CITY OF
WOLVERHAMPTON
COUNCIL

# Health and Wellbeing Board

29 July 2015

**Time** 2.00 pm **Public Meeting?** YES **Type of meeting** Oversight

**Venue** Committee Room 3 - Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

## Information for the Public

If you have any queries about this meeting, please contact the democratic support team:

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# Agenda

## Part 1 – items open to the press and public

*Item No.* *Title*

**MEETING BUSINESS ITEMS - PART 1**

1 **Apologies for absence (if any)**

2 **Notification of substitute members (if any)**

3 **Declarations of interest (if any)**

4 **Minutes of the previous meeting** (Pages 5 - 12)
[To approve the minutes of the previous meeting (3 June 2015) as a correct record]

5 **Matters arising**
[To consider any matters arising from the minutes of the meeting held on 3 June 2015]

6 **Summary of outstanding matters** (Pages 13 - 16)
[To consider and comment on the summary of outstanding matters]

7 **Health and Wellbeing Board Forward Plan 2015/16** (Pages 17 - 20)
[To consider and comment on the items listed on the Forward Plan]

8 **Primary Care Co-Commissioning** (Pages 21 - 26)
[To consider a report which outlines the content of the guidance received to date, assesses the opportunities and risk of each co-commissioning level and its preferred option of level 2 (Joint Commissioning) for Wolverhampton City Clinical Commissioning Group]

[Steven Marshall]

9 **Update from the Wolverhampton Clinical Commissioning Group in response to the recommendations made by the Francis Inquiry** (Pages 27 - 34)
[To provide a further assurance report to the Health and Wellbeing Board that the CCG continues to consider and reflect on the implications of the Mid Staffordshire NHS Trust reports and system wide change necessary to improve patient safety, clinical effectiveness and patient experience]

[Manjeet Garcha]

10 **Obesity Call to Action - Update and progress made towards developing an Action Plan to tackle obesity in Wolverhampton** (Pages 35 - 48)
[To update the Board on the development of a whole system obesity action plan and associated governance arrangements and to promote an element of challenge to progress and stimulate ideas for contribution across the partnership]

[Ros Jervis]

11 **Public Health Annual Report 2014/15**

[To receive a PowerPoint presentation in connection with the Public Health Annual Report]

[Ros Jervis]

12 **Wolverhampton City Council and Wolverhampton Clinical Commissioning Group Mental Health Strategy 2014 - 16** (Pages 49 - 142)

[To consider a report on a proposal to increase capacity within CAMHS commissioning across Wolverhampton City Council and Wolverhampton Clinical Commissioning Group. This will deliver a dedicated whole systems project across CAMHS Tiers 1 – 4 that will deliver a sustainable model into 2020/21, deliver QIPP in the short, medium and longer term, deliver to the key strategic drivers and ambitions of Future in Mind and transform lives of the children and young people of Wolverhampton]

[Sarah Fellows]

13 **Joint Strategy for Urgent Care - Equality Analysis** (Pages 143 - 196)

[To consider the Equality Impact Analysis undertaken in respect of the Joint Strategy for Urgent and Emergency Care for patients using services in Wolverhampton to 2016/17]

[Steven Marshall]

14 **Better Care Fund - Update** (Pages 197 - 202)

[To receive a report on the development and progress of the Better Care Fund, in particular the Intermediate Care and Primary and Community Care workstreams, to appraise the Board of the next steps and to secure continuing support from the whole Health and Social Care Economy to facilitate the successful delivery of the Better Care Programme]

[Viv Griffin / Steven Marshall]

15 **Minutes from Sub Groups** (Pages 203 - 214)

[To receive feedback from the following Sub Groups]

**(i) Children’s Trust Board (Cllr Val Gibson)**
**(ii) Integrated Commissioning and Partnership Board (Linda Sanders)**

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# Health and Wellbeing Board

Minutes - 3 June 2015

## Attendance

**Members of the Health and Wellbeing Board**

| | |
|---|---|
| Cllr Sandra Samuels (Chair) | Cabinet Member for Health and Wellbeing |
| Cllr Val Gibson | Cabinet Member for Children and Families |
| Ros Jervis | Director of Public Health |
| Simon Hyde | West Midlands Police |
| Cllr Roger Lawrence | Leader of the Council |
| Cllr Elias Mattu | Cabinet Member for Adults |
| Linda Sanders | Strategic Director, People |
| Cllr Paul Singh | Shadow Cabinet Member for Health and Wellbeing |
| Jeremy Vanes | Royal Wolverhampton NHS Trust |

**Council employees and representatives of partner organisations**

| | |
|---|---|
| Carl Craney | Democratic Support Officer |
| Viv Griffin | Service Director - Disability and Mental Health |
| David Johnson | Project Lead - Primary Care Regeneration |
| Steven Marshall | Director of Strategy & Transformation |
| Donald McIntosh | Chief Officer, Wolverhampton Healthwatch |

## Part 1 – items open to the press and public

*Item No.* *Title*

1 **Apologies for absence (if any)**

Apologies for absence had been received from Alan Coe (Independent Chair, Wolverhampton Safeguarding Children's Board), Professor Linda Lang (University of Wolverhampton) and Tim Johnson (Strategic Director, Place, Wolverhampton City Council).

2 **Notification of substitute members (if any)**

No notifications of substitutes had been received.

3 **Chair's Opening Remarks**

i) The Chair, Cllr Sandra Samuels welcomed Members and Officers to the first meeting of the Health and Wellbeing Board in the 2015/16 Municipal Year. She invited those present to introduce themselves and introductions were duly made.

ii) The Chair reminded the Board of the continuing financial challenges faced and of the need as stakeholders to work together to integrate health and social care provision in the city

iii) The Chair advised the Board that it was proposed to hold the next “away Day” on 7 October 2015 between 09:30 – 12:00 hours followed by a formal meeting of the Board commencing at 13:30 hours. A suitable venue for the “Away Day” and Board meeting would be identified in due course.

iv) The Chair reported that she had been approached by James Brackley, a Researcher at Birmingham University, who was undertaking a PhD in Public Health and Local Government, for agreement to be allowed to film the proceedings of the July meeting. Carl Craney, Democratic Support Officer, informed the Board that this was permissible under the Council’s Constitution.

v) the Chair informed the Board that a number of television and radio stations, including BBC1, BBC2, 5 Live and Radio WM, had expressed an interest in covering the initiatives in Wolverhampton on tackling obesity.

4 **Declarations of interest (if any)**

No declarations of interest were made.

5 **Minutes of the previous meeting**

Resolved:

That the minutes of the meeting held on 4 March 2015 be confirmed as a correct record and signed by the Chair subject to the following amendments:
i) the title of Richard Welch being changed to “Head of Healthier Place”;
ii) the title of Steven Marshall being changed to “Director of Strategy and Transformation”.

6 **Matters arising**

With reference to Minute No. 5 (Matters arising) and with particular reference to vacancies on the Governing Body of the Wolverhampton Clinical Commissioning Group, the Chair enquired whether these had yet been filled. Steven Marshall, Director of Strategy and Transformation, Wolverhampton Clinical Commissioning Group, confirmed that they had.

With reference to Minute No. 8 (Obesity Call to Action – Update and progress made towards developing an Action Plan to tackle obesity in Wolverhampton), the Chair advised that Professor Kevin Fenton, National Director Health and Wellbeing PHE, had yet to visit the city. Donald McIntosh, Chief Officer, reported that Maxine Bygrave, Chair, Wolverhampton Healthwatch, would be leaving the organisation shortly and that a recruitment campaign would be commenced.

With reference to Minute No. 12 (Joint Strategic Needs Assessment (JSNA) Qualitative Chapter: Patient Safety) Ros Jervis, Service Director, Public Health and Wellbeing, reported that an update on the JSNA would be submitted to the meeting scheduled for 7 October 2015.

With reference to Minute No. 13 (Wolverhampton City Clinical Commissioning Group and Wolverhampton city Council Mental Health Strategy), Viv Griffin, Service Director, Disability and Mental Health, reported that the Crisis Concordat was now an integral part of the Better Care Fund programme.

7 **Summary of outstanding matters**

The Service Director, Disability and Mental Health presented a report which detailed the current position with a variety of matters considered at previous meetings of the Board. She reported that a quarterly Balanced Scorecard would be presented in connection with the Better Care Fund.

Resolved:

That the report be received and noted.

8 **Health and Wellbeing Board Forward Plan 2015/16**

The Service Director, Mental Health and Disability presented the Health and Wellbeing board Forward Plan for 2015/16 and advised that she would be meeting with the Service Director, Public Health and Wellbeing and the Director of Strategy and Transformation to populate further the Forward Plan.

Resolved:

That the Forward Plan be received and noted.

