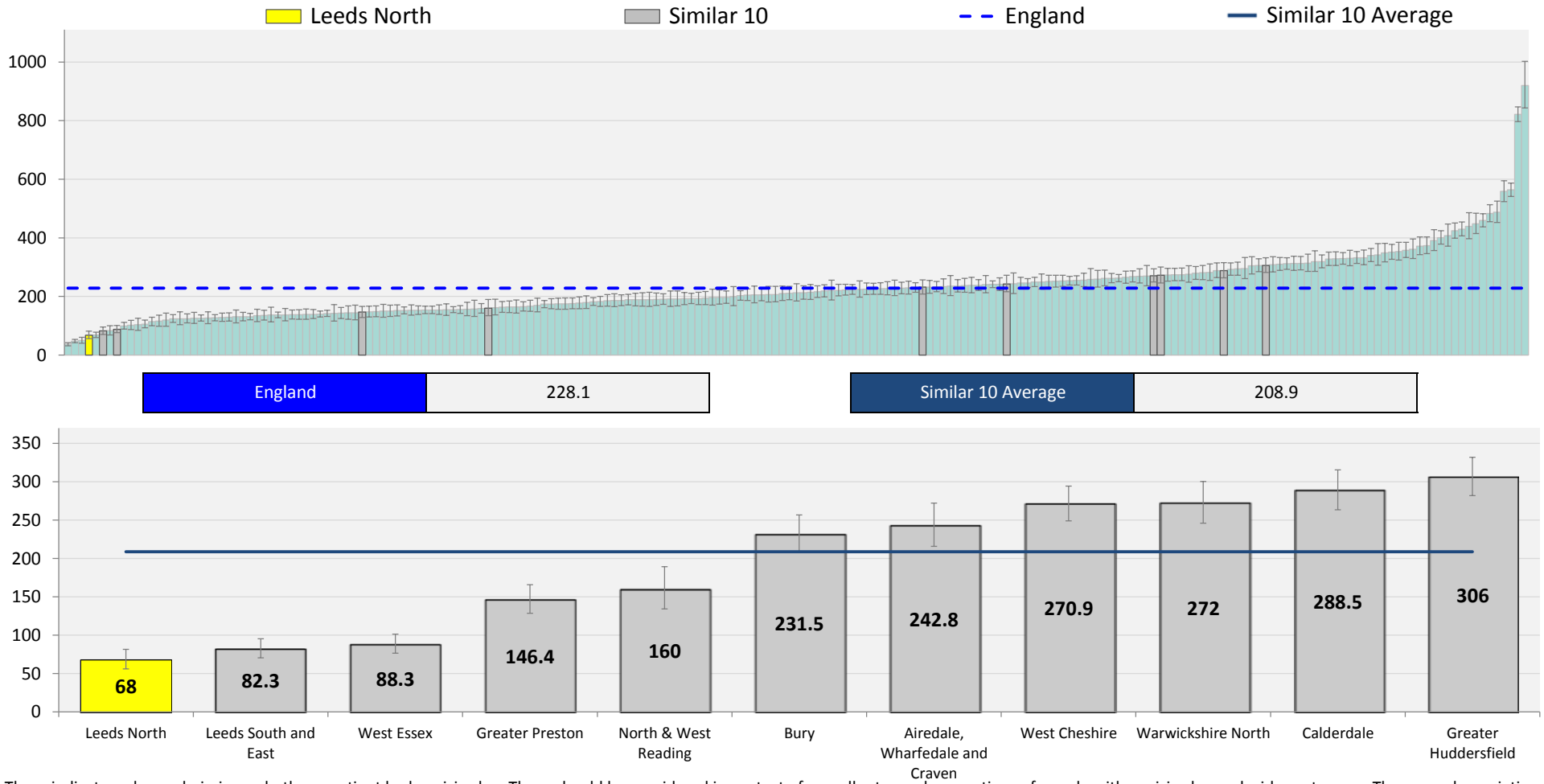
Rate of admissions to hospital for people aged 18+ who have a crisis plan in place per 100,000



These indicators show admissions whether a patient had a crisis plan. These should be considered in context of overall rates and proportions of people with a crisis plan and wider outcomes. There may be variation across CCGs in the quality of those crisis plans in place.

Definition: Rate of admissions to hospital for people aged 18+ who have a crisis plan in place per 100,000
Source: MHLDDS
Year: 2014/15

Rate of admissions to hospital for people aged 18+ who do not have a crisis plan in place per 100,000



These indicators show admissions whether a patient had a crisis plan. These should be considered in context of overall rates and proportions of people with a crisis plan and wider outcomes. There may be variation across CCGs in the quality of those crisis plans in place.

Definition: Rate of admissions to hospital for people aged 18+ who do not have a crisis plan in place per 100,000
Source: MHLDDS
Year: 2014/15

Admissions and discharges

This section of the pack presents information on patients in contact with mental health services who were admitted to hospital for a mental health condition. It does not cover admissions to general acute hospitals, for example where the primary diagnosis of the patient's admission was for a physical health problem.

Admissions to inpatient care have remained stable for the past three years for adults but the severity of need and the number of people being detained under the Mental Health Act continues to increase, suggesting opportunities to intervene earlier are being missed. By 2020/21, NHS England will invest to increase funding to improve pathways in and out of mental health secure care, with a focus on expanding community-based services for people who require them. This is intended to prevent avoidable admissions and support 'step down' and ongoing recovery in the community as soon as appropriate for the individual and as close to home as possible.

By 2020/21, all areas will provide crisis resolution and home treatment teams (CRHTTs) that are resourced to operate in line with recognised best practice – delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute in-patient admissions. The majority of CRHTTs are not currently sufficiently resourced to operate 24/7, with caseloads above levels that allow teams to fulfil their core functions of a community-based crisis response and intensive home treatment as an alternative to admission, putting extra pressure on hospital beds.

Reducing hospital attendance case study: Yorkshire Ambulance Service

Background

Staff at Yorkshire Ambulance Service NHS Trust were receiving high numbers of 999 calls from those experiencing a mental health crisis. In addition, ambulance crews often identify mental illness or substance misuse issues in those they see. These patients may never have sought support for their problems, and so ambulance clinicians may represent their only route to treatment. In the past, staff had few referral choices in either of these situations. 999 responders had little option but to send an ambulance, and if an ambulance was dispatched it often resulted in a patient ending up at hospital – even if there wasn't necessarily a medical need for the person to be there. This increased pressure on ambulances and A&E, meaning they were less able to support those for whom their care was most appropriate.

The approach

Yorkshire Ambulance Service NHS Trust has introduced a number of initiatives to bolster care for those with mental illness or substance misuse issues. These include: Mental health nurses within the 999 control room: These clinicians offer specialist advice and support to ambulance staff caring for patients with mental ill health or substance misuse issues. They help triage patients, identifying what support is needed and how urgently. The setup was piloted in December 2014, and implemented formally from April 2015. Funding was secured from the local clinical commissioning group, and the system was quickly set up through the recruitment of agency mental health nurses and the development of appropriate governance.

Continued on the next page…

Reducing hospital attendance case study: Yorkshire Ambulance Service

If a full assessment shows a patient has no medical need to go to hospital but a clear need for mental health support, ambulance staff can refer individuals directly to a specialist mental health team.

Emergency clinicians are able to have a direct conversation with a member of the team 24/7 and together they can ensure the patient gets the most appropriate care.

An ambulance call out can be an opportunity for a person to agree something needs to change with their use of alcohol. Yorkshire Ambulance staff can now refer patients directly to the local alcohol misuse provider service if a patient accepts an offer of support – again, referrals can be made 24/7.

Outcomes

Since the introduction of specialist nurses to the 999 control room, the number of patients in a mental health crisis who have needed to be taken to hospital has decreased. Staff report they are better able to meet the needs of people displaying mental health issues, and are able to ensure ambulances are only dispatched when that is the best care option for them. This increases the availability of ambulance resources for other patients.

Further information

For more information visit: http://nhsconfed.org/resources/2016/06/yorkshire-ambulance-service-nhs-trust-and-public-health-england-care-integration

Reducing hospital attendance case study: Safe Haven Café Aldershot

Background

In 2010 the Kings Fund published a report entitled *Mental Health and the Productivity Challenge*. The evidence presented in the report demonstrated that there was scope to improve productivity in mental health care, and that there were also opportunities for mental health services to support productivity improvements in other areas of the NHS and in public spending more widely. One of the more promising areas for improvement was reduction of unnecessary bed use in acute and secure psychiatric wards.

Since that time mental health services across England have introduced a range of innovative ways of providing alternatives to sending patients in crisis to A&E.

The approach

The 'Safe Haven' café in Aldershot, on the Surrey and Hampshire border, has been open all year round since 2014 and is an evening drop in where people can go if they need support. NHS workers and third sector partners are on site to provide mental health crisis support which has helped some people avoid the need for NHS care including A&E altogether.

Surrey & Borders Partnership NHS Foundation Trust is contracted by the CCG to run the café in partnership with two third sector organisations which provide the staffing. The service has brought partners across the statutory and third sectors together in an innovative way which has been crucial to its success. It provides mental health support in a welcoming environment provided by trained psychiatric nurses and other mental health professionals as well as peer support.

Anyone suffering from a mental health problem, diagnosed or not, can drop in for a cup of tea and a chat and can request more formal help if needed.

Continued on the next page…

Reducing hospital attendance case study: Safe Haven Café Aldershot

Dr Andy Whitfield, Clinical Chair of North East Hampshire and Farnham CCG, said: “The café is an excellent example of the Five Year Forward View in action. It shows partners from all sectors working together to provide a service that is close to people’s homes, easy to access at times of need and clearly filling a gap in provision.

“We asked service users what they wanted and this was their idea which proves that putting patients at the heart of change is the key to providing the right kind of care and reducing need for costly NHS beds.”

Outcomes

Service users say the café has helped them in many ways including preventing some from committing suicide and helping others combat loneliness, homelessness and general crisis.

The service is de-escalating and preventing crises and avoiding the need for people to present to mainstream services, reducing demand and releasing capacity.

A separate study carried out for Surrey and Borders Partnership NHS Foundation Trust (SABP) by Mental Health Strategies found that from April to October 2014, the number of admissions to acute in-patient psychiatric beds fell by 33% from within the ‘Safe Haven’ catchment area.

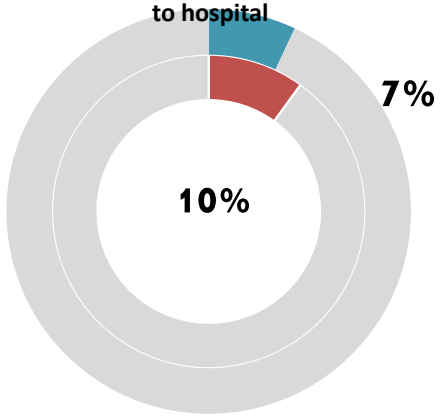
Further information

For more information please visit https://www.england.nhs.uk/mentalhealth/case-studies/aldershot/

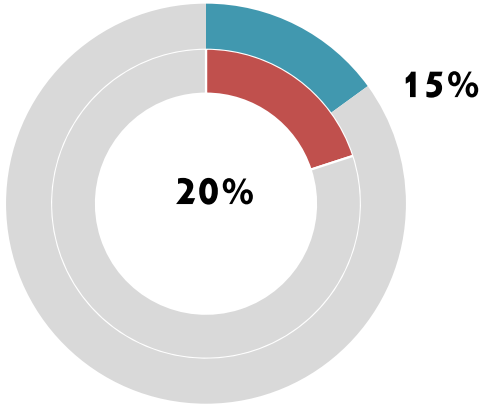
There is also a short video**:** https://www.youtube.com/watch?v=qvYw-eTqHR4

NHS Leeds North CCG - Hospital admissions Profile

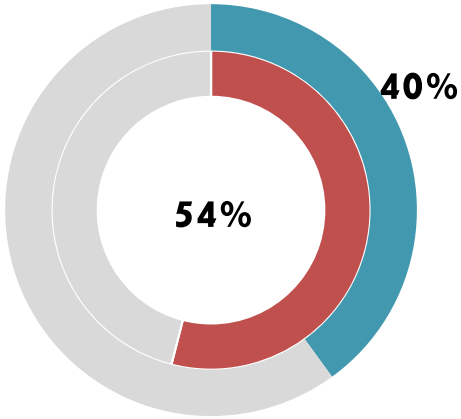
% Patients in the Non Psychosis super class who were admitted to hospital



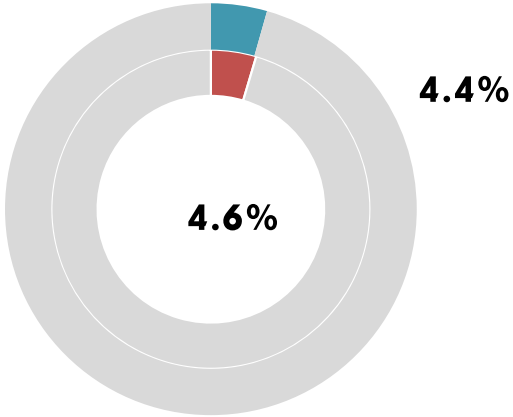
% Patients in the Psychosis super class who were admitted to hospital



% All admissions that are by patients in settled accommodation



% People aged 18+ in contact with mental health services who had a hospital admission

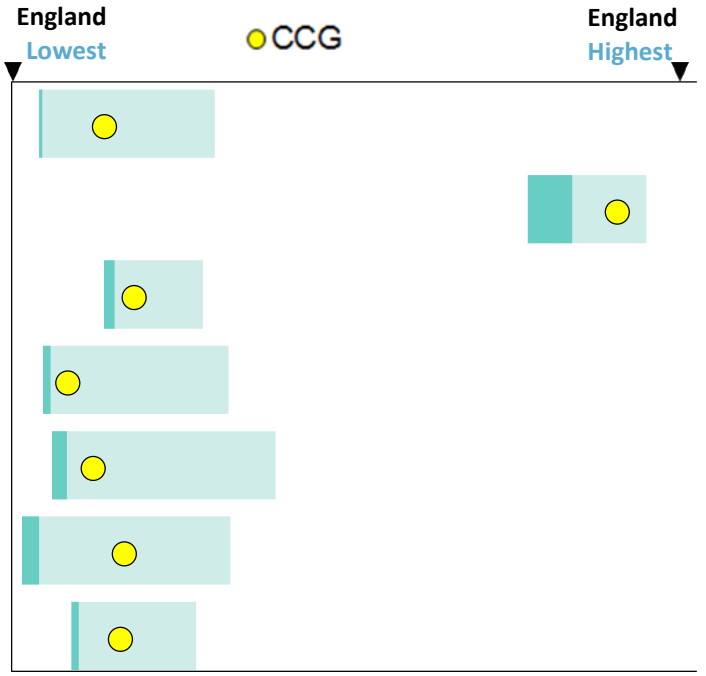


CCG

Average of similar 10 CCGs

Admissions and discharges

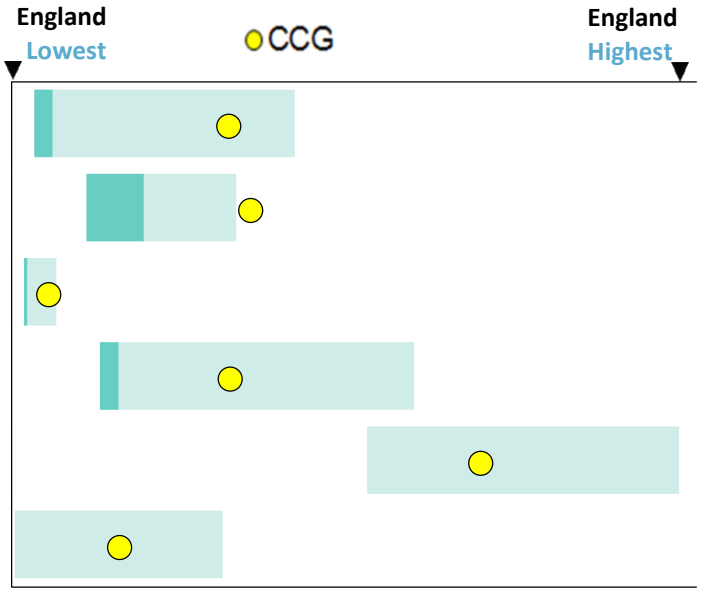
Indicator	Time Period	CCG Value
Rate of admissions to hospital - people aged 18+ - per 100,000	2014/15	233.7
Patients with 1 admission in 2014/15 as a percentage of all patients admitted - 18+	2014/15	82.0
Patients with 2 admissions in 2014/15 as a percentage of all patients admitted - 18+	2014/15	13.1
Patients with 3 of more admissions in 2014/15 as a percentage of all patients admitted - 18+	2014/15	4.9
Rate of admissions to hospital - people aged 18-35 - per 100,000	2014/15	258.0
Rate of admissions to hospital - people aged 36-64 - per 100,000	2014/15	224.6
Rate of admissions to hospital - people age 65+ - per 100,000	2014/15	206.8



These indicators show admissions to hospital by different groups as well as percentages. Rates of admissions show rates of admissions rather than unique people admitted - so patients admitted more than once in 2014/15 will be counted for each individual admissions. Lower admission rates may reflect better community care provision, but should also be considered alongside indicators related to clustering that indicate the case mix of patients in contact with services within a CCG. Rates of admissions and bed days may vary by CCG due to the types of beds available in acute providers. Data is therefore not always directly comparable between CCGs. CCGs should use local data related to bed types to fully understand admission rates.

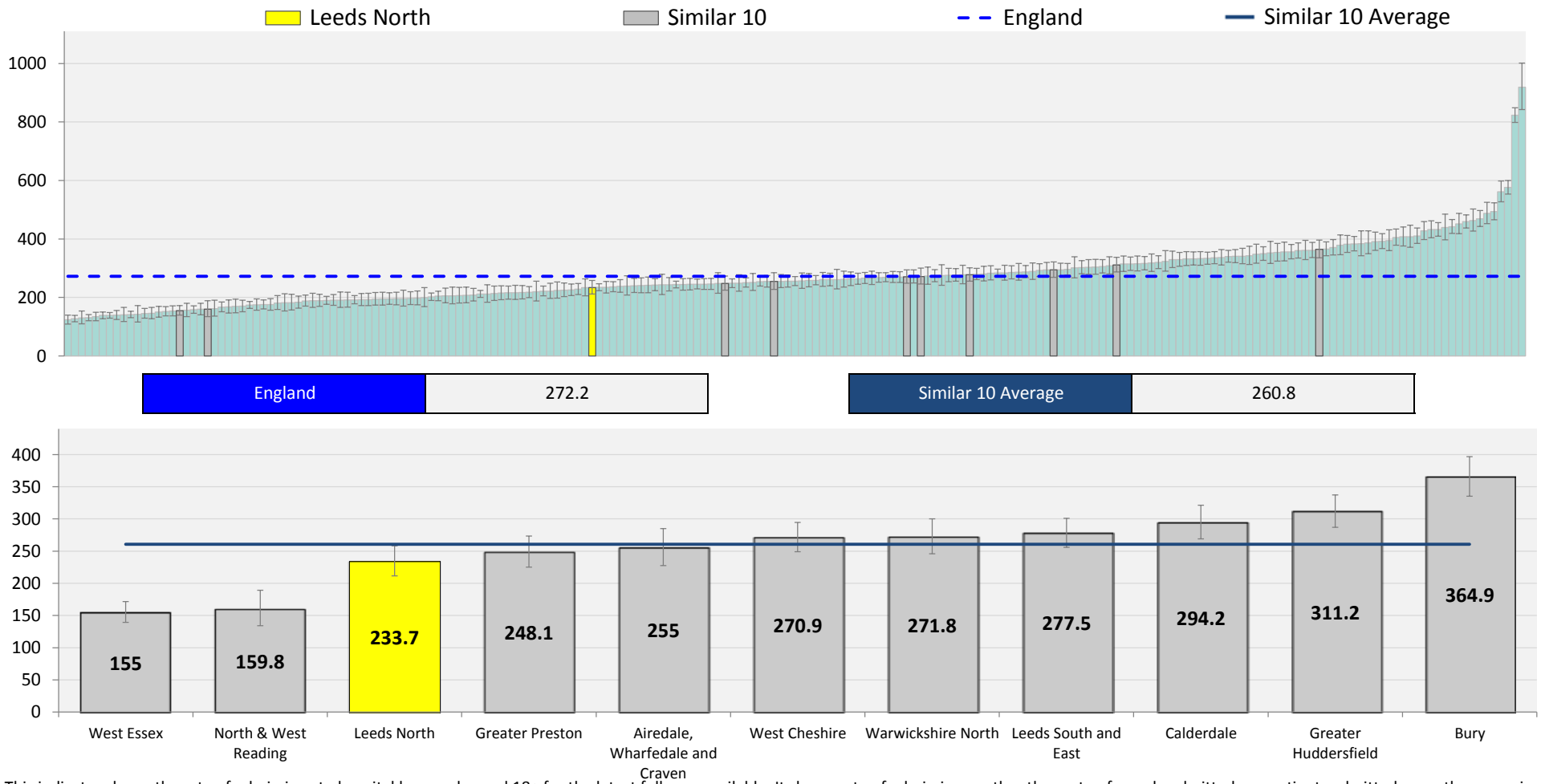
Admissions and discharges continued

Indicator	Time Period	CCG Value
Percentage of patients in the Non-psychosis super class who were admitted to hospital	2014/15	10.2
Percentage of patients in the Psychosis super class who were admitted to hospital	2014/15	19.6
Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital (end of quarter snapshot)	2015/16 Q2	3.0
Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital	2014/15	4.6
Percentage of mental health admissions which were an emergency (quarterly)	2014/15 Q2	76.9
Rate of discharges from hospital by people aged 18+ - per 100,000	2014/15	239.6



These indicators show percentage of people in contact with services admitted to hospital for the latest quarter and latest full year available. These indicators should therefore be considered alongside information relating to data recording quality in this pack. Lower admission rates may reflect better community care provision, but should also be considered alongside indicators related to clustering that indicate the case mix of patients in contact with services within a CCG.Rates of admissions and bed days may vary by CCG due to the types of beds available in acute providers. Data is therefore not always directly comparable between CCGs. CCGs should use local data related to bed types to fully understand admission rates.

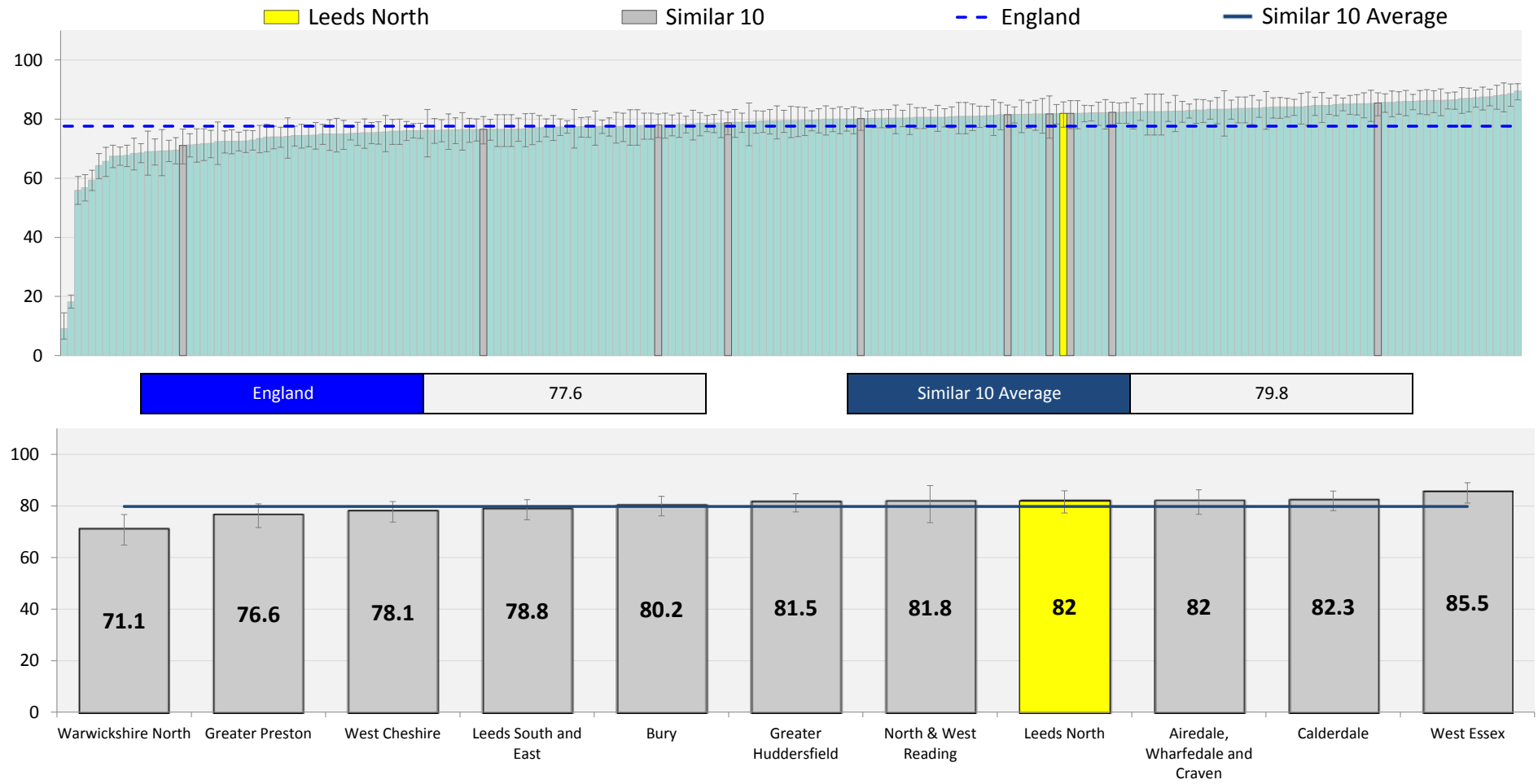
Rate of admissions to hospital - people aged 18+ - per 100,000



This indicator shows the rate of admissions to hospital by people aged 18+ for the latest full year available. It shows rate of admissions, rather than rate of people admitted - so patients admitted more than once in 2014/15 will be counted for each individual admissions.

