Primary care mental health engagement – you said /we did

	Recommendations (You said)	What did the commissioners do? (We did)
Information	**Support local and national campaigns** to raise awareness of mental ill health, in particular with older people and men.	The new service will address and monitor any under-representation in accessing services, including men and older people. The service is expected to proactively promote the service with the identified under-represented groups. We are also involved in developing the new mental health strategy for the city. Male suicide and self-harm prevention will be part of the strategy. Opportunities to support local and national campaigns as part of the new service delivery will be explored.
	Consider working with other local organisations to **develop information about:** • **how to access mental health services in the city**. • **what services are available** (in particular perinatal services, carers and partners) This information should be available in a variety of formats.	The new service is expected to develop links with other services like social prescribing, social care, perinatal, family members and carers, and others. Delivery of psychological and peer support for people with CMHD in the perinatal period and their partners is an element of the new service. Proactive promotion and marketing to different sections of the community will include working with other agencies and organisations to ensure that people are appropriately supported to access the service and psychological therapies. The new service is expected to provide information in an accessible format and in a range of styles that respond to the needs of people from various communities, including those of hard of hearing and those who don't speak English as a first language.

Primary care mental health engagement – you said /we did

Accessibility	**Waiting times**	
	Develop ways to **reduce waiting times** for mental health services in the city. This should include: - Waiting for initial assessment - Waiting for interventions, such as CBT and counselling Develop ways to **enable service users to 'track' their waiting times** Explore ways to **stay in touch with service users and referrers** while they wait for assessment and interventions.	The waiting times for accessing the service will be measured around the national targets and an element of the payment for services will be linked to meeting the expected targets Further investment has been made in the current services to address the waiting times during 2018-19 Options will be explored as part of the new service to improve how service users are kept in touch with whilst waiting for assessment and interventions, including receiving updates about waiting times.
	Referral process - Consider a **single point of access to services** which can be used directly by patients or by a variety of different organisations. - Provide **a variety of different ways people can refer into the service**. This might include: - Face-to-face referrals - Online referrals - Telephone referrals	The new service is expected to have a comprehensive digital offer which will allow people to access the service though online referrals and to book onto classes directly. The service will be expected to be able to receive referrals via: - Online/website; - Email; - Telephone; - Post; - Drop in. GP surgery staff, such as the doctors, nurses and receptionist, will be able to refer the patient directly to the primary care liaison service /primary care liaison practitioner. We believe that this will help with reducing waiting times.

Primary care mental health engagement – you said /we did

	Criteria for accessing service • Consider ways to **simplify the criteria for accessing the service**. This might include providing clear information to patients, referrers and wider stakeholders about who is suitable for the service.	The new service will use proactive promotion and marketing to ensure that patients, referrers and wider stakeholders are aware of the service and who is suitable for it.
	Communication between services • Improve communication and collaboration between the services that provide PCMHS.	The service will be part of an information system with other services such as, community mental health team, primary care mental health teams, GPs, which will support communication and to sharing of information between services. Collaboration and partnership working with other PCMHS is noted as a requirement within the service specification.
	Location and opening times • Consider ways to **provide local services that are available outside of traditional working hours**.	The provider is expected to provide a choice of community locations, such as GP practice, voluntary organisations, community service or other location. It is expected from the service provider that the venues will be in suitable premises that are compliant with the Disability Discrimination Act. Premises should be accessible, both physically and through transport links, including for people with limited physical mobility. The service is expected to offer flexibility in terms of appointment times and provide evening and weekend options.

Primary care mental health engagement – you said /we did

Quality of service	Person centred care plan	The provider is expected to deliver a personalised service/interventions that are tailored to individual needs, such as:
	• Consider **working with service users to create a person centred care plan** that considers missed appointments and sets out a clear plan of action. • Consider improving **flexibility around the number of sessions available** through PCMHS **Treatment** • Consider **providing a range of treatment options** for patients and working with patients to understand the most suitable course of treatment for them.	• Patients to have a choice of interventions/therapy and a choice of how it is delivered (e.g. face to face, via telephone or online) • Patients to also have a choice of when and where to be seen and arrangements will be mutually agreed between patient and therapist as part of good care planning. • The treatments offered to patients to be evidence based and offered in the appropriate dosage by a trained and accredited workforce.
	Discharge • Work with service users to **develop clear discharge care plans**. These care plans might consider crisis management and fast track back into treatment • Consider **working in partnership with voluntary sector organisations when developing discharge plans**. Be mindful of resource implications for voluntary sector organisations and identify additional funding when appropriate.	The service is expected to support every patient to exit the service with a co-produced bespoke discharge plan. The service will ensure discharge support to patients including self-management tools, relapse prevention advice, and agreed actions to take if becoming unwell. This will include links to services and resources within the person's local community to increase resilience and support self-management; including access to peer support, voluntary networks and social prescribing; For people who relapse there will be a fast track process to re-access the service.
	Staff • Consider **providing adequate training and supervision of staff**. • Provide services users and carers an opportunity to evaluate the service being provided to them. • Where possible ensure continuity of care.	The service is expected to have staff that is appropriately skilled, trained, qualified, Disclosure & Barring Service (DBS) enhanced checked and approved.

Primary care mental health engagement – you said /we did

		It is also expected that the staff will adhere to Co-production standards.

Equality of access – improving access and providing services for people with diverse needs	Develop services that are accessible to groups with protected characteristics. In particular consider:
	• **Age specific interventions** for older people and younger people
	• **Managing the transfer of care** for people moving out of area
	• **Providing information that is relevant and accessible** to all people from all communities in Leeds, especially people;
	    o With sensory impairments
	    o From BAME backgrounds
	    o From Gypsy & Traveller community
	    o Who are male
	• **Providing services that are accessible to people from all communities**, in particular people:
	    o with sensory impairments
	    o from BAME groups
	    o from Gypsy & Traveller community
	    o with young children
	    o from LGB+ community
	    o who have a gender identity different from the one they were assumed to be at birth
	    o who are asylum seekers or refugees.
		The service is expected to proactively promote the service with groups that are under-represented in the service.
		
		Where a patient requires additional support to access the service, we expect the provider to ensure that provision is made, such as to offer:
		• Translation services;
		• Easy read;
		• Sign language/BSL.
		
		The service will follow the Accessible Information Standard. The Accessible Information Standard tells organisations how they should ensure that disabled patients receive information in formats that they can understand and they receive appropriate support to help them to communicate.

	We recommend that the PCMHS **routinely gathers equality monitoring data** and the **experience** of service users, their carers and wider stakeholders. This should be used to develop the service.	We expect the service to monitor access of people with protected characteristics.