9 **Dates and times of meetings**

Resolved:

That the arrangements for meetings of the Board during the 2015/16 Municipal Year as detailed below be noted:
29 July 2015 commencing at 14:00 hours;
7 October 2015 commencing at 12:30 hours;
2 December 2015 commencing at 14:00 hours;
10 February 2016 commencing at 12:30 hours and
27 April 2016 commencing at 14:00 hours.

10 **Integrated Commissioning Update**

The Director of Strategy and Transformation presented a report which informed the Board on the development of integrated commissioning within Wolverhampton, the next steps and to secure system leadership support for the development of integrated commissioning. He explained that previously the Better Care Fund and Integrated Commissioning Care had been considered by one Board but these had now been separated out. The report detailed the core aims of integrated commissioning. The first meeting of the Integrated Commissioning Board (ICB) had been held during week commencing 25 May 2015 and would now meet on a monthly basis.

Cllr Paul Singh enquired as to how engagement would be undertaken with unpaid carers. The Director of Strategy and Transformation explained that this would be carried out through the Wider Community Network Team as part of the Better Care Fund and acknowledged the need to work with the unpaid carers. Donald McIntosh reminded the Board that Wolverhampton Healthwatch was a member of the ICB and that it would assist in ensuring an opportunity was given on engagement with both carers and service users. The Service Director, Mental Health and Disabilities reported that carer support was part of the Better Care Fund model following on from the Care Act and that these carers were entitled to a personal assessment of their needs. Cllr Paul Singh expressed concern that many of the carers were too busy caring for relatives / dependents / friends to be aware of any assistance available to them personally. He suggested that there was an urgent need for them to be made aware of the availability of such entitlements. Linda Sanders, Strategic Director, People, reported that carers and service users were involved with the Wolverhampton Information Network. In response to a question from the Chair, the Strategic Director confirmed that a Carers Forum operated within the city.

Resolved:

1. That the plans for the development of an integrated approach to commissioning, as detailed in the report, be approved;
2. That the benefits articulated by developing an approach to integrated commissioning in support of the delivery of the Health and Wellbeing Strategy and shared commissioning priorities be noted;
3. That a report on the roles and responsibilities of the various partner organisations involved in integrated commissioning be submitted to a future meeting of the Board.

11 **Joint Strategy for Urgent Care - Equality Analysis**

The Director of Strategy and Transformation explained that there had been some confusion surrounding the production and circulation of this report and that whilst it had not been circulated it had been produced. The Chair advised that it had not been received for circulation by the City Council.

Donald McIntosh requested that the Board receive an update on the progress with the new Emergency Care facility at New Cross Hospital. The Director of Strategy and Transformation reported that construction was underway, that the Invitation to Tender (ITT) exercise had been launched some three weeks ago with a closing date during week ending 19 June 2015 with the submissions being assessed during July / August 2015 and a contract award in September with implementation from April 2016. Jeremy vanes, Chair, Royal Wolverhampton NHS Trust (RWT) advised that the RWT element of the project (ground floor) would be open to the public from November 2015 and extended an invitation to the Board to visit the facility. The Chair nominated the Democratic Support Officer to co-ordinate arrangements for such a visit.

The Director of Strategy and Transformation reminded the Board that the upper floor of the facility would provide 24 hour General Practitioner (GP) based service.

The Chair of RWT commented that the forthcoming Winter was likely to be another difficult period in terms of capacity but that the project for the new facility had progressed very well. The Chair enquired as to whether there were sufficient bed spaces given the 3.5% reduction in bed spaces at New Cross Hospital. The Chair of RWT commented that the use of Cannock Chase Hospital for “cold case” surgery would ease the pressure on demand for bed spaces and that other actions were being taken to reduce pressures.

The Strategic Director, Place, enquired as to whether any other issues needed to be considered in relation to the Equality Analysis. The Director of Strategy and Transformation advised that the increase in attendances at the Accident and Emergency (A and E) Department would be addressed once the new facility was functioning fully given that many of those presenting did not require admission to hospital. The 24 hour GP facility offering 24 hour GP services would also lead to a reduction of the pressures experienced in the A and E Department. Issues which remained to be addressed fully included Discharge Planning and Social Work Assessment to speed up release for care in the community thus freeing up bed spaces.

The Chair acknowledged the difficulties faced by both secondary and tertiary care providers and enquired as to the possibility in providing additional step down facilities. The Director of Strategy and Transformation responded that the provision of additional beds was not at the heart of the problem but rather whether the tri-partite (CCG / RWT / WCC) discharge policies were working appropriately. The Strategic Director, Place, echoed the comments now made and commented that the percentage of Adult Social Care was high on bed based services and that the balance needed to be addressed towards care at home with service users remaining at home. She reported that currently a number of Social Worker posts were filled by Agency Staff but this was being addressed. Donald McIntosh advised that Wolverhampton Healthwatch was working with the Local Pharmacy Committee with a view to additional services being provided by local pharmacies for minor ailments rather than escalation up to the A and E Department. Cllr Paul Singh referred to anecdotal evidence of a delayed discharge due to the delays in the necessary community care arrangements being put in place. The Strategic Director, place, undertook to discuss the maater with Cllr Singh outside the meeting.

Resolved:

1. That consideration of the Joint Strategy for Urgent Care – Equality Analysis be deferred until the next meeting;
2. That a visit to the new facilty at New Cross Hospital be arranged.

12 **Better Care Fund Programme Update**

The Director of Strategy and Transformation presented a report which provided a briefing on the activity against plan for the Better Care Fund (BCF) programme, which appraised the Board of progress against workstreams and the overall programme since the last update and on the reporting and approval requirements against the national quarterly submissions.

The Service Director, Mental Health and Disabilities, drew to the attention of the Board that the Section 75 agreement between Wolverhampton City Council and Wolverhampton City Clinical Commissioning Group had been agreed formally for the 2015/16 year. She advised that the BCF programme Board would monitor expenditure on behalf of this Board with regular reports being submitted. Any changes to the Agreement would require the approval of the City Council's Cabinet and the Commissioning Group's Board.

The Strategic Director commented that it was essential that delivery was concentrated upon given the financial pressures faced by both organisations. Donald McIntosh acknowledged that the emphasis of the Better Care Fund was a different approach to that applied previously but drew to the attention of the Board that although engagement with the third sector was underway at workstream level there was no involvement at Programme Lead level. The Director of Strategy and Transformation advised that where the third sector was involved it would be at Team level rather than Programme Lead level but undertook to check that they were involved. The Strategic Director reported that with the Dementia and Mental Health workstreams the voluntary and community sectors were actively involved but that opportunities existed to strengthen the involvement in the Primary and Community Care workstream.

Resolved:

1. That the revised integrated governance structure be approved;
2. That the process for submitting the quarterly mandated Better Care Fund reports be approved;
3. That the plan on a page of individual programmes within the programme be approved;
4. That the formal agreement of the Better Care Fund Section 75 Agreement between Wolverhampton City council and Wolverhampton City Council Clinical Commissioning Group for the 2015/16 year be noted.

13 **Minutes from Sub Groups**
**(i) Children's Trust Board**

Cllr Val Gibson presented the minutes of the meeting of the Children's Trust Board held on 18 March 2015.

**(ii) Transformation Commissioning Board**

The Service Director, Disability and Mental Health presented the minutes of the meeting of the Transformation Commissioning Board held on 29 January 2015. She drew to the attention of the Board that this group would in future be titled "Integrated Commissioning Board" with responsibility for adult and children.

Resolved:

That the minutes of the Sub Groups be noted.

14 **Exclusion of Press and Public**

Resolved:

That in accordance with Section 100A(4) of the Local Government Act 1972 the press and public be excluded from the meeting for the following items of business as they involve the likely disclosure of exempt information as set out in Paragraphs 1 and 2 of the Act.

## Part 2 – Matters not open to the public and press

15 **NHS Capital Programme**

David Johnson, Project Lead – Primary Care Regeneration, NHS England presented a report on developments being progressed currently by NHS England in collaboration with Wolverhampton City Clinical Commissioning Group and NHS Property Services.

Resolved:

That the report be received and noted.

16 **Transforming Care**

The Service Director Disability and Mental Health presented a report which detailed the work undertaken to date to deliver the Transforming Care agenda in Wolverhampton following the abuse of adults with learning disabilities at an independent hospital, Winterbourne View. The report detailed the background to the winterbourne Concordat, the more recent national work programme Transforming Care and the position of Wolverhampton in its delivery.

Resolved:

That the report be received and noted.

**Agenda Item No. 6**

CITY OF WOLVERHAMPTON COUNCIL

# Health and Wellbeing Board

29 July 2015

| | | |
|---|---|---|
| **Report Title** | Summary of outstanding matters | |
| **Cabinet Member with Lead Responsibility** | Councillor Sandra Samuels<br>Health and Wellbeing | |
| **Wards Affected** | All | |
| **Accountable Director** | Viv Griffin – Service Director – Disability and Mental Health | |
| **Originating service** | Governance | |
| **Accountable officer(s)** | Carl Craney | Democratic Services Officer |
| | Tel | 01902 55(5046) |
| | Email | carl.craney@wolverhampton.gov.uk |

**Recommendations for noting:**

The Health and Wellbeing Board is asked to consider and comment on the summary of outstanding matters

## 1.0 Purpose

1.1 The purpose of this report is to appraise the Board of the current position with a variety of matters considered at previous meetings of the Health and Wellbeing Board.

## 2.0 Background

2.1 At previous meetings of the Board the following matters were considered and details of the current position is set out in the fourth column of the table.

| DATE OF MEETING | SUBJECT | LEAD OFFICER | CURRENT POSITION |
|---|---|---|---|
| 31 March 2014 | Health and Well Being Strategy – Performance Monitoring | Helena Kucharczyk (WCC) | Quarterly reports (included with Better Care Fund updates) |
| 31 March 2014 | NHS Capital Programme – NHS England – GP practices in Wolverhampton | Les Williams / Dr Kiran Patel (NHS England) | Quarterly reports |
| 3 September 2014 | Joint Strategy for Urgent Care – Equality Analysis | Delivery Plan | Report to this meeting |
| 7 January 2015 | Implementation of Action Plans following Francis Inquiry – Update | Six monthly updates | Reports to July 2015 and January 2016 meetings and six monthly thereafter |
| 4 March 2015 | Scoping the JSNA and analysing best exemplars nationally | Ros Jervis (WCC) | Report to a future meeting |
| 3 June 2015 | Integrated Commissioning | Roles and responsibilities of the various partner agencies involved in Integrated Commissioning | Report to a future meeting as part of a Better Care Fund – Update report. |

## 3.0 Financial implications

3.1 None arising directly from this report. The financial implications of each matter will be detailed in the report submitted to the Board.

## 4.0 Legal implications

4.1 None arising directly from this report. The legal implications of each matter will be detailed in the report submitted to the Board.

## 5.0 Equalities implications

5.1 None arising directly from this report. The equalities implications of each matter will be detailed in the reports submitted to the Board

## 6.0 Environmental implications

6.1 None arising directly from this report. The environmental implications of each matter will be detailed in the report submitted to the Board.

## 7.0 Human resources implications

7.1 None arising directly from this report. The human resources implications of each matter will be detailed in the report submitted to the Board.

## 8.0 Corporate landlord implications

8.1 None arising directly from this report. The corporate landlord implications of each matter will be detailed in the report submitted to the Board.

## 9.0 Schedule of background papers

9.1 Minutes of previous meetings of the former Shadow Health and Well Being Board and associated reports and previous meetings of this Board and associated reports

**Agenda Item No. 7**

CITY OF WOLVERHAMPTON COUNCIL

# Health and Wellbeing Board

29 July 2015

| | |
|---|---|
| **Report Title** | Health And Wellbeing Board – Forward Plan 2015/16 |
| **Cabinet Member with Lead Responsibility** | Councillor Sandra Samuels<br>Health and Wellbeing |
| **Wards Affected** | All |
| **Accountable Director** | Viv Griffin – Service Director – Disability and Mental Health |
| **Originating service** | Disability and Mental Health |
| **Accountable officer(s)** | Viv Griffin Service Director<br>Tel 01902 55(5370)<br>Email Vivienne.Griffin@wolverhampton.gov.uk |

## Recommendation

That the Board considers and comments on the items listed in the Forward Plan

| MEETING | TOPIC | LEAD OFFICER |
|---|---|---|
| **29 July 2015** | Minutes from Sub Groups | Viv Griffin / Linda Sanders / Ros Jervis (WCC) |
| | Primary Care Commissioning | Steven Marshall (WCCCG) |
| | Update on progress with implementing recommendations from the Francis Inquiry | Manjeet Garcha (WCCCG) |
| | Obesity Action Plan | Ros Jervis (WCC) |
| | Public Health Annual Report 2014/15 | Ros Jervis (WCC) |
| | CAMHS System Transformation | Viv Griffin (WCC) / Steven Marshall (WCCCG) |
| | Joint Strategy for Urgent Care – Equality Analysis | Steven Marshal (WCCCG) |
| | Better Care Fund Update<br>• Primary and Community Care<br>• Re-ablement and Intermediate Care | Viv Griffin (WCC) / Steven Marshall (WCCCG) |
| **7 October 2015** | Minutes from Sub Groups | Viv Griffin / Linda Sanders / Ros Jervis (WCC) |
| | Infant Mortality | Ros Jervis (WCC) |
| | JSNA Options Appraisal | Ros Jervis (WCC) |
| | Better Care Fund Update<br>• Dementia | Viv Griffin (WCC) / Steven Marshall (WCCCG) |

- Mental Heath

| | | |
|---|---|---|
| | CCG Commissioning Intentions | Steven Marshal (WCCCG) |
| | NHS Capital Programme – Update | Dr Kiran Patel (NHS England – Local Area Team) |
| **2 December 2015** | Minutes from Sub Groups | Viv Griffin / Linda Sanders / Ros Jervis (WCC) |
| **10 February 2016** | Minutes from Sub Groups | Viv Griffin / Linda Sanders / Ros Jervis (WCC) |
| | NHS Capital Programme – Update | Dr Kiran Patel (NHS England – Local Area Team) |
| | Update on progress with implementing recommendations from the Francis Inquiry | Dr Helen Hibbs (WCCCG) |
| **27 April 2016** | Minutes from Sub Groups | Viv Griffin / Linda Sanders / Ros Jervis (WCC) |

**To be added at some appropriate point: Youth Offending Team input**
**Joint Strategic Needs Assessment**

**Agenda Item No.** 8

CITY OF
WOLVERHAMPTON
COUNCIL

# Health and Wellbeing Board

29 July 2015

| | |
|---|---|
| **Report title** | Update on Primary Care Co-Commissioning |
| **Cabinet member with lead responsibility** | Councillor Sandra Samuels<br>Health and Wellbeing |
| **Wards affected** | All |
| **Accountable director** | Steven Marshall |
| **Originating service** | Wolverhampton CCG) |
| **Accountable employee(s)** | Steven Marshall Director of Strategy & Transformation<br>Email steven.marshall3@nhs.net |
| **Report to be/has been considered by** | Wolverhampton CCG Governing Body 14 July April 2015 |

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**Recommendation(s) for action or decision:**

The Health and Wellbeing Board is recommended to:

1. Provide appropriate feedback to the CCG

**Recommendations for noting:**

The Health and Wellbeing Board is asked to note:

1. The contents of the report

## 1.0 Purpose

This paper outlines the content of the guidance received to date, assesses the opportunities and risk of each co-commissioning level and its preferred option of level 2 (joint Commissioning) for Wolverhampton CCG

## 2.0 Background

2.1 Primary Care Co-Commissioning is one of a series of changes set out in the NHS Five Year Forward View. It offers CCGs a choice of three levels of co-commissioning primary medical services with NHS England, which following the Health and Social Care Act 2012, has overall legal responsibility for primary care commissioning.

The expected benefits for patients and the public include:

- Improved access to primary care and wider out-of-hospital services, with more services available closer to home
- High quality out-of-hospitals care
- Improved health outcomes, equity of access, reduced inequalities and
- A better patient experience through more joined up services

2.2 Furthermore, it will enable the development of a more collaborative approach to designing local solutions for workforce, premises and information management and technology challenges.

2.3 Primary care co-commissioning is the beginning of a longer journey towards place based commissioning – where different commissioners come together to jointly agree commissioning strategies and plans, using pooled funds, for services for a local population.

2.4 The three levels of co-commissioning offered to CCGs by NHS England are:

**Level 1: Greater involvement in primary care decision-making** – Greater involvement in primary care co-commissioning is simply an invitation to CCGs to collaborate more closely with their NHS England teams to ensure that decisions taken about healthcare services are strategically aligned across the local health economy.

**Level 2: Joint commissioning arrangements** – A joint commissioning model enables one or more CCGs to assume responsibility for jointly

commissioning primary medical services with their NHS England sub-region. There are two possible models:
**Joint committee**: a joint committee makes a decision on matters in the scope of the joint committee, which could include NHS England's functions and CCG's functions.

**Committees in common: "**committees in common" come together but they make individual decisions. Multiple joint committees could meet as "committees in common" if they choose to.

**Level 3: Delegated commissioning arrangements** – