

**MENTAL HEALTH
COMMISSIONING
STRATEGY
2018/19-2020/21**

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1. INTRODUCTION AND OVER VIEW

The **FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH (2016)** reminds us that mental health problems can affect people in all walks of life and at any point in their lives, including new mothers, children, teenagers, adults and older people. Mental Health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year which is roughly the cost of the entire NHS. We also know that mental health problems are widespread, at times disabling, but also often hidden. One in four adults will experience at least one diagnosable mental health difficulty in any one year. The following paragraph from the **FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH** summarises the current need to re-energise and improve mental health care to meet increased demand and improve outcomes:

‘For far too long, people of all ages with mental health problems have been stigmatised and marginalised, all too often experiencing an NHS that treats their minds and bodies separately. Mental health services have been underfunded for decades, and too many people have received no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths. But in recent years, the picture has started to change. Public attitudes towards mental health are improving, and there is a growing commitment among communities, workplaces, schools and within government to change the way we think about it. There is now a cross-party, cross-society consensus on what needs to change and a real desire to shift towards prevention and transform NHS care.’

Harnessing the change in public attitudes and the growing commitment to preventing and treating mental health difficulties and delivery of the FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH imperatives via commissioning and delivery of safe, sound and supportive mental health services and care pathways is a key strategic priority for our health and social care economy therefore. This is aligned with a number of other key deliverables such as reducing health inequalities, reducing the impact of long term conditions upon quality of life and improving patient and carer experience as outlined in our **Wolverhampton Health and Well-Being Board Strategy** and the **NHS Wolverhampton Clinical Commissioning Group Operational Plan**.

It is acknowledged that the role of local government has a major contribution to make to effective mental health and well-being. In the Local Government Association's (LGA) "Being mindful of mental health – the role of local government in mental health and being" (June 2017) it states that "Council services from social care to parks to open space to education to housing help to make up the fabric of mental health support for the people in our communities." (p.4) It aspires to the creation of "mentally healthy "places for people of all ages across their whole life-course.

These national and local contexts are aligned with a number of other key deliverables such as reducing health inequalities, reducing the impact of long term conditions upon quality of life and improving patient and carer experience as outlined in our Wolverhampton Joint Health and Well-Being Board Strategy and the NHS Wolverhampton Clinical Commissioning Group Operational Plan.

The NHS Wolverhampton Clinical Commissioning Group and the City of Wolverhampton Council and Mental Health Strategy 2018/19-2020/21 is a collaborative commissioning statement of intent wherein we outline our commissioning plans to develop our **Mental Health Integrated Care System** a mental health 'whole system' which will deliver improved outcomes for the people of our City in line with local needs and local and national priorities in line with the FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH deliverables. We will achieve this by working in partnership with key agencies, partners and stakeholders including our patients,

services users and their carers, our registered and resident populations, the Voluntary and Community Sector, NHS and Independent Sector Providers and our partners in the Black Country and West Birmingham Sustainability and Transformation Partnership (BC&WB STP) and the West Midlands Combined Authority (WMCA) for example. Our **WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM** will deliver engagement across partners, agencies and service users and their carers and co-ordinate delivery of our implementation plan and engagement across partners, stakeholders, service user and carer groups and the wider general public.

We will develop a **Mental Health Integrated Care System** building on the changes and developments of the Joint Mental Health Commissioning Strategy developed in 2014/15 and responding to key local and national priorities and deliverables and priorities including the **Better Care Fund**, the **Joint Dementia Strategy 2015-2017**, the **Wolverhampton Joint Autism Strategy 2016-2021** the **Wolverhampton CAMHS Transformation Plan 2017-20**, the **Black Country and West Birmingham Sustainability and Transformation Plan (2017)** and the **NHS England Mental Health Transformation Blue Print** out lined in **Future in Mind**, **Promoting, protecting and improving our children and young people's mental health and wellbeing (2015)**, the **Five Year Forward View for Mental Health (2016)**, **Implementing the Five Year Forward View for Mental Health (2017)** and **Next Steps on the NHS Five Year Forward View (2017)**, the **General Practice Forward View (2016)**, **BETTER BIRTHS Improving outcomes of maternity services in England A Five Year Forward View for maternity care (2016)**, **Transforming care: A National response to Winterbourne View Hospital (2012)**, **Building the right support - A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition (2015)**, the **NHS England CCG Guidance for Operational and Activity Plan 2018/19** the **CCG Improvement and Assessment Framework 2018/19**, **Stepping Forward to 2020/21: the Mental Health Workforce Plan for England (2017)**, the **Prevention concordat for better mental health (2017)**, **Surviving or Thriving? The state of the UK's mental health – the Mental Health Foundation (2017)** and **THRIVE WEST MIDLANDS an**

Action Plan to drive better mental health and wellbeing in the West Midlands (2016), and the LGA's "Being mindful of mental health – the role of local government in mental health and being" (2017).

A link to the WOLVERHAMPTON CAMHS PLAN is provided below:

<https://wolverhamptonccg.nhs.uk/publications/miscellaneous/2286-camhs-plan-refresh-2017-final/file>

Some Key Important Points are highlighted in the table below

Some Key Important Points	
1.	Our <u>Mental Health Integrated Care System</u> will promote a “mentally healthy Wolverhampton,” building resilience amongst the whole population starting in childhood and seeking to prevent mental distress. Our system will respond pro-actively and with compassion to the impact of mental health difficulties and mental illness on individuals, families, communities and our City as a whole delivering mental health promotion and local anti-stigma campaigns and initiatives that support self-help and self-management, peer support, autonomy, self-efficacy, personal growth and recovery across universal, primary, secondary and tertiary services.
2.	Our <u>Mental Health Integrated Care System</u> will ensure that patients, service users and carers and the general public are engaged and involved in the design and delivery of services, care pathways and initiatives and that patients and

service users are pro-actively listened to and are supported to self-manage at every step of their journey, taking and maintaining autonomous ownership and co-production of their **personalised care plans** and that **carers are supported and enabled as equal partners** with health and social care professionals every step of the way.

3. Our **Mental Health Integrated Care System** will **connect mental and physical health initiatives care pathways and services** championing ‘no health without mental health’, placing a focus upon early intervention and prevention at every stage of the service user and carer care pathway, **improving physical health, increasing the life expectancy of people with mental health difficulties and their carers and improving the quality of life ‘adding life to years and years to life’ delivering mental and physical health promotion** at every stage of the care pathway and **making every contact count**. This will be especially evident via developments in Universal Services, Primary Care Services and also via **Primary and Secondary IPS** and **Mental Health First Aid Training** and **robust care pathways across mental and physical health**.
4. Our **Mental Health Integrated Care System** will work to **support and strengthen the Voluntary and Community Sector (VSC) involvement in the design and delivery of universal primary secondary and tertiary care** increasing the capacity to deliver peer and self-support initiatives that are connected and seamless with statutory health and social care, aiming to deliver a **mental health information revolution** that provides easily accessible advice and guidance about self-help, peer support, care pathways and services with targeted information for at risk groups.
5. Our **Mental Health Integrated Care System** will deliver an **evidenced based set of care pathways and services** that provide **connectivity across universal, primary, secondary and tertiary care** with seamless points of transition including from **CAMHS to AMHS and from AMHS to Older Adult Services** and with timely access and egress to services, care pathways and initiatives with personalised care which appropriately and robustly utilises the framework of the **Care Programme Approach (CPA)**.
6. Our **Mental Health Integrated Care System** will deliver Interventions to support the specific needs and vulnerabilities of key

groups including disabled people, people with learning difficulties and older people both in terms of social isolation and self-efficacy and barriers to accessing appropriate levels of support (including barriers to communication in the case of people with sensory impairments and c/ or physical disabilities and / or LTCs for example). This will include focussed support to carers both in terms of access to and responsiveness of services but also by ensuring there are adequate and supportive 'carers care plans' especially for carers of people with high levels of need including people subject to Section 117 Mental Health Act 1983 and the **Care Programme Approach (CPA)**.

7. Our **Mental Health Integrated Care System** will work to **reduce the impact of known risk issues and inequalities upon mental health, delivering a focus upon the wider determinants of mental health, providing dedicated and targeted support that responds to the particular needs of** people who are economically inactive, un-employed people, people with housing needs and / or who are homeless, people with physical disabilities and / or a long term condition, people with a neurological condition such as Autism and / or ADHD (Attention Deficit Hyperactivity Disorder), people with enduring mental health difficulties such as depression and anxiety, psychosis and personality disorder, people who have a history of mental or physical trauma including sexual abuse and exploitation, bullying including work and school based bullying, domestic violence and veterans, people from Black and Minority Ethnic Groups (BAME), and / or LGBT+ (Lesbian Gay Bisexual Transgender Questioning Intersexual Asexual Groups), refugees, migrants and new arrivals, looked after children (LAC), women and their partners, children and families who have a mental health difficulty related to pregnancy and / or child birth, people who have a history of offending behaviour, Veterans and Serving Members of her Majesty's Armed Forces and their families and carers, and people with a dual diagnosis (alcohol and/ or substance misuse) supporting us all to **achieve self-efficacy, fulfil personal hopes, dreams, goals and aspirations and thrive**.

8. Our **Mental Health Integrated Care System** will deliver a 'Think Family' approach **responding pro-actively to the needs of poor parental and spousal mental health upon the mental health and developmental milestones of children**

and adolescents, partners and the whole family and within this context will deliver a focus upon perinatal mental health working with partners in Childrens and Maternity Services Universal and Primary Care Services Public Health Teams and Mental Health Secondary and Tertiary Services across our Sustainability and Transformation Partnership (STP) to deliver a perinatal mental health 'whole system' of care pathways and services that achieves the key outputs of the **Black Country and West Birmingham Local Maternity System (LMS)** including the aspirations of **Better Births Improving outcomes of maternity services in England A Five Year Forward View for maternity care (2016)** for our local system. This will include a focus upon **reducing maternal mental health related deaths including deaths related to alcohol and / or substance misuse and suicide**. This will also include a focus upon improved health and developmental outcomes for the child, sibling, partner and the whole family.

9. Our **Mental Health Integrated Care System** will deliver a set of **interoperational processes systems care pathways and services across primary secondary and tertiary care to ensure more pro-active and responsive approaches within primary care for people with mental health difficulties** – delivered by staff within NICE Guidance compliant services with mental health expertise in line with the **General Practice Forward View – blurring some boundaries across primary and secondary care for people with mental health difficulties and improving systems and processes for better shared care**. This will involve inclusion of mental health staff working in and embedded in primary care services and primary care and mental health multi-disciplinary team meetings in each GP practice and in every Primary Care Group including the Vertical Integration with the Royal Wolverhampton NHS Trust. There will be a particular focus upon improving access and responsiveness to evidence based care including physical health checks for people with SMI (Severe Mental Illness), improved care pathways for people with co-occurring mental health problems .and physical ill health including Long Term Conditions (LTCs) - such as Diabetes, Cancer, Cardio-Vascular Disease including Stroke and Heart Disease, Chronic Obstructive Pulmonary Disease, Neurological Disorders, Dementia, Physical Disability, Musculoskeletal Disorders and or

Acquired Brain Injury - shared care and improved information sharing, improved referral processes for mental health secondary care generally but including a focus on improved referral processes for primary care and social care staff and staff working in statutory and non-statutory services and looking at ways to support and improve self-referral and access support and advice for carers.

10. Our **Mental Health Integrated Care System** will support the mental health needs of all staff patients and service users and carers including friends and family members and informal carers by ensuring appropriate levels and types of support across the system and particularly at times of escalation and crisis helping us all to work together and support each other with professionalism and with accountability and in enabling, kind and compassionate ways.

Ten ways to look after your Mental Health (The Mental Health Foundation, 2017) are highlighted in the table below.



Across our Mental Health Integrated Care System we will operate as 'ONE SILO' – operating as 'ONE SILO' means that there will be pro-active seamless support for people of all ages delivered with a cohesive set of values based on our vision for our City

Our values will focus upon compassionate kind empathic responsive effective evidence based and empowering and enabling care, treatment and support that directs and enables individuals to achieve autonomy, self-efficacy growth and recovery and supports the achievement of optimum health to achieve wider personal aspirations hopes dreams and goals

Working as **ONE SILO** we will reduce the mortality gap, increase numbers of people in evidence based treatment, improve data collection and measurement to demonstrate improvement and exponential improvement and **integrate mental health care and physical health care and social care pathways systems and processes** achieving key deliverables of the mental health improvement blueprint. This is an important part of achieving mental health 'parity of esteem' which includes a focus on the performance management of CCGs regarding equity of access to evidence based care and treatment, equity of status in the measurement of mental health outcomes (including the April 2017 Mental Health Standard Data Set) and equity of funding both in terms of the CCG Mental Health Investment Standard but also with release of NHS England targeted investment funding (IAPT Expansion, Mental Health Liaison, Crisis and Urgent Care, Perinatal Mental Health and New Models of Care Vanguard).

Five Key Priorities of our Mental Health Commissioning Strategy 2018/19-2020/21 are therefore

Building our strategy from the Five Year Forward View for Mental Health (2016) and Future in Mind (2015) the **KEY FIVE PRIORITIES** are as follows:

- **Integration of mental and physical health - closing the mortality gap** - having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50% and doubles the risk of coronary heart disease in adults. People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population (Future in Mind 2015). Five Year Forward View For Mental Health highlights that people with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care by an average of 45 % whereas providing dedicated mental health provision can improve outcomes, such as in the case of Type 2 diabetes, £1.8 billion of additional costs can be attributed to poor mental health. Pilot schemes show providing such support improves health and cuts costs by 25%.
- **Improving access to the quality and evidence base and improving access to and responsiveness of services, referral to treatment and waiting times - closing the treatment gap** - a UK epidemiological study suggests that less than 25% – 35% of individuals with a diagnosable mental health condition accessed appropriate help (Future in Mind 2015). In addition there is a strong link between parental (especially maternal) mental health and children's mental health. Future in Mind highlights that according to a recent study, maternal perinatal depression, anxiety and psychosis together carry a long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK, equivalent to a long-term cost of just under £10,000 for every single birth in the country and that almost three-quarters of this cost (72%) relates to the impact on the child / infant. £1.2 billion of the long-term cost is borne by the NHS (Future in Mind, 2015). **There is a requirement for access to evidence based interventions across the lifespan and that access to services in a NICE concordant evidence based care pathway is measured and reported along with measurement of outcomes.** (See Fig. 2 below).

- **Improving Data Quality – closing the data quality gap** - our system recognises that there is a need for good, transparent, regular data and information that is collected in line with national requirements reporting recording new KPIs / measurements etc. including use of the APRIL 17 New MH SDS and the monitoring new access and waiting times and referral to treatment standards such as within IAPT, Early Intervention In Psychosis and Eating Disorders Services. We will build on our achievements in promoting better, more joined-up data.
- **CCGs commitment to Mental Health Investment Standard - closing the parity of esteem / funding gap** (in addition to the Mental Health Investment Standard our commitment to parity of esteem includes submitting applications for NHS E Transformation funding and funding for New Models of Care that meet our local needs and needs on a BC&WB footprint).
- **Improving the Wider Determinants of Mental Health – closing the early intervention and prevention gap** - the Five Year Forward View for Mental Health highlights that between 60–70 % of people with common mental health problems are in work, yet few employees have access to specialist occupational health services and that for people being supported by secondary mental health services, there is a 65 % employment gap compared with the general population. People with mental health problems are also often overrepresented 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. Children living in poor housing have increased chances of experiencing stress, anxiety and depression. People in marginalised groups are at greater risk, including people from BAME and LGBT+

groups, disabled people, care leavers, people who have had contact with the criminal justice system, amongst others. BAME households are more likely to live in poorer or over-crowded conditions, increasing the risks of developing mental health problems. People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a Learning Disability and /or Autism are also at higher risk. As many as nine out of ten people in prison have a mental health, drug or alcohol problem. **These statistics emphasise the requirement for a focus upon the wider determinants of mental health and targeted mental health promotion across the lifespan and across universal services and primary secondary and tertiary care delivered as part of our local Prevention Concordat.**

Early Intervention in Psychosis

If everyone who needed
Early Intervention in
Psychosis received a
service, each year the
NHS would save



£44 million

Source: National Institute for Health and Care Excellence, 2014. Costing statement: Psychosis and schizophrenia in adults: treatment and management

This Mental Health Commissioning Strategy 2018/19 – 2020/21 describes our plans therefore regarding delivery against the mental health improvement blue print to develop our **Mental Health Integrated Care System** and close gaps in service provision across our footprint working with partners across our STP to deliver evidence based services of critical mass and at scale and pace delivering value for money and avoiding unnecessary duplication of costs.

Areas of particular development include the IAPT Expansion (including Perinatal IAPT, IAPT for LTCs, and increasing access to IAPT for Older People and People from BAME Groups), Urgent Care Services, Planned Care Services, Perinatal Mental Health Services, Early Intervention in Psychosis Services, Personality Disorder Services, Neurodevelopmental Services, Assertive Outreach Services (in Adult Community Mental Health / Community Recovery Teams), and Dual Diagnosis Services (Alcohol and Substance Misuse and Mental Health Services). Medical staffing across some services requires some review to ensure an appropriate distribution of senior clinicians across the Primary, Secondary and Tertiary Care i.e. Community and In-patient services to deliver fidelity with the evidence base and deliver admission avoidance and right care in the right place and at the right time for example.

Wider approaches led by the Council will also contribute in this context: the development of the £3m “Wolves Into Work” programme supporting people with disabilities – including those with mental health needs – to return to employment; the use of a £10m “HeadStart” programme promoting the mental health of children and young people in the City; recognition of the City of Wolverhampton as a Dementia friendly city; suicide prevention; ongoing support to family carers; etc.

We will redesign care pathways across primary and secondary care mental health to ensure early intervention and prevention and prevent avoidable use of secondary and tertiary care including Out of Area Treatments (OATs) such acute overspill placements.

This approach is both clinically and financially inefficient with poor outcomes for patients and their carers - such as delays accessing services and longer recovery periods - and higher financial costs.

BC&WB STP level collaborative commissioning across the mental health improvement blue print where appropriate and required and some other areas of critical need will allow re-calibration and re-specification of some services including their financial profiles to ensure value for money and provide opportunities for reinvestment where there are gaps or service development requirements for example.

Improving the quality and responsiveness of key services with adherence to an agreed evidence base across a broader footprint is therefore a key ambition as is improving the clinical effectiveness of services whilst achieving value for money by driving down costs associated with sub-optimal delivery models. This includes a focus upon improving services associated with frequent relapse rates and re-admissions, lengths of stay and discharge delays and inefficient mental / physical health care pathways including those for people with long term conditions and /or people who self-harm for example (including high volume service users).

New or revised services and service specifications will be delivered within the financial envelope our commissioning authorities i.e. NHS W CCG and CWC. Resources – including key elements of our workforce - will be used to best effect with strong clinical and medical leadership evident at each part of the **Mental Health Integrated Care System**. This is in addition to any transformation funds applied for and received from NHS England for example including ‘Winter Pressures’ and A&E Delivery Board funding used to ‘pump prime’ change. Compliance with the Mental Health Investment Standard will be supported across all CCG commissioned activity. A **Financial Plan** will form part of the **Mental Health Strategy Implementation Plan**.

THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH DELIVERABLES are outlined in the table below:

The Five Year Forward View For Mental Health Deliverables (NHS England - 2017)

Overall Goals for 2017-2019

Implementing the Mental Health Forward View (2017) sets out clear deliverables for putting the recommendations of the Independent Mental Health Taskforce Report into action by 2020/21. The publication of Stepping Forward to 2020/2021 in July 2017 provides a roadmap to increase the mental health workforce needed to deliver this.

Deliverables for 2018/19 and 2019/2020 2020//2021

Each CCG must meet the Mental Health Investment Standard (MHIS) by which their 2018/19 investment in mental health rises at a faster rate than their overall programme funding. CCGs' auditors will be required to validate their 2018/19 year-end position on meeting the MHIS.

Ensure that an additional 49,000 children and young people receive treatment from NHS-commissioned community services (32% above the 2014/15 baseline) nationally, towards the 2020/21 objective of an additional 70,000 additional children and young people. Ensure evidence of local progress to transform children and young people's mental health services is published in refreshed joint agency Local Transformation Plans aligned to STPs.

Make further progress towards delivering the 2020/21 waiting time standards for children and young people's eating disorder services of 95% of patient receiving first definitive treatment within four weeks for routine cases and within one week for urgent cases (in WOLVERHAMPTON this standard is also being applied to our Adult Eating Disorder Service).

Deliver against regional implementation plans to ensure that by 2020/21, inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements, within a context of 150-180 additional beds.

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Continue to increase access to specialist perinatal mental health services, ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%.
Continue to improve access to psychological therapies (IAPT) services with, maintaining the increase of 60,000 people accessing treatment achieved in 2017/18 and increase by a further 140,000 delivering a national access rate of 19% for people with common mental health conditions with support from Health Education England (HEE) who are commissioning of 1,000 replacement practitioners and a further 1,000 trainees to expand services. This will release 1,500 mental health therapists to work in primary care. Approximately two-thirds of the increase to psychological therapies should be in new integrated services focused on people with co-morbid long term physical health conditions and/or medically unexplained symptoms, delivered in primary care. Continue to ensure that all IAPT access, waiting time and recovery standards are met.
Continue to work towards the 2020/21 ambition of all acute hospitals having mental health crisis and liaison services that can meet the specific needs of people of all ages including children and young people and older adults; and deliver Core 24 mental health liaison standards for adults in 50% of acute hospitals subject to hospitals being able to successfully recruit.
Ensure that 53% of patients requiring early intervention for psychosis receive NICE concordant care within two weeks.
Support delivery of STP-level plans to reduce all inappropriate adult 'acute overspill' out of area placements (OATs) by 2020/21, including increasing investment for Crisis Resolution Home Treatment Teams (CRHTTs) to meet the ambition of all areas providing CRHTTs resourced to operate in line with recognised best practice by 2020/21.
Review all patients who are placed out of area to ensure that have appropriate packages of care.
Deliver annual physical health checks and interventions, in line with guidance, to at least 280,000 people with a severe mental health illness (SMI).
Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and

home treatment teams and mental health liaison services in acute hospitals.
Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.
Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population.
Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.
Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism.
Provide a 25% increase nationally on 2017/18 baseline in access to Individual Placement and Support services (IPS).
Maintain the dementia diagnosis rate of two thirds (66.7%) of prevalence and improve post diagnostic care (in WOLVERHAMPTON as we are achieving this target we have a 'stretch target'. Have due regard to the NHS implementation guidance on dementia focusing on post-diagnostic care and support.
Support disabled people and people with complex health needs to benefit from a personal health budget, with expansion to over 20,000 people in 2017/18 and 40,000+ in 2018/19.
Continue to maintain focus on diagnosis and post-diagnostic support for people with dementia and their carers (key drivers to keeping in their own homes, preventing crises and avoiding unnecessary admission to hospital).
Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and

home treatment teams and mental health liaison services in acute hospitals.
Increase baseline spend on mental health to deliver the Mental Health Investment Standard.
Eliminate out of area placements for non-specialist acute care by 2020/21.
Measurable improvement on all areas of Prime Minister's challenge on dementia 2020, including: <ul style="list-style-type: none"> • maintain a diagnosis rate of at least two thirds • increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral • improve quality of post-diagnosis treatment and support for people with dementia and their carers
To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce).
Access and waiting time standards for mental health services embedded, including: 50% of people experiencing first episode of psychosis to access treatment within two weeks; and 75% of people with relevant conditions to access talking therapies in six weeks; 95% in 18 weeks.
Deliver the contribution to the mental health workforce expansion as set out in the HEE workforce plan, supported by STP-level plans. At national level, this should also specifically include an increase of 1,500 mental health therapists in primary care in 2018/19 and an expansion in the capacity and capability of the children and young people's workforce building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence based interventions by 2020/21.
Deliver against multi-agency suicide prevention plans, working towards a national 10% reduction in suicide rate by 2020/21.
Deliver liaison and diversion services to 83% of the population.
Ensure all commissioned activity is recorded and reported through the Mental Health Services Dataset.

2. INFORMATION REGARDING PREVALENCE AND NEED

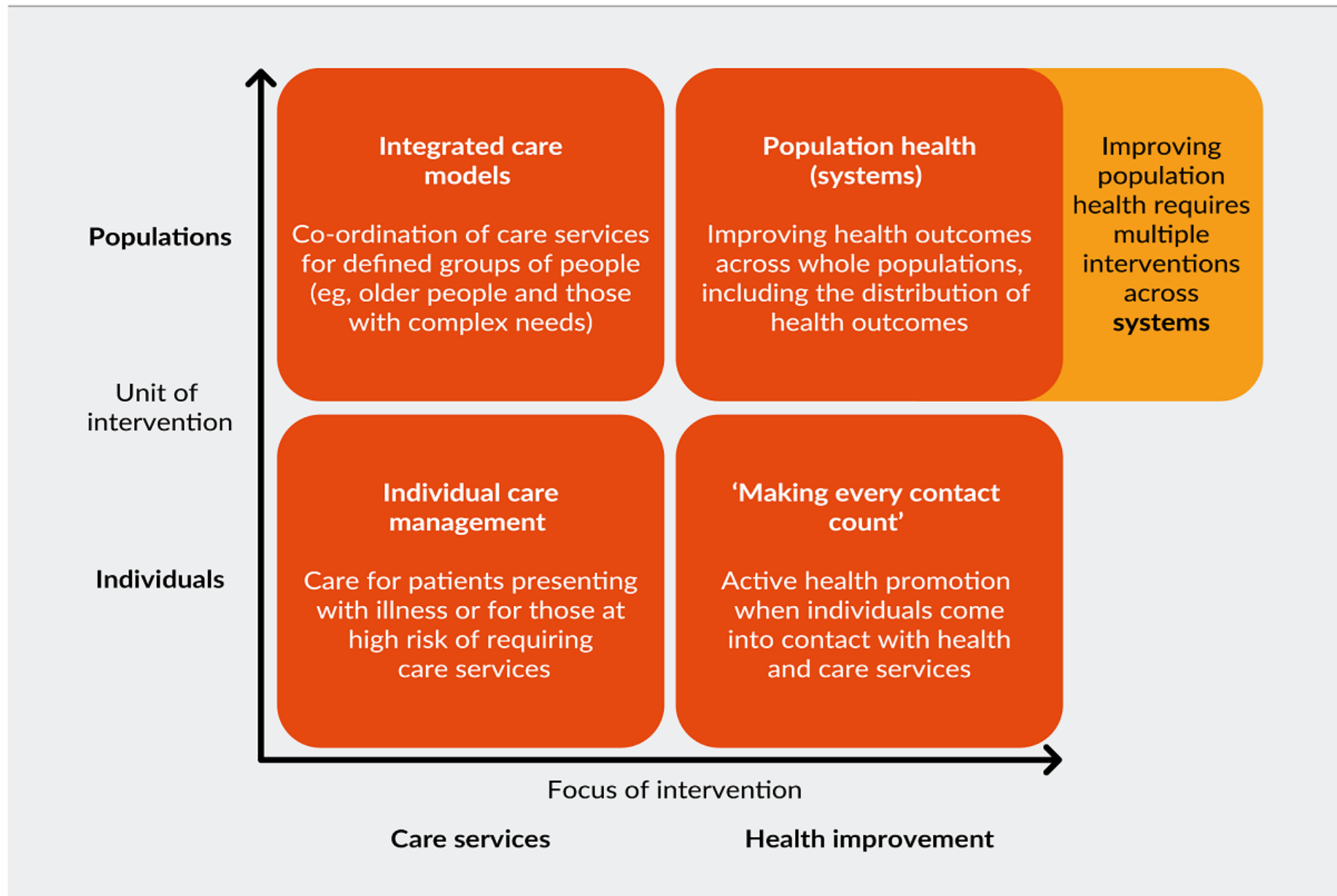
This section of our strategy outlines key information and associated priorities and deliverables in terms of our understanding of the local and national picture in terms of mental health need.

Our **Mental Health Integrated Care System** will respond **pro-actively and with compassion** to the impact of mental health difficulties and mental illness on individuals, families, communities and our City delivering mental health promotion and local anti-stigma campaigns and initiatives that support self-help, peer support, autonomy, self-efficacy, personal growth and recovery across universal, primary, secondary and tertiary services.

Integrated Care is described by the Kings Fund (Ham, 2017) below:

‘Breaking down barriers means co-ordinating the work of general practices, community services and hospitals to meet the needs of people requiring care. This is particularly important for the growing numbers of people with several medical conditions who receive care and support from a variety of health and social care staff.....The NHS also needs to give greater priority to the prevention of ill health by working with local authorities and other agencies to tackle the wider determinants of health and wellbeing. This means tackling risk factors such as obesity and redoubling efforts to reduce health inequalities. And it means fully engaging the public in changing lifestyles and behaviours that contribute to ill health and acting on the recommendations of the Marmot report and other reviews to improve population health..... Integrated care happens when NHS organisations work together to meet the needs of their local population. Some forms of integrated care involve local authorities and the third sector in working towards these objectives alongside NHS organisations. The most ambitious forms of integrated care aim to improve population health by tackling the causes of illness and the wider determinants of health.’

The significance of understanding population need is demonstrated in the Kings Fund diagram below (Fig 3):



Local and national population based information has and will inform the development and implementation of our **Mental Health Integrated Care System**.

The report of the Mental Health Foundation Thriving or Surviving (2017) – “To help us all live mentally healthier lives” <https://www.mentalhealth.org.uk/sites/default/files/surviving-or-thriving-state-uk-mental-health.pdf> has highlighted that only a small minority of people in England (13%) report living with high levels of good mental health. **The figures show that the experience of poor mental health, while touching every age and demographic, is not evenly distributed. If you are female, a young adult, on low income or unemployed, living alone or in a large household, your risks of facing mental ill health are higher.**

In addition the **THRIVE WEST MIDLANDS an Action Plan to drive better mental health and wellbeing in the West Midlands (2016)**. <https://www.wmca.org.uk/media/1420/wmca-mental-health-commission-thrive-full-doc.pdf> describes the priorities for mental health and well-being for our City.

THRIVE is driven by the local government perspective on mental health which has been most recently articulated in the LGA 2017 Report “Being mindful of mental health – the role of local government in mental health and being.”

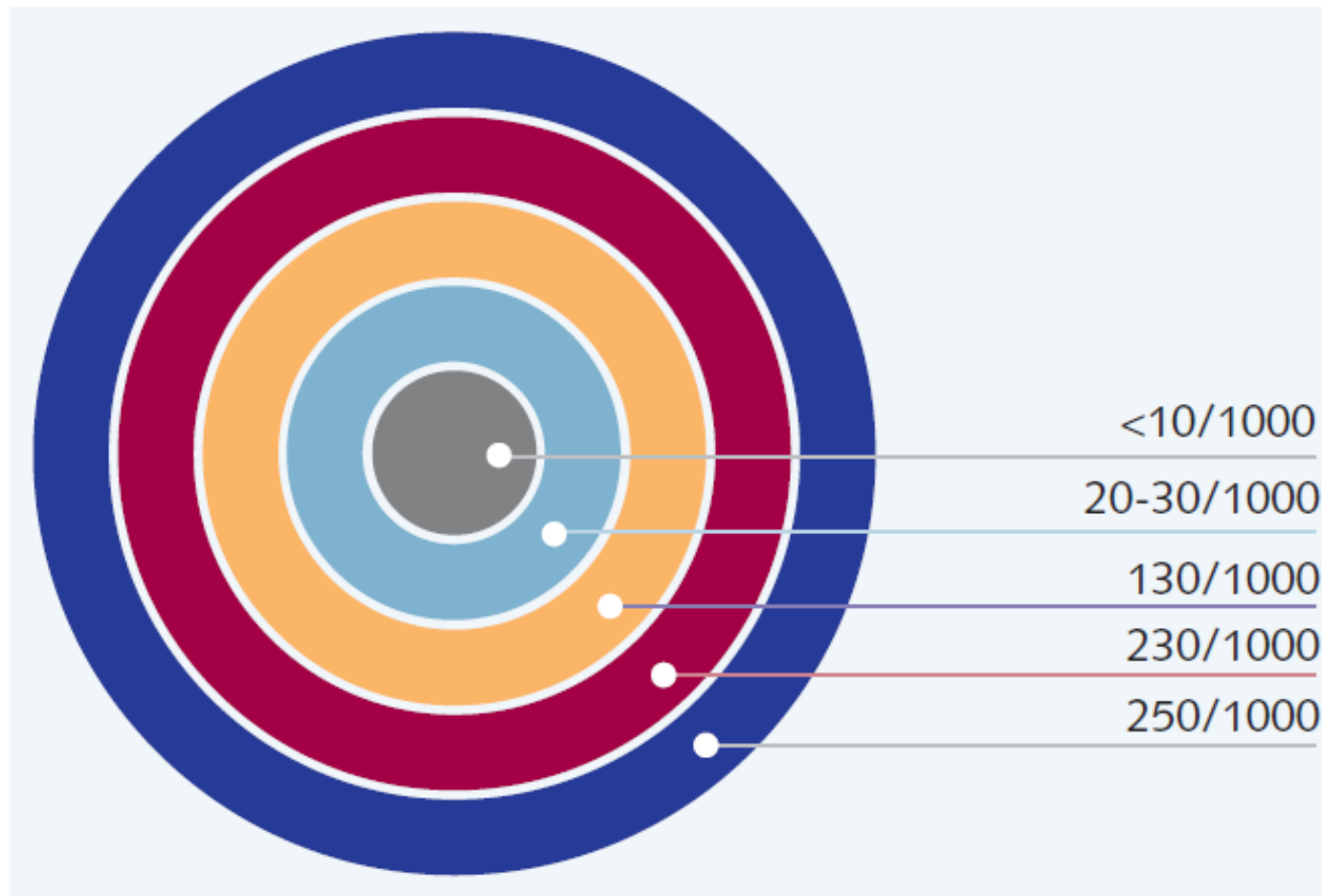
Our commissioning priorities outlined in this strategy re-fresh will respond to the critical issues and factors that exist in Wolverhampton in terms of levels of inequality in health and social outcomes and also address our knowledge and understanding of local levels and type of mental health need and our response to tackling inequalities and preventing mental health difficulties occurring wherever possible.

A local assessment of need is attached as Appendix 1.

A summary of some key demographic and local and national prevalence related data is described below.

The illustration below is taken from the Joint Commissioning Panel for Mental Health guidance 'Practical Mental Health Commissioning' (2011).

Numbers of people affected by mental health problems



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

Number of people affected by mental health problems

The table below shows the number of people affected by mental health problems by applying the above prevalence to Wolverhampton's 2011 census total population of 248,470, of whom adults are 186,508.

	Prevalence	Wolverhampton
Number of people at risk of mental health problem	250/1,000	46,627
Of those at risk attending GP	230/1,000	42,897
Subsequently diagnosed as having mental health problem	130/1,000	24,246
Referred to Specialist Mental Health Service	20-30/1,000	5,595
Admitted to Mental Health Hospital	<10/1,000	1865

The following three tables show the number of patients on GP systems who are recorded as having general, common mental illnesses and severe mental illness by ethnic and age group

Age	0-16	17-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100+	Total
General												
Anxiety	42	42	243	329	377	351	287	226	100	18		2015
Depression	31	101	1477	2173	2534	2391	1574	954	432	82	1	11750
Phobias	2	1	23	36	34	34	34	13	7	1		185
OCD	11	10	62	82	71	44	31	18	5	1		335
Common Mental Illness												

DRAFT MENTAL HEALTH COMMISSIONING STRATEGY 2018/19-2020/21

Depressive Episode	53	159	2041	3191	3766	3624	2494	1568	725	148	5	17774
General	6	4	47	55	89	77	79	66	31	7		461
Mixed	8	11	59	103	115	148	102	66	32	6		650
Panic Disorder	2	5	17	42	44	46	35	21	13	2		227
PTSD	12	15	148	203	197	163	92	36	8	1		875
Severe Mental Illness												
Bipolar	2	3	51	106	111	126	84	60	20	2		565
Schizophrenia		1	13	43	61	64	45	32	15	2		276
Total	169	352	4,181	6,363	7,399	7,068	4,857	3,060	1,388	270	6	35,113

Mental Health Illness by ethnic group

69.4% (n=24,383) of patients from white ethnic origin, 10.5% (n=3,687) Asian, 3.6% (1,278) Black, 14.1% (4,946) other and 2.3% (n=819) from mixed ethnic origin have mental health illnesses.

	Asian or Asian British	Black or Black British	Mixed	Other Ethnic Groups	White	Grand Total
General						
Anxiety	273	73	36	309	1324	2015
Depression	1216	442	278	1456	8358	11750
Phobias	15	3	4	32	131	185
OCD	59	6	5	42	223	335
Common Mental Illness						
Depressive Episode	1656	593	407	2674	12444	17774
General	61	11	9	43	337	461
Mixed	79	19	12	77	463	650
Panic Disorder	39	5	3	33	147	227

DRAFT MENTAL HEALTH COMMISSIONING STRATEGY 2018/19-2020/21

PTSD	139	67	30	160	479	875
Severe Mental Illness						
Bipolar	91	25	22	84	343	565
Schizophrenia	59	34	13	36	134	276
Total	3,687	1,278	819	4,946	24,383	35,113

Mental Health Illness by gender

Women predominantly have more (62.5%) recorded mental health illnesses compared to men (37.5%).

	Female	Male	Total
General			
Anxiety	1198	817	2015
Depression	7510	4240	11750
Phobias	100	85	185
OCD (Obsessive compulsive disorder)	175	160	335
Common Mental Illness			
Depressive Episode	11297	6477	17774
General Episode	249	212	461
Mixed anxiety and depressive disorder	393	257	650
Panic Disorder	160	67	227
PTSD (post traumatic distress disorder)	428	447	875
Severe Mental Illness			
Bipolar	318	247	565
Schizophrenia	102	174	276
Total	21,930	13,183	35,113

The Wolverhampton 2011 census describes our resident population as 248,470. The average age in Wolverhampton is 39 years, which is similar to the England average; however Wolverhampton has a slightly higher proportion of children aged under 16. In terms of ethnicity, 68% Wolverhampton residents are from a white ethnic background with the remaining 32% of residents belonging to black minority ethnic backgrounds (BAME). Wolverhampton has high numbers of new arrivals arriving into the City each year including traveller families (estimated 2700 families in 2012). In terms of levels of deprivation in our City Wolverhampton is the 21st most deprived Local Authority in the country, with 51.1% of its population falling amongst the most deprived 20% nationally. Deprivation is disproportionate across the city, with the more affluent wards in the west of the city. A number of sources of evidence suggest that a number of equalities and demographic factors can have a significant effect on the local need and uptake of mental health services, including:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism
- Lesbian, gay, bisexual and transgender people (LGBT+) and / or children and young people who are questioning their sexual orientation and / or gender (LGBT+)
- Substance misuse

- Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying

Interventions to support the specific needs and vulnerabilities of key groups should include disabled people, people with learning difficulties and older people both in terms of social isolation and self-efficacy and barriers to accessing appropriate levels of support (including barriers to communication in the case of people with sensory impairments and c/ or physical disabilities and / or LTCs for example). We will extend our support to carers both in terms of access to and responsiveness of services but also by ensuring there are adequate and supportive 'carers care plans' especially for carers of people with high levels of need including people subject to Section 117 Mental Health Act 1983 and the Care Programme Approach (CPA).

In addition we wish to place a particular focus upon the needs of people of all ages with conditions such as Autism and Attention Deficit Hyperactivity Disorder, Personality Disorder and Veterans and Serving Members of Her Majesty's Armed Forces and their families. We will also focus specifically upon the needs of both Older People and Children and Young People transitioning to Adult Mental Health Services, all of whom are at risk of falling between gaps in services or lack of connectivity across / between services.

Mental health services and care pathways and services should also specifically consider and address the mental health needs of pre and post-natal mothers, people with co-morbid substance misuse and people with learning disabilities (national prevalence of people with learning disabilities with co-occurring mental health problems is estimated to be 25–40%, 'No Health without Mental Health', 2011).

Perinatal Mental Health

The impact of perinatal mental ill health is highlighted in Future in Mind (2015) as per the information below:

‘There is a strong link between parental (particularly maternal) mental health and children’s mental health. For this reason, it is as important to look after maternal mental health during and following pregnancy as it is maternal physical health. According to a recent study, maternal perinatal depression, anxiety and psychosis together carry a long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK, equivalent to a long-term cost of just under £10,000 for every single birth in the country.³⁶ Nearly three-quarters of this cost (72%) relates to adverse impacts on the child rather than the mother. Some £1.2 billion of the long-term cost is borne by the NHS.’

As referenced in earlier and later sections of this document over the past 18 months WOLVERHAMPTON CCG has hosted a project on behalf of our BC&WB STP and LMS partners. We have successfully applied for NHS ENGLAND TRANSFORMATION FUNDING to develop a Specialist Perinatal Community Mental Health Service operating across our BC&WB footprint to enable our health and social care community to pro-actively respond to local/national risk factors and train staff across our maternity, health visiting and primary and secondary care mental health system in rapid identification of risk and evidence based assessment.

We expect the majority of referrals into our SPA to come from ante and post-natal screening by midwives and also health visitors, GPs and staff in primary and secondary mental health services. Self-referral is accepted. (There are 20,000 births per annum (ONS) across the BC&WB STP- 5% of these women will be seen by the SCPMHS).

We have worked to pro-actively target areas of particular need using local knowledge by GP surgery and electoral ward including key risk and deprivation markers in line with national and local risk factors/history as follows:

- Perinatal mental health difficulties

- Childhood abuse and neglect
- Domestic violence
- Poverty/deprivation/economically inactive/unemployed
- Poor housing/accommodation status
- Sexual violence/abuse
- Interpersonal conflict
- Inadequate social support
- Alcohol or substance misuse
- Unplanned or unwanted pregnancy
- Birth trauma, premature birth, child mortality, still birth
- Child removed/placed in care
- Children attaining poor developmental milestones
- Migration status/new arrivals
- People from Black and Minority Ethnic Groups
- Forced marriage
- Family dysfunction

To ensure our SPCMHS achieves the transformation required our service specification includes a focus upon multi-agency and multi-disciplinary person and family centred care ensuring that we:

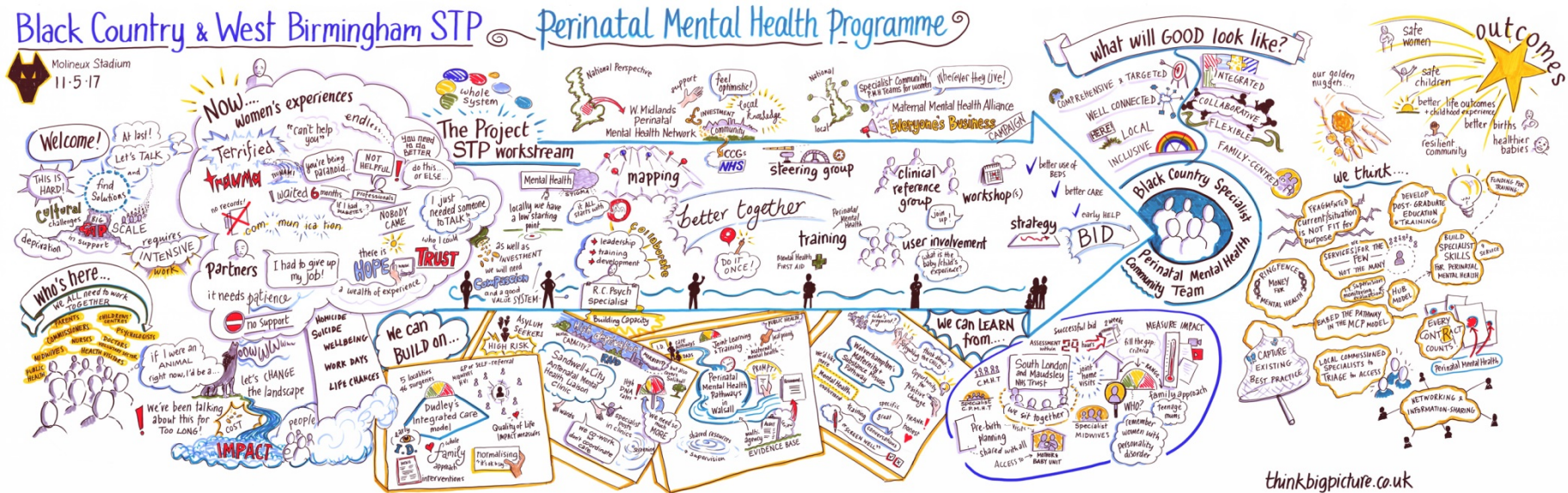
- promote the self-efficacy and resilience of the patient, child, family, friends and carers

- provide evidenced-based treatment and care pathways across a range of bio-medico-psycho-social interventions and access to vocational/training/employment support
- reduce maternal/child deaths from psychiatric causes (suicide or substance misuse)
- use evidence based risk tools such as Whooley questions, Beck and Edinburgh Scale
- monitor outcomes via evidence based outcome and reporting tools includes PREMS, PROMS and CROMS
- enhance the experience/outcomes of women by promoting informed choice from preconception counselling to 1 year following their delivery, having the infant mother and their relationship triad as the paramount focus
- incorporate lived experience in shaping thereby improving the experience of service users

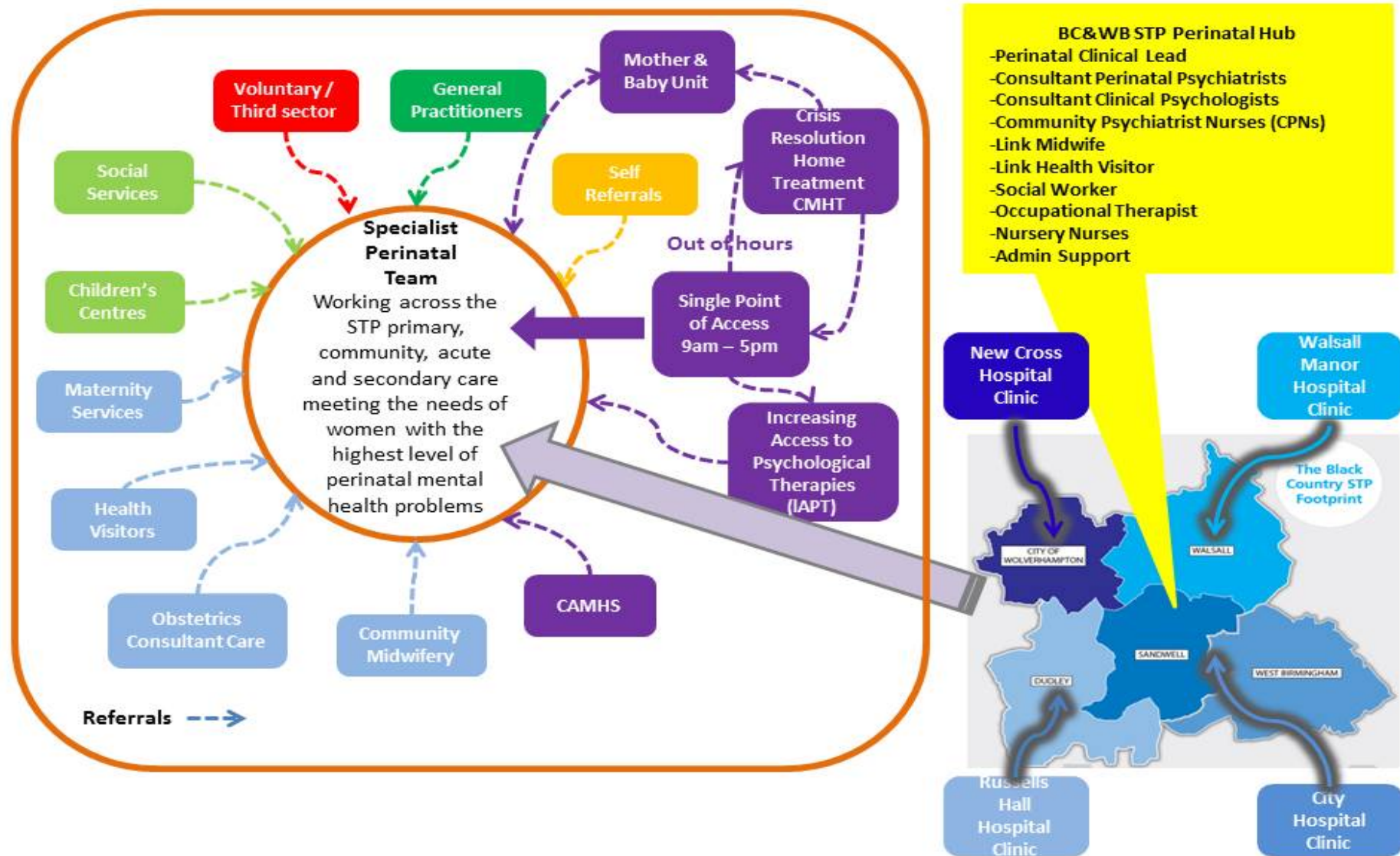
Our Black Country and West Birmingham Perinatal Mental Health Whole System is described in the diagram below:

Key outcome themes are:

- perinatal mental health parity of esteem
- Integrated care and multi-agency working
- Early detection and prediction of risk and promotion of mental health and wellbeing
- Rapid access to intervention
- Access to perinatal mental health bio-medico-psycho-social therapies
- Support for mothers, their partners, children and wider family including stigma reduction



Black Country and West Birmingham (BC&WB) STP Specialist Perinatal Community Mental Health Service Model



Black and Minority Ethnic Groups

The over representation of people from BAME groups has locally and nationally focussed upon the need to commission culturally sensitive services particularly for particular groups of men and women including new arrivals. In Wolverhampton we need to continue to address over representation of key groups specifically in relating to formal admission under the Mental Health Act 1983. The relatively low prevalence of numbers of children from BAME groups referred to Tier 2 and Tier 3 CAMHS (less than 20% of referrals, compared with 41% of the population of children and young people in our City) suggests that prevention and early intervention should include a focus upon targeted interventions for children and young people and their parents and carers from BAME groups and communities of new arrivals.

Dual Diagnosis

The term “Dual Diagnosis” covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. Supporting people with mental health difficulties and substance misuse difficulties can be a significant challenge affecting the diagnosis, care and treatment of service users. Substance misuse should be understood to be usual rather than exceptional amongst people with severe mental health difficulties (Mental Health Policy Implementation Guide, Dual Diagnosis Good Practice Guide, 2002). Substance misuse and mental health difficulties may interact in a way which makes diagnosis, treatment and recovery more complex.

The term Dual Diagnosis can apply to people who:

- Develop mental health symptoms after problematic substance misuse use.
- Have a pre-existing mental health problem and then start using substances problematically.

Fragmented care across a number of different services can cause people to fall out of services, receive an inadequate or inappropriate type or level of service, or no service at all. An integrated approach provides better outcomes, providing locally agreed, evidence based care pathways for targeted groups within mainstream mental health and substance misuse services.

Substance Use and Psychiatric Syndromes (Rassool 2009):

- 74.5% of users of drug services, and 85.5% of users of alcohol services experienced mental health problems.
- Most experienced affective disorders i.e. anxiety / depression or psychosis.
- 38.5% were receiving no treatment for their mental health difficulty.
- 44% of mental health service users reported drug / alcohol use at hazardous or harmful levels in the past year.

Key Findings Cannabis and Psychosis Study - University Kings College London Study 2015

- 24% of all new psychosis patients were using potent cannabis such as 'skunk'
- Risk for users of cannabis developing psychosis three times higher and five times higher for daily users

'Approximately 40% of people with psychosis misuse substances at some point in their lifetime, at least double the rate seen in the general population. In addition, people with coexisting substance misuse have a higher risk of relapse and hospitalisation, and have higher levels of unmet needs compared with other inpatients with psychosis who do not misuse substances.'

'People with psychosis commonly take various non-prescribed substances as a way of coping with their symptoms, and in a third of people with psychosis, this amounts to harmful or dependent use. The outcome for people with psychosis and coexisting substance

misuse is worse than for people without coexisting substance misuse, partly because the substances used may exacerbate the psychosis and partly because substances often interfere with pharmacological or psychological treatment.’

(NICE Clinical Guideline, 2011)

Rassool (2009) – Problems associated with Dual Diagnosis

- Increased likelihood of self-harm
- Increased risk of HIV infection
- Increased use of institutional services
- Poor compliance with medication or treatment
- Homelessness
- Increased risk of violence
- Increased risk of victimisation or exploitation
- Higher recidivism
- Contact with the criminal justice system
- Family problems
- Poor social outcomes including impact on family and carers
- Denial of substance of misuse
- Negative attitudes of healthcare professionals
- Social exclusion

Why do Substance Use and Psychiatric Disorders Commonly Co-Occur? (Rassool 2009, adapted from NIDA, 2007)

‘Developmental Disorders – they often begin in adolescence or even childhood, periods when the brain is undergoing dramatic developmental changes. Early exposure to drugs of addiction can change the brain in ways that increase the risk for mental illness just as early symptoms of psychiatric disorder may increase vulnerability to alcohol and drug use.’

Genetic vulnerabilities – Evidence suggests that common genetic factors may pre-dispose individuals to both psychiatric disorders and addiction or to having a greater risk of the second disorder once the first appears.’

‘Environmental triggers – Stress, trauma (for example physical or sexual abuse) and early exposure to drugs are common factors that can lead to addiction and to psychiatric disorders particularly in those with underlying genetic vulnerabilities.’

Alcohol and Mental Health (Rassool 2009)

- 85.5% of users of alcohol services experienced mental health problems (Weaver et al 2002)
- Most had affective disorders (depression), anxiety and psychosis.
- Common links include depression, suicidal behaviour, OCD, anxiety disorders, bipolar disorders, schizophrenia and personality disorders.
- Alcohol is used to medicate psychological distress or symptoms (self-medication).

Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual

In 2013 a survey of Wolverhampton’s LGBT+ community highlighted significant mental health difficulties and concerns amongst respondents, in excess of what is understood nationally regarding higher levels of suicide, depression and self-harm within this group (LGBT+ Wolverhampton, 2013). The survey highlighted the prevalence of self-harm, suicidal ideation, depression and experience of bullying amongst the LGBT+ community locally and the important role of peer support in terms of improving outcomes and facilitating access to care pathways and services within the City.

Autism and Suicide

A 2016 study in Sweden revealed suicide is a leading cause of premature death in people with autism spectrum disorder, while research from Coventry University in 2014 showed 66% of adults newly diagnosed with Asperger Syndrome reported having contemplated ending their own lives.

It is estimated that 1 to 1.5 percent of the population has an autism spectrum condition. Approximately 50 per cent of people with autism also have a learning disability, and 30 per cent of people with autism experience severe mental health difficulties. National and local data indicate that people aged 55 and over with autism who probably have never received a diagnosis are the least likely of all age groups to access the support they may require. Most people with autism will not require long-term specialist health and social services, but they may need support at certain stages of their life to learn to manage and overcome their social, communication and sensory difficulties. In addition, the lives of people with autism could be significantly enhanced if their needs are known and recognised and those who interact with them have an awareness of the condition. Only 15% of adults diagnosed with autism in the UK are in full-time paid employment. National data show that children and young people with autism are more likely to experience difficulties at school. 27 per cent had been excluded from school and 50 per cent had changed schools other than age related transitions. This affects their lives as adults which this strategy addresses.

The Wolverhampton Joint Autism Strategy 2016 -2021 identified nine key objectives, with associated priorities:

1. Understanding local needs by collecting accurate data about autism
2. Providing access to high quality information, advice and support

3. Developing a clear and consistent diagnostic pathway, including post-diagnostic support
4. Increasing awareness and understanding of autism
5. Supporting children and young people with autism in preparing for adulthood
6. Enabling access to lifelong learning, increasing skills and inclusive employment
7. To help people with autism to keep healthy
8. Living well and increasing independence for people with autism
9. Access to support for families, parents and carers of people with autism

Adult Attention Deficit Hyperactivity Disorder symptoms may include:

- Impulsiveness
- Disorganization and difficulties prioritising tasks
- Poor time management skills
- Difficulties focusing on a task
- Difficulty multitasking
- Excessive activity or restlessness
- Poor planning
- Low frustration tolerance

- Frequent mood swings
- Problems following through and completing tasks
- Hot temper
- Trouble coping with stress

ADHD has been linked to:

- Poor school or work performance
- Unemployment
- Contact with the criminal justice system
- Alcohol or other substance abuse
- Frequent car accidents or other accidents
- Unstable relationships
- Poor physical and mental health
- Poor self-image
- Suicide attempts
- Coexisting conditions

Mood disorders - Many adults with ADHD also have depression, bipolar disorder or another mood disorder. While mood problems aren't necessarily due directly to ADHD, a repeated pattern of failures and frustrations due to ADHD can worsen depression.

Anxiety disorders - Anxiety disorders occur fairly often in adults with ADHD. Anxiety disorders may cause overwhelming worry, nervousness and other symptoms. Anxiety can be made worse by the challenges and setbacks caused by ADHD.

Other psychiatric disorders - Adults with ADHD are at increased risk of other psychiatric disorders, such as personality disorders, intermittent explosive disorder and substance abuse.

Learning disabilities - Adults with ADHD may score lower on academic testing than would be expected for their age, intelligence and education. Learning disabilities can include problems with understanding and communicating.

SF DON'T FORGET REFERENCE

Sexual Abuse

Data highlighted in 'No Health without Mental Health' (2011) identifies that although women are at greater risk of childhood sexual abuse and sexual violence (an estimated 7–30% of girls), 3–13% of boys have also experienced childhood sexual abuse. Whilst we need to understand more about the impact of sexual violence locally, nationally it is understood that 1 in 10 women have experienced some form of sexual victimisation, including rape and some studies have shown that 50% of female patients in psychiatric wards have lifetime experience of sexual abuse 'No Health without Mental Health' (2011).

Personality Disorder

Personality Disorder

The Community Mental Health Profile for Wolverhampton identifies that Wolverhampton is '**significantly worse**' than the England average in the following key factors in terms of deprivation and indicators of mental health prevalence and performance against key outcomes:

- Working age adults who are unemployed
- Percentage of the relevant population living in the 20% most deprived areas in England
- Episodes of violent crime
- Statutory homeless households
- Percentage of 16-18 year olds not in employment, education or training
- Percentage of the population with a limiting long term illness
- Percentage of adults (18+) with learning disabilities
- Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders
- Rate of Hospital Admissions for alcohol attributable conditions
- Percentage of referrals entering treatment from Improving Access to Psychological Therapies
- Numbers of people on a Care Programme Approach, rate per 1,000 population

The Community Mental Health Profile for Wolverhampton identifies that Wolverhampton is '**significantly better**' or '**not significantly different**' than the England average in the following key factors:

- Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population (**significantly better**)
- First time entrants into the youth justice system 10 to 17 year olds
- Percentage of adults (16+) participating in recommended level of physical activity
- Percentage of adults (18+) with dementia
- Ratio of recorded to expected prevalence of dementia
- Percentage of adults (18+) with depression (**significantly better**)
- Directly standardised rate for hospital admissions for mental health (**significantly better**)

- Directly standardised rate for hospital admissions for unipolar depressive disorders
- Directly standardised rate for hospital admissions for Alzheimer's and other related dementia (**significantly better**)
- Allocated average spend for mental health per head
- In-year bed days for mental health, rate per 1,000 population (**significantly lower**)
- Number of contacts with Community Psychiatric Nurse, rate per 1,000 population (**significantly better**)
- Number of total contacts with mental health services, rate per 1,000 population (**significantly higher**)
- People with mental illness and or disability in settled accommodation (**significantly better**)
- Indirectly standardised mortality rate for suicide and undetermined injury
- Improving Access to Psychological Therapies - Recovery Rate
- Excess under 75 mortality rate in adults with serious mental illness (**significantly better**)

The Right Care Data identifies the following key issues / areas for improvement for WOLVERHAMPTON

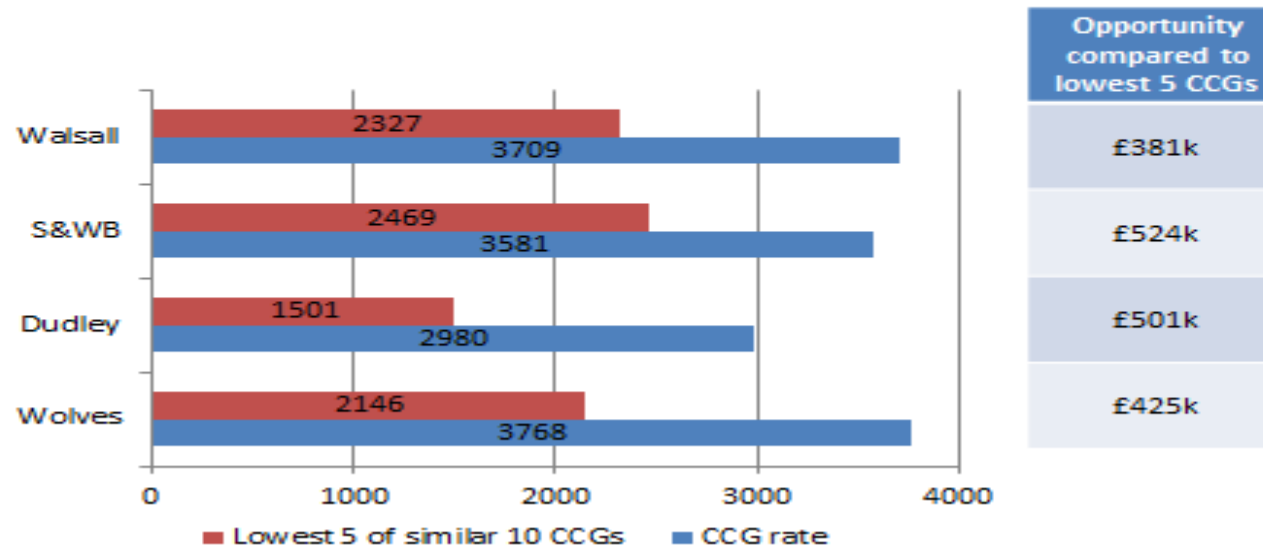
(Dear All please note I have asked NHS E for the refreshed Right Care information as some of this is no longer valid / out of date e.g. EIP)

Severe mental illness pathway

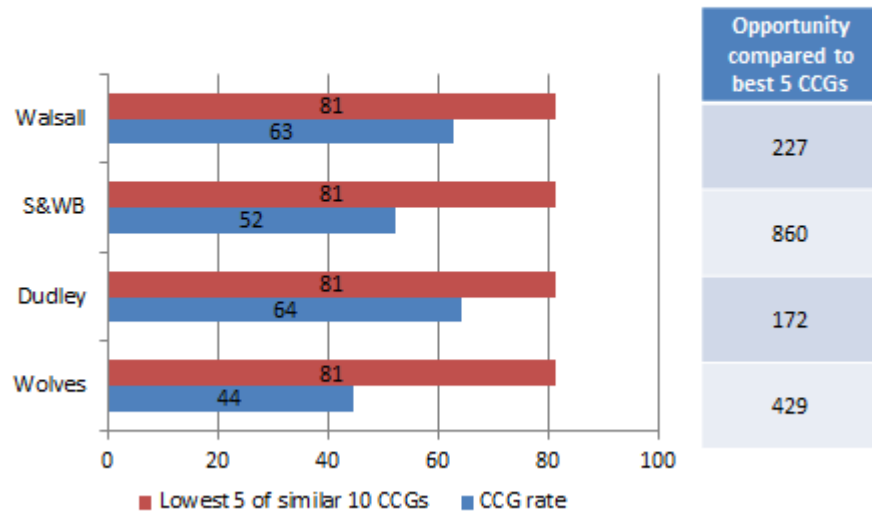


	2015	2012	2015/16	2015/16	2014/15	April 2016- August 2016	April 2016- August 2016	2015/16 Q4 (Year End)	2015/16 Q2	2015/16 Q4	2015/16 Q4	2014/15	2015/16 Q2	2015/16 Q2	2015/16 Q2
	Deprivation	Estimate of people with a psychotic disorder	People with SMI known to GPs: % on register	Primary care prescribing spend	Physical health checks	% of EIP referrals waiting <2 wks to start treatment (Complete)	% of EIP referrals waiting >2 wks to start treatment (Incomplete)	New cases of psychosis served by Early Intervention teams	People treated by Early Intervention Teams	People on Care Programme Approach	% Service users on CPA	Mental health hospital admissions	People subject to mental health act	People on CPA in employment	% adults on CPA in settled accommoda tion
STP opportunity (to Best 5)					840 Pats.	17 Pats.	12 Pats.				1,216 Pats.	807 Adm.	112 Ppl.	102 Ppl.	80 Ppl.
Wolverhampton	▲	△	▲	▲	■	■	▽	▽	▽	▽	▽	■	■	▽	■
Walsall	▲	▽	▽	▲	△	△	△	▽	▽	▽	▲	■	■	▽	■
Dudley	▲	▲	▲	▲	▽	△	▽	△	▲	▽	▲	■	■	■	■
Gandwell and West Birmingham	▲	▲	▲	▲	■	■	△	▽	▲	▽	▽	■	△	▽	△

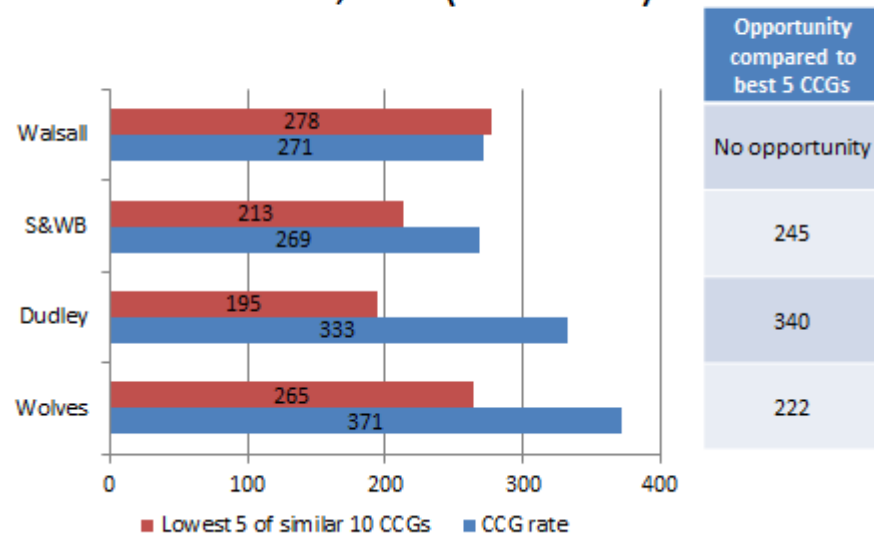
Psychosis primary care prescribing per 1,000 ASTRO-PU population (2015-16)



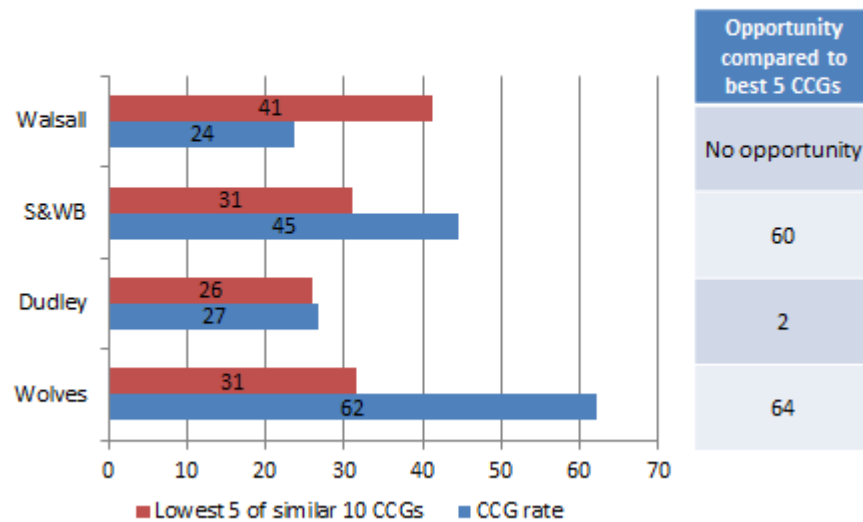
Percentage of people in the psychosis superclass who are on CPA (2014-15)



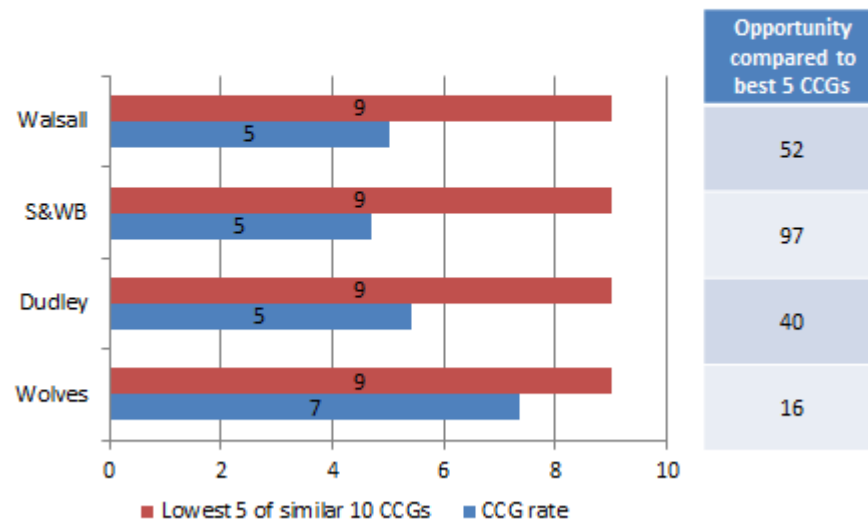
Mental Health hospital admissions per 100,000 (2014-15)



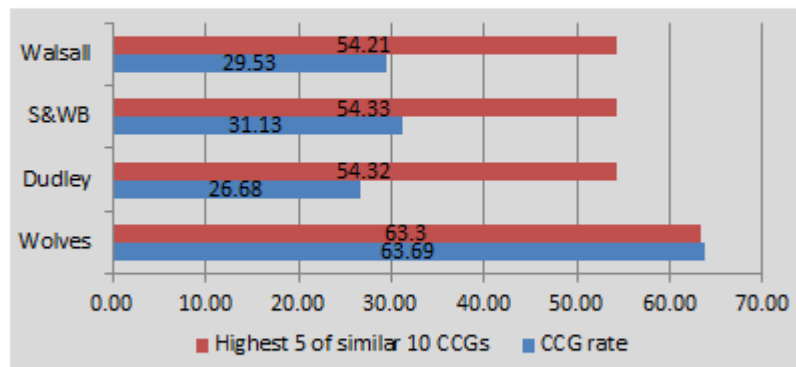
People subject to the Mental Health Act per 100,000 (2014-15)



Percentage of people on CPA in employment (2014-15)

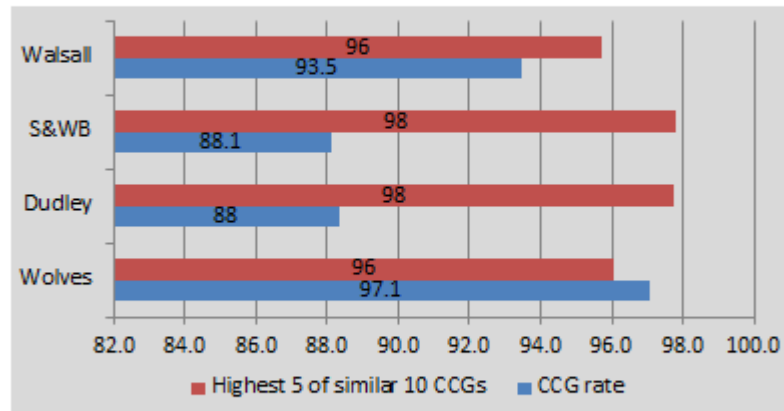


Percentage of people in contact with mental health services with their accommodation status recorded (2015/16 Q2)



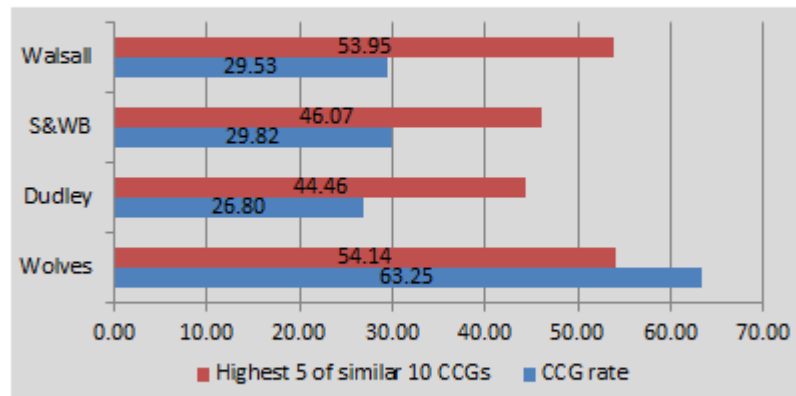
Opportunity – 4824 more people with accommodation status recorded. NB.
Wolverhampton higher than average of highest 5 and therefore not included.

Percentage of cases where the ethnicity of the patient have been recorded (2014/15)



Opportunity – 2705 more cases with ethnicity recorded.

Percentage of people in contact with mental health services with their employment status recorded (2015/16 Q2)



Opportunity – 3608 more people with employment status recorded. NB.
Wolverhampton higher than average of highest 5 and therefore not included.

Further detail regarding Right Care information is provided with the needs assessment information in Appendix 1.

The above information identifies key priorities however which are to:

- Reduce numbers of people accessing hospital based care –increasing community based support – reducing relapse and readmission rates
- Increase numbers of patients receiving CPA based care with crisis care plans and carers care plans

- Reduce numbers of people detained under the Mental Health Act
- Improve primary care based support (high numbers of primary care based prescribing)
- Improve Early Intervention in Psychosis access rates
- Improve SMI Physical Health Checks in Primary Care
- Ensure Care Plans are culturally competent – responding to ethnicity and cultural requirements of the patient and family and address housing and employment needs

Key national prevalence detail from the Five Year Forward View for Mental Health (2016) is outlined below

Young People

‘Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. One in ten children aged 5 – 16 has a diagnosable problem such as conduct disorder (6 per cent), anxiety disorder (3 per cent), attention deficit hyperactivity disorder (ADHD) (2 per cent) or depression (2 per cent). Children from low income families are at highest risk, three times that of those from the highest. Those with conduct disorder - persistent, disobedient, disruptive and aggressive behaviour - are twice as likely to leave school without any qualifications, three times more likely to become a teenage parent, four times more likely to become dependent on drugs and 20 times more likely to end up in prison.’

Mothers

‘One in five mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease. Mental health problems not only affect the health of mothers but can also have longstanding effects on children’s emotional, social and cognitive development.’

Physical Health

‘Physical and mental health are closely linked – people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.’ In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care by an average of 45 per cent. Yet much of the time this goes unaddressed. There is good evidence that dedicated mental health provision as part of an integrated service can substantially reduce these poor outcomes. For example, in the case of Type 2 diabetes, £1.8 billion of additional costs can be attributed to poor mental health. Yet fewer than 15 per cent of people with diabetes have access to psychological support. Pilot schemes show providing such support improves health and cuts costs by 25 per cent.’

Stable employment and housing

‘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. Between 60–70 per cent of people with common mental health problems are in work, yet few employees have access to specialist occupational health services. 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 overrepresented 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. Children living in poor housing have increased chances of experiencing stress, anxiety and depression.’

Veterans

‘Only half of veterans of the armed forces experiencing mental health problems like Post Traumatic Stress Disorder seek help from the NHS and those that do are rarely referred to the right specialist care. ... It is essential that more is done to ensure their needs are identified early and they are supported to access specialist care swiftly.’

Older People

‘One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression. Diagnosing depressive symptoms can be difficult and we know that some clinicians believe treatment for depression is less effective in older people, despite evidence to the contrary.’

The University of Wolverhampton held an international conference on loneliness in February 2018 (more information at: <https://www.wlv.ac.uk/research/institutes-and-centres/centre-for-film-media-discourse-and-culture/loneliness/> Loneliness can occur at any age and not just amongst older people. The City of Wolverhampton Council has commissioned a provider to support our work to address this issue cf. <http://www.thesocialhub.org.uk/wolverhampton.html>.

Marginalised Groups

‘People in marginalised groups are at greater risk, including black, Asian and minority ethnic (BAME) people, lesbian, gay, bisexual and transgender people, disabled people, and people who have had contact with the criminal justice system, among others. BAME households are more likely to live in poorer or over-crowded conditions, increasing the risks of developing mental health problems. People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a learning disability or autism are also at higher risk. As many as nine out of ten people in prison have a mental health, drug or alcohol problem.’

Suicide

‘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. The rise is most marked amongst middle aged men. Suicide is now the leading cause of death for men aged 15–49. Men are three times more likely than women to take their own lives - they accounted for four out of five suicides in 2013. 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.’

The above national prevalence information has also been used to inform our strategic vision and direction of travel.

In line with the Mental Health Five Year Forward View and the WOLVERHAMPTON CRISIS CONCORDAT our implementation plan will include specific actions to substantially reduce Mental Health Act detentions and also include targeted work to reduce the current significant overrepresentation of BAME and any other disadvantaged groups within detention rates.

In addition we will work with BAME communities to develop trust in services and ensure pro-active community support. We will work with the voluntary and community sector that play a critical role in supporting groups that are currently less well served by services such as BAME communities, children and young people, older people, lesbian, gay, bisexual and transgender people, and people with multiple needs. This will include developing peer support which is highly valued, especially by young people and BAME adults, and should be developed as a core part of the multi-disciplinary team. In addition The NHS Workforce Race Equality Standard (WRES) has no equivalent for people accessing services. The Five-year Delivering Race Equality programme concluded in 2010 that there had been no improvement in the experience of people from minority ethnic communities receiving mental health

care (The Five Year Forward View for Mental Health, 2016). We will use our new Strategy and Strategy Implementation Plan for a local re-focus on this priority.

The Five Year Forward View for Mental Health emphasises that 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. Men of African and Caribbean heritage are up to 6.6 times more likely to be admitted as inpatients or detained under the Mental Health Act, indicating a systemic failure to provide effective crisis care for these groups, and that some groups are disproportionately represented in detentions to acute and secure inpatient services, and are affected by long stays. For example, men of African Caribbean ethnic origin are twice as likely to be detained in low secure services than men of white British origin and stay for twice as long in those services on average suggesting a failure to ensure equal access to earlier intervention and crisis care services.

3. VISION AND VALUES

Our vision for mental health services in Wolverhampton is to develop a Mental Health Integrated Care System of health and social care pathways and services that will deliver mental health promotion, early intervention and prevention, assessment and diagnosis and care, treatment and intervention whilst also promoting independence, autonomy, self-efficacy and recovery across the life course.

Our aim is to work with service users and carers and across all partners and stakeholders to prevent people entering statutory services where possible and to provide care pathways into and through services to provide the right care in the right place and at the right time when this is required, including across Universal, Primary, Secondary, Tertiary statutory

and non-statutory services and with a focus upon mental health promotion, self-help, peer support and public mental health as part of our Prevention Concordat Strategy.

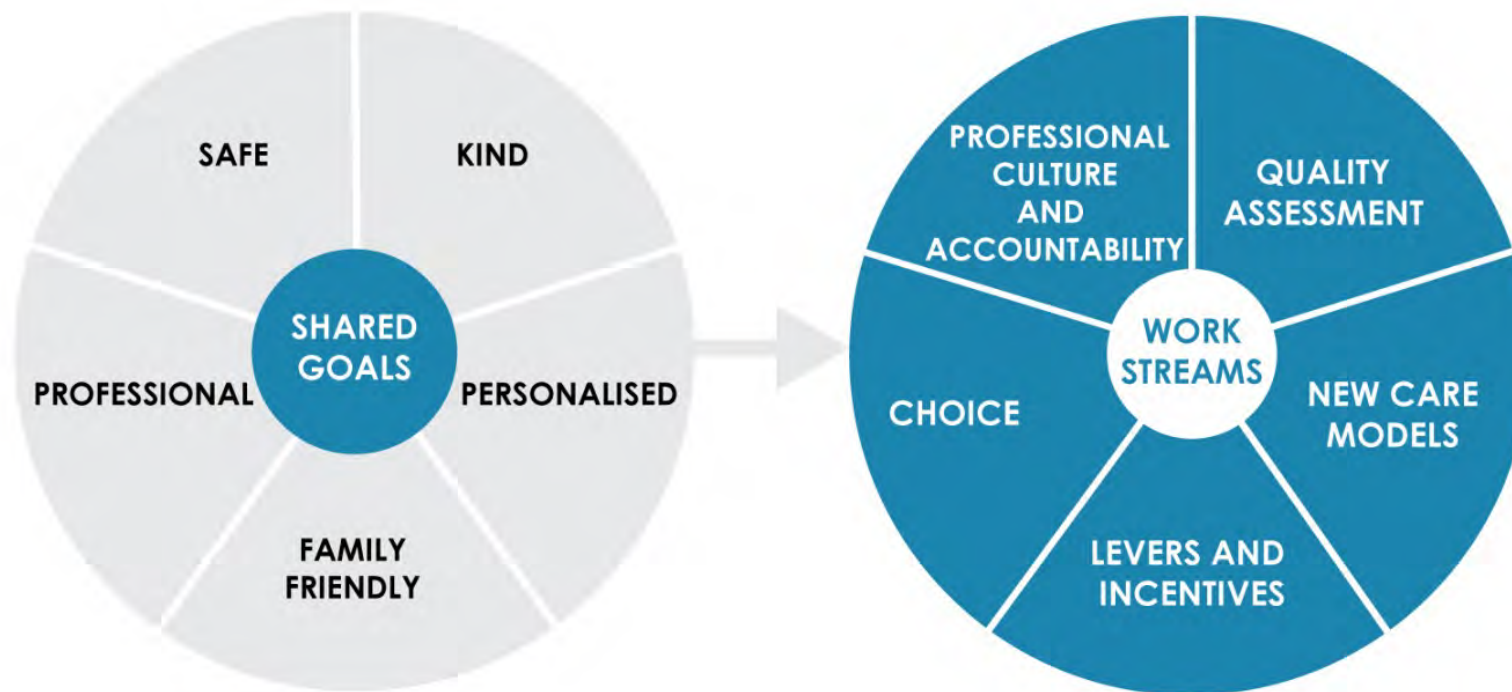
Coproduction with all service users and carers and staff across our Mental Health Integrated Care System is a key and important focus of our vision and values. We will all work together to establish the self-efficacy and recovery of our system, remove the stigma associated with mental health and support each other to thrive and grow.

Our commissioned model will meet the requirements of the Five year Forward View for Mental Health and the GP Five Year Forward View and the LGA 2017 Report “Being mindful of mental health – the role of local government in mental health and being;” and in addition support the delivery of aligned health and social care outcomes in line with the Better Care Fund to promote independence, improve physical health, optimise self-efficacy recovery and increase social inclusion at all stages of the care pathway and across the Mental Health Integrated Care System.

MAKING EVERY CONTACT COUNT we will develop a Mental Health Integrated Care System which provides pro-active care and support from the very first point of contact with the system so that from referral / self-referral service users and carers feel appropriately supported, signposted and directed as they access / egress care pathways with ease. We will develop a Mental Health Integrated Care System which will deliver evidence based, timely and responsive assessment diagnosis intervention treatment care and support with professionalism, accountability, kindness and compassion and providing opportunities for recovery, self-efficacy and growth, supporting people of all ages to achieve personal aspirations, hopes, dreams and goals.

The aspirations of our vision and values and new care model are outlined in the diagram below:

(I HAVE PUT THE FOLLOWING DIAGRAM ABOUT VALUES IN AS AN EXAMPLE THAT I LIKE IT'S FROM BETTER BIRTHS – I'M WORKING ON ONE OF MY OWN)



Our Mental Health Integrated Care System will be a lamp, a lifeboat and a ladder.

(BCPFT are asking patients to do art work for this bit)



Be a lamp, or a
lifeboat, or a ladder.

Rumi

quote fancy

Key aspirations of our vision

Our vision is based on national and local prevalence and risk issues as well as local and national policy and strategic priorities and imperatives have informed our commissioning mental health strategy for Wolverhampton. This includes the mandate to NHS England that sets out the Government's commitment to give mental health parity of esteem with physical health and for us in WOLVERHAMPTON includes a commitment to:

- Removing the stigma attached to mental illness and mental ill health.
- Improving the access, responsiveness quality and of mental health services across the lifespan in line with the Five Year Forward View for Mental Health (removing the quality, treatment and evidence base gap) and ensuring that all patients have access to NICE compliant care
- A Primary Care Mental Health Revolution in line with the Five Year Forward View for Mental Health and the GP Forward View so that mental health services are interoperational with and embedded across primary care allowing access to shared systems such as graph net and doc man to improve the speed and accessibility of information sharing and to deliver e referrals and e discharge and advice and guidance across primary and secondary care and with primary care mental health therapists working across primary and secondary care
- A focus upon better integration of mental and physical health services across Primary Care Mental Health services and Acute and Community Services with a specific focus upon developing Mental Health Liaison CORE 24, improving the life expectancy of people with Severe Mental Illness (SMI) and also all people with mental health difficulties and delivering the IAPT programme for people with Long Term Conditions
- A Perinatal Mental Health programme delivered with Black Country and West Birmingham STP colleagues and the University of Wolverhampton that focuses upon integrated care across Maternity Womens and Childrens Services to improve the health of the mother, child, siblings, father and wider family in line with the BC&WB LMS

- A specific focus on mental health and wellbeing and mental health promotion across the lifespan and across universal primary secondary and tertiary services so that people are better able to access advice and guidance peer support self-help and self-management at every stage of the care pathway
- Improved data collation in line with the Five Year Forward View for Mental Health and the revised Mental Health Standard Data Set to ensure reporting and exponential improvements across new waiting times and access services and compliance with the Mental Health Five Year Forward View
- An information revolution so that people of all ages have better access to advice and information of all types so that people are better able to access advice and guidance peer support self-help and self-management at every stage of the care pathway. **This includes a specific focus on alcohol and substance misuse and the mental health related risks associated with both alcohol and substance misuse but also targeted interventions for individuals / communities with specific risks such as physical ill health and disability and / or neurological conditions, people from lesbian, gay, bisexual or transgender intersex or asexual groups, people experiencing poverty deprivation unemployed or who are economically inactive, people who are lonely and isolated, people who are homeless or in unsuitable accommodation, new arrivals into our City, veterans people who are homeless and people who are victims of bullying harassment and / or physical and / or sexual abuse and/ or trauma and people at risk of exploitation of any form.**
- Alignment with our dedicated transformation programme for children and young people's services to enhance access to evidence-based therapies (the Wolverhampton Local CAMHS Plan).
- Providing settled accommodation for people with mental illness to support their recovery and a pathway across, hospital based care, residential and nursing care, supported accommodation, domiciliary care and general needs housing.
- Improved access to joined-up and integrated health and social care as part of Section 117 MHA 1983 arrangements.

- Improving access to both Primary and Secondary IPS for people with mental health and / or physical health difficulties in line with our WMCA hosted RCT and our STP Secondary IPS model
- Support for CCG's commissioning Mental Health services from NHS England to commission evidence based services locally that are compliant with NICE Guidance and Quality Standards.
- Improved offender mental health – improve connectivity across our mental health and criminal justice services and NHS England commissioned Secure Care, Prison In-reach and the Reach Out Programme.
- Using the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children's mental health services
- Developing use of PROMS CROMS PREMS and QALYS
- Delivery of our Better Care Fund Mental Health Urgent and Planned Care Pathways
- Delivery of our Better Care Fund Dementia Care Pathway – in line with our refreshed Dementia Strategy
- Delivery of our Autism Strategy with a focus upon staff training and support and alignment with access to employment and suicide prevention initiatives specifically to address high prevalence for people with autism in suicide and unemployment statistics
- Improved access to diagnosis care and support for people with ADHD – with focus on criminal justice support for people who have offended and focus on people at risk of offending and focus on people who misuse alcohol and or other substances to manage ADHD symptoms.
- Improved access to diagnosis care and support for people with Personality Disorder
- A refresh of our City's CPA Policy to ensure compliance with national guidance and deliver robust care plans and crisis plans for patients and carers across primary secondary and tertiary care
- Reducing Out of Area Treatments to zero by 2020/21 in line with the Five Year Forward View for Mental Health Mental Health

- A focus upon improve care pathways for high volume services uses building on the national CQUIN from 2017/18 and across 2018/19 to ensure pro-active support and intervention to reduce hospital and A&E attendances and admissions to RWT.
- A better and more comprehensive care pathway for people who have dual diagnosis i.e. mental health and alcohol and / or substance misuse that includes a specific function for specialist support and also three levels of staff training to ensure patients receive the right care in the right place and at the right time that is compassionate and NICE compliant and that patients do not fall through gaps
- WORKFORCE – support the development of the next generation of practitioners and leaders through continued participation in the Think Ahead programme for Social Workers working in Mental Health and other areas across the NHS.
- Deployment of a city-wide mental health social work team to help people with access to the provisions of the Care Act 2014, working with communities to provide or arrange support that help keep people with mental health needs well and independent.

The vision outlined above includes all elements of commissioned service delivery, including Health, Social Care, Education, Voluntary and Community and Third Sector and Independent Sector Services, Out of Area Treatments (OATs), mental health services commissioned by NHS England such as Secure Services and other specialised mental health services including CAMHS TIER 4 and In-patient Eating Disorder Services and In-patient Perinatal Mental Health Services and services to support veteran and serving members of the Armed Forces mental health and Prison In-reach Mental Health Services . The service development changes outlined in our priorities and implementation plan will increase capacity and capability within services locally to improve individual, familial and community resilience by increasing protective factors and promoting independence, increasing self-efficacy, reducing risk and enabling recovery.

For our local Wolverhampton **Mental Health Integrated Care System** to work effectively services will have a clear role, work to a defined set of clear system wide values and understand how the workings of each component part are connected to the delivery and ambitions and aspirations of the whole system, to deliver a set of clear care pathways and specified outcomes to meet the needs of our population. This will involve commissioning to increase the effectiveness and efficiency of services, improve care pathways and communication across the whole system and reduce duplication across service providers. This will include increasing capacity and capability locally to support people with severe and enduring and / or complex mental health needs and ensure effective and robust care coordination using the Care Programme Approach guidance 'Refocusing the Care Programme Approach Policy and Positive Practice Guidance' (HM Government 2008) and in addition respond to the independent review on the use of the Mental Health Act (cf. <https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act>).

It will also include interventions and actions that support the needs and requirements of people in Wolverhampton that have particular vulnerabilities including:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism

- Lesbian, gay, bisexual and transgender people (LGBT+) and / or children and young people who are questioning their sexual orientation and / or gender (LGBT+)
- Substance misuse
- Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying

The key building blocks of our refreshed and broader approach will include:

- **More appropriate and responsive services** – achieved by improving services and up skilling the workforce across the stepped care model to better respond to the needs of key groups to enable all members of the population to access all of our services equally and by working with all key stakeholders to that ensure that together we have a joined up approach to challenging and addressing the broader determinants of mental ill-health and stigma and discrimination and promote parity of esteem, compassion, equality and respect diversity and human rights. .
- **Wider community engagement** – achieved by extending stakeholder engagement to capture agencies, voluntary groups and organisations that can have a strategic and day to day influence on the wider determinants of mental health and embedding agreed key deliverables into the Resilience Plan and Implementation Plan. Supported by our Community Development Workers. In the Local Authority, an Equality Analysis is required for every policy and strategy and one has been undertaken in respect of this Strategy to support CCG and Council partnership. More information at <http://www.wolverhampton.gov.uk/corporate/equalities-and-diversity>
- **Better information, communication and marketing** - achieved by improved data collation, capture and analysis of the City's vulnerable groups, mapping their needs and requirements and monitoring agreed actions via the implementation plan.

This will include a regular census of mental health patients and public mental health needs across the City and delivery of a pro-active marketing campaign aligned to parity of esteem and national campaigns such as Beat Bullying, Time to Change, Health Poverty Action, and Child Sexual Exploitation of the NSPCC.

4. OUR MODEL OF CARE

Our **Mental Health Integrated Care System** will allow service users to transition through and into and out of secondary mental health services and into primary care, and re-enter components of the system if / as required. Fundamental principles underlining this approach will include:

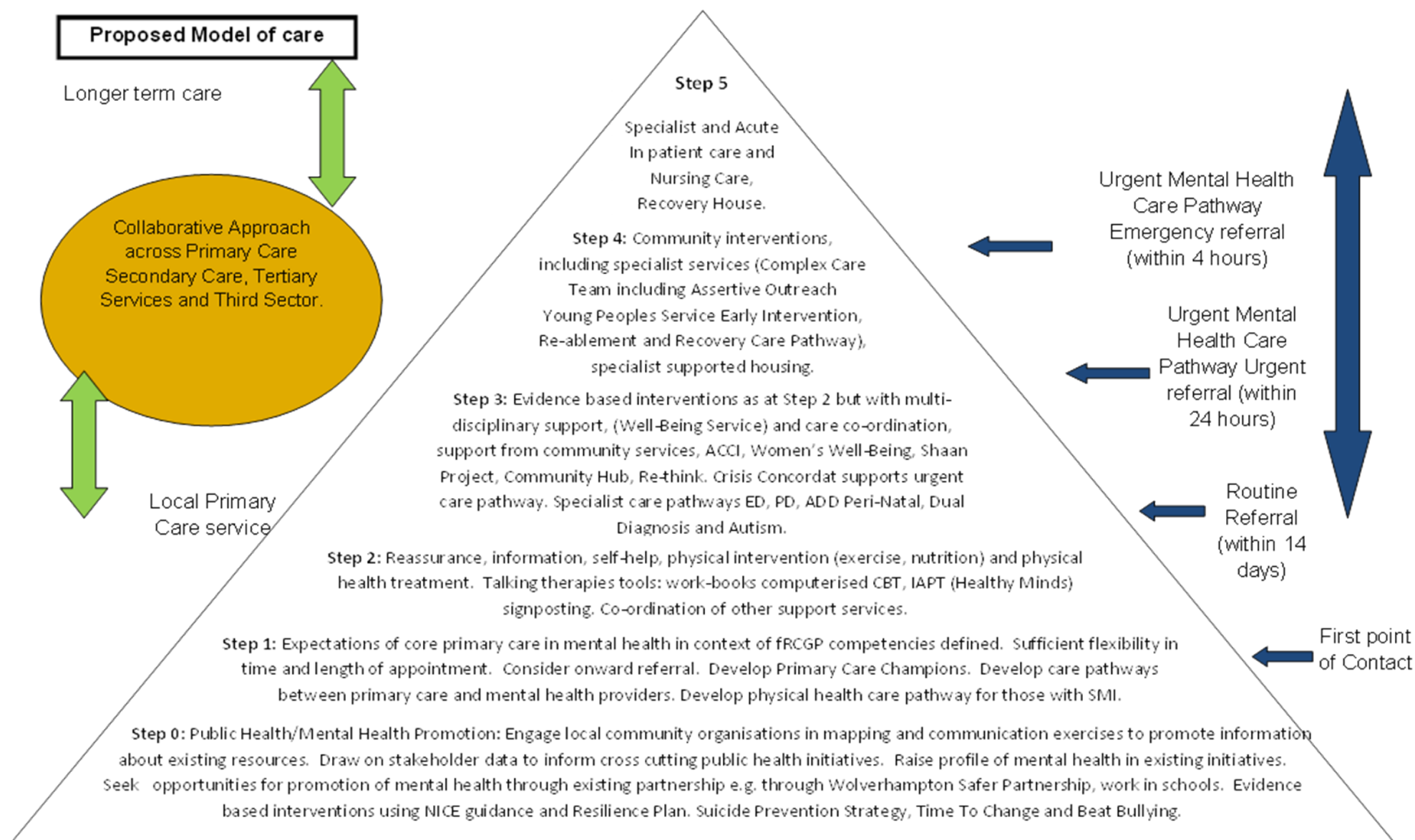
- A mental health 'whole system' of care pathways and services delivering recovery orientated interventions and support.
- The Mental Health Better Care Fund Urgent and Planned Mental Health and Dementia Care Pathways delivering integrated health and social care
- Improved connectivity and joined up ness across and communication with universal, primary care, secondary and tertiary mental health services.
- A set of services and care pathways collaboratively commissioned across our Black Country and West Birmingham STP
- Clear access and / or referral criteria at every stage of the patient journey
- Transition into and out of services as appropriate and in keeping with the Care Programme Approach.
- Access to services 24/7 365.
- Greatest level of service provision for those with the highest levels of need.
- Promoting independence autonomy self-efficacy and improving recovery rates across the whole service model.

- Increased flexibility regarding the application of the care cluster model in terms of access to and treatment with health services.
- Age appropriate services with transition protocols from Children and Young Peoples Services to Adult Services and from Adult to Older Adult Services as appropriate / required

Our refreshed model is described across TIERS 1-5 in the diagram below

The TIERS of our MENTAL HEALTH INTEGRATED CARE SYSTEM are described as follows in the diagram below:

- **Tier 1 Universal Services**
- **Tier 2 Primary Care / Primary Care facing Services**
- **Tier 3 Secondary Community Mental Health Services including some specialist Community Mental Health Services provided on a wider i.e. STP footprint**
- **Tier 4 Tertiary Mental Health Services including Nursing and Residential and In-patient Services**
- **Tier 5 and above NHS England commissioned services such as Highly Specialist In-patient Services such as and including Secure Care, Perinatal Mental Health and Eating Disorder In-patient Services**



Universal Services

The prevention concordat aims to 'deliver a tangible increase in the adoption of public mental health approaches' across local authorities, the NHS, employers and other public, private and voluntary sector organisations. Our Wolverhampton Prevention Concordat will aim to ensure that we improve mental health across the wider determinants of mental health, such as housing, education, employment alcohol and substance misuse, physical ill health and / or disability and poverty and deprivation.

The Prevention Concordat for Better Mental Health Programme aims to facilitate local and national action around preventing mental health problems and promoting good mental health. (The Prevention Concordat for Better Mental Health programme of work is one of the recommendations in the 'Five Year Forward View for Mental Health', 2016).

We will utilise the resource planning guide to put in place effective prevention planning arrangements working with our partners and stakeholders across our Mental Health Integrated Care System to improve mental health and wellbeing and prevent mental health difficulties and reduce and eliminate the stigma attached to mental ill health. We will align this with our public health interventions regarding obesity, smoking, and alcohol and substance misuse are all strongly associated with poor mental health (Kings Fund, Getting Serious about Public Mental Health, 2017).

Primary Care Mental Health and Primary Care facing Mental Health Services and Developments and including Alignment with the General Practice Forward View

The **GENERAL PRACTICE FORWARD VIEW** (2016) describes the need to increase mental health therapists embedded in Primary Care and to develop co-located multidisciplinary teams, working across several practices, providing an enhanced level of

care to patients with complex needs including older and frailer people and people with multiple co-morbidities both at home and in supported housing, including care homes, identified via a risk stratification approach, including people with mental health difficulties.

The NHS WOLVERHAMPTON CLINICAL COMMISSIONING GROUP PRIMARY CARE MODEL is outlined in the diagram below:

V12 November 2017

New Models of Care (Wolverhampton)

NHS
Wolverhampton
Clinical Commissioning Group

Multi-speciality Care Provider is a new deal for GP's as part of the 5 Year Forward View. This would take the shape of being a collaboration of a group practices i.e. federations, networks or single organisation(s). This is not only an opportunity to standardise back office functions and avoid replication but also a way of expanding leadership to include many healthcare professionals. Across the grouping there will be a collaborative approach to service provision whilst there will be a greater convenience for patients shifting the majority of outpatient consultations & ambulatory care out of hospital settings.

Primary & Acute Care Systems (PACs/VI)

This model is based on:-

- Collaboration between NHS Trusts and GP Practices
- Practices have entered into a sub-contract agreement with the trust (GMS/PMS)
- Meet the needs of registered list(s) of patients
- Opportunity for trust's to kick-start primary care expansion but reinforce out of hospital care
- Potential to take accountability for all health needs of a registered list of patients.
- Greater level of back office support which is intended to improve the business element of General Practice.

Primary Care Home is a joint NAPC and NHS confederation programme.

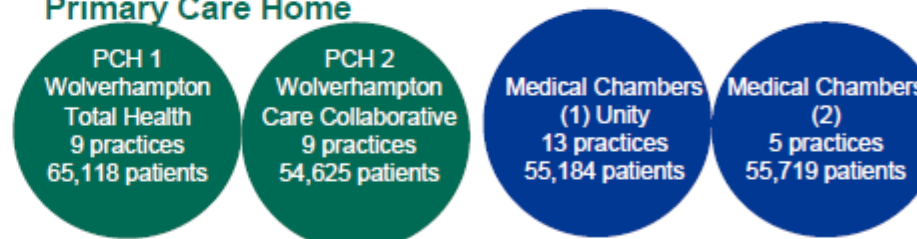
The model is based on:-

- Care hubs/neighbourhood approach
- Practices working together at scale to provide care closer to home
- Supported by the new models programme featuring provision of care to a defined, registered population between 30-50,000 people
- Function with an integrated workforce with a strong focus on partnerships spanning primary/secondary/social care
- Combined focus on the personalisation of care with improvements in population health outcomes, alignment of clinical & financial drivers with appropriate shared risks and rewards.

Vertical Integration (VI)



Primary Care Home



Data based on Practice Actual List Size(s) July 2017

In WOLVERHAMPTON we will deliver a set of interoperational process systems care pathways and services across primary secondary and tertiary care to ensure more pro-active and responsive approaches within primary care for people with mental health difficulties – delivered by staff and NICE compliant services with mental health expertise in line with the General Practice Forward View. We aim to – blur some boundaries across primary and secondary care for people with mental health difficulties and improving systems and processes for better shared care including access to prescriptions across primary and secondary care with consideration given to Nurse Prescribers in Primary Care. Our aim is to create ‘fuzziness’ and flexibility to deliver a more responsive system that can respond pro-actively to make ‘every contact count’.

This will involve inclusion of mental health staff working in and embedded in primary care services and primary care and mental health multi-disciplinary team meetings in each GP practice and in every Primary Care Group including the Vertical Integration with the Royal Wolverhampton NHS Trust. There will be a particular focus upon improving access and responsiveness to evidence based care including physical health checks for people with SMI (Severe Mental Illness), improved care pathways for people with co-occurring mental health problems and physical ill health including Long Term Conditions (LTCs), shared care and improved information sharing, improved referral processes for mental health secondary care generally but including a focus on improved referral processes for primary care and social care staff and staff working in statutory and non-statutory services and looking at ways to support and improve self-referral and access support and advice for carers.

This is to ensure that GPs will have greater access to mental health treatment pathways, and greater support embedded in primary care and improved and more rapid processes including e-referral and e-discharge and advice and guidance. .

Key services include:

- Primary Care Counselling Service (Relate and partners)

- IAPT, PERINATAL IAPT and IAPT LTC Wolverhampton Healthy Minds (BCPFT) IAPT for BAME Groups Older People and Carers
- Base 25 Counselling and Drop In Services
- Secondary IPS (DWMHPT)
- Primary IPS RCT (with WMCA) (Remploy)
- Social Prescribing Pilot (WOLVERHAMPTON VSC)
- Depression Care Pathway (BCPFT)
- Physical Health Checks and Care Pathway in keeping with the Lester Guidance for example and NICE Clinical Guidance and Quality Standards (Shared Care BCPFT and Primary Care)

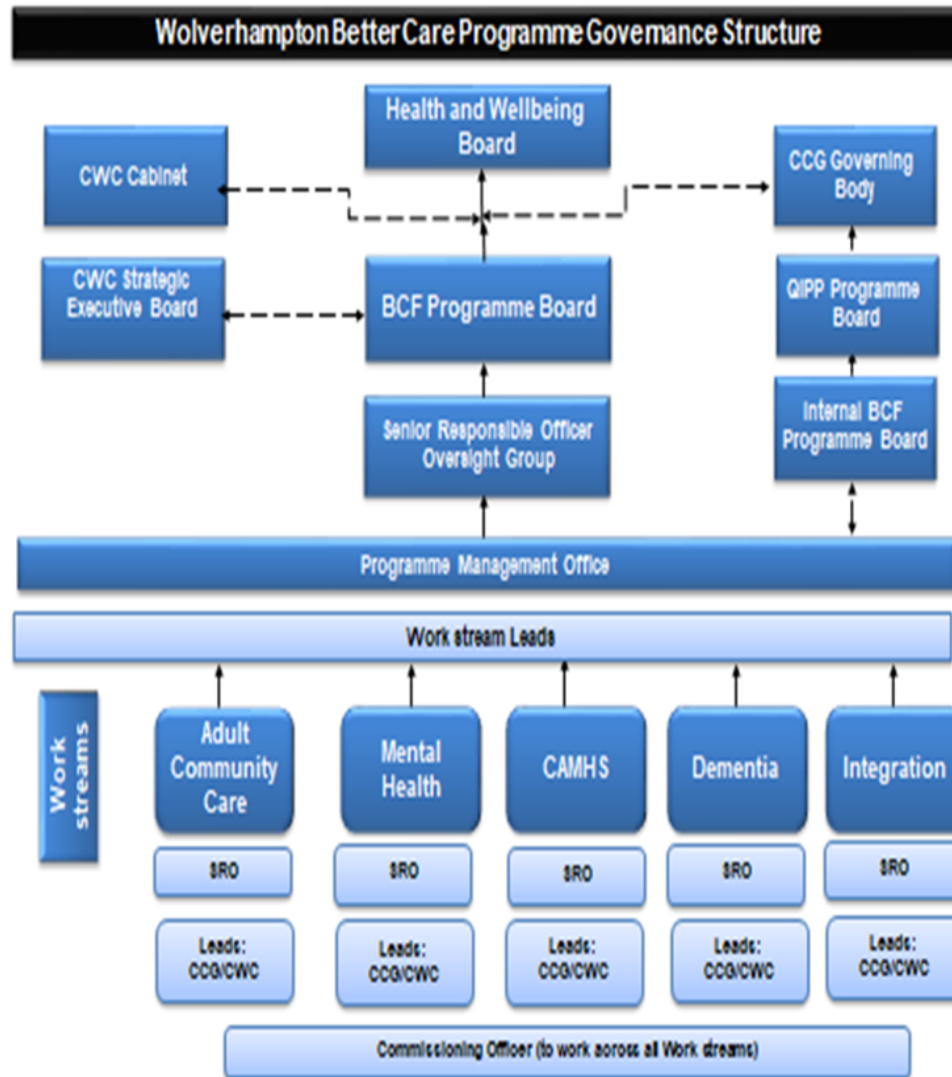
The Better Care Fund

The Mental Health Better Care Fund work stream focuses on developing responsive and effective integrated care pathways to ensure that people have access to early intervention and prevention, treatment, care and support – ensuring robust and evidenced based out of hospital and hospital based care.

There is connectivity across primary care, mental health and physical health care ‘joining up’ with initiatives that are and / or will be commissioned on a BC&WB STP footprint.

There must be a strong consideration / focus on self-efficacy personalised care access to evidence based care and accommodation and employment focussed support and also pro-actively supporting carers .

The WOLVERHAMPTON BETTER CARE FUND GOVERNANCE STRUCTURE is outlined in the table below:



The Better Care Fund provides an opportunity to develop a single pooled budget to allow health and social care services to work together more closely. Wolverhampton's Better Care Plans are an integral and important component of our vision for mental health services in Wolverhampton. Wolverhampton's Better Care Plans include three integrated care pathways in mental health services, the **Mental Health Urgent Care Pathway, Mental Health Planned Care Pathway and the Dementia Care Pathway**. (Please note that the Better Care Fund Dementia Care Pathway is addressed in detail in our Dementia Strategy)

The **Mental Health Urgent Care Pathway** provides emergency and urgent assessment, treatment, intervention and care and support within an integrated health and social care model for people who are 16 plus with acute and severe mental health difficulties who require high levels of care and support in urgent and / or emergency situations. This will be aligned with our Crisis Concordat Action Plan and Declaration (adolescents who are 16 and 17 but remain school / full time education will receive urgent care support from CAMHS) with a transition plan to adult services. There is a focus upon a pathway of services that holds people in crisis in supportive services whilst pro-actively delivering interventions to swiftly increase recovery promote independence, self-efficacy and self-management whilst delivering personalised and evidenced based care.

Key services include:

- SINGLE POINT OF ACCESS (SPA)
- STREET TRIAGE (commissioned on STP footprint across BC&WB)
- MENTAL HEALTH LIAISON SERVICE (MHLS) ENHANCED / CORE 24 (24/7 365) (including Older Adult MHLS)
- SECTION 136 MHA SUITE
- CRISIS RESOLUTION HOME TREATMENT (CRHT) CORE (24/7 365) (including Older Adult CRHT which also forms part of the Better Care Fund Dementia Care Pathway)

- MENTAL HEALTH IN-PATIENT CARE (including Penn In-patient Wards including Older Adult Services, Acute Overspill Out of Area Treatments – OATs)
- PSYCHIATRIC INTENSIVE CARE (PIC)
- DUAL DIAGNOSIS CARE PATHWAY (Mental Health and Alcohol and Substance Misuse)

The Mental Health Planned Care Pathway provides assessment, treatment, intervention and care and support within an integrated health and social care model for people who are 16 plus with continuing and enduring mental health difficulties who require high levels of care and support as the journey to full and / or optimum recovery continues . This will be aligned with our Crisis Concordat Action Plan and Declaration (adolescents who are 16 and 17 but remain school / full time education will receive planned mental health care support from CAMHS) with a transition plan to adult services. There is a focus upon the development of robust multi-agency discharge planning and packages of care delivered via the Care Programme Approach and in partnership with Primary Care and non-statutory and Voluntary and Community Sector Services to allow people to receive support across a pathway of services including accommodation based support that promotes independence, self-efficacy and self-management whilst delivering personalised and evidenced based care.

Key services include:

- COMMUNITY RECOVERY SERVICE and PERSONALITY DISORDER HUB (including ASSERTIVE OUTREACH TEAM, encompassing services currently known as the WELL-BEING SERVICE and COMPLEX CARE)
- SECTION 117 MENTAL HEALTH ACT 1983 COMMUNITY CARE PACKAGES
- SPECIALIST MENTAL HEALTH SUPPORTED ACCOMMODATION and STEP DOWN
- SPECIALIST NURSING and RESIDENTIAL and DOMICILIARY CARE

- MENTAL HEALTH IN-PATIENT CARE (including more specialist hospital placements for people stepping down from NHS England funded Secure Care and / or people requiring specialist In-patient support and treatment including Rehabilitation and / or Personality Disorder In-patient Care)
- DUAL DIAGNOSIS CARE PATHWAY (Mental Health and Alcohol and Substance Misuse)






Better Care Fund Key Activity for 2018 -2019 and beyond Urgent and Planned Mental Health

Completed 2017/18 programme	Community Prevention Support	Integrated Discharge Planning
<p>Activity:</p> <ul style="list-style-type: none"> On-going implementation of Mental Health Liaison & Crisis Resolution Home Treatment moving toward fidelity with CORE Model/s (as per FVYRFWMH) with focus on high volume service users as per national CQUIN. Designated SW role in Mental Health Urgent Care Pathway (A&E Delivery Board funded) focusing on improved patient flow. Service mapping and gap analysis –focus on prevention of crisis. 	<p>Activity:</p> <ul style="list-style-type: none"> Using mapping and scoping to improve information and guidance and pathway support for people with mental health difficulties to better prevent crisis and relapse and optimise early intervention support Develop a shared vision for urgent and planned mental health which can be really joined up with primary care voluntary and community sector and tertiary care Ensure a focus upon dual diagnosis care urgent and planned care which ensures that people do not ‘fall through gaps’ 	<p>Activity:</p> <ul style="list-style-type: none"> Develop shared vision regarding multi- agency discharge and care planning that is compliant with the Care Programme Approach (CPA) Agree Section 117 Protocols and Processes as enablers to delivering improved patient flow and recovery focussed services Consider dedicated resource to aid patient flow in the planned care process (replicating urgent care dedicated resource and further embedding joint / integrated practice)

The Dementia Care Pathway

The work stream focuses on developing a responsive and effective integrated care pathway that makes sure people have access to early intervention and prevention, treatment, care and support. Care pathway design, implementation and delivery will form the basis of the City's refreshed Dementia Strategy. There will be connectivity across primary care, mental health and physical health care 'joining up' initiatives for frailty, LTCs and Dementia preventing hospitalisation. There must be a strong consideration / focus on personalised care and living well and supporting carers.

The NHS England Well Pathway for Dementia is described in the diagram below.

NHS ENGLAND TRANSFORMATION FRAMEWORK – THE WELL PATHWAY FOR DEMENTIA				
PREVENTING WELL	DIAGNOSING WELL	SUPPORTING WELL	LIVING WELL	DYING WELL
 <p>Risk of people developing dementia is minimised</p>	 <p>Timely accurate diagnosis, care plan, and review within first year</p>	 <p>Access to safe high quality health & social care for people with dementia and carers</p>	 <p>People with dementia can live normally in safe and accepting communities</p>	 <p>People living with dementia die with dignity in the place of their choosing</p>
"I was given information about reducing my personal risk of getting dementia"	<p>"I was diagnosed in a timely way"</p> <p>"I am able to make decisions and know what to do to help myself and who else can help"</p>	<p>"I am treated with dignity & respect"</p> <p>"I get treatment and support, which are best for my dementia and my life"</p>	<p>"I know that those around me and looking after me are supported"</p> <p>"I feel included as part of society"</p>	<p>"I am confident my end of life wishes will be respected"</p> <p>"I can expect a good death"</p>
STANDARDS:	STANDARDS:	STANDARDS:	STANDARDS:	STANDARDS:
<p>Prevention⁽¹⁾</p> <p>Risk Reduction⁽⁵⁾</p> <p>Health Information⁽⁴⁾</p> <p>Supporting research⁽⁵⁾</p>	<p>Diagnosis⁽¹⁾⁽⁵⁾</p> <p>Memory Assessment⁽¹⁾⁽²⁾</p> <p>Concerns Discussed⁽³⁾</p> <p>Investigation⁽⁴⁾</p> <p>Provide Information⁽⁴⁾</p> <p>Integrated & Advanced Care Planning⁽¹⁾⁽²⁾⁽³⁾⁽⁵⁾</p>	<p>Choice⁽²⁾⁽³⁾⁽⁴⁾, BPSD⁽⁶⁾⁽²⁾</p> <p>Liaison⁽²⁾, Advocates⁽³⁾</p> <p>Housing⁽³⁾</p> <p>Hospital Treatments⁽⁴⁾</p> <p>Technology⁽⁵⁾</p> <p>Health & Social Services⁽⁵⁾</p> <p>Hard to Reach Groups⁽³⁾⁽⁵⁾</p>	<p>Integrated Services⁽¹⁾⁽³⁾⁽⁵⁾</p> <p>Supporting Carers⁽²⁾⁽⁴⁾⁽⁵⁾</p> <p>Carers Respite⁽²⁾</p> <p>Co-ordinated Care⁽¹⁾⁽⁵⁾</p> <p>Promote independence⁽¹⁾⁽⁴⁾</p> <p>Relationships⁽³⁾, Leisure⁽³⁾</p> <p>Safe Communities⁽³⁾⁽⁵⁾</p>	<p>Palliative care and pain⁽¹⁾⁽²⁾</p> <p>End of Life⁽⁴⁾</p> <p>Preferred Place of Death⁽⁵⁾</p>
<p>References: (1) NICE Guideline. (2) NICE Quality Standard 2010. (3) NICE Quality Standard 2013. (4) NICE Pathway. (5) Organisation for Economic Co-operation and Development (OECD) Dementia Pathway. (6) BPSD – Behavioural and Psychological Symptoms of dementia.</p>				
RESEARCHING WELL				
<ul style="list-style-type: none"> Research and innovation through patient and carer involvement, monitoring best-practice and using new technologies to influence change. Building a co-ordinated research strategy, utilising Academic & Health Science Networks, the research and pharmaceutical industries. 				
INTEGRATING WELL				
<ul style="list-style-type: none"> Work with Association of Directors of Adult Social Services, Local Government Association, Alzheimer's Society, Department of Health and Public Health England on co-commissioning strategies to provide an integrated service ensuring a seamless and integrated approach to the provision of care. 				
COMMISSIONING WELL				
<ul style="list-style-type: none"> Develop person-centred commissioning guidance based on NICE guidelines, standards, and outcomes based evidence and best-practice. Agree minimum standard service specifications for agreed interventions, set business plans, mandate and map and allocate resources. 				
TRAINING WELL				
<ul style="list-style-type: none"> Develop a training programme for all staff that work with people with dementia, whether in hospital, General Practice, care home or in the community. Develop training and awareness across communities and the wider public using Dementia Friends, Dementia Friendly Hospitals/Communities/Homes. 				
MONITORING WELL				
<ul style="list-style-type: none"> Develop metrics to set & achieve a national standard for Dementia services, identifying data sources and set 'profiled' ambitions for each. Use the Intensive Support Team to provide 'deep-dive' support and assistance for Commissioners to reduce variance and improve transformation. 				

Key aspirations / goals are as follows:

Implementing NHS E access and waiting time/s for dementia so people with dementia have equal access to diagnosis as for other conditions (setting the national average for an initial assessment at six weeks)

Achieving and maintaining the dementia diagnosis rate. NHS England agreed a national ambition for diagnosis rates that two thirds of the estimated number of people with dementia in England should have a diagnosis with appropriate post-diagnostic support. (dementia diagnosis rate is included in the CCG Assessment Framework).

Post diagnostic care and support. This includes:

- **Propose / implement measure/s of effectiveness of post-diagnostic care** in sustaining independence and improving quality of life.
- **Deliver improvements in post-diagnostic support**, for example **ensuring that people with dementia have a care plan** on discharge from secondary care services; and **increasing the health and wellbeing support offered to carers of patients** diagnosed with dementia
- **Local care pathway re-design in line with the NHS E `Well Pathway for Dementia`** which covers preventing well, living well, supporting well and dying well.

Compliance across services with the NHS I Dementia assessment and improvement framework - October 2017 – 8 STANDARDS which are as follows:

- diagnosis
- person-centred care
- patient and carer information and support
- involvement and co-design
- workforce education and training
- leadership
- environment
- nutrition and hydration.

Key Deliverables are as follows:

- Delivering Early Intervention and Prevention
- Delivering living well (life to years)
- Supporting people with highest level of need across primary mental health and physical health is our key challenge (including end of life)
- Joining things up across mental health physical health and primary care
- Reducing delayed discharges / unplanned admissions
- Ensuring connectivity with community and hospital based admission avoidance and frailty care pathways
- Delivering Personalisation (need a focus on both Personal Budgets and Personal Health Budgets)
- Implementing Mental Health Liaison CORE 24 is key challenge /opportunity (in line with FYRFVMH)

- Supporting nursing and residential care – home in-reach service
- Delivering annual care plan reviews in primary care (ensuring full alignment with new CPA Policy implementation across BCPFT)

Key services include:

- OLDER ADULTS COMMUNITY MENTAL HEALTH TEAM
- DAY SERVICES – BLAKENHALL DAY SERVICES and THE GROVES DAY HOSPITAL
- The MEMORY CLINIC
- EARLY ONSET DEMENTIA SERVICES
- MENTAL HEALTH LIAISON SERVICE (MHLS) ENHANCED / CORE 24 (24/7 365) (including Older Adult MHLS)
- The DEMENTIA OUTREACH TEAM
- CRISIS RESOLUTION HOME TREATMENT (CRHT) CORE (24/7 365) (including Older Adult CRHT which also forms part of the Better Care Fund URGENT MENTAL HEALTH Care Pathway)
- OLDER ADULT MENTAL HEALTH IN-PATIENT CARE (including Penn In-patient Wards including Older Adult Services, WARD C22 at RWT and Acute Overspill Out of Area Treatments – OATs)
- COMMUNITY CARE PACKAGES INCLUDING NURSING RESIDENTIAL AND DOMICILIARY CARE INCLUDING CONTINUING HEALTHCARE (CHC)

Better Care Fund Key Activity for 2018 -2019 and beyond Urgent and Planned Mental Health

Completed 2017/18 programme	Community Prevention Support	Integrated Discharge Planning
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<p>Activity:</p> <ul style="list-style-type: none"> • On-going implementation of Mental Health Liaison & Crisis Resolution Home Treatment moving toward fidelity with CORE Model/s (as per FVYRFWMH) with focus on high volume service users as per national CQUIN. • Designated SW role in Mental Health Urgent Care Pathway (A&E Delivery Board funded) focusing on improved patient flow. • Service mapping and gap analysis –focus on prevention of crisis. 	<p>Activity:</p> <ul style="list-style-type: none"> • Using mapping and scoping to improve information and guidance and pathway support for people with mental health difficulties to better prevent crisis and relapse and optimise early intervention support • Develop a shared vision for urgent and planned mental health which can be really joined up with primary care voluntary and community sector and tertiary care • Ensure a focus upon dual diagnosis care urgent and planned care which ensures that people do not ‘fall through gaps’ 	<p>Activity:</p> <ul style="list-style-type: none"> • Develop shared vision regarding multi- agency discharge and care planning that is compliant with the Care Programme Approach (CPA) • Agree Section 117 Protocols and Processes as enablers to delivering improved patient flow and recovery focussed services • Consider dedicated resource to aid patient flow in the planned care process (replicating urgent care dedicated resource and further embedding joint / integrated practice)
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Services that will be delivered locally but commissioned on a BC&WB STP foot print

The five work programmes of the BC&WB STP Mental Health Work Stream have developed following a series of meetings and workshops with commissioners and providers which began in May 2016 and have involved key clinical leads, including CCG GP

leads for Mental Health and Senior Managers and Clinicians within the Mental Health Provider Trusts. The 'Working as One Commissioner' work programme have agreed to collaboratively commission a set of services to strengthen and energise the CCGs delivery of the improvement blue print for Mental Health both in terms of the delivery of transformed service models and CCG targets.

Expected benefits include; pooling and best use of expertise and resources, efficiencies achieved through economies of scale, achieving a critical mass required for some more specialist services, reducing the need for out of area treatments and interventions including acute overspill and some regional and sub- regional specialisms, building on areas of best practice and optimising opportunities to achieve value for money via delivery of a clinically effective and efficient whole system.

Collaborative commissioning as per the BC&WB STP mental health plan will ensure that the health systems work together better to: eliminate duplication and gaps and ensure compliance with the 'mental health blue print' as outlined in Implementing the Five Year Forward View for Mental Health (2017) and the local needs and gap analysis that has informed development of the plan. This will provide for gaps in service from within the current financial envelope/s of the four CCGs of the BC&WB STP (NHS DUDLEY CCG, NHS SANDWELL CCG NHS WALSALL CCG and NHS WOLVERHAMPTON CCG) and allow joint applications for transformation funds from NHS England. This approach will ensure that whilst services are delivered locally they can be commissioned on a critical mass basis – pooling expertise and resources and ensuring value for money – and preventing high cost OATs wherever possible and / or appropriate.

Improving the quality and responsiveness of key services with adherence to an agreed evidence base across a broader footprint is a key area of risk mitigation. This will allow commissioners to improve the clinical effectiveness of services whilst achieving value for money by driving down costs associated with sub-optimal delivery models. This includes a focus upon improving services associated with frequent relapse rates and re-admissions, lengths of stay and discharge delays and inefficient mental / physical

health care pathways including those for people with long term conditions and /or people who self-harm for example (including high volume service users). A copy of the BC&WB FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH PLAN is attached as Appendix 3.

The link to the full BC&WB STP Plan can be found below:

http://sandwellandwestbhamccg.nhs.uk/images/161020_Black_Country_STP_-_October_Submission_V0_8_clean.pdf

The current portfolio of services to be delivered on a BC&WB STP wide basis are:

- EARLY INTERVENTION IN PSYCHOSIS (EIP) (14-65 years)
- EATING DISORDERS (ED) (all age)
- SPECIALIST PERINATAL MENTAL HEALTH COMMUNITY SERVICE
- SPECIALIST COMMUNITY PERSONALITY DISORDER SERVICE
- SPECIALIST COMMUNITY AUTISM AND ADHD SERVICES (including assessment and diagnosis and on-going support for people with high levels of need)
- VETERANS CARE PATHWAY (ALIGNMENT WITH NHS E COMMISSIONED SERVICES)
- STREET TRIAGE
- MENTAL HEALTH CRIMINAL JUSTICE CARE PATHWAYS AND SERVICES (including LIAISON and DIVERSION SERVICES and THE FORENSIC LIAISON SCHEME) ensuring alignment with Secure Services and Prison In-reach Services commissioned by NHS ENGLAND.
- PSYCHIATRIC INTENSIVE CARE (PIC)
- ALIGNMENT of INITIATIVES CARE PATHWAYS AND SERVICES with the WEST MIDLANDS COMBINED AUTHORITY

THRIVE ACTION PLAN

Overall the full complement of re-modelled services is as follows

<u>Mental Health Services</u>	<u>Commence</u>	<u>Complete</u>
<p><u>Universal Services</u></p> <p>The prevention concordat aims to ‘deliver a tangible increase in the adoption of public mental health approaches’ across local authorities, the NHS, employers and other public, private and voluntary sector organisations. Our Wolverhampton Prevention Concordat will aim to ensure that we improve mental health across the wider determinants of mental health, such as housing, education, employment alcohol and substance misuse, physical ill health and / or disability and poverty and deprivation.</p> <p>The Prevention Concordat for Better Mental Health Programme aims to facilitate local and national action around preventing mental health problems and promoting good mental health. (The Prevention Concordat for Better Mental Health programme of work is one of the recommendations in the ‘Five Year Forward View for Mental Health’, 2016).</p> <p>We will utilise the resource planning guide to put in place effective prevention planning arrangements working with our partners and stakeholders across our</p>	2018/19	2020/21

<p>Mental Health Integrated Care System to improve mental health and wellbeing and prevent mental health difficulties and reduce and eliminate the stigma attached to mental ill health. We will align this with our public health interventions regarding obesity, smoking, and alcohol and substance misuse are all strongly associated with poor mental health (Kings Fund, Getting Serious about Public Mental Health, 2017).</p>		
<p><u>Primary Care Mental Health Services</u></p> <p>Refreshing evidence based care pathways to deliver early intervention and prevention and the GP Five Year Forward View and the Five Year Forward View for Mental Health deliverables including IAPT PERINATAL IAPT and LTC IAPT IPS & SMI Physical Health Checks in Primary Care and also delivering Primary and Secondary Care MDT meetings in each Primary Care Group including the Vertical Integration. There will be a focus upon improving BAME and Older People IAPT access and outcomes</p> <p><u>Services in Scope</u></p> <ul style="list-style-type: none"> • Primary Care Counselling Service (Relate and partners) • IAPT, PERINATAL IAPT and IAPT LTC Wolverhampton Healthy Minds (BCPFT) IAPT for BAME Groups Older People and Carers • Base 25 Counselling and Drop In Services 	<p>2018/19</p>	<p>2019/20</p>

<ul style="list-style-type: none"> • Secondary IPS (DWMHPT) • Primary IPS RCT (with WMCA) (Remploy) • Social Prescribing Pilot (WOLVERHAMPTON VSC) • Depression Care Pathway (BCPFT) • Physical Health Checks and Care Pathway in keeping with the Lester Guidance for example and NICE Clinical Guidance and Quality Standards (Shared Care BCPFT and Primary Care) 		
<p><u>Better Care Fund Mental Health Urgent and Planned Care Pathways</u></p> <p>Refreshing evidence based care pathways which integrate health, social care and to improve acute and crisis based support and on-going planned person centred care to achieve the Five Year Forward View for Mental Health deliverables and compliance with NICE GUIDANCE and the CPA.</p> <p><u>Services in scope</u></p> <ul style="list-style-type: none"> • SINGLE POINT OF ACCESS (SPA) (BCPFT) 	2018/19	2020/21

<ul style="list-style-type: none"> • STREET TRIAGE (commissioned on STP footprint across BC&WB) • MENTAL HEALTH LIAISON SERVICE (MHLS) ENHANCED / CORE 24 (24/7 365) (including Older Adult MHLS) (BCPFT) • SECTION 136 MHA SUITE (BCPFT) • CRISIS RESOLUTION HOME TREATMENT (CRHT) CORE (24/7 365) (including Older Adult CRHT which also forms part of the Better Care Fund Dementia Care Pathway) (BCPFT) • MENTAL HEALTH IN-PATIENT CARE (including Penn In-patient Wards including Older Adult Services, Acute Overspill Out of Area Treatments – OATs) (BCPFT, Cygnet Healthcare and NCA) • PSYCHIATRIC INTENSIVE CARE (PIC) (BCPFT and NCA) • DUAL DIAGNOSIS CARE PATHWAY (Mental Health and Alcohol and Substance Misuse) (BSMHFT and BCPFT) • COMMUNITY RECOVERY SERVICE and PERSONALITY DISORDER HUB (including ASSERTIVE OUTREACH TEAM, encompassing services currently known as the WELL-BEING SERVICE and COMPLEX 		
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<p>CARE)</p> <ul style="list-style-type: none"> • SECTION 117 MENTAL HEALTH ACT 1983 COMMUNITY CARE PACKAGES • SPECIALIST MENTAL HEALTH SUPPORTED ACCOMMODATION and STEP DOWN (including ACCI and VICTORIA COURT) • SPECIALIST NURSING and RESIDENTIAL and DOMICILIARY CARE (including ACCI and VICTORIA COURT) • MENTAL HEALTH IN-PATIENT CARE (including more specialist hospital placements for people stepping down from NHS England funded Secure Care and / or people requiring specialist In-patient support and treatment including Rehabilitation and / or Personality Disorder In-patient Care, such as Cygnet Healthcare) • DUAL DIAGNOSIS CARE PATHWAY (Mental Health and Alcohol and Substance Misuse) (BSMHFT and BCPFT) • Approved Mental Health Practitioners (AMHPs) including those from the Council who undertake assessments under the Mental Health Act 		
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<p>1983, the Mental Capacity Act 2005 and the Care Act 2014 (CWC.)</p> <ul style="list-style-type: none">• Other Council contributions such as the deployment of council care services across a range of community hubs, housing support and public health initiative (CWC.) <p><u>Better Care Fund Dementia Care Pathway</u></p> <p>Refreshing evidence based care pathways which integrate health, social care and to improve diagnosis and post diagnosis intervention and support to deliver the NHS England Well Pathway for Dementia and the NHS I Dementia Standards ensuring a focus upon personalisation, living well and ensuring pro-active and responsive support for people with high levels of need and their carers to achieve the Five Year Forward View for Mental Health deliverables and compliance with NICE GUIDANCE and the CPA.</p> <p><u>Services in scope</u></p> <ul style="list-style-type: none">• OLDER ADULTS COMMUNITY MENTAL HEALTH TEAM (BCPFT)• DAY SERVICES – BLAKENHALL DAY SERVICES and THE GROVES DAY HOSPITAL (BCPFT)• The MEMORY CLINIC (BCPFT)		
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<ul style="list-style-type: none"> • EARLY ONSET DEMENTIA SERVICES (BCPFT) • MENTAL HEALTH LIAISON SERVICE (MHLS) ENHANCED / CORE 24 (24/7 365) (including Older Adult MHLS) (BCPFT) • The DEMENTIA OUTREACH TEAM (RWT) • CRISIS RESOLUTION HOME TREATMENT (CRHT) CORE (24/7 365) (including Older Adult CRHT which also forms part of the Better Care Fund URGENT MENTAL HEALTH Care Pathway) (BCPFT) • OLDER ADULT MENTAL HEALTH IN-PATIENT CARE (including Penn In-patient Wards including Older Adult Services, WARD C22 at RWT and Acute Overspill Out of Area Treatments – OATs) (BCPFT, RWT and others) • Community care packages including Nursing Residential and Domiciliary Care including Continuing Healthcare (CHC) (various) 		
<p>BC &WB STP Commissioned Services</p> <p>Refreshing evidence based care pathways to achieve the Five Year Forward View for Mental Health deliverables on an STP footprint to pool expertise and</p>	2018/19	2020/21

<p>resources and improve the capacity and capability of the system.</p> <p><u>Services in scope</u></p> <ul style="list-style-type: none"> • Early Intervention in Psychosis - 14-65 years (BCPFT & DWMHPT) • Eating Disorders – all age (BCPFT) • Specialist Perinatal Mental Health Community Service all age (BSMHFT, BCPFT & DWMHPT) • Specialist Community Personality Disorder Service (BCPFT & DWMHPT) • Specialist Community Autism and ADHD Service (DWMHPT) • Street Triage (BCPFT & DWMHPT) • Mental Health Criminal Justice Care Pathways and Services including liaison and diversion services and the Forensic Liaison Scheme (BCPFT & DWMHPT) • Secondary IPS (DWMHPT) • Psychiatric Intensive Care (BCPFT – Male – Female currently NCA) 		
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<ul style="list-style-type: none">• Veterans Care Pathway (alignment with NHS E commissioned services)• Alignment with the West Midlands Combined Authority THRIVE Action Plan		
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5. **KEY PRIORITIES**

The priorities for implementation will be aligned with those outlined in the CCG Operational Plan/s, the BC&WB STP Plan and the Joint Health and Well-being Strategy. In summary the key issues and priorities include the following:

- Integrated and / or aligned health and social care pathways are required across all stages of the service user journey, including universal, primary, secondary and tertiary care. This will require remodelling some aspects of the commissioned service provision.
- Clear pathways for engagement with primary care are also needed to support the mental and physical health needs of people with Mental Health difficulties and / or a Learning Disability to ensure parity of esteem and reduce inequalities. This

will require dedicated mental health support in primary care, primary care multi-disciplinary mental health team meetings and primary care champions in all secondary and tertiary services.

- Consultant Psychiatry and medical support and expertise require re-focussing and balancing across the primary, secondary, and tertiary care elements of the system. Our re-commissioned model will require increased access to Consultant Psychiatry expertise across our **Mental Health Integrated Care System** with improved referral processes to access clinical and medical support, improved clinician to clinician communication across primary care and mental and physical health services to improve access to assessment and treatment interventions and to achieve parity of esteem. Medical staffing across some services and care pathways may require some review to ensure an appropriate distribution of senior clinicians across the primary, secondary and tertiary care i.e. community and In-patient services to deliver fidelity with the evidence base and deliver highest standards of evidenced based care and admission avoidance for example. This will involve developing the role of Primary Care Mental Health staff as Advanced Nurse Prescribers (ANPs).
- Greater flexibility is needed regarding the application of the care cluster model (this is the model that is the framework for the payment system that is mental health payment by results). This is required both in terms of access to and treatment with health services so that the unique and specific needs of people are adequately supported and to allow greater alignment between services where the cluster model does not apply such as CAMHS, Learning Disabilities and Neurological Disorders.
- Achieving and sustaining recovery within the health model for patients of all clusters and especially for those patients clusters 3 and above experiencing non-psychotic conditions should re-focus to move include treatment support and interventions beyond an IAPT model of care and to provide continuing support as required. A refreshed approach to the care cluster model is required to allow greater flexibility across the service model and to ensure that people receive the right level of continuing support and achieve sustained recovery.

- The application of the Care Programme Approach must be re-focussed across the **Mental Health Integrated Care System** to ensure appropriate levels of community support, relapse prevention and crisis plans and support for carers. Our re-commissioned must achieve an approach to CPA locally that is consistent with national guidance.
- An 'all age approach' is required in keeping with national guidelines so that there is flexibility regarding transition into age specific services and the unique needs of individuals are recognised and to achieve parity of esteem across the life span with improved planning at times of transition. Improved joint working across adults and children's services is required to ensure that the needs of families in contact with mental health services are addressed in entirety, and that the needs of children and young people are assessed and monitored when parents / guardians are experiencing mental health difficulties and vice versa.
- There is a need to improve access to assertive support and treatment at home, and increase capacity and capability within drop in and day services and step-down services, to increase recovery rates, support sustained recovery and reduce relapse and prevent admission to hospital wherever possible.
- Access to and egress from care pathways including those providing access to specialised services and / or services commissioned by NHS England nationally must be un-impeded by and differing commissioning arrangements for different elements of the care pathway (i.e. into and out of secure and specialised care).
- Further development of local care pathways for people with Autism, Attention Deficit Disorder, Personality Disorders, Dual Diagnosis and Perinatal Mental Health is required to provide access to specialised assessment and treatment that is co-ordinated with across primary, secondary and tertiary care.
- Access to services and support across providers of supported accommodation and nursing residential and domiciliary care services should be commissioned using a care pathway approach that improves access to the correct level of support and

allows transition through services to services to promote independence and facilitate recovery and optimise effective and efficient use of resources within the market locally.

- BC&WB STP wide access to local female Psychiatric Intensive Care (PIC) is required to improve patient care pathways and quality of experience and reduce / remove Acute Overspill Out of Area Treatments (OATs).
- An STP wide collaborative approach with other local commissioners of mental health services is required, to pool resources and provides economies of scale.
- Improved access to information and communication for service users and carers and all key stakeholders regarding all matters pertaining to mental health and emotional wellbeing is required. This should harness and optimise the potential of the internet and social media and simple tele-health.
- Improved and co-ordinated commissioning approaches with substance misuse commissioning colleagues is required to ensure clearly commissioned care pathways between and across mental health and substance misuse services, and to co-ordinate health promotion campaigns as part of the Dual Diagnosis Care pathway.

Responding to the specific needs and requirements of key vulnerable groups will form a key element of the Wolverhampton **Suicide Prevention Plan** and the **Wolverhampton Crisis Concordat Declaration and Wolverhampton Crisis Concordat Action Plan**. The Wolverhampton suicide prevention plan is known as the Wolverhampton Mental Health Resilience Plan and describes those interventions highlighted within the Wolverhampton Health and Well-Being Strategy that focus upon mental health promotion, early intervention and prevention and are detailed within the table below and which will be aligned with the Mental Health Strategy Implementation Plan and our WOLVERHAMPTON CRISIS CONCORDAT Declaration and Action Plan:

Neeraj to insert SUICIDE PREVENTION SUMMARY here

Sarah to insert CRISIS CONCORDAT HERE

In response to the above identified key issues an implementation plan is included as Appendix 2.

In addition to the above it is important that care commissioned and delivered meets the requirements of the **CARE PROGRAMME APPROACH**. Refocusing the Care Programme Approach - Policy and Positive Practice Guidance (2008) identifies the following **issues to consider when deciding if support of CPA needed:**

Severe mental disorder (including personality disorder) with high degree of clinical complexity

Current or potential risk(s), including:

- Suicide, self-harm, harm to others (including history of offending)
- Relapse history requiring urgent response
- Self-neglect /non concordance with treatment plan

Vulnerable adult /child safeguarding including for example:

- exploitation e.g. financial/sexual
- financial difficulties related to mental illness
- disinhibition
- physical/emotional abuse
- cognitive impairment
- child safeguarding issues
- Current or significant history of severe distress/instability or disengagement
- Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse
- learning disability

- Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies
- Currently/recently detained under Mental Health Act or referred to crisis/home treatment team
- Significant reliance on carer(s) or has own significant caring responsibilities

Experiencing disadvantage or difficulty as a result of:

- Parenting responsibilities
- Physical health problems/disability
- Unsettled accommodation/housing issues
- Employment issues when mentally ill
- Significant impairment of function due to mental illness
- Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices);
- Sexuality or gender issues

Refocusing the Care Programme Approach - Policy and Positive Practice Guidance (2008) provides the following Statement of Values and Principles:

- The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery.
- It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties.
- It recognises the individual as a person first and patient/service user second.

- Care assessment and planning views a person 'in the round' seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical health and well-being.
- Self-care is promoted and supported wherever possible.
- Action is taken to encourage independence and self determination to help people maintain control over their own support and care.
- Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.
- Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care.
- The quality of the relationship between service user and the care co-ordinator is one of the most important determinants of success.
- Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.

Refocusing the Care Programme Approach - Policy and Positive Practice Guidance (2008) provides the following summary of the main similarities and differences between service responses to service users needing the support of (new) CPA and those that do not:

Service users needing (new) CPA	Other service users
<p><u>An individual's characteristics:</u></p> <p>Complex needs; multi-agency input; higher risk.</p>	<p><u>An individual's characteristics:</u></p> <p>More straightforward needs; one agency or no problems with access to other agencies/support; lower risk.</p>
<p><u>What the service users should expect:</u></p> <ul style="list-style-type: none"> • Support from CPA care co-ordinator (trained, part of job description, co-ordination support recognised as significant part of caseload). • A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks. • An assessment of social care needs against FACS eligibility criteria (plus Direct Payments). • Comprehensive formal written care plan: including risk and safety/contingency/crisis plan. • On-going review, formal multi-disciplinary, multi-agency review at least once a year but likely to be needed more regularly • At review, consideration of on-going need for (new) CPA support • Increased need for advocacy support. • Carers identified and informed of rights to own 	<p><u>What the service users should expect:</u></p> <ul style="list-style-type: none"> • Support from professional(s) as part of clinical/practitioner role. Lead professional identified. • Service user self-directed care, with support. • A full assessment of need for clinical care and treatment, including risk assessment. • An assessment of social care needs against FACS eligibility criteria (plus Direct Payments). • Clear understanding of how care and treatment will be carried out, by whom, and when (can be a clinician's letter). • On-going review as required. • On-going consideration of need for move to (new) CPA if risk or circumstances change. • Self-directed care, with some support if necessary. • Carers identified and informed of rights of own assessment.

assessment.	
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6. IMPLEMENTATION, NEXT STEPS AND 14 KEY GOALS

Our **WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM** will deliver engagement across partners, agencies and service users and their carers and co-ordinate delivery of our implementation plan and engagement across partners, stakeholders, service user and carer groups and the wider general public.

For the purposes of delivery of a **Mental Health Integrated Care System** the implementation plan attached as Appendix 2 is structured across the **14 Key Goals** described below.

<p>1. <u>DEVELOP AN ALL AGE APPROACH ACROSS OUR SERVICE MODEL THAT INCORPORATES THE NEEDS OF PEOPLE UNDER 18 YEARS WHO REQUIRE TRANSITION TO ADULT MENTAL HEALTH SERVICES.</u></p>
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<p>We will develop a commissioning plan / care pathway/s that align all initiatives within the MENTAL HEALTH STRATEGY</p>

IMPLEMENTATION PLAN with existing and future plans regarding CAMHS as described in the WOLVERHAMPTON CAMHS PLAN ensuring that there is safe sound support transition to Adult Services that are consistent, seamless, age appropriate and inclusive and support the needs of Children and Young People at transition and preparing for transition to ADULT SERVICES in line with good practice as outlined in NICE GUIDANCE the CPA, CONTINUING CARE and CONTINUING HEALTHCARE GUIDANCE.

LEAD MULTI-AGENCY FORUM/S – CAMHS TRANSFORMATION BOARD AND WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

2. DEVELOP AN ALL AGE APPROACH ACROSS OUR ADULT AND OLDER ADULT SERVICE MODEL THAT INCORPORATES AND ADDRESSES THE NEEDS OF PEOPLE OVER 65 YEARS WHO REQUIRE TRANSITION TO OR ACCESS / ENTRY TO OLDER ADULT MENTAL HEALTH SERVICES.

We will develop care pathway/s and services that align all initiatives within the implementation plan across Adult and Older Adults Mental Health Services so that services are consistent, seamless, age related and inclusive. Service re-design and delivery across the BETTER CARE FUND URGENT AND PLANNED AND DEMENTIA CARE PATHWAYS will be joined up and coterminous. Our refreshed Dementia Strategy will sit aside our Mental Health Strategy and will respond to relevant NICE GUIDANCE and CARE PATHWAYS and we will ensure older people and/ or people with dementia have equity of access to mental and physical health services and that care plans in both primary and secondary meet the requirements of the CPA for service users and carers.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

3. DEVELOP A LOCAL PREVENTION CONCORDAT

We will develop a local PREVENTION CONCORDAT with key stakeholders via the MENTAL HEALTH STAKEHOLDER FORUM. This will help us to deliver targeted mental health promotion and early intervention and prevention interventions cross our commissioned services, and to work with partners across universal primary secondary and tertiary care and partners and stakeholders in education, employment, leisure and housing and voluntary and community sector services, for example to focus initiatives upon the wider determinants of health and mental and physical health promotion. Our information revolution will provide signposting navigation advice and guidance and self-management self-care and peer support. This approach will include initiatives to address the broader determinants of mental ill-health including issues pertaining to:

- Parental mental health
- Mental Health Promotion
- Physical health and disability
- Leisure and physical activity
- Bullying
- Mental Health in the work place
- Self-harm
- Substance misuse
- Improved information and communication
- Targeted Interventions for carers
- Targeted interventions for at risk groups (BAME, LGBT+)
- Debt Advice
- Un-employment
- Educational attainment

- Ending stigma attached to mental health

In addressing those issues highlighted above the Resilience Plan will incorporate the Suicide Prevention Plan and will assess, map and scope the needs of the City's key vulnerable groups people affected by vulnerabilities related to and including:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism
- Lesbian, gay, bisexual and transgender people (LGBT+) and / or children and young people who are questioning their sexual orientation and / or gender (LGBT+)
- Substance misuse
- Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying

4. MAINTAIN OUR WOLVERHAMPTON SUICIDE PREVENTION STRATEGY

We will maintain our local multi-agency Suicide Prevention Strategy with key stakeholders. This will be aligned with the WOLVERHAMPTON CRISIS CONCORDAT and will respond to local needs across each of the National Suicide Prevention

Strategy areas for action:

- Reduce the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

This will incorporate learning from the Preventing Suicide in England: One year on First Annual Report (2014), and local data regarding current trends and new messages from research, including the use of social media, learning regarding 7 day follow up, health and social care assessments, treatment and clinical interventions for people with depression and people at risk of self-harm, and specific vulnerabilities related to age, gender and ethnicity and the specific needs of the LGBT+ community and people who misuse substances.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON SUICIDE PREVENTION STAKEHOLDER FORUM

5. DEVELOP PRIMARY CARE MENTAL HEALTH

To ensure best practice in terms of early intervention and prevention, improving the physical health of people with mental health difficulties and improving care pathways into and out of secondary services for people of all ages, we will commission mental health care pathways in primary care supported by primary care champions and workers in primary care facing and secondary services. This will include pathways of care for people with specialised mental health needs such as autism, attention deficit disorder, eating disorders, perinatal mental health, depression and personality disorder, dual diagnosis and the primary care support needs of people taking anti-psychotic medication. This will include review of all of our well-being and support services commissioned from

community and voluntary sector organisations and third sector organisations to strengthen early intervention and prevention initiatives. This includes delivery of IAPT, LTC IAPT, increasing IPAT access for BAMES and PERINATAL IAPT and delivering SMI PHYSICAL HEALTH Checks and social prescribing pilot. This will also include delivery of e referrals and e discharge and advice and guidance across primary and secondary care.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

6. DELIVER THE BETTER CARE FUND URGENT MENTAL HEALTH CARE PATHWAY

As part of our Better Care Fund development plans to implement the Integrated Mental Health Urgent Care Pathway we will review the current model. We will re-commission MENTAL HEALTH LIAISON ENHANCED CORE 24 and CRISIS RESOLUTION HOME TREATMENT fidelity with NHS E CORE. We will review the capacity and capability of the health and social care urgent mental health care pathways to increase the capacity and capability of the service to meet the needs of people of all ages outside normal working hours and respond to requests for assessment under the Mental Health Act. We will commission a service model and care pathway that provides an integrated colocated and aligned approach to mental health urgent care within a multi-disciplinary context, including access in an emergency to specialist medical and Consultant Psychiatry support that is consistent with Royal College guidelines and the Care Programme Approach. We will deliver our WOLVERHAMPTON CRISIS CONCORDAT DECLARATION AND ACTION PLAN through this work stream.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

7. DELIVER THE BETTER CARE FUND PLANNED MENTAL HEALTH CARE PATHWAY

We will re-commission and implement an integrated planned care pathway promoting independence, self-efficacy and recovery as part of our Better Care Fund plans. This will promote independence, facilitate recovery and allow service users to progress along the care pathway and prevent relapse and re-admission. The integrated pathway will also allow pooled and effective deployment of and efficient use of resources across the 'whole system' that responds to local need and demand management. This will facilitate step-down from in-patient, specialised and secure care, allow repatriation to local services from 'out of area placements' and consolidate commissioning approaches for people requiring continued support in supported housing, nursing and residential care and hospital placements into an aligned care pathway of continued support. Our commissioned integrated care pathway will provide capacity and capability locally to support people with the highest levels of need, promoting independence and recovery, and will allow the re-allocation of resources from acute, specialised, 'out of area' placements to local community based services maintaining recovery and promoting independence, self-efficacy autonomy and recovery in the mid to long term. We will review our current commissioning model of the Complex Care Service and Well-Being Service. This will include reviewing the capacity and capability of the service to offer support and interventions of an assertive outreach model, the function of the personality disorder hub and the forensic team. This is to increase the capacity and capability of local services to support people with the highest levels of need, and provide step-down from secure care and specialised services locally and 'out of area' and reduce relapse and re-admission/s. The model will also be reviewed to allow patients to receive on-going support from the service and for services users in the service to receive care planning support and interventions that are compliant with the national guidance regarding the Care Programme Approach.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

8. MAINTAIN OUR WOLVERHAMPTON CRISIS CONCORDAT

We will maintain our local multi-agency WOLVERHAMPTON CRISIS CONCORDAT ensuring connectivity with this initiative and the Suicide Prevention Strategy and the Better Care Fund Mental Health Urgent and Planned Care and Dementia Strategies and the WOLVERHAMPTON Local CAMHS Plan. We will ensure minimum 6 monthly reviews of the WOLVERHAMPTON CRISIS CONCORDAT DECLARATION and ACTION PLAN with all service user and carer groups.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

9. DELIVER SOME MORE SPECIALIST MENTAL HEALTH CARE PATHWAYS AND SERVICES ACROSS A BC&WB STP FOOTING

Collaborative commissioning as per the outputs of the BC&WB STP Mental Health Work Stream will ensure that the health needs of people with mental health difficulties will be met in a timely and holistic manner as per NICE guidance and from diagnosis to early intervention and care, treatment and support, improving quality of life. We will pool resources and expertise to deliver a critical mass of specialist services that are locally delivered and financially sustainable across our BC&WB footprint. We work with providers of health and social care services to commission and implement specialist care pathways for the following:

- Eating Disorders
- Early Intervention in Psychosis
- Personality Disorder
- Perinatal Mental Health
- Attention Deficit Disorder and Autism
- Psychiatric Intensive Care
- Street Triage

- Criminal Justice Mental Health (including Court Diversion and Liaison and the Forensic Liaison Scheme)
- Veteran Mental Health
- Alignment with the West Midlands Combined Authority THRIVE Action Plan

This will increase capacity and capability, providing specialist assessment and intervention within mainstream mental health services within the local system and facilitating effective liaison with specialist services commissioned by NHS England. This will include review of our current commissioning of all out of area mental health admissions to identify opportunities to maximise the resources available within local services as alternatives to out of area admissions and to identify 'preferred providers' for Female Psychiatric Intensive Care (PIC) in the short term, whilst liaising with local providers and commissioners regarding a medium to longer term solution. We will optimise the available capacity and capability within community recovery and promoting independence services within our local health and social care economy both with the public sector and independent sector services as an integral part of the local 'whole system' as required. We will realise cost efficiency savings by reducing the numbers of all types of out of area placements and reducing lengths of stay. We will work with local providers to develop capacity and capability of locally commissioned services to meet the needs of people who are discharged and / or transferred from secure and specialised services, so that we can optimise deployment of and efficient use of resources across the 'whole system' that is consistent with local need, allow repatriation to local services from 'out of area placements' and consolidate commissioning approaches sub –specialisms including hospital placements for rehabilitation. Our commissioned integrated care pathway will provide capacity and capability locally to support people with the highest levels of need, promoting independence and recovery.

**LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM and BC&WB STP
MENTAL HEALTH WORKSTREAM**

10. DELIVER ROBUST CARE PATHWAYS ACROSS PRIMARY, SECONDARY AND TERTIARY CARE TO ENSURE THAT

PEOPLE WITH A LEARNING DISABILITY / AND OR AUTISM AND CO-OCCURRING MENTAL HEALTH DIFFICULTIES
CAN ACCESS APPROPRIATE AND SEAMLESS HELP, CARE, TREATMENT AND SUPPORT

In line with Transforming care: A National response to Winterbourne View Hospital (2012), Building the right support - A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition (2015) we will develop robust care pathways across Learning Disability and Mental Health Services to support the specific needs of people with a learning disability / and or autism and co-occurring mental health difficulties to ensure equal access to assessment and diagnosis and post diagnosis care treatment and support and this will be delivered in line with the requirements of the Care Programme Approach (CPA) as appropriate / required.

11. DELIVER TARGETED INTERVENTIONS TO SUPPORT THE NEEDS OF MARGINALISED AND / OR SELDOM HEARD
GROUPS INCLUDING SPECIFIC ACTIONS TO REDUCE THE NUMBERS OF BAME PEOPLE DETAINED UNDER THE
MENTAL HEALTH ACT

In line with the Mental Health Five Year Forward View and the WOLVERHAMPTON CRISIS CONCORDAT we will include work across partners and with local community groups to provide a dedicated focus upon people who are marginalised, people who have particular vulnerabilities, and people who have difficulties accessing right care in the right place at the right time including people for example with Autism / and or ADHD, people with a Learning Disability, people with Dual Diagnosis and / or a Personality Disorder and people from BAME and LGBT+ groups and Veterans, refugees new arrivals and asylum seekers and Serving Members of Her Majesty's Armed Forces and their families for example to ensure improved access to and support and treatment from mental health services providing right care at the right time in the right place. This will include specific actions to substantially reduce Mental Health Act detentions and also include targeted work to reduce the current significant overrepresentation of BAME and any other disadvantaged groups within detention rates.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

12. DELIVER A WORK FORCE PLAN & ALIGN ACROSS BC&WB STP FOOTING

We will develop a work force plan in line with Stepping Forward to 2020 and align with developments and initiatives across our STP to allow development of recruitment and retention and training, supervision and mentorship of all staff across our **Mental Health Integrated Care System** to develop capacity and capability to support and deliver new service models and facilitate delivery of local priorities and the priorities of the Five Year Forward View for Mental Health. As we do this we will develop and demonstrate sound processes to support and recruit staff with lived experience of mental difficulties and support the mental health and emotional well-being of all our staff.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM and BC&WB STP MENTAL HEALTH WORKSTREAM

13. DELIVER A FINANCIAL PLAN & ALIGN ACROSS BC&WB STP FOOTING

We will develop a Mental Health Strategy Financial Plan and align with developments and initiatives across our STP to deliver financially sustainable services and deliver value for money whilst covering critical gaps and meeting the mental health investment

standard. New or revised services and service specifications will be delivered within the financial envelope our commissioning authorities i.e. NHS W CCG and CWC. Resources – including key elements of our workforce - will be used to best effect with strong clinical and medical leadership evident at each part of the Mental Health Integrated Care System. This is in addition to any transformation funds applied for and received from NHS England for example including ‘Winter Pressures’ and A&E Delivery Board funding used to ‘pump prime’ change. Compliance with the Mental Health Investment Standard will be supported across all CCG commissioned activity.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

14. DELIVER A GOVERNANCE, COMMUNICATION AND ENGAGEMENT PLAN AND ALIGN WITH WORK ACROSS AN BC&WB STP FOOTING

We will develop a governance, communication and engagement plan and align with developments and initiatives across our STP to ensure co-production with and continuing engagement with all relevant forums and service users and carers and the general public to support delivery of our strategy including the anti-stigma, mental health promotion and advice and guidance elements to achieve parity of esteem with physical health and improve our City’s mental health.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM and BC&WB STP MENTAL HEALTH WORKSTREAM

Summary

The priorities outlined in our Joint Commissioning Mental Health Strategy to achieve our **Mental Health Integrated Care System** have been developed from our knowledge of local need and national best practice and policy implementation guidance and the directives of the **Five Year Forward View for Mental Health**. The priorities outlined and deliverables outlined in this document will

commission a 'whole system' of integrated mental health and social care fit for the future to offer parity of esteem and the right care, in the right place at the right time. This will include targeted supportive and preventative interventions to strengthen self-efficacy, independence and autonomy and resilience and a programme of investment in evidence based services, care pathways and initiatives to deliver improved access across universal primary urgent planned and specialist care to ensure improved service user and carer outcomes personal growth and recovery. This will achieve 'parity of esteem' for mental health services and care pathways in comparison with physical health services in terms of access to evidence based services, quality of service user and carer experience and service user outcomes and promote and ensure integrated approaches with physical health which are fit for the future and ensure improved information sharing improved connectivity across systems and processes including digital records and care plans. Our values driven approach will focus upon empowerment, self-efficacy and improving accessibility effectiveness and responsiveness whilst delivering transformation and modernity supporting our service users and carers to live happy and fulfilling lives.

“Quality of care can become synonymous with quality of life and satisfaction with care an important component of life satisfaction”. (Locker and Dent - 1978)

6. LIST OF APPENDICES

- Appendix 1 – Needs Assessment Information
- Appendix 2 – Strategy Implementation Plan
- Appendix 3 BC&WB Five Year Forward View For Mental Health Delivery Plan