APPENDIX

Progress towards Parity of Esteem using the 10 best practice Indicators

	Best Practice Indicator	Leicestershire	Rutland	Leicester City
1.	**Information systems** Information systems are in development including specific reference to connecting physical health and mental health information for the individual. As a minimum people with SMI have a summary patient passport			
2.	**Vision and Plan** A clear and compelling vision and plan for change has been agreed including where organisational leadership lies. A concordat approach confirms who signed up to implementation. There is evidence of involvement of a wide range of organisations and experts by experience in the development of the plan using a specific joint strategic needs assessment			
3.	**Physical Health** As part of commissioning services for people with SMI, all providers from all sectors have a specific component in the SLA/contract, which highlights the need to improve the physical health of people with SMI. This should include CQUINs (Commissioning for Quality and Innovation) where appropriate. Individual health records including as a minimum a comprehensive annual health check, specific information and access to health promotion activities etc. Offering appropriate interventions based on the outcome of the comprehensive health check should also be recorded. This information should be routinely reviewed through the CCG/LA integrated commissioning approach. There should be links into the urgent care system.			
4.	**Smoking Cessation** Specific services have been commissioned which explicitly support people with SMI to stop smoking based on clear evidence and local understanding of need. The service is targeted and impact is being measured and shared.			
5.	**Mental Health Organisation (MHO**) The organisation has a clear strategy and yearly plan in place stating the role it will take to improve the physical health needs of people with serious mental illness. This strategy has been co produced with people who are or have been using the service and their carers. There are baseline measures in place and a clear way of measuring progress. Primary Care/GPs are aware of who the person is who is the support to that person. The strategy includes specific training and support for everyone to be made aware of the impact of prescribing in relation to hunger and weight gain.			

6.	**Community Services** The organisation has a specific and clear strategy in place about how it will ensure people with SMI have access to the services it provides for the rest of the population including access to specific pathways and skills for people with long term conditions e.g. diabetes. Such a strategy should evidence how it is working with the local provider of services for people with SMI. Clear measures should be in place to inform people of progress.	No Information	No Information	No Information
7.	**Acute Services Strategy** The organisation has a specific and clear strategy in place about how it will ensure people with SMI have access to the services it provides for the rest of the population including access to specific pathways e.g. diabetes, COPD etc. Such a strategy should evidence how it is working with the local provider of services for people with SMI. Clear measures should be in place to inform people of progress.	No Information	No Information	No Information
8.	**Acute Services Workforce** There are specific job roles in place within the organisation including liaison psychiatry that focus on working with people with SMI where the physical health needs of someone is the cause of repeat attendances to A and E.			
9.	**Primary Care** Each practice can routinely provide information in relation to QOF measures where used and has access to a lead primary care practitioner within the locality who has a specific interest in the health, wellbeing and physical health needs of people with SMI registered with each practice.			
10.	**Outcome Based Care** Once a person has a diagnosis of serious mental illness they should work with their named key/case worker on developing a joint outcome based care plan e.g. outcomes star. There should be clear access to as much information as possible to enable this plan to be co produced.			