Definition: Rate of admissions to hospital - people aged 18+ - per 100,000
Source: MHLDDS
Year: 2014/15

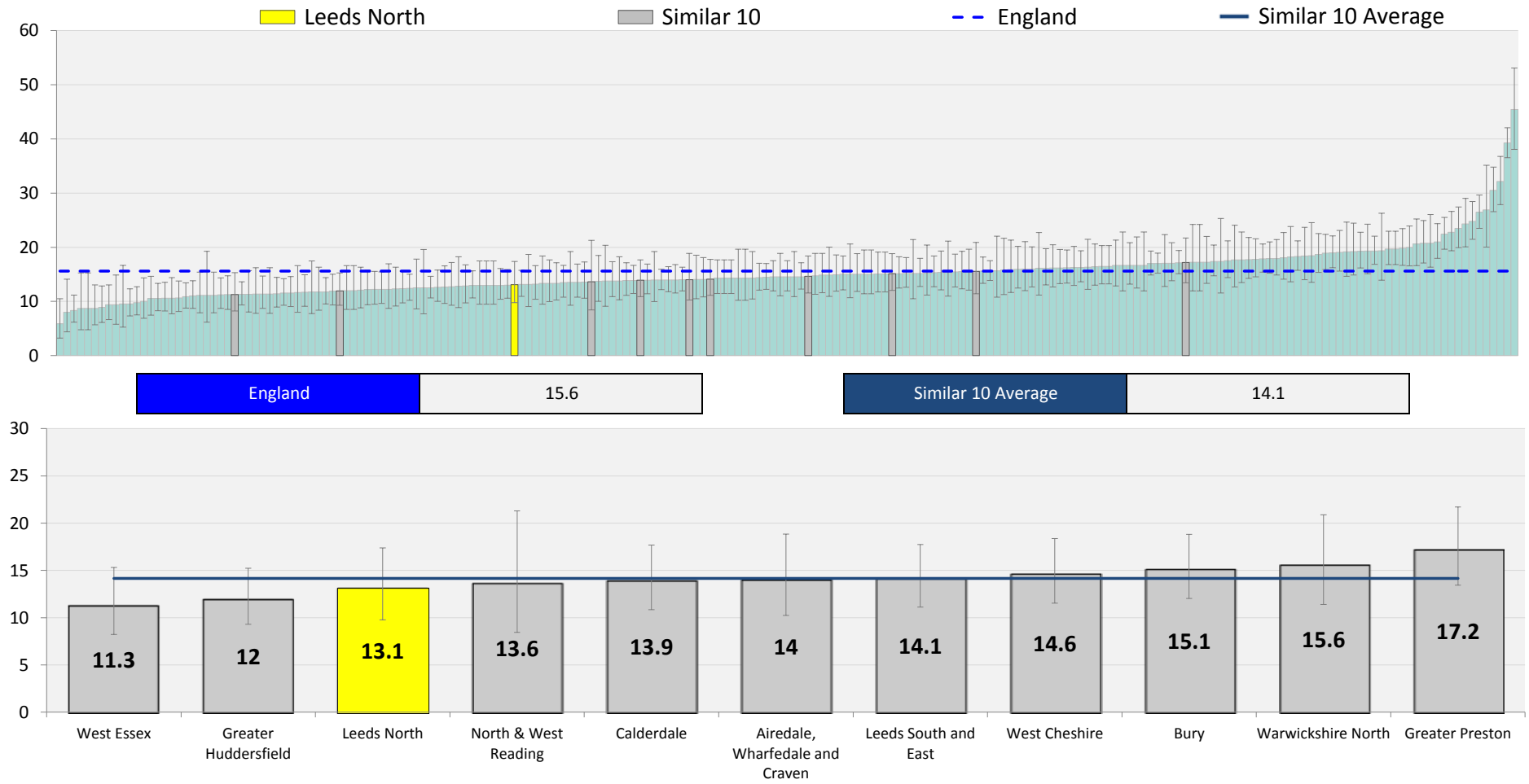
Patients with 1 admission in 2014/15 as a percentage of all patients admitted - 18+



This indicator shows the percentage of patients that were admitted who only had one admission in 2014/15. It should be considered alongside the two indicators which show the percentage who had 2 admissions and the percentage who had 3 or more. Admissions indicators should be considered alongside bed days indicators in the following section of this pack.

Definition: Patients with 1 admission in 2014/15 as a percentage of all patients admitted - 18+
Source: MHLDDS
Year: 2014/15

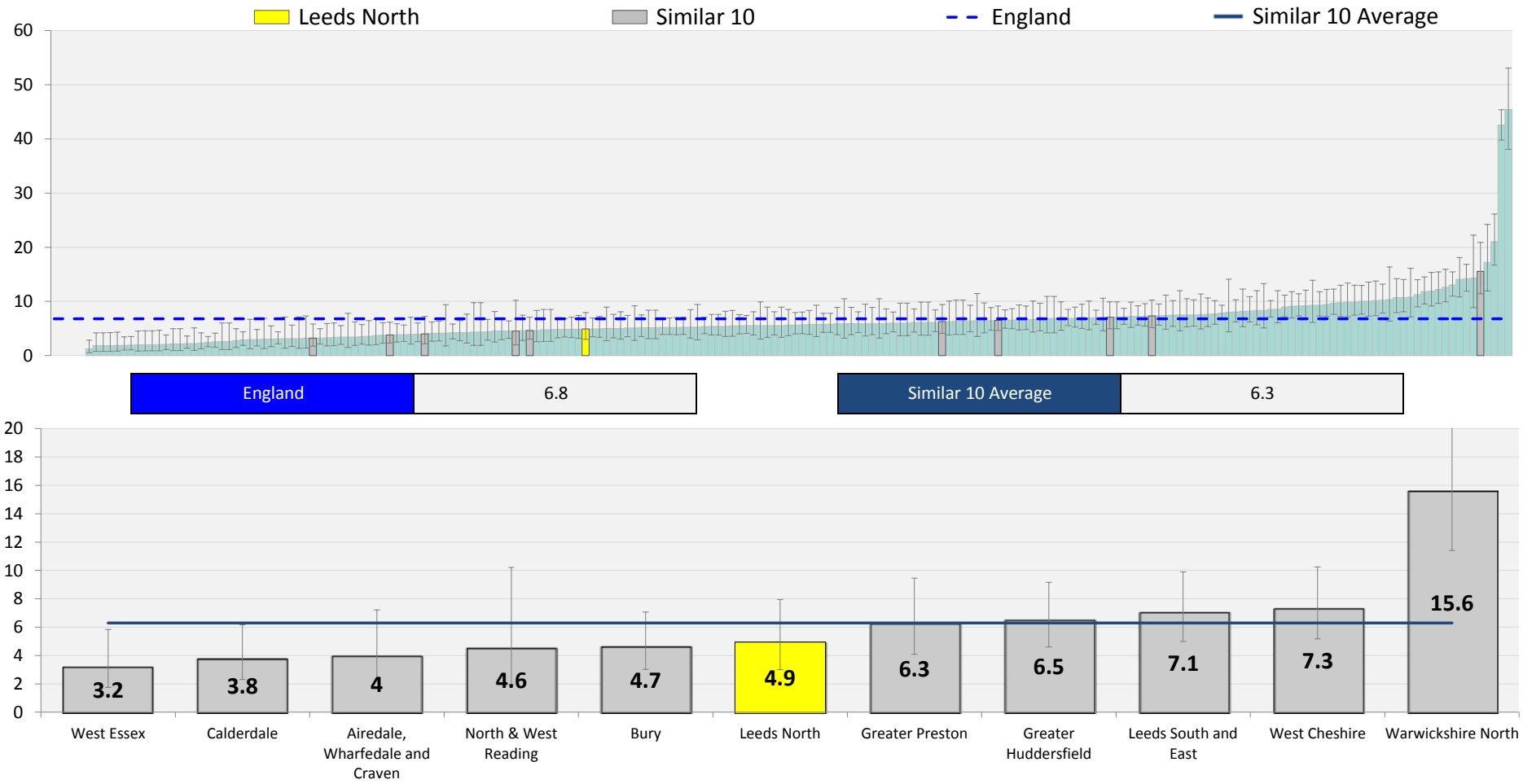
Patients with 2 admissions in 2014/15 as a percentage of all patients admitted - 18+



This indicator shows the percentage of patients that were admitted who had 2 admissions in 2014/15. It should be considered alongside the two indicators which show the percentage who had 1 admission and the percentage who had 3 or more. Admissions indicators should be considered alongside bed days indicators in the following section of this pack.

Definition: Patients with 2 admissions in 2014/15 as a percentage of all patients admitted - 18+
Source: MHLDDS
Year: 2014/15

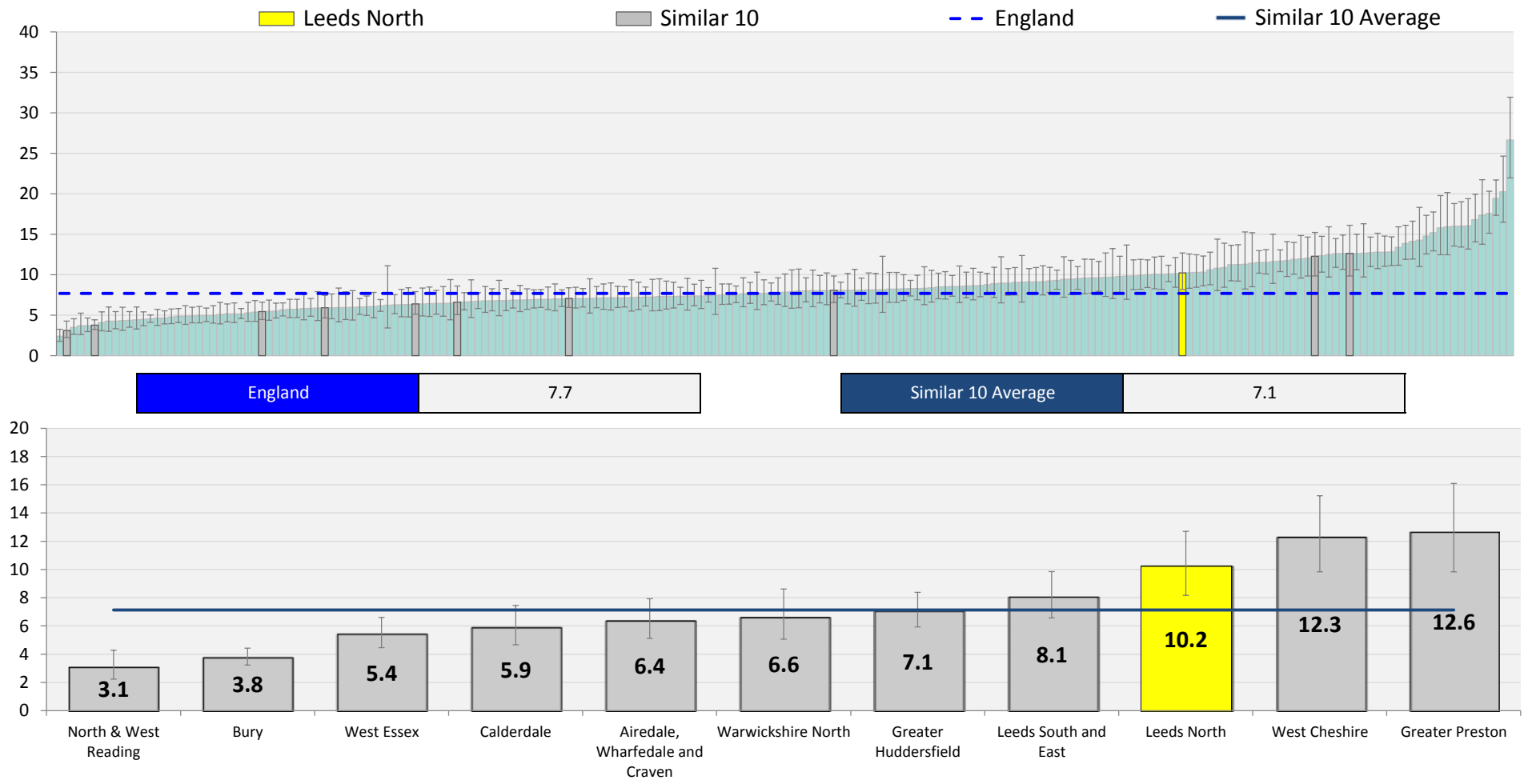
Patients with 3 of more admissions in 2014/15 as a percentage of all patients admitted - 18+



This indicator shows the percentage of patients that were admitted who 3 or more admissions in 2014/15. It should be considered alongside the two indicators which show the percentage who had 1 admission and the percentage who had 2. Admissions indicators should be considered alongside bed days indicators in the following section of this pack.

Definition: Patients with 3 of more admissions in 2014/15 as a percentage of all patients admitted - 18+
Source: MHLDDS
Year: 2014/15

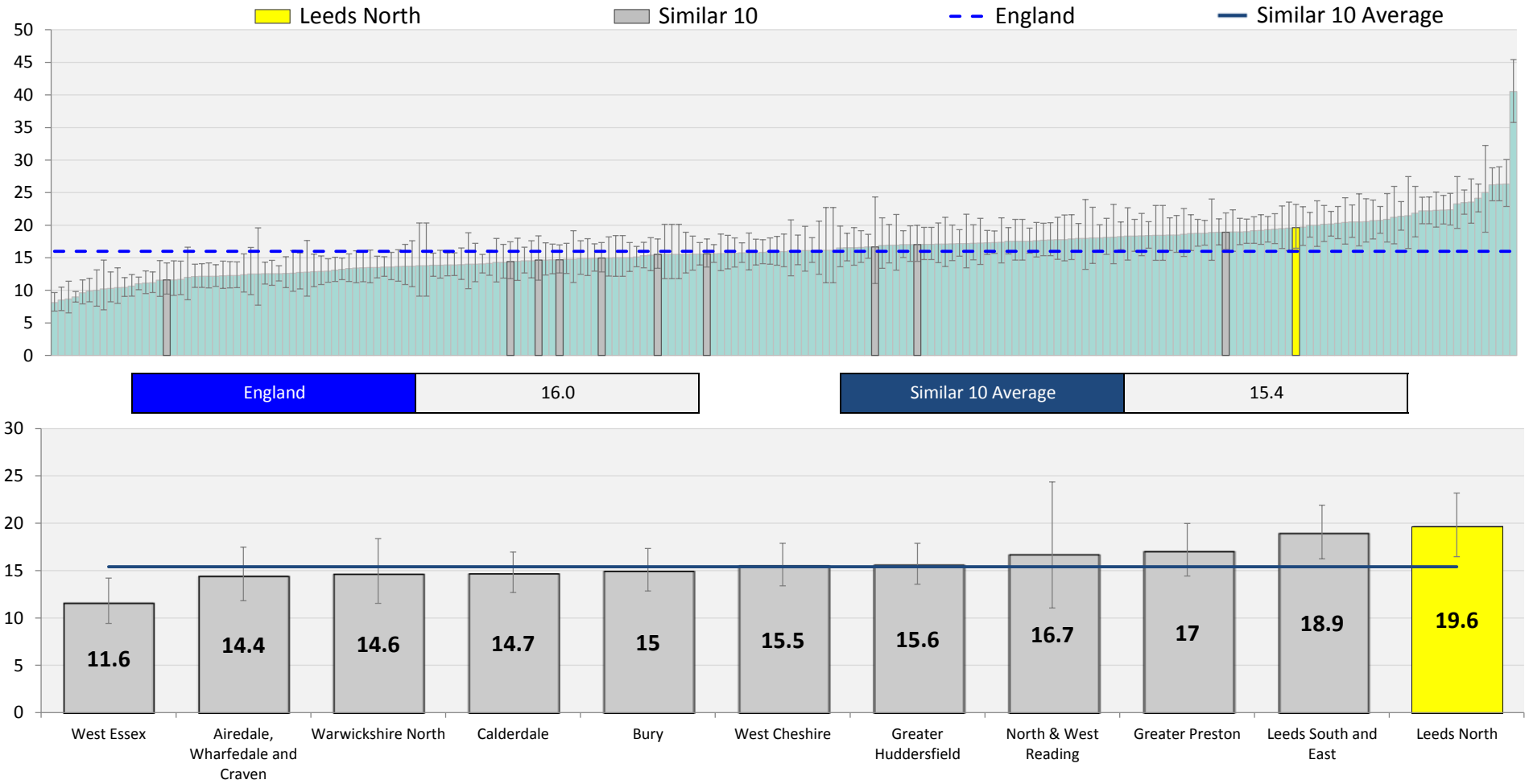
Percentage of patients in the Non-psychosis super class who were admitted to hospital



This indicator shows the percentage of patients allocated to the Non-Psychosis cluster who were admitted to hospital at some point during 2014/15.

Definition: Percentage of patients in the Non-psychosis super class who were admitted to hospital
Source: MHLDDS
Year: 2014/15

Percentage of patients in the Psychosis super class who were admitted to hospital



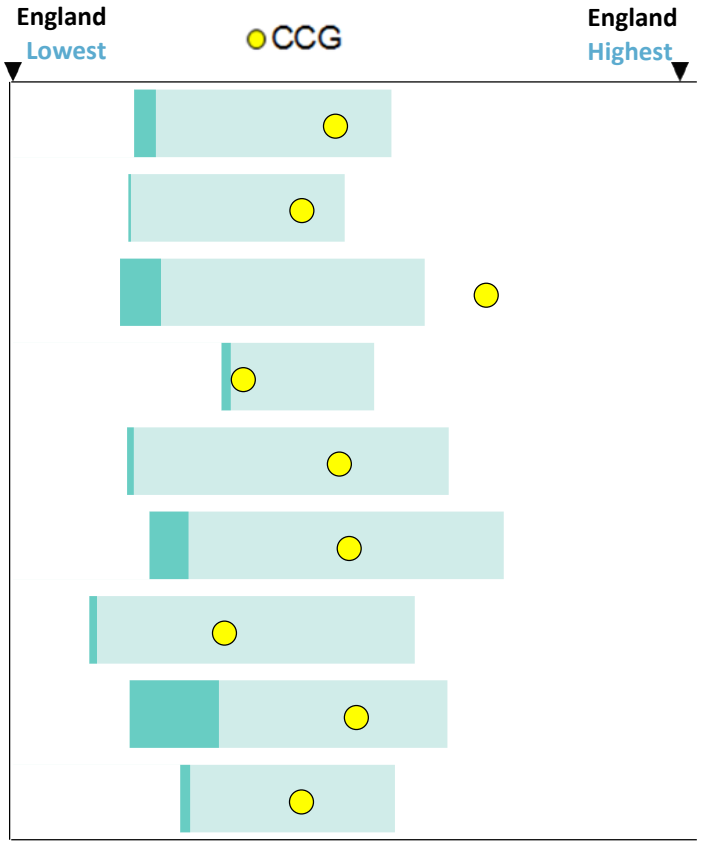
This indicator shows the percentage of patients allocated to the Psychosis cluster who were admitted to hospital at some point during 2014/15.

Definition: Percentage of patients in the Psychosis super class who were admitted to hospital
Source: MHLDDS
Year: 2014/15

NHS Leeds North CCG
- Length of Stay Profile

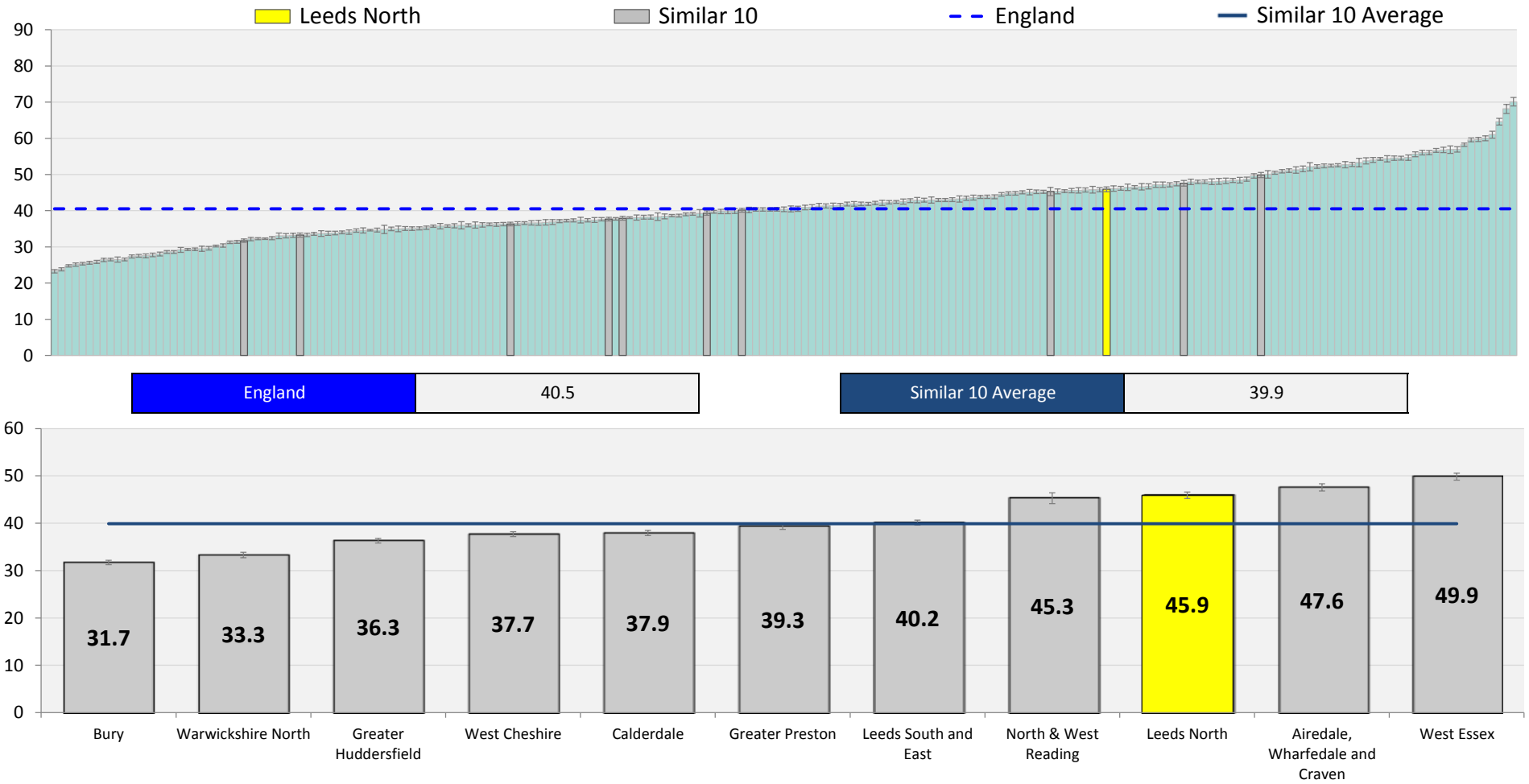
Inpatient bed days

Indicator	Time Period	CCG Value
Average inpatient length of stay (in days) for people aged 18+	2014/15	45.9
Rate of total bed days for people aged 18+ - per 100,000	2014/15	11103.5
Average inpatient length of stay (in days) for patients aged 18-35	2014/15	51.5
Average inpatient length of stay (in days) for patients aged 36-64	2014/15	35.3
Average inpatient length of stay (in days) for patients aged 65+	2014/15	64.2
Average inpatient length of stay (in days) for patients in the Non-psychosis super class 18+	2014/15	37.0
Average inpatient length of stay (in days) for patients in the Psychosis super class 18+	2014/15	47.7
Percentage of admissions where the length of stay (in days) was more than 30 days	2014/15	41.8
Percentage of admissions where the length of stay (in days) was more than 60 days	2014/15	21.5



These indicators show average lengths of stay for inpatient admissions for different groups of patients. The calculated average length of stay includes bed days where the patient was on home leave from an inpatient stay. The data for the indicator for percentage of admissions that are longer than two months is a subset of the data for the indicator for percentage of admissions that are longer than one month. Differences in length of stay may be accounted for by different composition of bed types within a given CCG. For instance, longer average stays in secure beds is expected compared to average stays in acute beds.

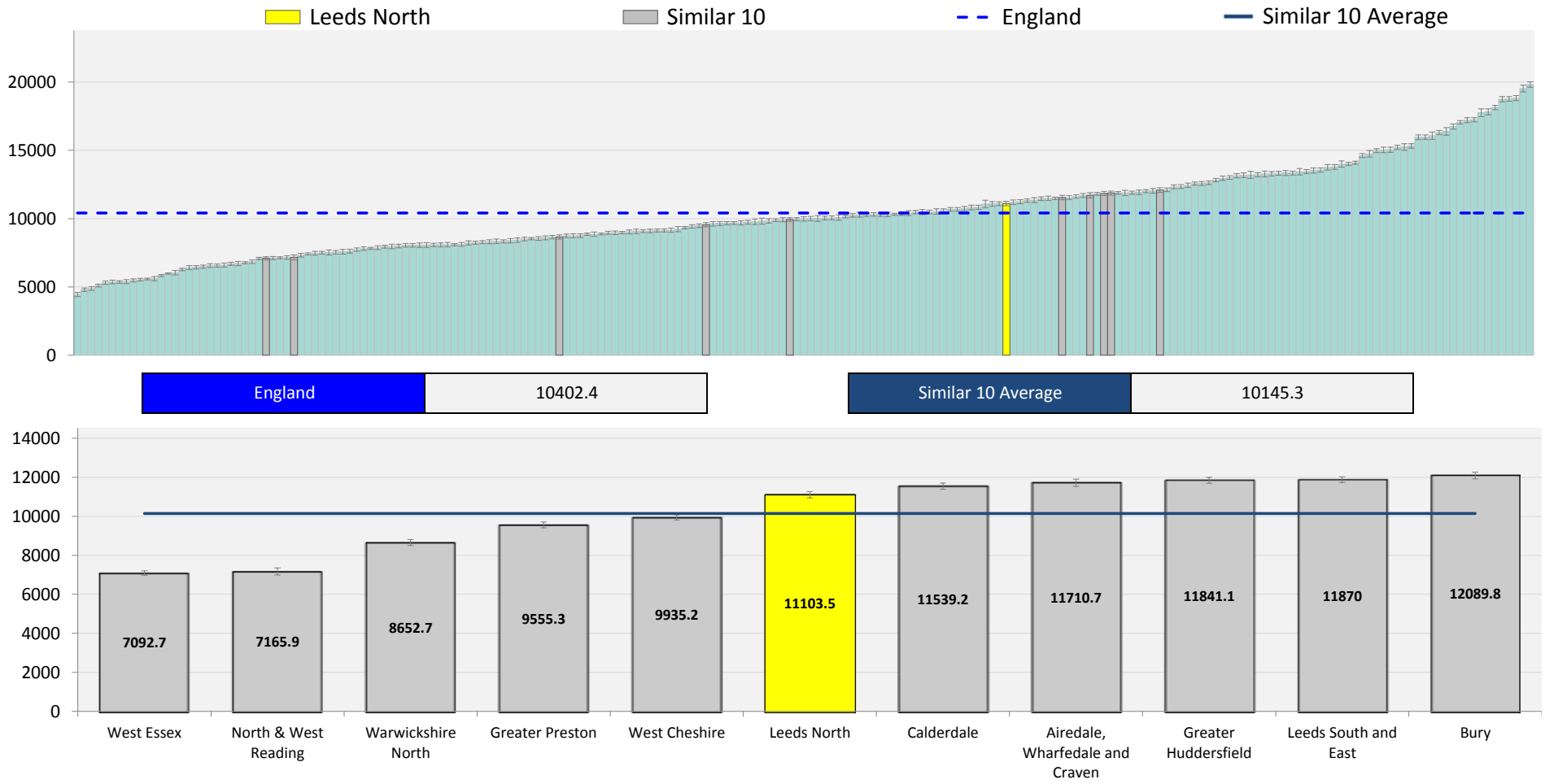
Average inpatient length of stay (in days) for people aged 18+



This indicator shows the average length of stay per admission for people aged 18 and over. It includes bed days where the patient was on home leave from an inpatient stay.

Definition: Average inpatient length of stay (in days) for people aged 18+
Source: MHLDDS
Year: 2014/15

Rate of total bed days for people aged 18+ - per 100,000



This shows the total number of inpatient bed days for people admitted to hospital who were aged 18+. The figures include bed days where the patient was on home leave from an inpatient stay.

Definition: Rate of total bed days for people aged 18+ - per 100,000
Source: MHLDDS
Year: 2014/15

Secure mental health services

Secure mental health services provide accommodation, treatment and support for people with severe mental health problems who pose a risk to the public.

Key messages

A new secure mental health care programme is being led by NHS England which aims to deliver the recommendations in the Five Year Forward View for care in the least restrictive setting, as close to home as possible, and with a stronger focus on recovery.

The new programme will work with stakeholders across the secure care system in order to:

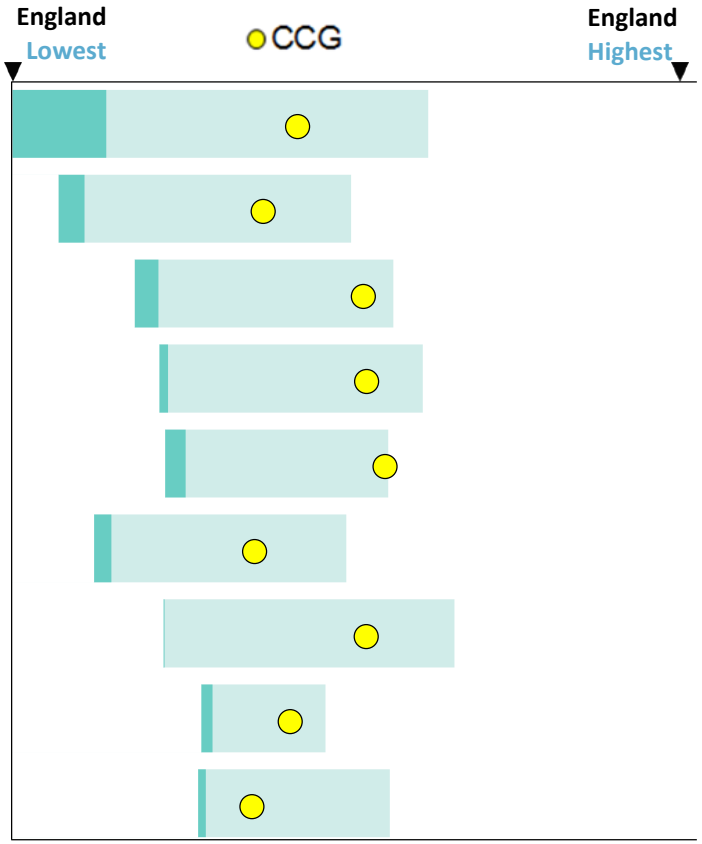
- Ensure that individuals receive care in the most appropriate setting
- Identify co-commissioning funding and service models
- Increase provision of community based services and reduce dependency on beds
- Tackle inequalities for groups that are over-represented in the system, and seek to ensure that out of area placements are substantially reduced
- Identify where efficiencies can be realised and reinvested in mental health services

For patients and their families this will mean accessing care closer to home, with a shorter length of stay in hospital and increased opportunities to receive comprehensive community support.

This is a new programme and any future development will be posted on the NHS England secure mental health care web page: : https://www.england.nhs.uk/mentalhealth/adults/secure-care/

Secure mental health services

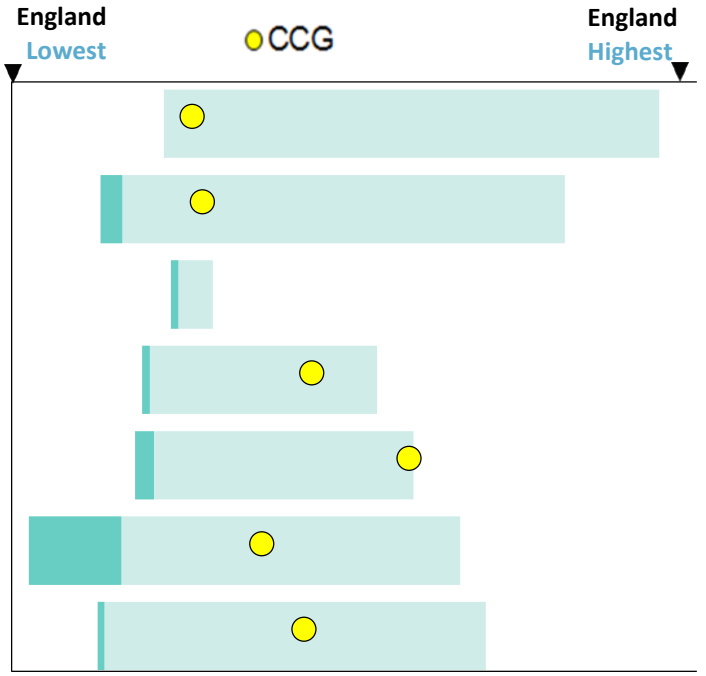
Indicator	Time Period	CCG Value
Rate of people subject to the Mental Health Act - per 100,000 (end of quarter snapshot)	2015/16 Q2	50.9
Rate of people subject to the Mental Health Act - per 100,000 population	2014/15	40.9
Rate of detentions on admission to hospital by people aged 18+ - per 100,000	2014/15	83.3
Rate of detentions under the Mental Health Act for people aged 18+ - per 100,000	2014/15	107.1
Rate of detentions under the Mental Health Act for people aged 18-35 - per 100,000	2014/15	133.1
Rate of detentions under the Mental Health Act for people aged 36-64 - per 100,000	2014/15	83.7
Rate of detentions under the Mental Health Act for people aged 65+ - per 100,000	2014/15	132.7
Percentage of detentions under the Mental Health Act that were females	2014/15	50.0
Percentage of detentions under the Mental Health Act that were males	2014/15	50.0



The official figures for detentions under the MHA in 2014/15 are those produced from the KP90 data collection released in Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment. The figures derived from MHLDDS are an undercount and should be viewed alongside the organisation level analysis in the KP90 report to understand the impact at provider and CCG level. All detentions includes; Detentions under Part ll, Detentions under Part lll, Detentions under previous legislation (Fifth Schedule) and other acts, Detentions subsequent to admission, Detentions following use of Place of Safety Order and Detentions following revocation of CTO.

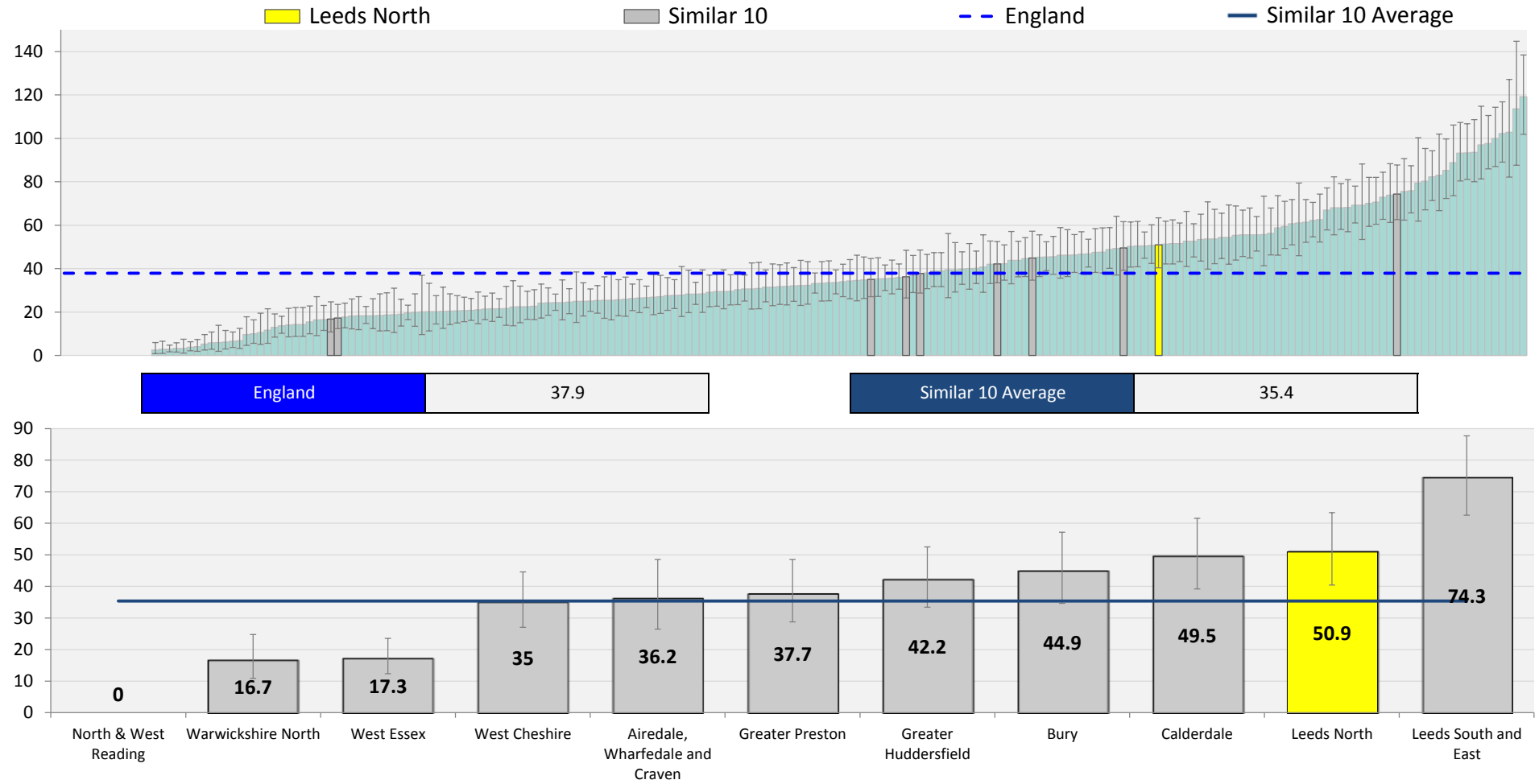
Secure mental health services continued

Indicator	Time Period	CCG Value
Percentage of people who have been detained more than once of all those detained	2014/15	9.1
Rate of people aged 18+ detained under the Mental Health Act twice during the year - per 100,000	2014/15	14.9
Rate of people aged 18+ detained under the Mental Health Act three or more times during the year - per 100,000	2014/15	No Data
Rate of detentions under Part 2 Section II of the Mental Health Act for people aged 18+ - per 100,000	2014/15	74.4
Rate of detentions under Part 2 Section III of the Mental Health Act for people aged 18+ - per 100,000	2014/15	32.8
Rate of Short Term Orders (Mental Health Act Sections 135 & 136 - Place of Safety Order) during the year - per 100,000	2014/15	40.7
Rate of Short Term Orders (Mental Health Act Sections 4 and 5) during the year - per 100,000	2014/15	20.7



Detentions under Part ll of the Mental Health Act includes; Detentions subsequent to admission, Detentions following use of Place of Safety Order (Section 135 to Section 2, Section 135 to Section 3, Section 136 to Section 2 and Section 136 to Section 3) and Detentions following revocation of CTO. Detentions under Part lll of the Mental Health Act includes; Section 35, Section 36, Section 37 (with Section 41 restrictions), Section 37 (without Section 41 restrictions), Section 45A, Section 47 (with Section 49 restrictions), Section 47 (without Section 49 restrictions), Section 48 (with Section 49 restrictions), Section 48 (without Section 49 restrictions), Other Sections - 38, 44 and 46. Short Term Orders are split out into two groups to reflect the different situations they are used in.

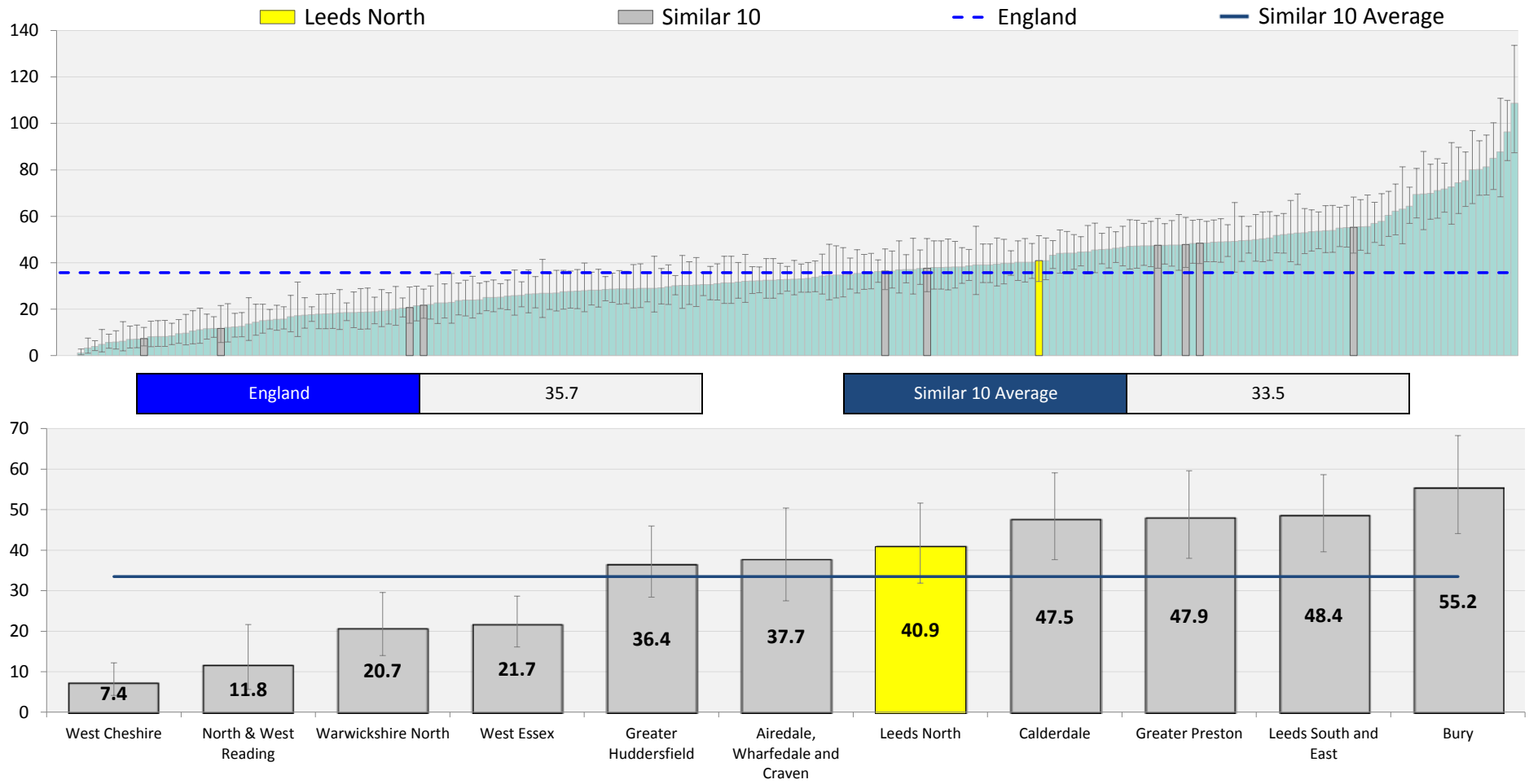
Rate of people subject to the Mental Health Act - per 100,000 (end of quarter snapshot)



This indicator shows the number of people who were subject to the Mental Health Act for the most recent quarter available. It is a crude rate and has not been standardised

Definition: Rate of people subject to the Mental Health Act - per 100,000 (end of quarter snapshot)
Source: Health & Social Care Information Centre, PHE Fingertips Severe Mental Illness Profile
Year: 2015/16 Q2

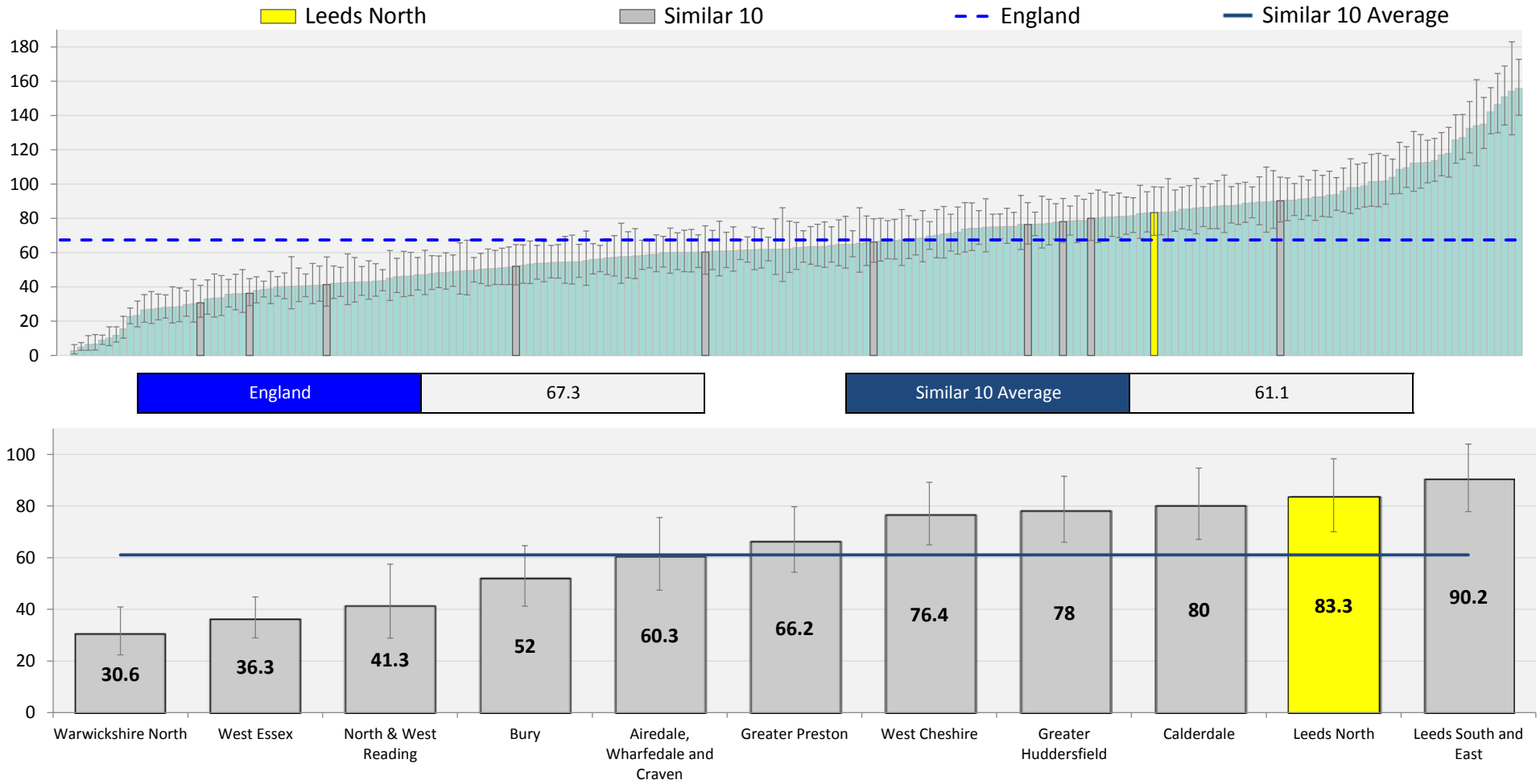
Rate of people subject to the Mental Health Act - per 100,000 population



This indicator shows the number of people who were subject to the Mental Health Act for the most recent full year available. It is indirectly age/sex standardised. The figures derived from MHLDDS are an undercount and should be viewed alongside the organisation level analysis in the KP90 report to understand the impact at provider and CCG level.

Definition: Rate of people subject to the Mental Health Act - per 100,000 population
Source: MHLDDS
Year: 2014/15

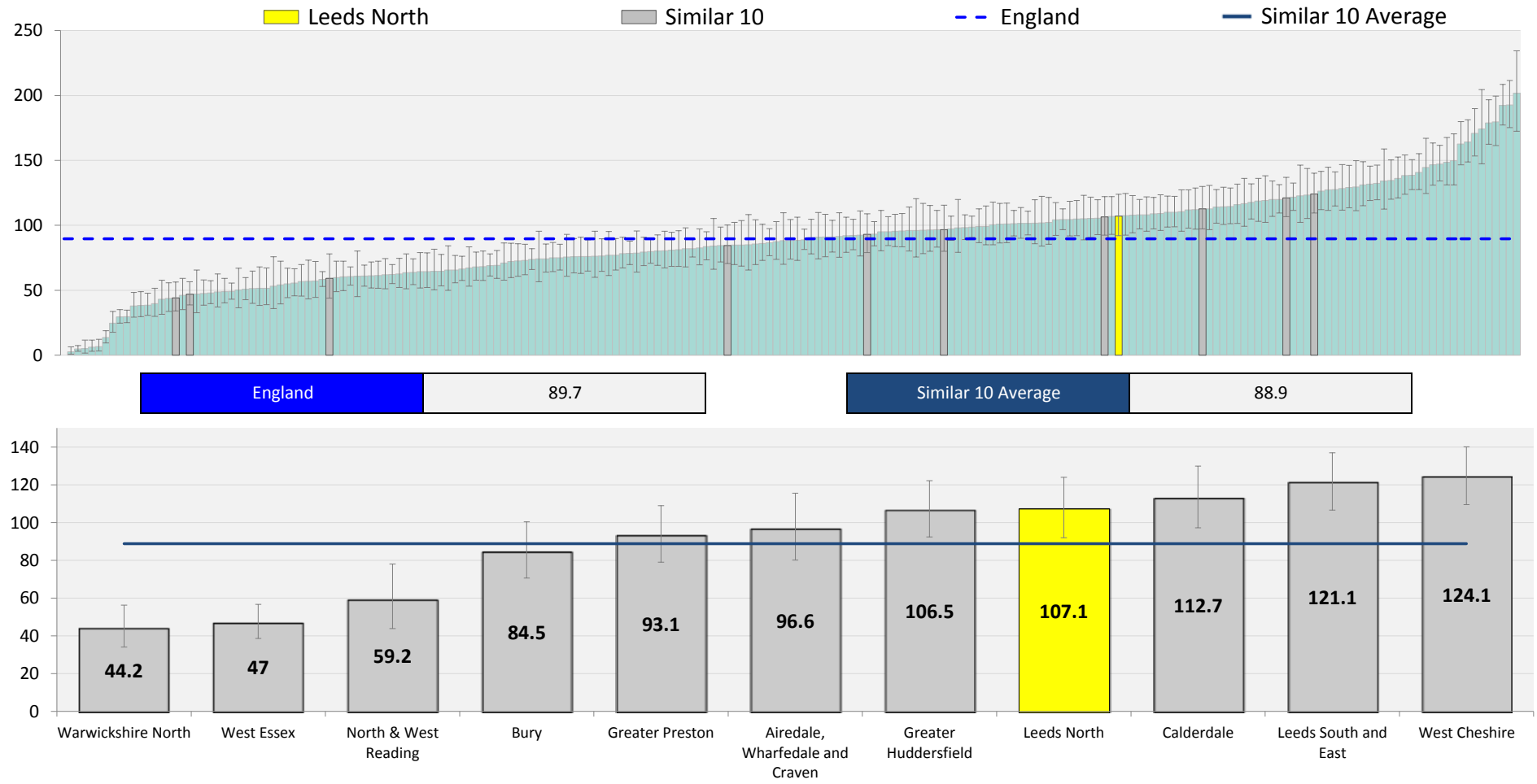
Rate of detentions on admission to hospital by people aged 18+ - per 100,000



This indicator shows the rate of detentions that occurred on admission to hospital rather than the rate of people detained. The figures derived from MHLDDS are an undercount and should be viewed alongside the organisation level analysis in the KP90 report to understand the impact at provider and CCG level.

Definition: Rate of detentions on admission to hospital by people aged 18+ - per 100,000
Source: MHLDDS
Year: 2014/15

Rate of detentions under the Mental Health Act for people aged 18+ - per 100,000



This indicator shows the rate of people who were detained under the MHA in 2014/15. The figures derived from MHLDDS are an undercount and should be viewed alongside the organisation level analysis in the KP90 report to understand the impact at provider and CCG level.

Definition: Rate of detentions under the Mental Health Act for people aged 18+ - per 100,000
Source: MHLDDS
Year: 2014/15

Outcomes

As seen earlier in the pack, people with severe mental illness (SMI), such as psychosis are at increased risk of poor physical health and die on average 15 to 20 years earlier than the general population. The main causes of premature death are from chronic physical conditions such as coronary heart disease, type 2 diabetes and respiratory disease.

Suicide is rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4,882 deaths in 2014. A quarter of people who took their own life had been in contact with a health professional, usually their GP, in the last week before they died. Most were in contact within a month before their death. More than a quarter (28 per cent) of suicides were amongst people who had been in contact with mental health services within 12 months before their death, amounting to almost 14,000 people in the ten years from 2003-2013. However, suicides amongst inpatients in mental hospitals have significantly declined over the same period, as a result of better safety precautions.

Outcomes

The indicators presented here cover a range of outcome measures not included in other sections of this pack. These relate to mortality, the extent to which people in contact with services are in education, employment and settled accommodation, and instances of self harm, assault and restraint occurring in mental health inpatient settings. CCGs should consider these alongside the full range of indicators in this pack.

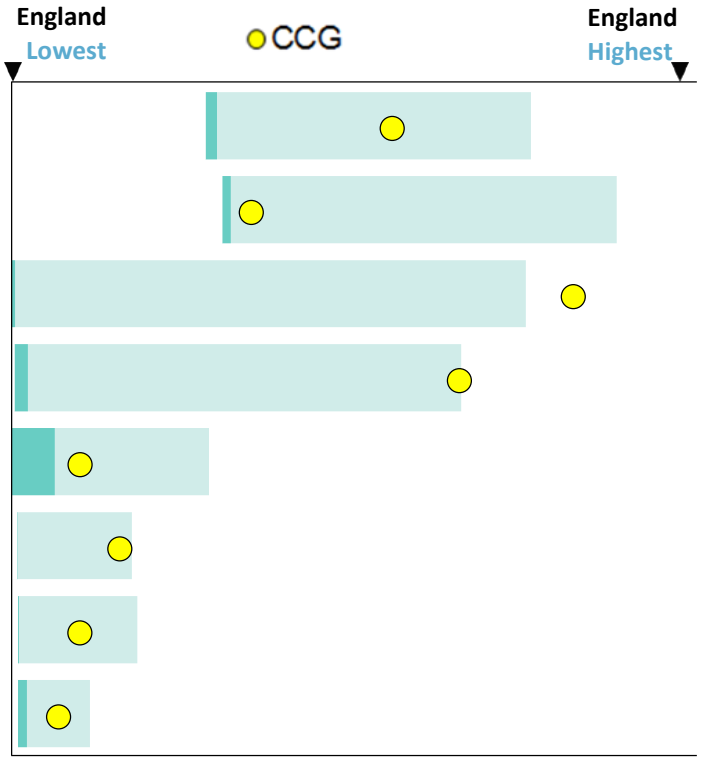
Stable employment and housing are both factors contributing to someone being able to maintain good mental health and are important outcomes for their recovery if they have developed a mental health problem. For people being supported by secondary mental health services, there is a 65 per cent employment gap compared with the general population. People with mental health problems are also often over-represented in high-turnover, low-pay and often part-time or temporary work.

Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high. Many patients in contact with mental health services are not recorded as being in stable and appropriate accommodation; even CCGs who benchmark well against their peers may have significant opportunities for improvements.

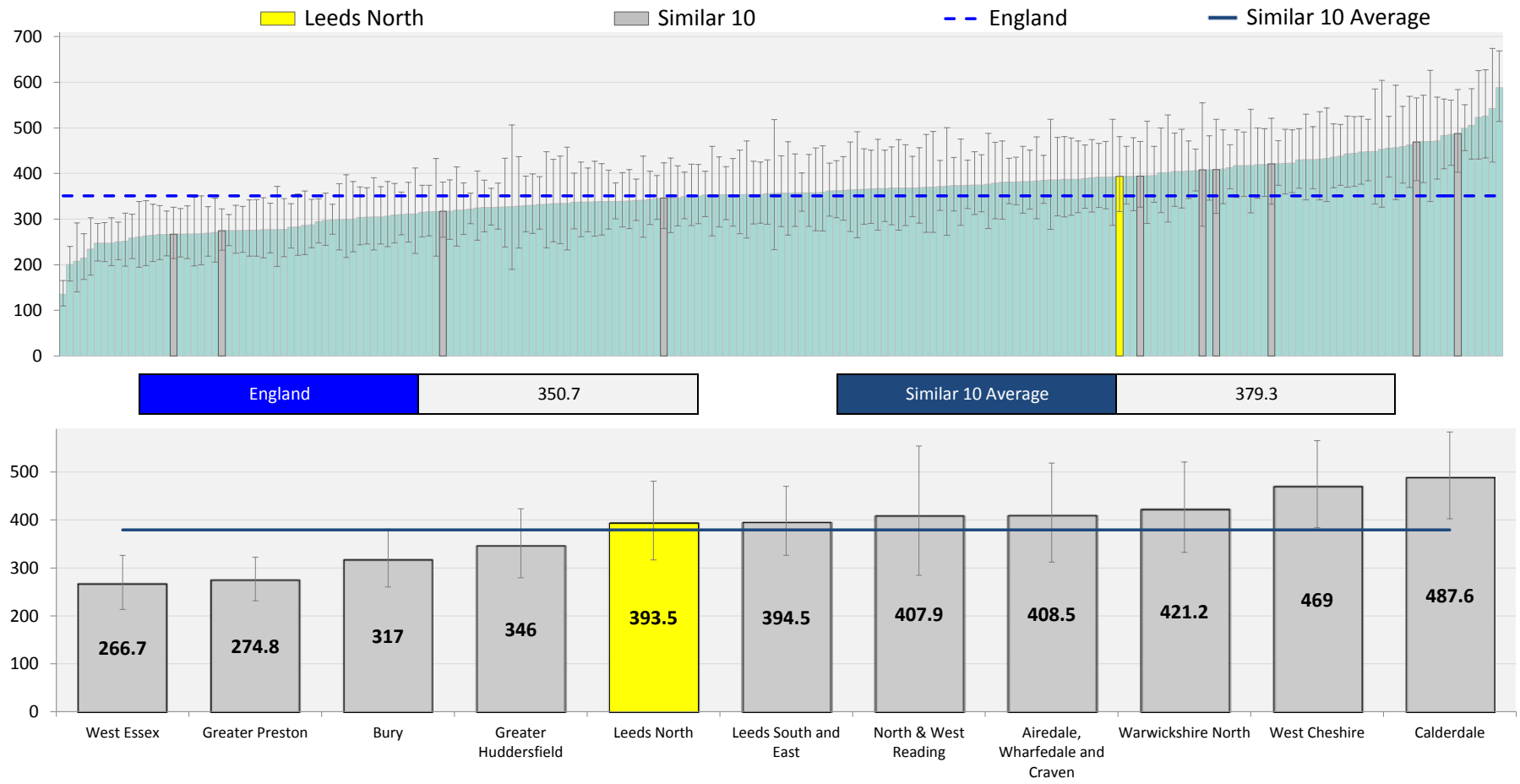
NHS England is also leading on a suite of personalised outcome measures across the mental health pathway. This work is due to start in earnest in 2017 and align with the development of new evidence based treatment pathways for mental health in line with recommendations in the Five Year Forward View.

Outcomes

Indicator	Time	CCG
Excess under 75 mortality in adults with Severe Mental Illness: standardised mortality ratio	2013/14	393.5
Rate of mortality from suicide, all ages - per 100,000	2012-14	5.9
Proportion of people aged 18-69 in contact with adult mental health services in employment	Q1 2016/17	15.5
Proportion of people aged 18-69 in contact with adult mental health services in stable accommodation	Q1 2016/17	46.4
Percentage of people aged 18-69 in contact with adult mental health services who are in education	2014/15	0.6
Rate of incidents of self harm by patients aged 18+ - per 100,000	2014/15	50.2
Rate of use of physical restraint of patients aged 18+ - per 100,000	2014/15	56.5
Rate of instances of assaults of patients aged 18+ - per 100,000	2014/15	18.1



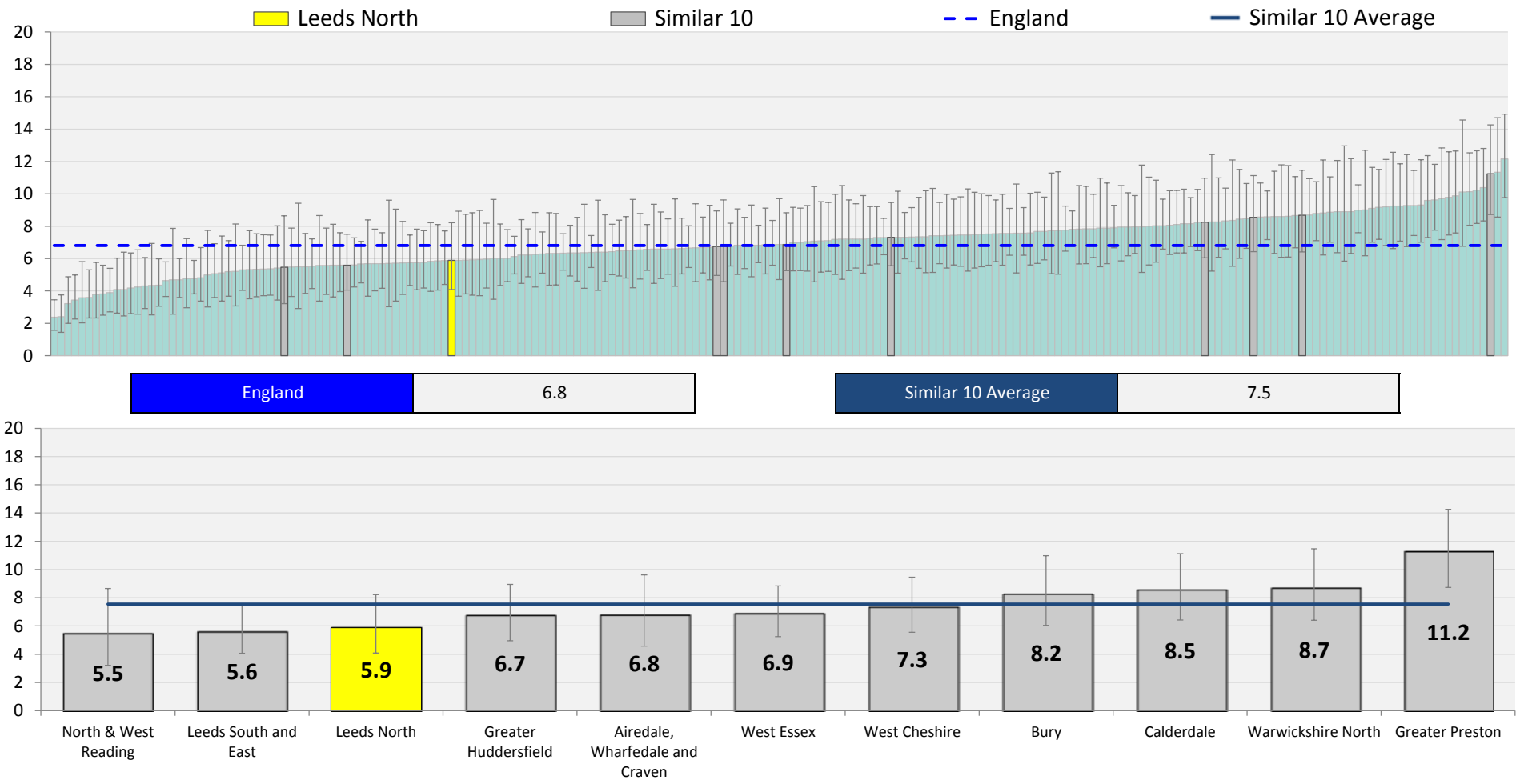
Excess under 75 mortality in adults with Severe Mental Illness: standardised mortality ratio



The indicator measures the increased mortality amongst the SMI population compared to the standard population. Standardised Mortality Ratio (SMR) is a ratio between the observed number of deaths in a study population and the number of deaths that would be expected, based on the age- and sex-specific rates in a standard population and the age and sex distribution of the study population. If the ratio of observed: expected deaths is greater than 1, there is said to be "excess deaths" in the population.

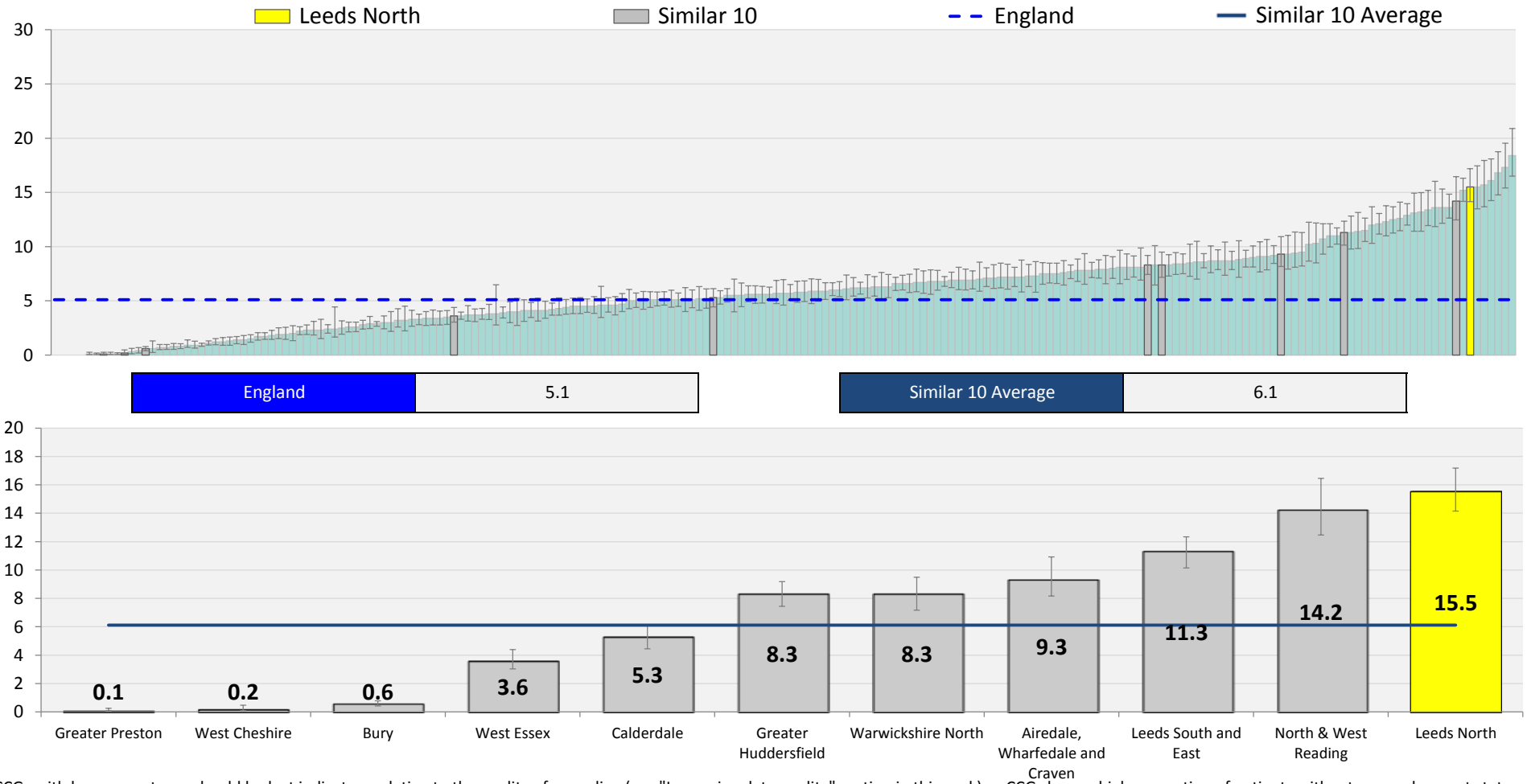
Definition: Excess under 75 mortality in adults with Severe Mental Illness: standardised mortality ratio
Source: Health & Social Care Information Centre (NHS Digital), PHE Fingertips Severe Mental Illness Profile
Year: 2013/14

Rate of mortality from suicide, all ages - per 100,000



Definition: Rate of mortality from suicide, all ages - per 100,000
Source: Primary Care Mortality Database, NHS Digital
Year: 2012-14

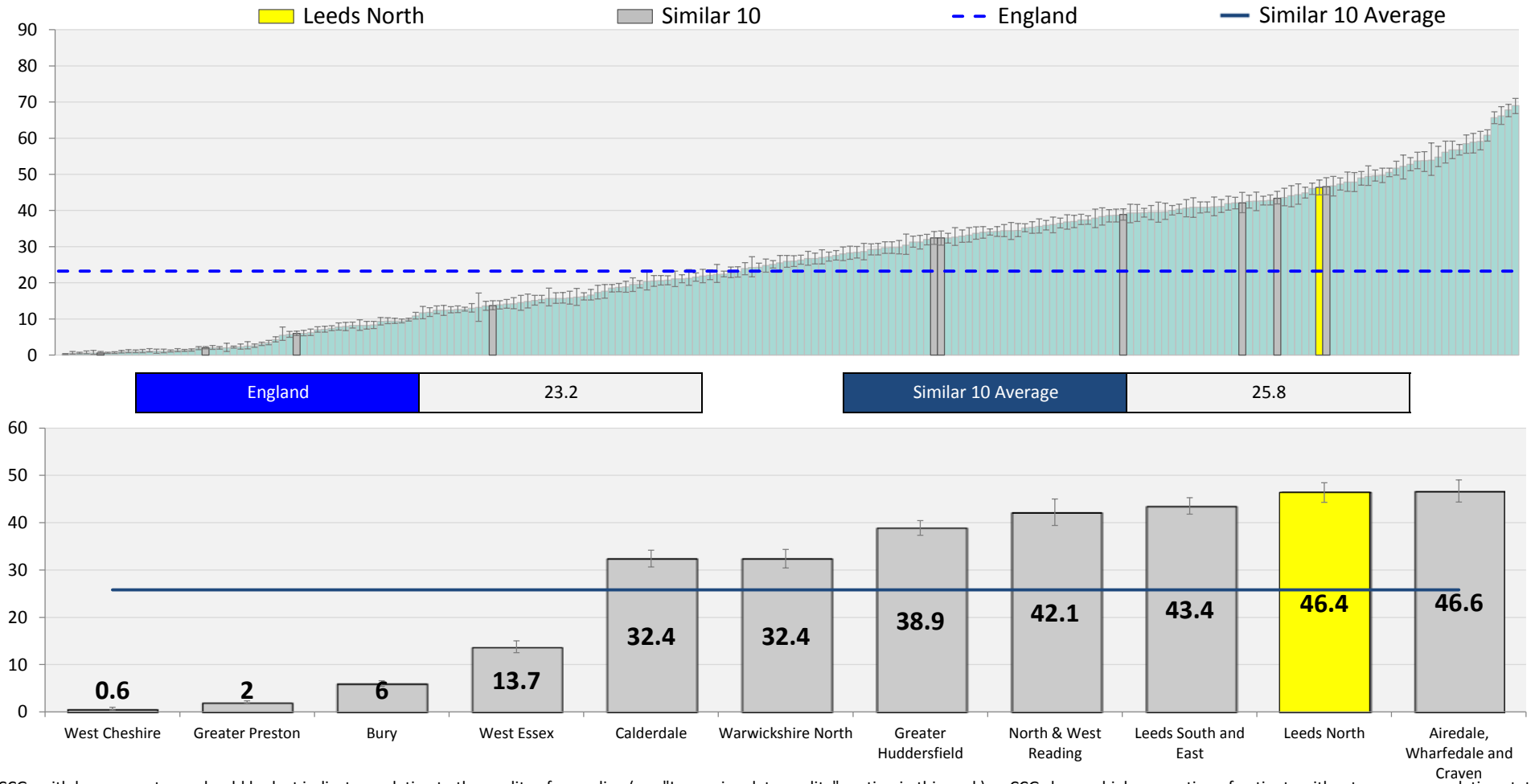
Proportion of people aged 18-69 in contact with adult mental health services in employment



CCGs with low percentages should look at indicators relating to the quality of recording (see "Improving data quality" section in this pack) as CCGs have a high proportion of patients without an employment status (which includes education) recorded.

Definition: Proportion of people aged 18-69 in contact with adult mental health services in employment
Source: MHSDS, NHS Digital
Year: Q1 2016/17

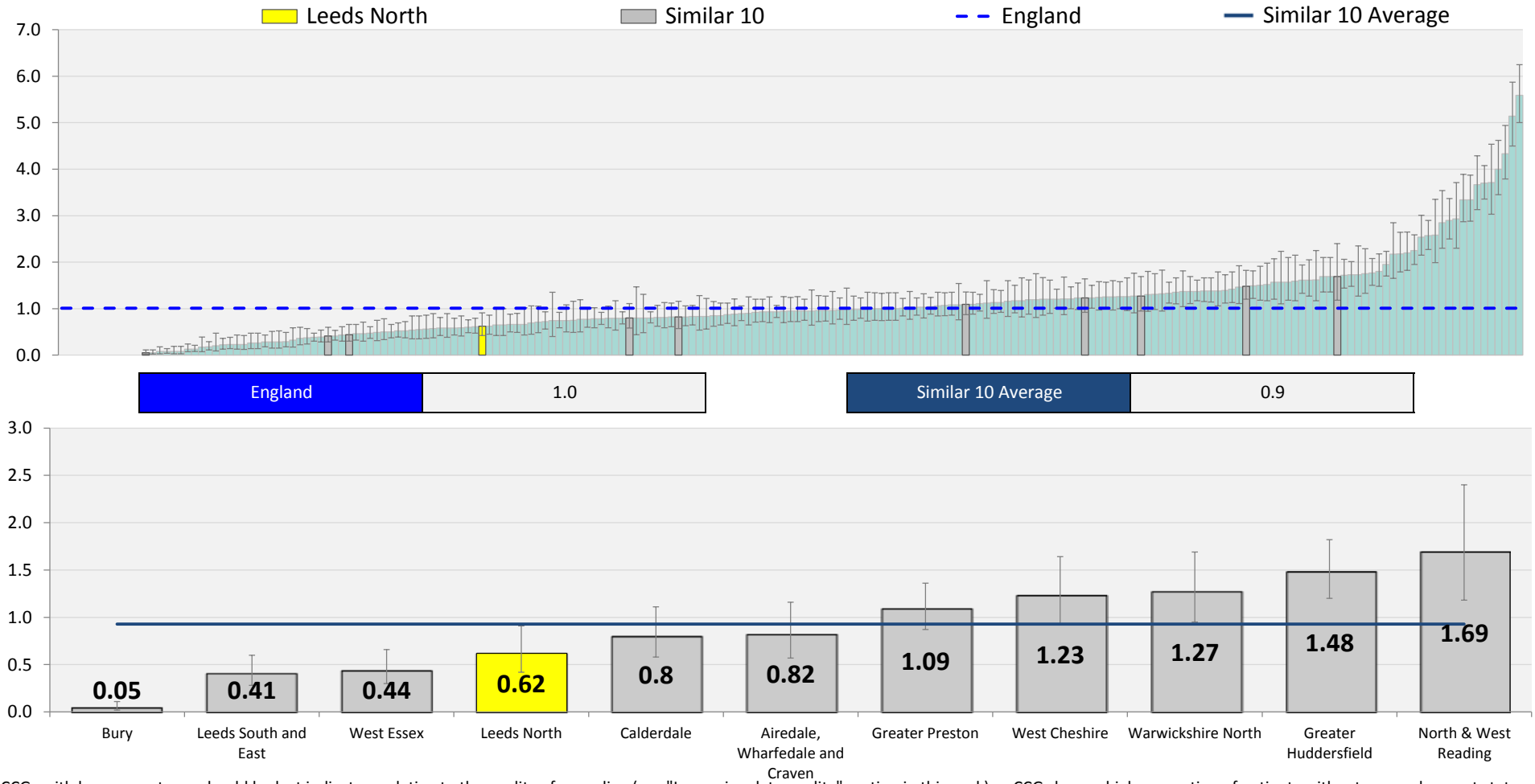
Proportion of people aged 18-69 in contact with adult mental health services in stable accommodation



CCGs with low percentages should look at indicators relating to the quality of recording (see "Improving data quality" section in this pack) as CCGs have a high proportion of patients without an accommodation status recorded.

Definition: Proportion of people aged 18-69 in contact with adult mental health services in stable accommodation
Source: MHSDS, NHS Digital
Year: Q1 2016/17

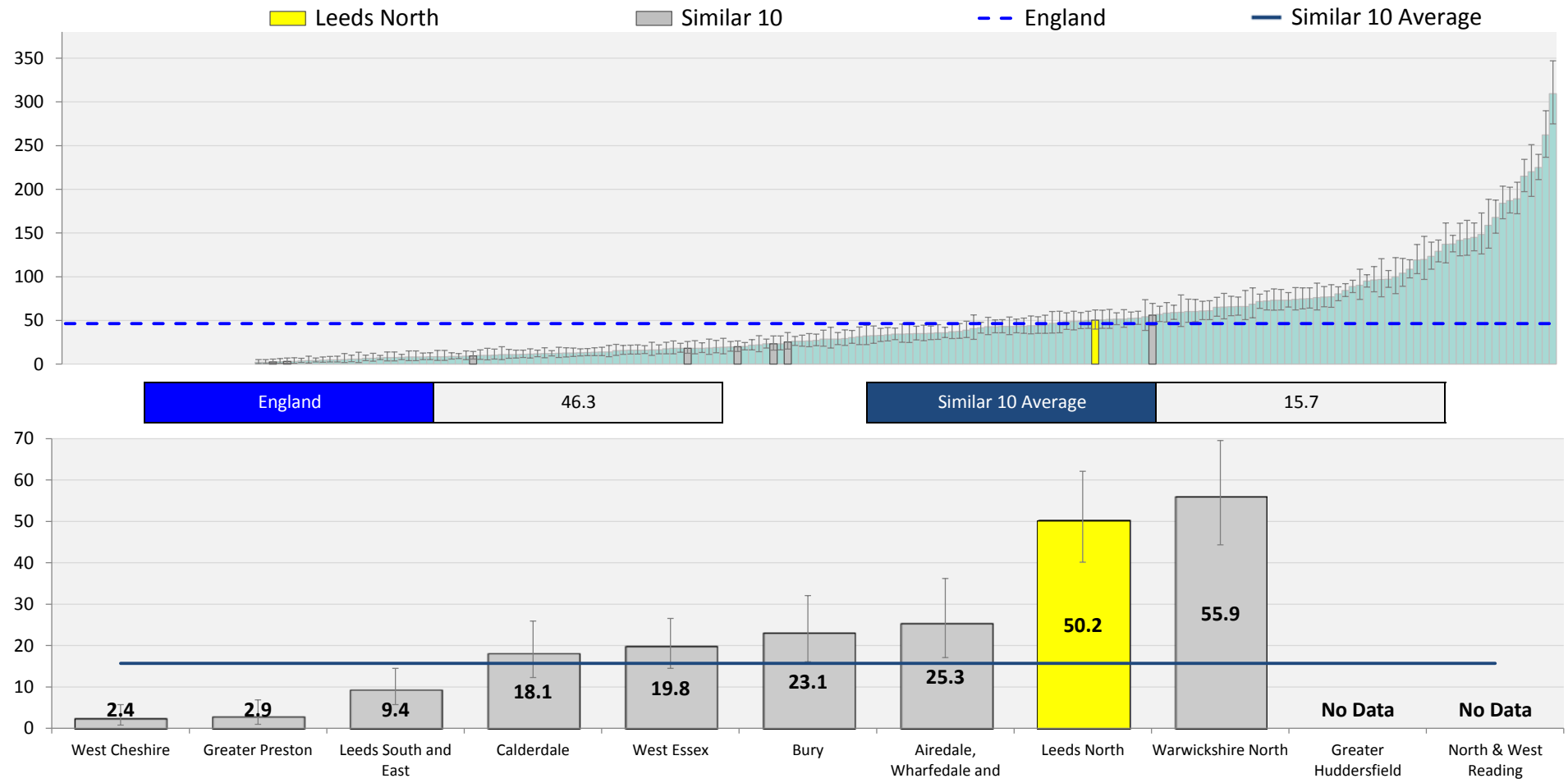
Percentage of people aged 18-69 in contact with adult mental health services who are in education



CCGs with low percentages should look at indicators relating to the quality of recording (see "Improving data quality" section in this pack) as CCGs have a high proportion of patients without an employment status (which includes education) recorded.

Definition: Percentage of people aged 18-69 in contact with adult mental health services who are in education
Source: MHLDDS
Year: 2014/15

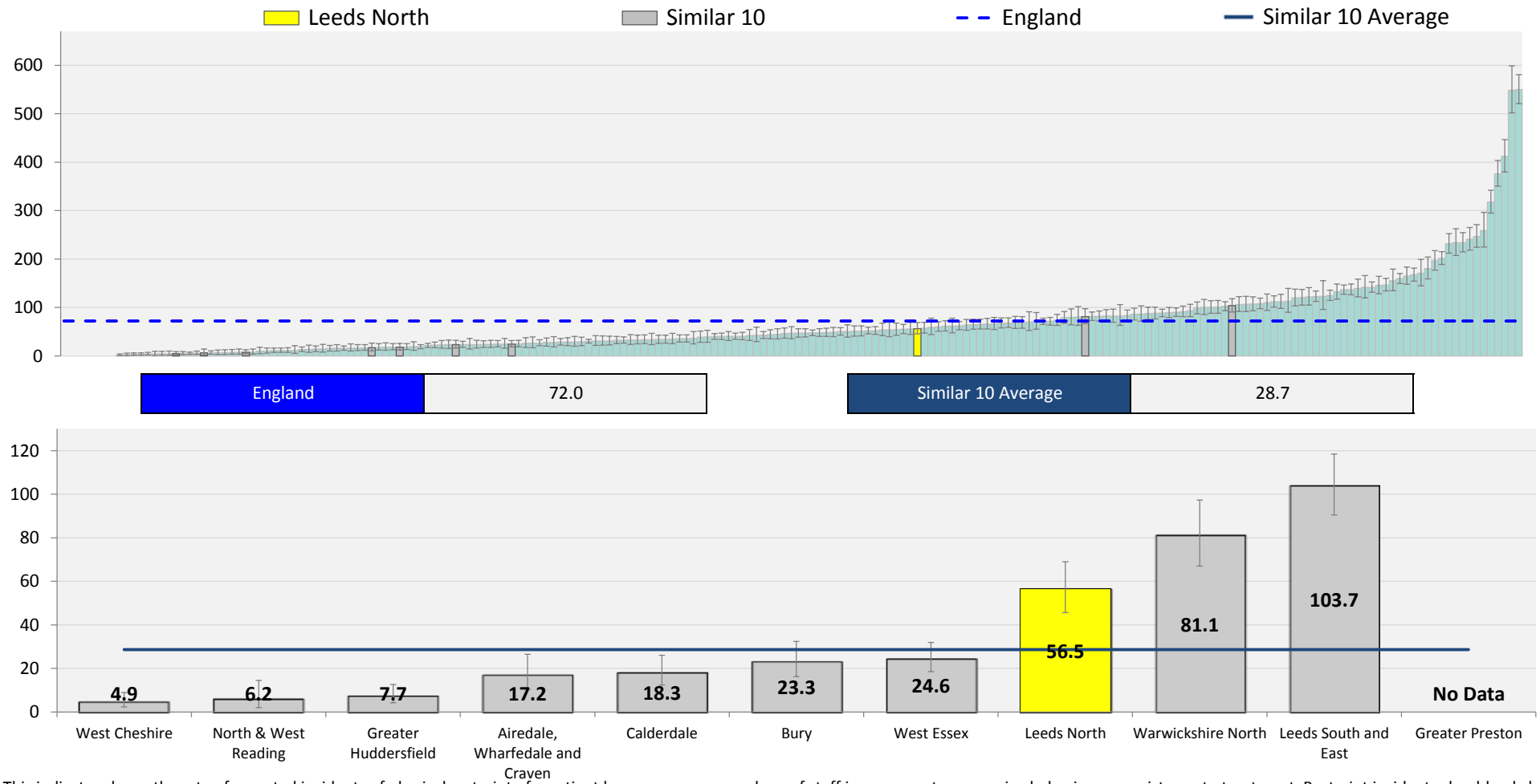
Rate of incidents of self harm by patients aged 18+ - per 100,000



This indicator shows the rate of reported incidents of self-harm by a patient. Reporting of self-harm instances are required for inpatients - very low values may indicate data quality issues for some CCGs. The definition of self-harm adopted by the guideline is “intentional self-poisoning or injury, irrespective of the apparent purpose of the act”.

Definition: Rate of incidents of self harm by patients aged 18+ - per 100,000
Source: MHLDDS
Year: 2014/15

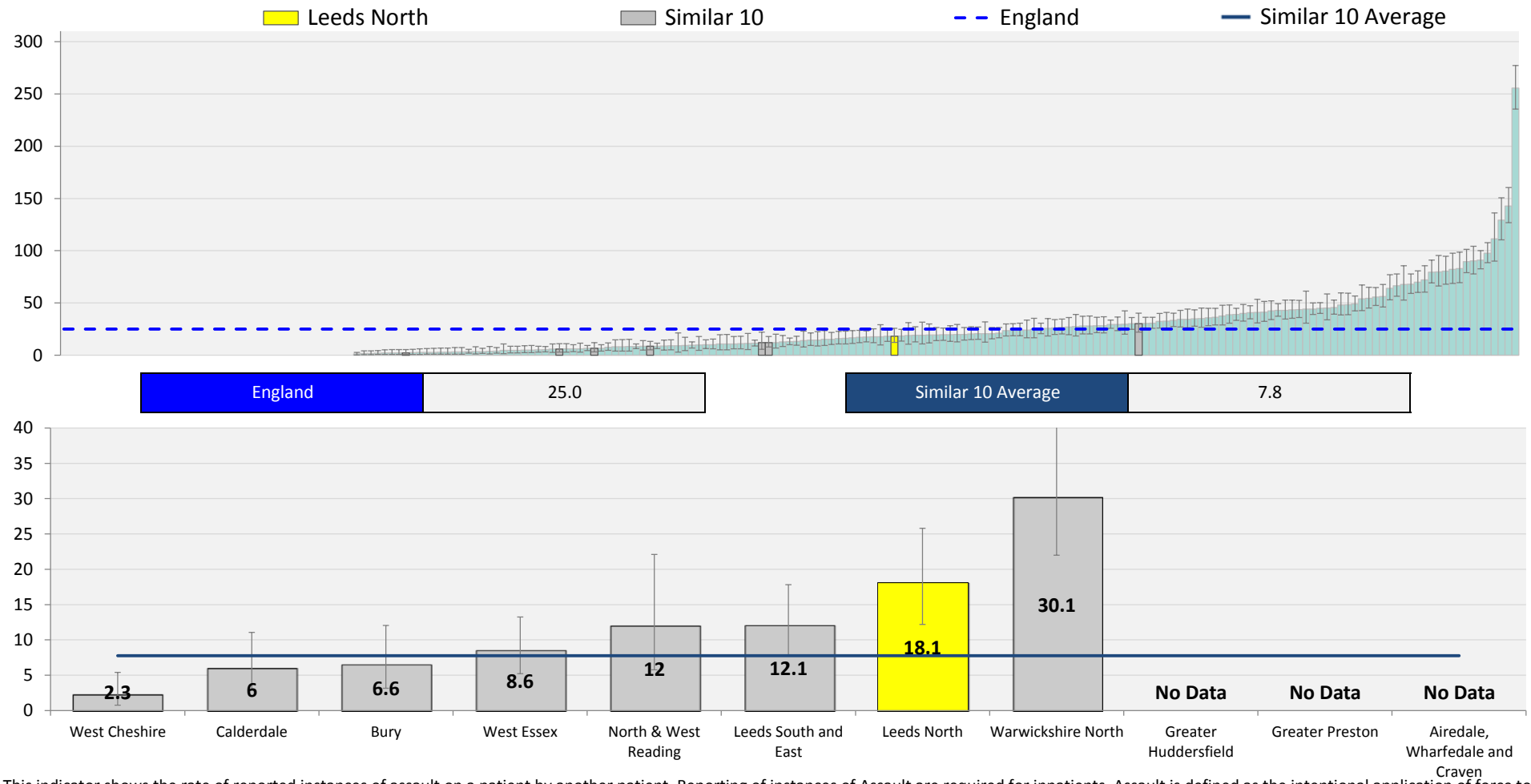
Rate of use of physical restraint of patients aged 18+ - per 100,000



This indicator shows the rate of reported incidents of physical restraint of a patient by one or more members of staff in response to aggressive behaviour or resistance to treatment. Restraint incidents should only be captured for inpatients. Any incident of restraint resulting in the Trust Restraint Policy being invoked should be reported.

Definition: Rate of use of physical restraint of patients aged 18+ - per 100,000
Source: MHLDDS
Year: 2014/15

Rate of instances of assaults of patients aged 18+ - per 100,000



This indicator shows the rate of reported instances of assault on a patient by another patient. Reporting of instances of Assault are required for inpatients. Assault is defined as the intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort.

Definition: Rate of instances of assaults of patients aged 18+ - per 100,000
Source: MHLDDS
Year: 2014/15

Dementia

Dementia is a growing challenge. As the population ages and people live for longer, it has become one of the most important health and care issues facing the world. In England it is estimated that around 676,000 people have dementia. In the whole of the UK, the number of people with dementia is estimated at 850,000.

Dementia mainly affects older people, and after the age of 65, the likelihood of developing dementia roughly doubles every five years. However, for some dementia can develop earlier, presenting different issues for the person affected, their carer and their family.

There are around 540,000 carers of people with dementia in England. It is estimated that one in three people will care for a person with dementia in their lifetime. Half of them are employed and it's thought that some 66,000 people have already cut their working hours to care for a family member, whilst 50,000 people have left work altogether.

There is a considerable economic cost associated with the disease estimated at £23 billion a year, which is predicted to triple by 2040. This is more than the cost of cancer, heart disease and stroke.

Dementia case study: Improving patient reviews in Harrogate

Background

In Harrogate, people with dementia traditionally had three routine reviews a year: two at the Tees, Esk and Wear Valleys NHS Foundation Trust memory clinic, and one at their GP practice. This limited the number of appointments available at the memory clinic, and meant those who really needed specialist care had to wait longer for it.

The approach

Harrogate and Rural District Clinical Commissioning Group (CCG) and Tees, Esk and Wear Valleys NHS Foundation Trust worked with local GP practices to improve the system for routine reviews. Since 2014, such reviews have been shared between the trust and GPs. Those with dementia are now seen alternately by their GP and the memory clinic at six monthly intervals. The relationships and confidence generated by this initiative is such that all people with uncomplicated dementia are now followed up entirely by their GP rather than at the hospital. The CCG has also worked with care homes to ensure specialist dementia care is available when needed, and simplified support packages for carers of those with the condition.

Continued on the next page…

Dementia case study: Improving patient reviews in Harrogate

Outcomes

Having two rather than three routine reviews a year increases convenience for patients. The change also made an additional 780 appointments available at the memory clinic for those who need specialist care. Hospital staff can now focus on those with complex problems, as well as young people and care home residents with dementia. They are also able to spend more time on diagnosis and support. Waiting times for appointments at the memory clinic have fallen from 74 to 28 days. In the event of a hospital stay for a crisis, people with dementia now have an average length of stay of 10.7 days, down from 19 previously.

The diagnosis rate for dementia has increased locally, meaning more of those who need support are identified and able to receive it.

Further information

For more information please visit: http://nhsconfed.org/resources/2016/06/harrogate-and-rural-district-ccg-improving-dementia

Dementia case study: Stockport CCG

Background

Stockport CCG had a dementia diagnosis rate of 40%. There were large increases in referrals to memory services and waiting times were increasing. Quality post-diagnostic support was not available to all those diagnosed with dementia.

The approach

To resolve these issues, Stockport CCG implemented a shared care pathway where the management of stable patients with dementia was conducted in primary care with support from a memory service. This meant that there was early recognition and initial diagnosis in primary care with final diagnosis and medication initiation via the memory service. Additional resources were brought in from the third sector to support this pathway.

Outcomes

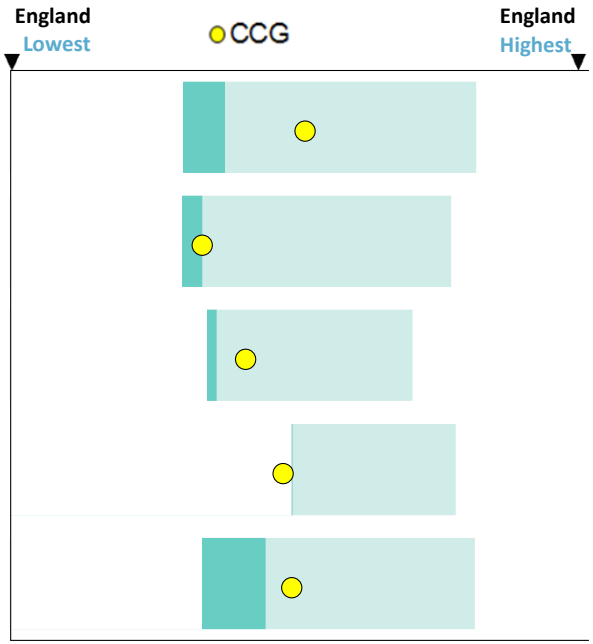
As a result of this action the diagnosis rate increased dramatically to over 72% by summer 2016. Additionally, waiting times to memory services were reduced, with 95% of referred patients being diagnosed within six weeks and all patients now receive two dementia reviews each year.

Further information

For more information about this case study please contact nicole.alkemade@nhs.net

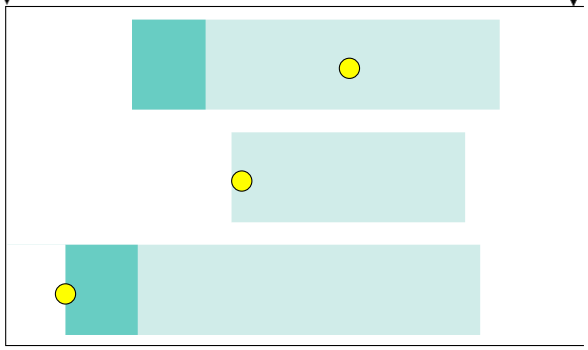
Dementia - Risk factors

Indicator	Time Period	CCG Value
Percentage of people aged 18+ who are self-reported occasional or regular smokers (GP Patient Survey)	2015/16	16.30
Percentage of physically inactive adults (Active People Survey)	2014	23.70
Percentage of patients with obesity on GP register (QOF)	2015/16	8.47
Percentage of people with hypertension on GP register (QOF)	2015/16	12.84
Percentage of people who have had a stroke or TIA on GP register (QOF)	2015/16	1.69



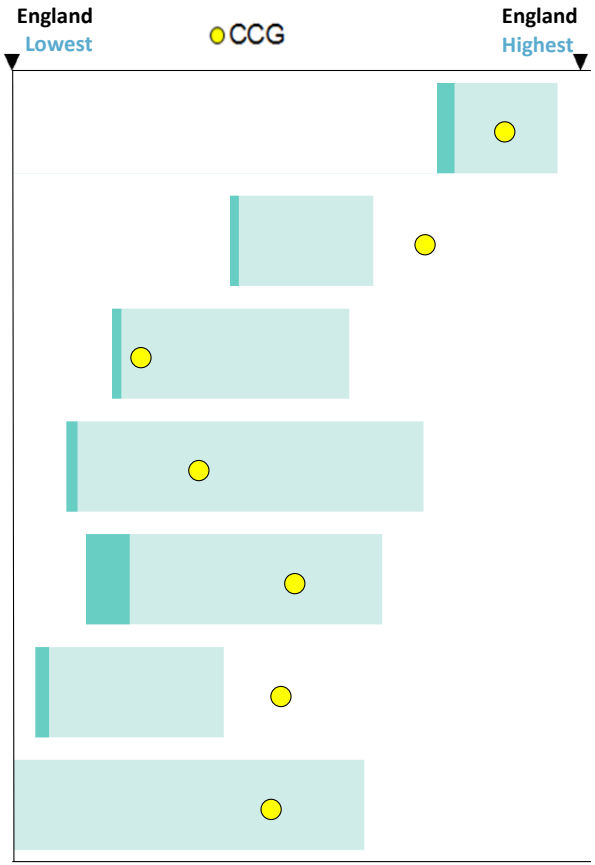
Dementia - Prevalence

Indicator	Time Period	CCG Value	England Lowest	CCG	England Highest
Percentage of people on GP registers aged 65+ with a recorded diagnosis of dementia	Sep 2015	4.60			
Percentage of people with dementia on GP register - all ages	2015/16	0.73			
Dementia diagnosis rate 65+	Aug 2016	59.26			



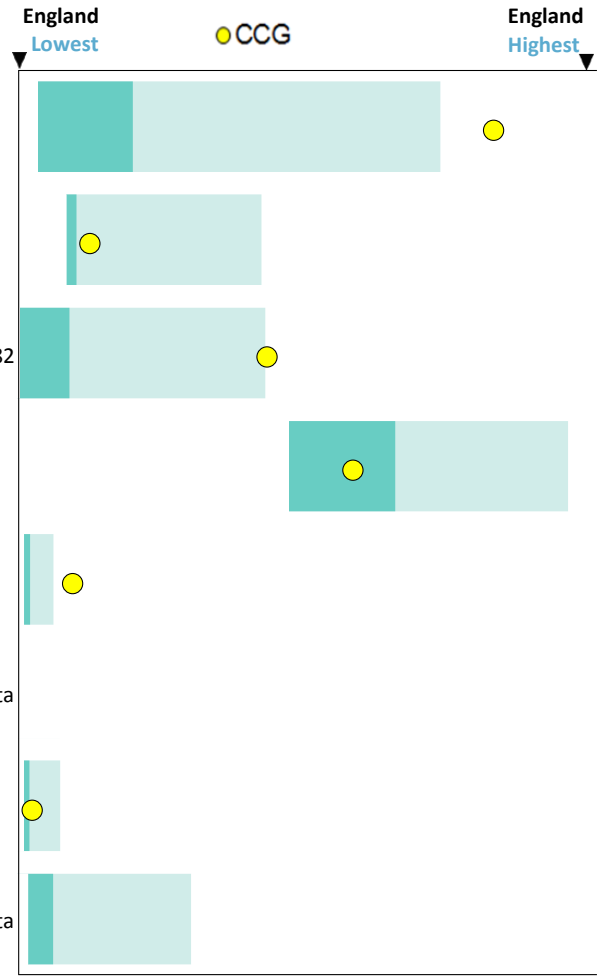
Dementia - Primary care and prescribing

Indicator	Time Period	CCG Value
Percentage of dementia patients whose care has been reviewed last 12 months (QOF)	2015/16	80.42
Percentage of dementia patients with blood tests recorded (QOF)	2015/16	62.07
Exceptions from checks: Percentage of people on Dementia registers excluded from checks (QOF)	2015/16	11.17
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Rivastigmine (Dementia)	2015/16	154.75
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Galantamine (Dementia)	2015/16	344.41
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Memantine Hydrochloride (Dementia)	2015/16	119.36
Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Donepezil Hydrochloride (Dementia)	2015/16	73.83



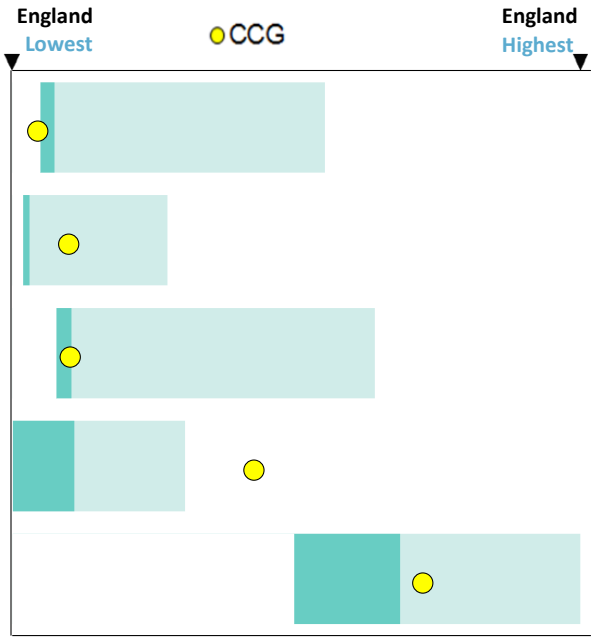
Dementia - Allocation to Organic super class

Indicator	Time Period	CCG Value
Percentage of people allocated to a cluster that are in the Organic super class (18-21)	2014/15	47.53
Rate of people aged 18-64 assigned to the Organic super class (18-21) per 100,000 18-64 population	2014/15	20.22
Rate of people aged 65+ assigned to the Organic super class (18-21) per 100,000 65+ population	2014/15	3093.82
Percentage of people in the Organic cluster who are of White ethnicity	2014/15	71.56
Percentage of people in the Organic cluster who are of Black/Black British ethnicity	2014/15	2.75
Percentage of people in the Organic cluster who are of Mixed ethnicity	2014/15	No Data
Percentage of people in the Organic cluster who are of Asian/Asian British ethnicity	2014/15	1.38
Percentage of people in the Organic cluster who are of Other ethnicity	2014/15	No Data



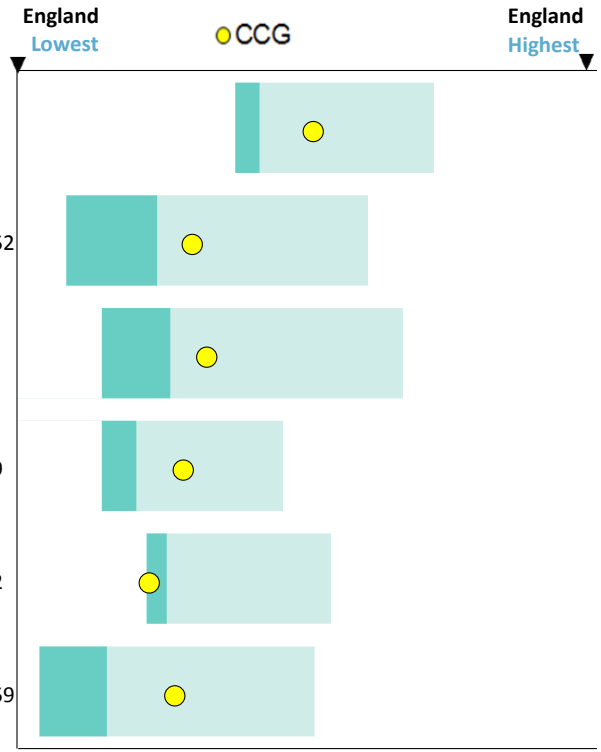
Dementia - Allocation to Organic super class continued

Indicator	Time Period	CCG Value
Percentage of patients in the Organic superclass who are on CPA	2014/15	4.76
Percentage of people in the Organic superclass with a crisis plan in place	2014/15	6.88
Percentage of patients in the Organic super class who were admitted to hospital	2014/15	1.81
Average inpatient length of stay (in days) for patients in the Organic super class	2014/15	94.50
Percentage of patients in Organic superclass (18-21) that were admitted to hospital - without a crisis plan	2014/15	75.00



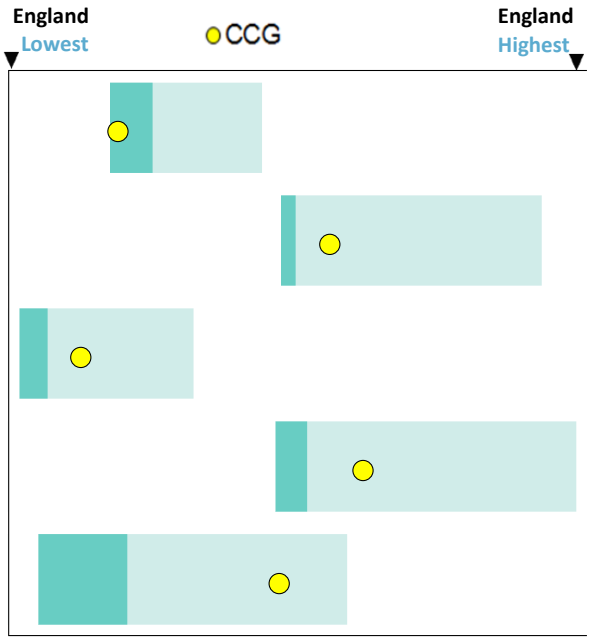
Dementia - Inpatient admissions

Indicator	Time Period	CCG Value
Dementia: ratio of inpatient service use to recorded diagnoses	2014/15	49.08
Rate of emergency hospital admissions of people aged 65+ with a mention of dementia - per 100,000	2014/15	3134.52
Percentage of emergency inpatient admissions for people (aged 65+) with dementia that are short stays (1 night or less)	2014/15	24.05
Rate of people (aged 65+) with a mention of Alzheimer's disease using inpatient hospital services per 100,000	2014/15	618.89
Rate of people (aged 65+) with a mention of Vascular dementia using inpatient hospital services per 100,000	2014/15	417.52
Rate of people (aged 65+) with a mention of unspecified dementia using inpatient hospital services per 100,000	2014/15	1287.59

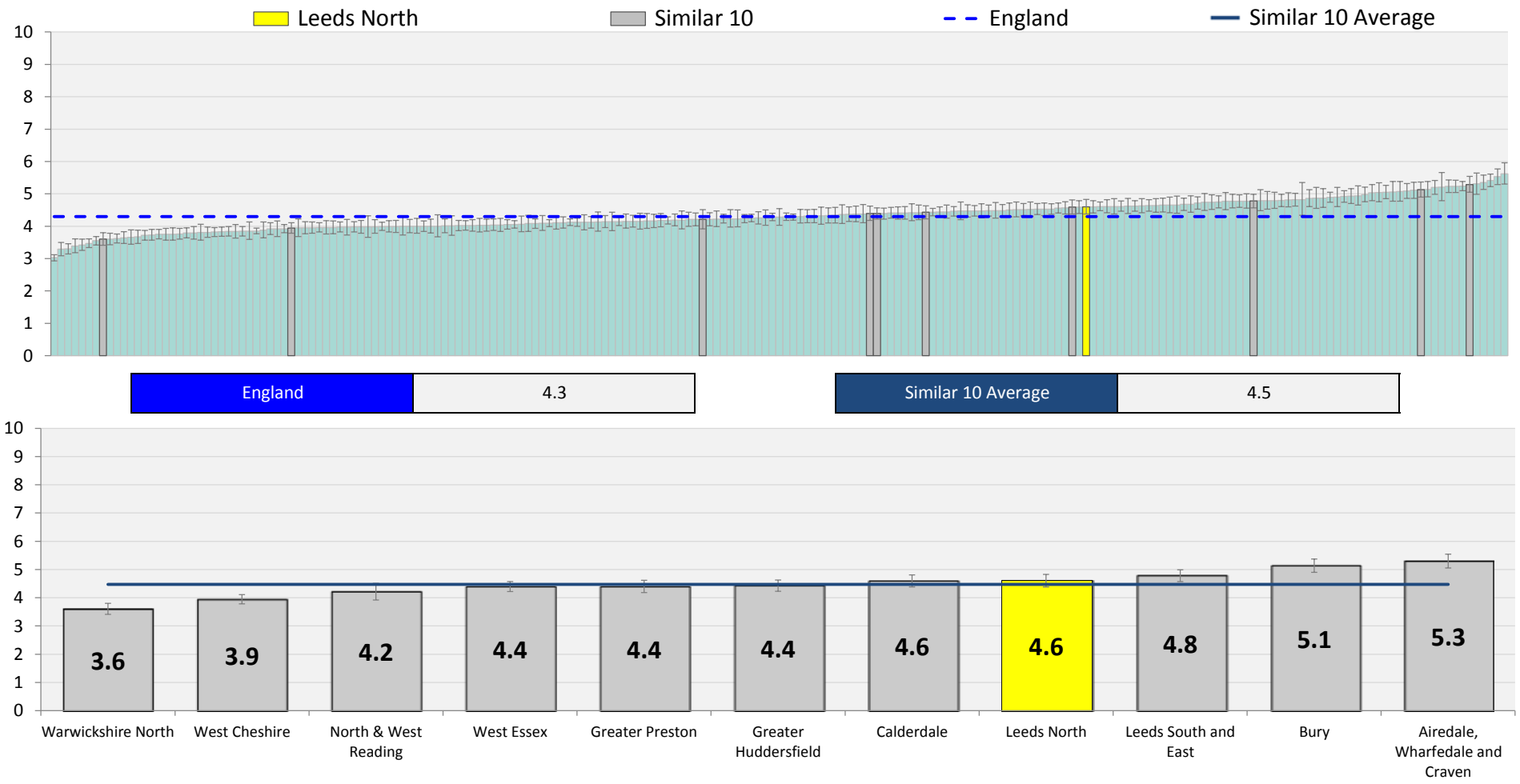


Dementia - End of Life

Indicator	Time Period	CCG Value
Rate of mortality in people aged 65+ with a recorded mention of dementia - per 100,000	2014	668.74
Percentage of deaths of people with a recorded mention of dementia aged 65+ that occurred in the person's usual place of residence	2014	61.76
Percentage of deaths of people aged 65+ with a recorded mention of dementia occurring at home	2014	6.23
Percentage of deaths of people aged 65+ with a recorded mention of dementia occurring in a care homes	2014	55.68
Percentage of deaths of people aged 65+ with a recorded mention of dementia occurring in a hospital	2014	36.63

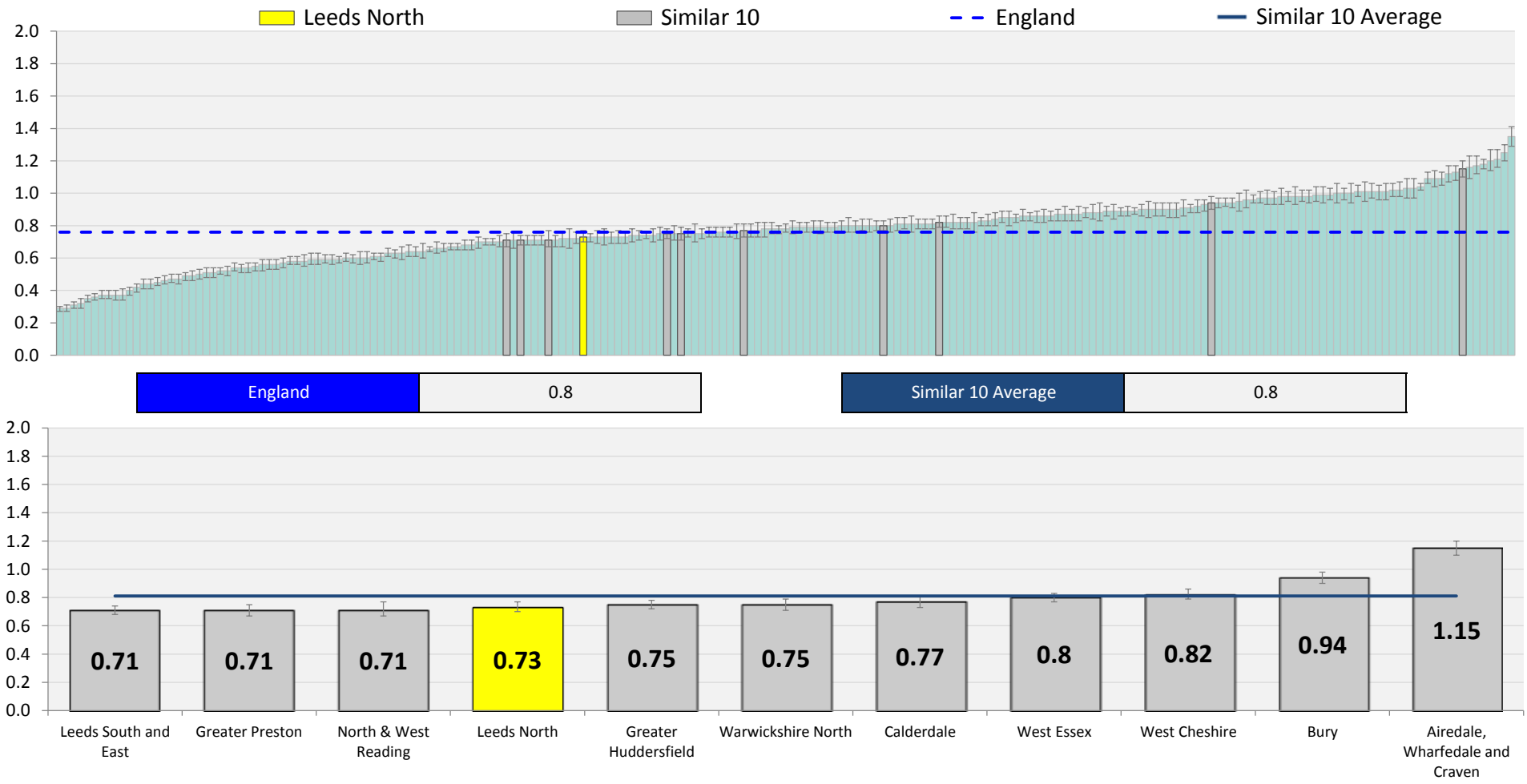


Percentage of people on GP registers aged 65+ with a recorded diagnosis of dementia



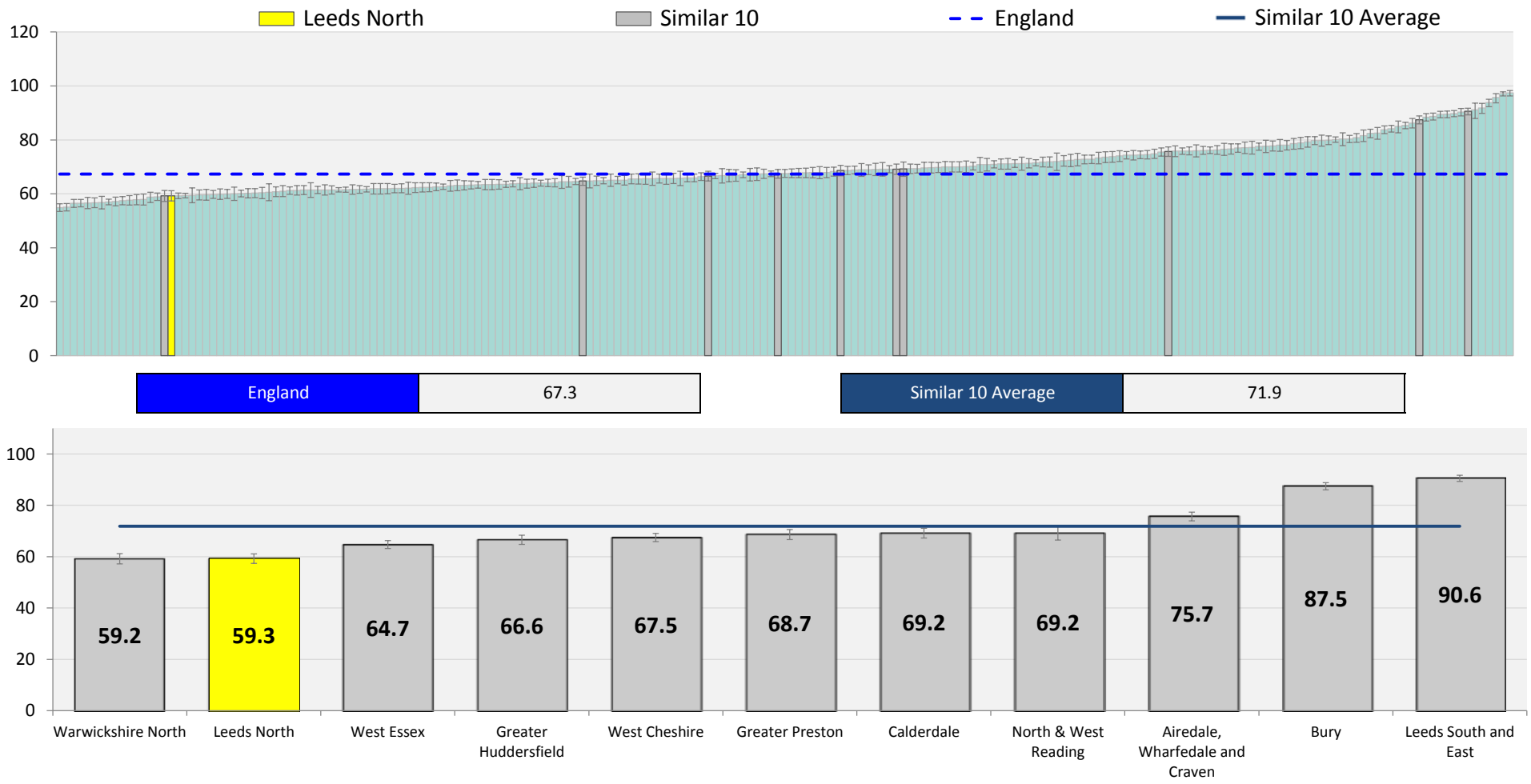
Definition: Percentage of people on GP registers aged 65+ with a recorded diagnosis of dementia
Source: Health and Social Care Information Centre (NHS Digital), PHE Fingertips Dementia Profile
Year: Sep 2015

Percentage of people with dementia on GP register - all ages



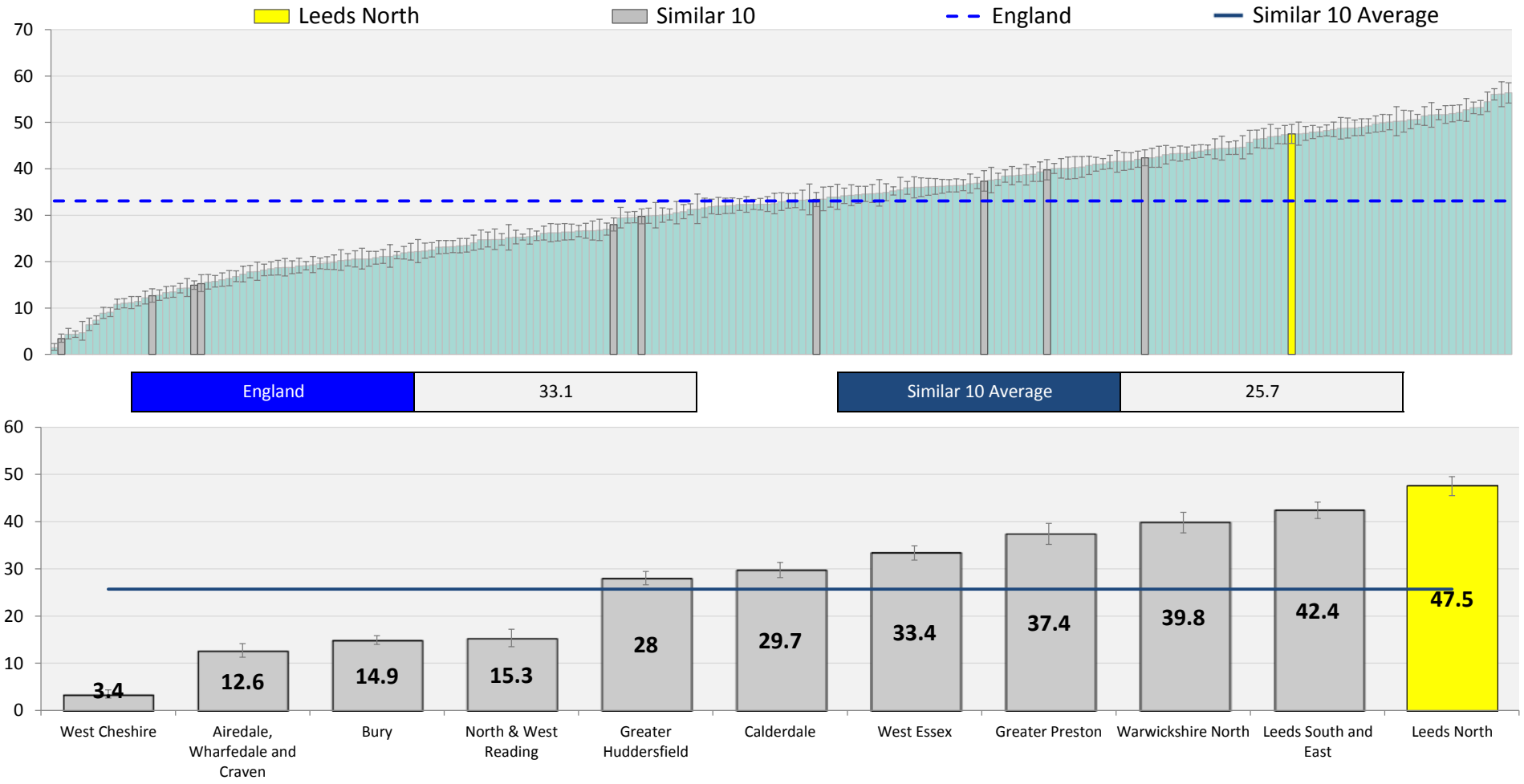
Definition: Percentage of people with dementia on GP register - all ages
Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre (NHS Digital)
Year: 2015/16

Dementia diagnosis rate 65+



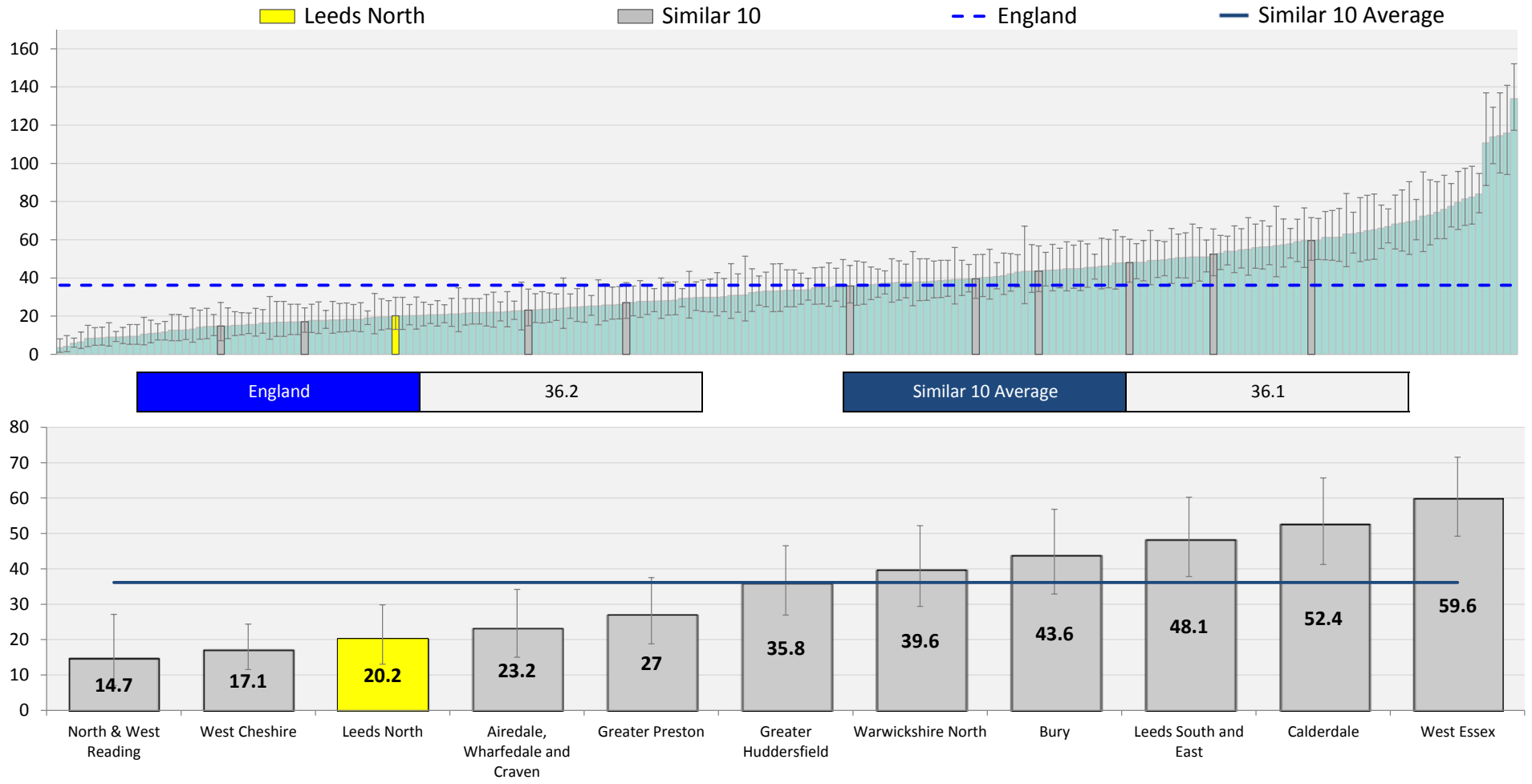
Definition: Dementia diagnosis rate 65+
Source: NHS Digital, Dementia diagnosis monthly workbook
Year: Aug 2016

Percentage of people allocated to a cluster that are in the Organic super class (18-21)



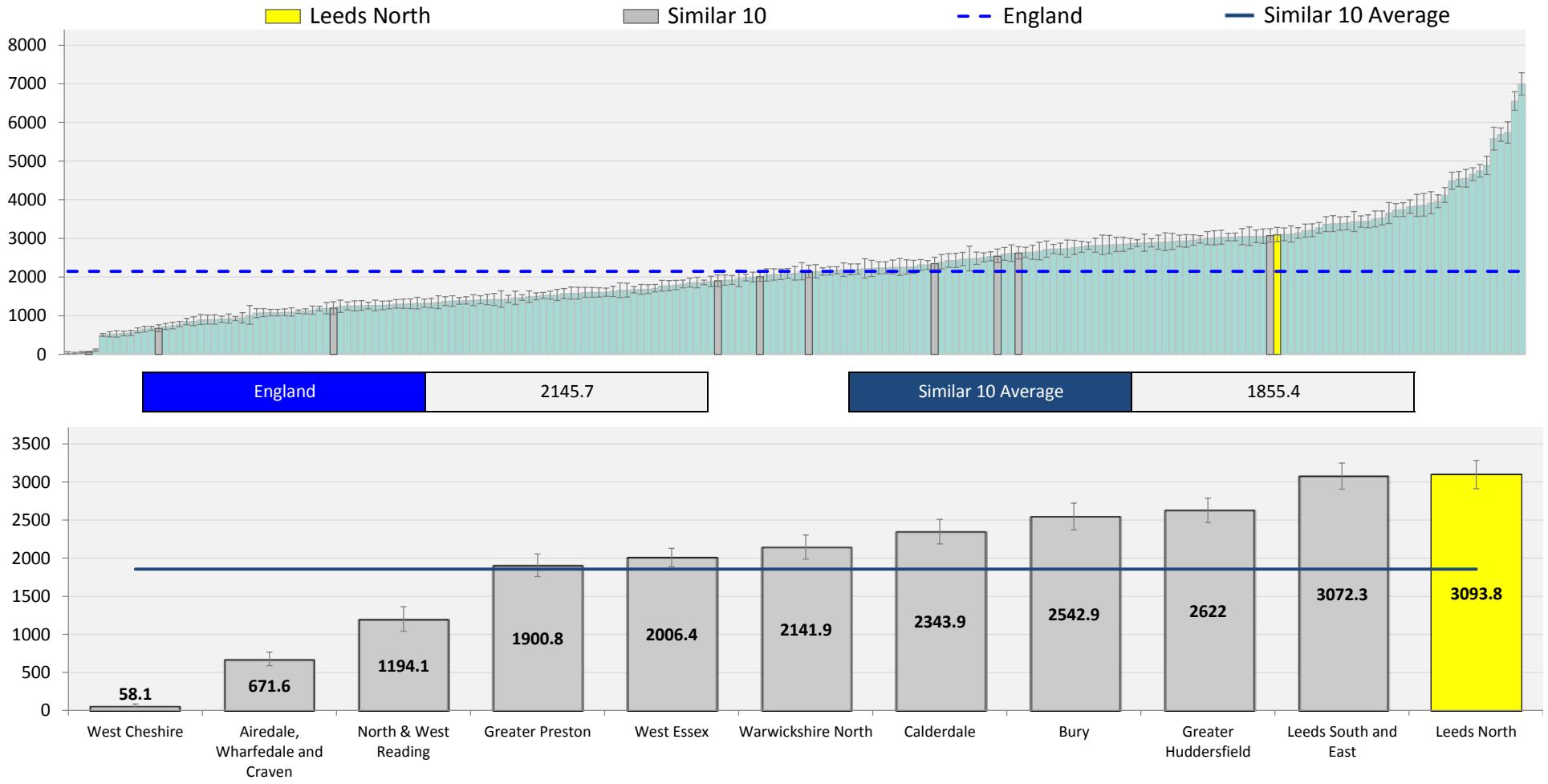
Definition: Percentage of people allocated to a cluster that are in the Organic super class (18-21)
Source: MHLDDS
Year: 2014/15

Rate of people aged 18-64 assigned to the Organic super class (18-21) per 100,000 18-64 population



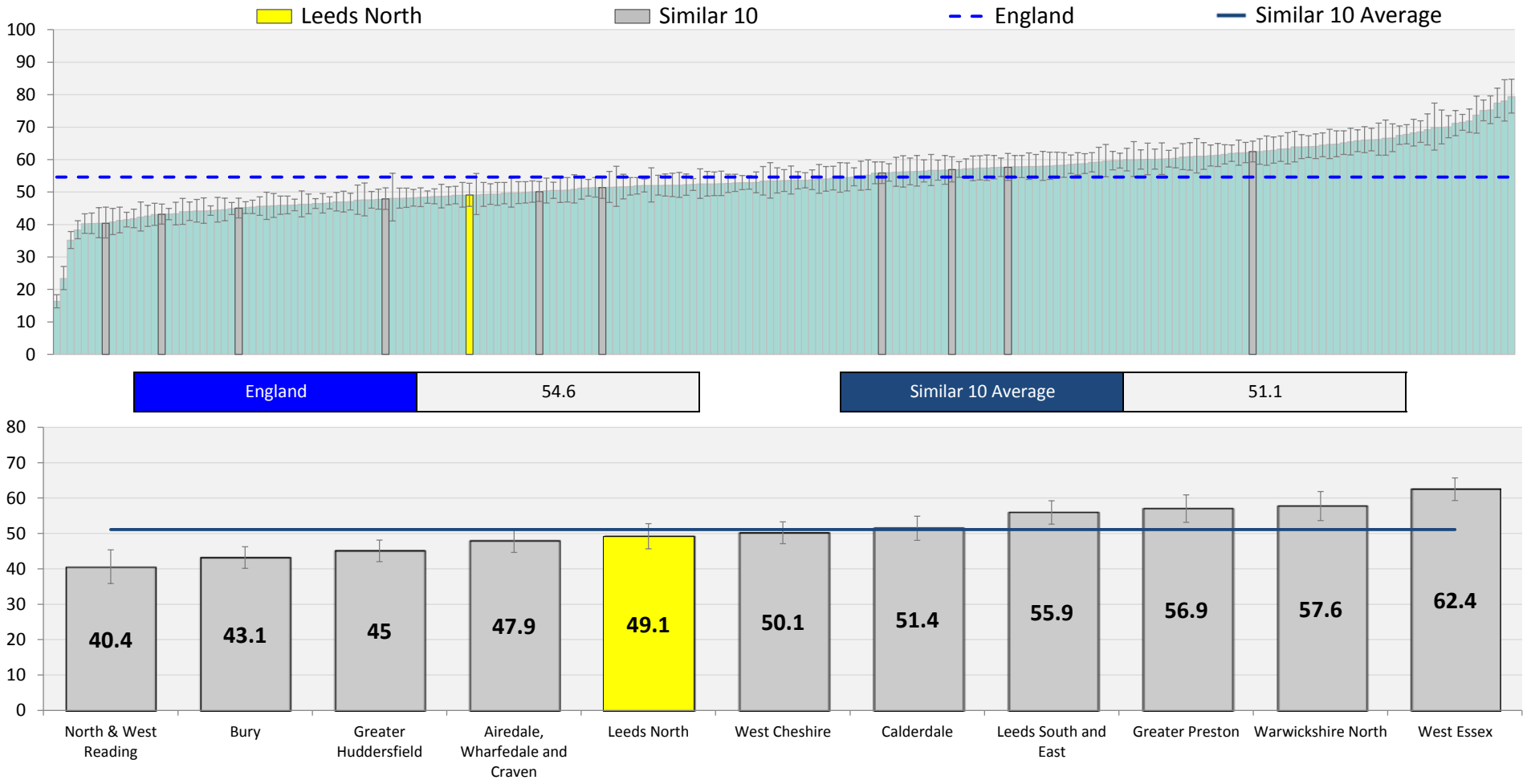
Definition: Rate of people aged 18-64 assigned to the Organic super class (18-21) per 100,000 18-64 population
Source: MHLDDS
Year: 2014/15

Rate of people aged 65+ assigned to the Organic super class (18-21) per 100,000 65+ population



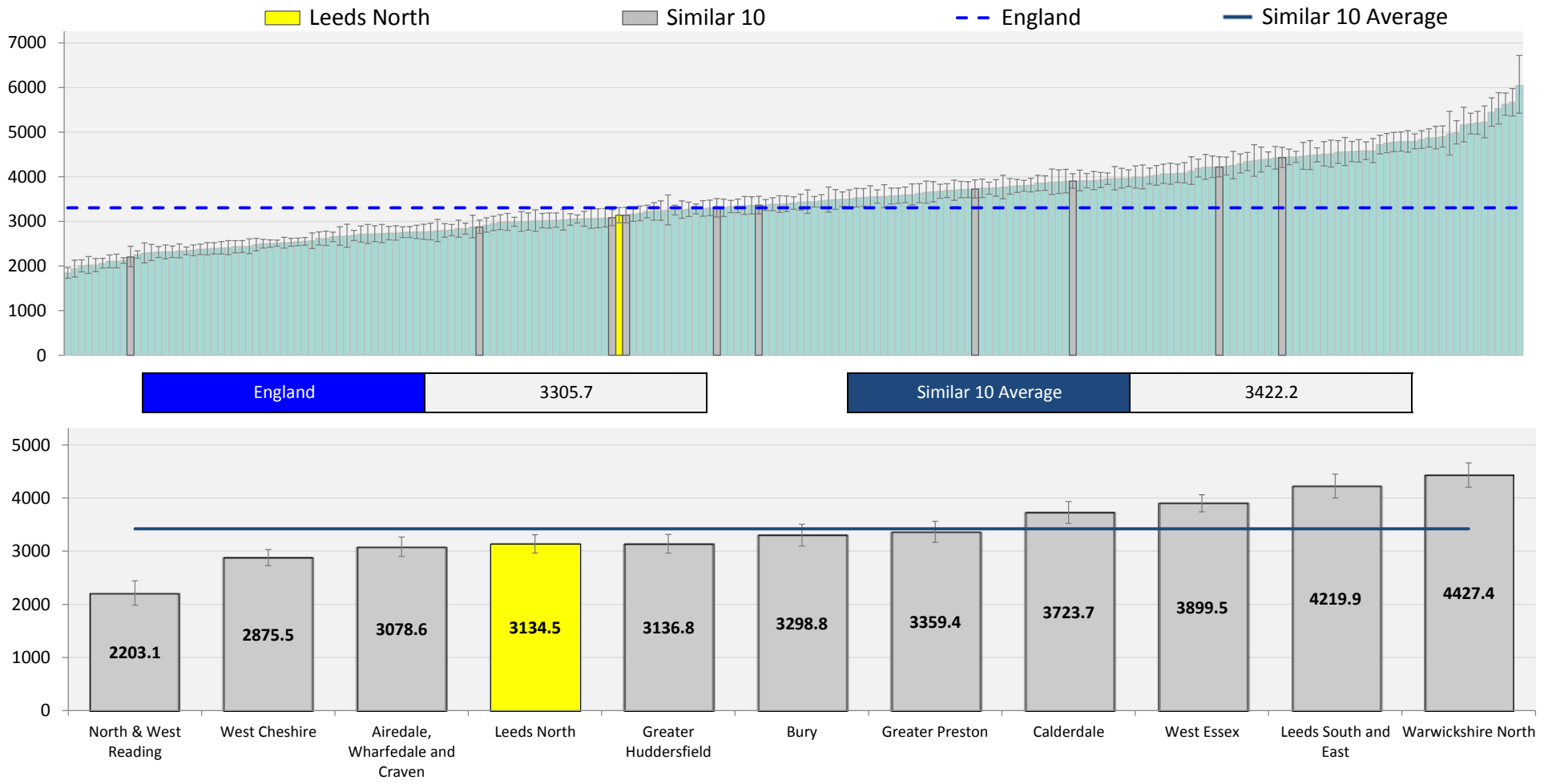
Definition: Rate of people aged 65+ assigned to the Organic super class (18-21) per 100,000 65+ population
Source: MHLDDS
Year: 2014/15

Dementia: ratio of inpatient service use to recorded diagnoses



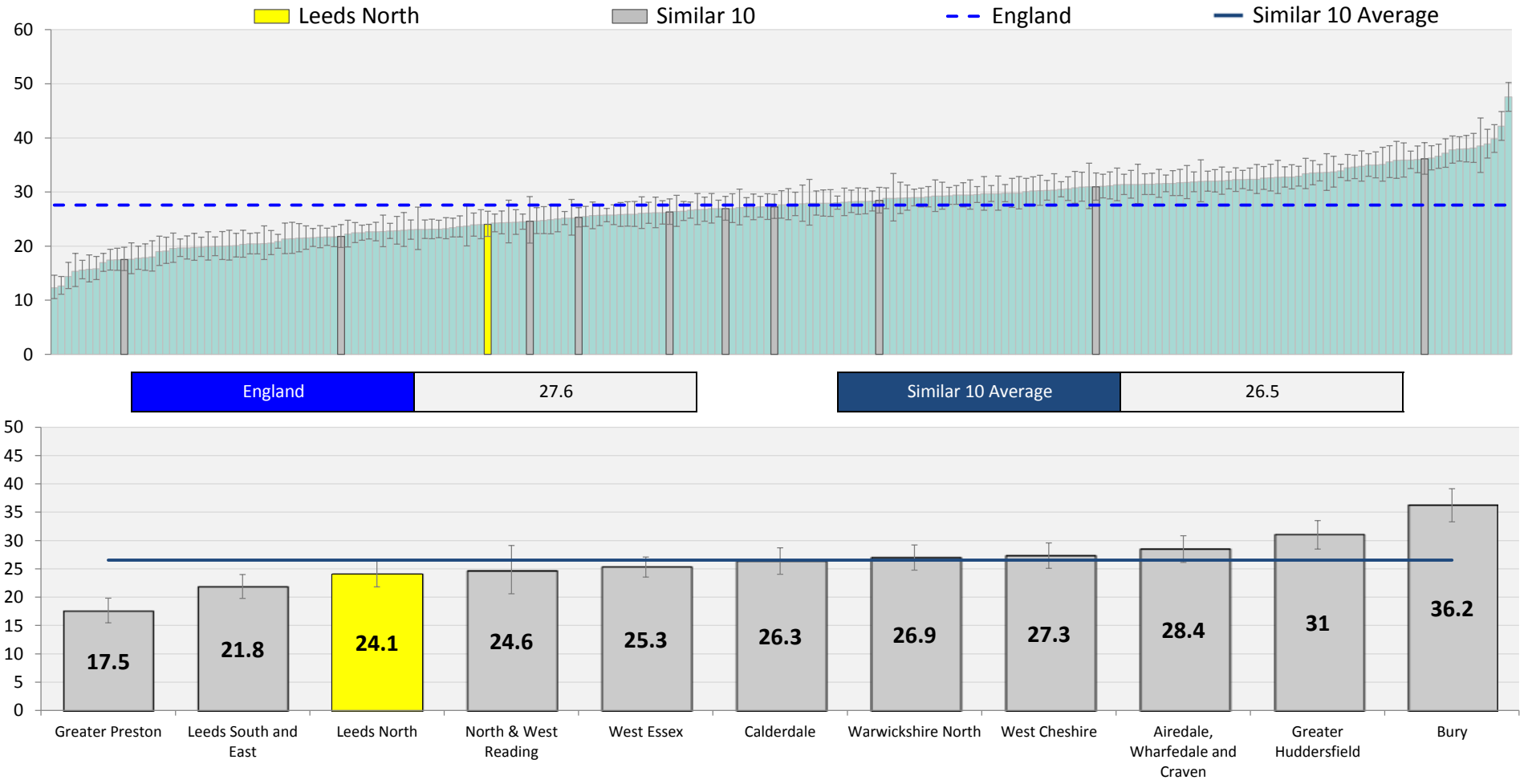
Definition: Dementia: ratio of inpatient service use to recorded diagnoses
Source: Health and Social Care Information Centre (NHS Digital), PHE Fingertips Dementia Profile
Year: 2014/15

Rate of emergency hospital admissions of people aged 65+ with a mention of dementia - per 100,000



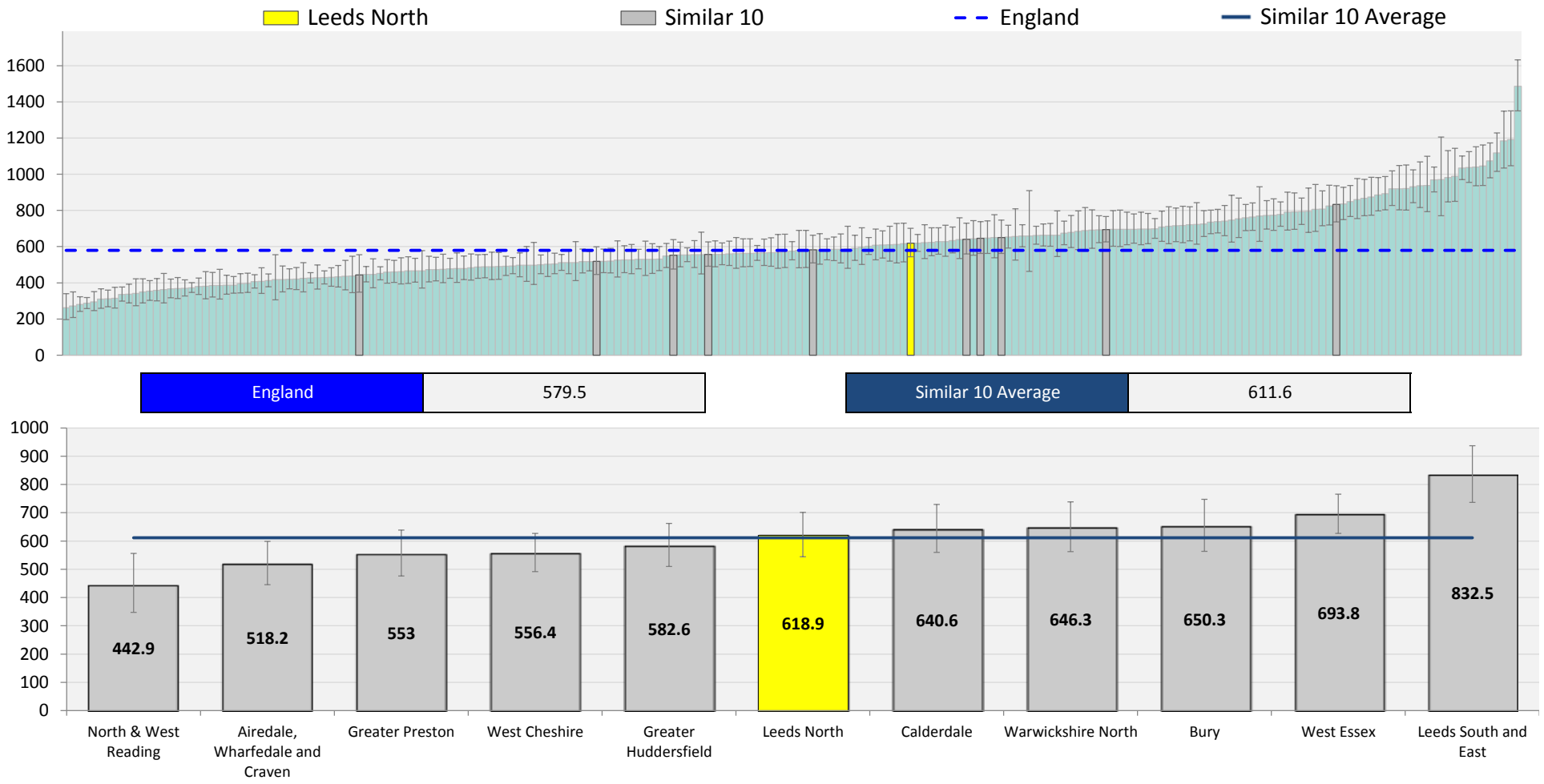
Definition: Rate of emergency hospital admissions of people aged 65+ with a mention of dementia - per 100,000
Source: Health and Social Care Information Centre (NHS Digital), PHE Fingertips Dementia Profile
Year: 2014/15

Percentage of emergency inpatient admissions for people (aged 65+) with dementia that are short stays (1 night or less)



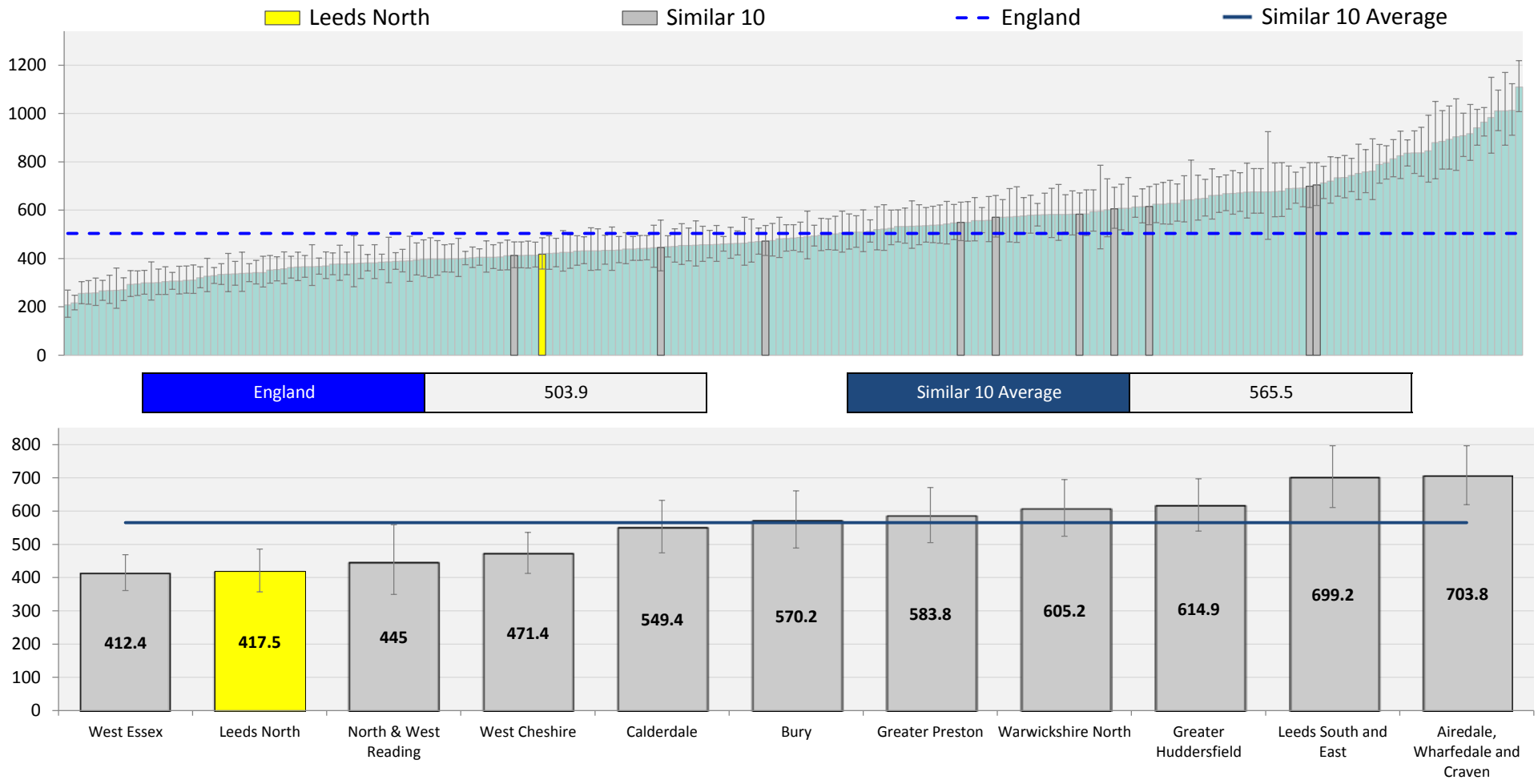
Definition: Percentage of emergency inpatient admissions for people (aged 65+) with dementia that are short stays (1 night or less)
Source: Health and Social Care Information Centre (NHS Digital), PHE Fingertips Dementia Profile
Year: 2014/15

Rate of people (aged 65+) with a mention of Alzheimer's disease using inpatient hospital services per 100,000



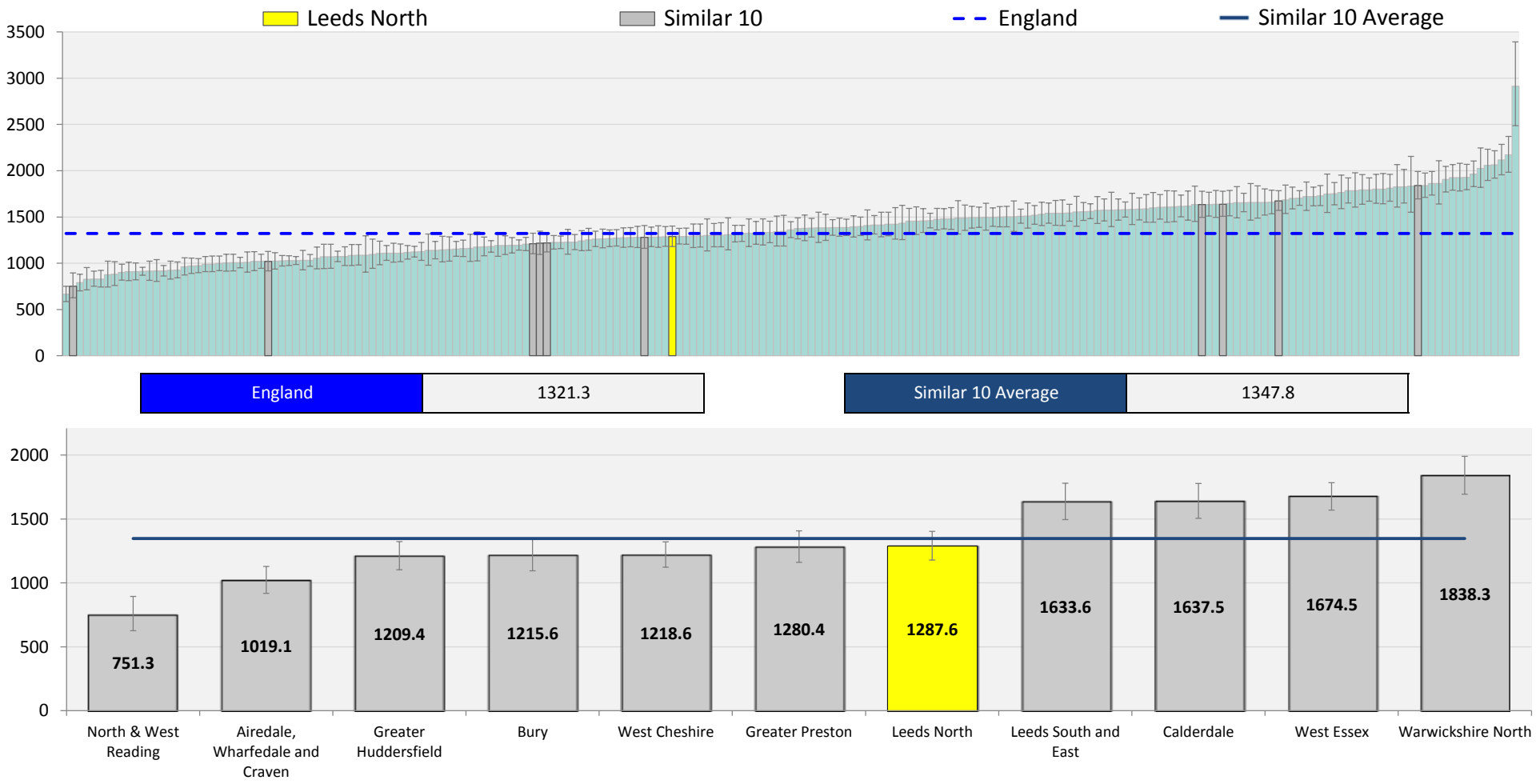
Definition: Rate of people (aged 65+) with a mention of Alzheimer's disease using inpatient hospital services per 100,000
Source: Health and Social Care Information Centre (NHS Digital), PHE Fingertips Dementia Profile
Year: 2014/15

Rate of people (aged 65+) with a mention of Vascular dementia using inpatient hospital services per 100,000



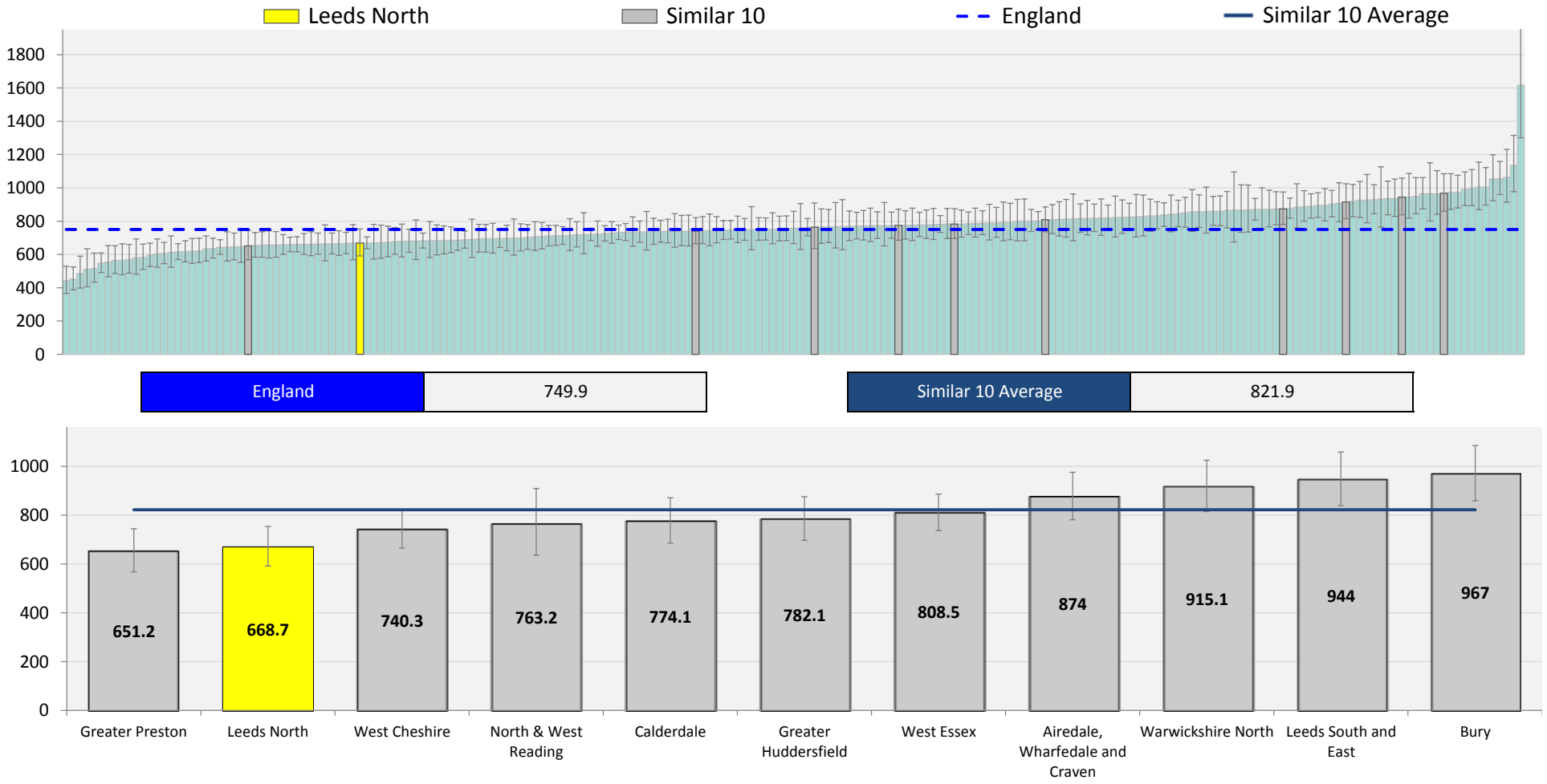
Definition: Rate of people (aged 65+) with a mention of Vascular dementia using inpatient hospital services per 100,000
Source: Health and Social Care Information Centre (NHS Digital), PHE Fingertips Dementia Profile
Year: 2014/15

Rate of people (aged 65+) with a mention of unspecified dementia using inpatient hospital services per 100,000



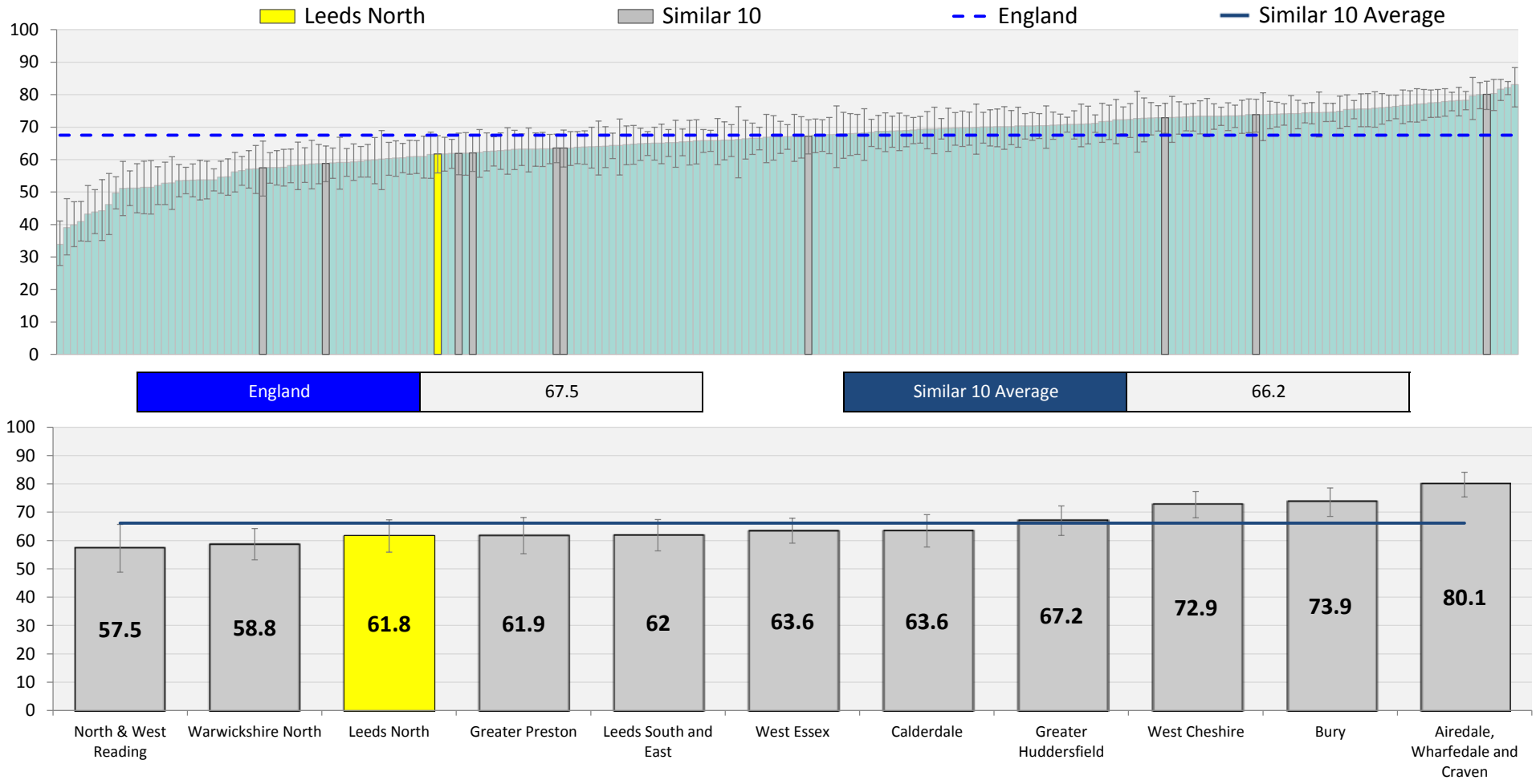
Definition: Rate of people (aged 65+) with a mention of unspecified dementia using inpatient hospital services per 100,000
Source: Health and Social Care Information Centre (NHS Digital), PHE Fingertips Dementia Profile
Year: 2014/15

Rate of mortality in people aged 65+ with a recorded mention of dementia - per 100,000



Definition: Rate of mortality in people aged 65+ with a recorded mention of dementia - per 100,000
Source: Public Health England (Office for National Statistics Mortality File), Fingertips Dementia Profile
Year: 2014

Percentage of deaths of people with a recorded mention of dementia aged 65+ that occurred in the person's usual place of residence



Definition: Percentage of deaths of people with a recorded mention of dementia aged 65+ that occurred in the person's usual place of residence
Source: Public Health England (Office for National Statistics Mortality File), Fingertips Dementia Profile
Year: 2014

Next steps and actions

Local health economies can take the following steps now:

- Identify the priority improvement opportunities in your locality and compare against current improvement activity and plans
- Engage with clinicians and other local stakeholders, including service users, public health teams in local authorities and commissioning support organisations and explore the priority opportunities further using local data
- Learn more about policy priorities from the Five Year Forward View for Mental Health Implementation plan https://www.england.nhs.uk/mentalhealth/taskforce/imp/
- Ensure planning round submissions, and returns for the CCG Improvement and Assessment Framework reflect the opportunities identified
- Discuss the opportunities highlighted in this pack as part of the STP planning process and consider STP wide action where appropriate
- Revisit the NHS RightCare website regularly as new content, including updates to tools to support the use of the Commissioning for Value packs, is regularly added
- Discuss next steps with your NHS RightCare Delivery Partner

Further support and information

The Commissioning for Value benchmarking tool, explorer tool, full details of all the data used, and links to other useful tools are available on the NHS RightCare website. Links are shown on the next page.

The NHS RightCare website also offers resources to support CCGs in adopting the Commissioning for Value approach. These include:

- New ‘Where to Look’ packs
- Focus packs for the highest spending programmes
- Online videos and ‘how to’ guides
- Case studies with learning from other CCGs

If you have any questions or require any further information or support you can email the Commissioning for Value support team direct at: england.healthinvestmentnetwork@nhs.net

Useful links

NHS RightCare website:
www.england.nhs.uk/rightcare

Commissioning for Value packs and products:
https://www.england.nhs.uk/rightcare/intel/cfv/

NHS RightCare casebooks:
https://www.england.nhs.uk/rightcare/intel/cfv/casebooks/

Commissioning for Value Similar 10 Explorer Tool:
https://www.england.nhs.uk/wp-content/uploads/2016/01/cfv-16-similar-10-explr-tool.xlsm

NHS England mental health resources for commissioners:
https://www.england.nhs.uk/mentalhealth/resources/

The Five Year Forward View for Mental Health:
https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

The Five Year Forward View for Mental Health Implementation plan:
https://www.england.nhs.uk/mentalhealth/taskforce/imp/

NHS England Mental Health Five Year Forward View Dashboard:
https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/10/fyfvmh-dashboard.xlsx

Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

PHE National Mental Health, Dementia and Neurology Intelligence Network:
http://www.yhpho.org.uk/default.aspx?RID=191242

Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of our values. Throughout the development of the policies and processes cited in this document we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to - and outcomes from - healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Guidance for NHS commissioners on Equality and Health Inequalities duties can be found at: https://www.england.nhs.uk/about/gov/equality-hub/legal-duties/

Annex: Individual drugs included in aggregate drug indicators

4.7.2 Opioid analgesics	4.10: Drugs used in substance dependence	4.11: Drugs for dementia	4.2: Drugs used in psychoses and related disorders
Methadone Hydrochloride	Acamprosate Calcium	Donepezil Hydrochloride	Amisulpride
	Buprenorph HCl/Naloxone HCl	Galantamine	Aripiprazole
	Buprenorphine Hydrochloride	Memantine Hydrochloride	Benperidol
	Bupropion Hydrochloride	Rivastigmine	Chlorpromazine Hydrochloride
	Disulfiram	Idebenone	Clozapine
	Methadone Hydrochloride		Flupentixol Decanoate
	Nalmefene		Flupentixol Hydrochloride
	Naltrexone Hydrochloride		Fluphenazine Decanoate
	Nicotine		Haloperidol
	Nicotine Bitartrate		Haloperidol Decanoate
	Varenicline Tartrate		Levomepromazine Hydrochloride
	Lofexidine Hydrochloride		Levomepromazine Maleate
			Lithium Carbonate
			Lithium Citrate
			Olanzapine
			Paliperidone
			Pipotiazine Palmitate
			Promazine Hydrochloride
			Quetiapine
			Risperidone
			Sulpiride
			Trifluoperazine
			Valproic Acid
			Zuclopenthixol Acetate
			Zuclopenthixol Decanoate
			Zuclopenthixol Hydrochloride
			Pericyazine
			Thioridazine
			Asenapine
			Pimozide
			Perphenazine
			Lurasidone
			Olanzapine Embonate
			Chlorprothixene
			Ziprasidone Hydrochloride
			Fluphenazine Hydrochloride
			Melperone Hydrochloride

Annex: Individual drugs included in aggregate drug indicators

4.4: CNS stimulants and drugs used for attention deficit hyperactivity disorder	4.1: Hypnotics and anxiolytics	4.3: Antidepressant drugs
Atomoxetine Hydrochloride	Buspirone Hydrochloride	Agomelatine
Dexamfetamine Sulfate	Chloral Hydrate	Amitriptyline Hydrochloride
Lisdexamfetamine Dimesylate	Chlordiazepoxide Hydrochloride	Citalopram Hydrobromide
Methylphenidate Hydrochloride	Clomethiazole	Citalopram Hydrochloride
Modafinil	Cloral Betaine	Clomipramine Hydrochloride
Caffeine Citrate	Diazepam	Dosulepin Hydrochloride
Caffeine	Loprazolam Mesilate	Doxepin
Guanfacine	Lorazepam	Duloxetine Hydrochloride
	Lormetazepam	Escitalopram
	Melatonin	Fluoxetine Hydrochloride
	Nitrazepam	Flupentixol Hydrochloride
	Oxazepam	Fluvoxamine Maleate
	Zaleplon	Imipramine Hydrochloride
	Zolpidem Tartrate	Lofepramine Hydrochloride
	Zopiclone	Mianserin Hydrochloride
	Amobarbital Sodium	Mirtazapine
	Clomethiazole Edisilate	Moclobemide
	Meprobamate	Nortriptyline
	Other Hypnotic Preps	Paroxetine Hydrochloride
	Secobarbital Sodium	Phenelzine Sulfate
	Butobarbital	Reboxetine
	Sodium Oxybate	Sertraline Hydrochloride
	Alprazolam	Tranylcypromine Sulfate
	Flurazepam Hydrochloride	Trazodone Hydrochloride
	Bromazepam	Trimipramine Maleate
	Amobarbital	Venlafaxine
		Vortioxetine
		Tryptophan
		Amoxapine
		Isocarboxazid
		Nefazodone Hydrochloride
		Oxitriptan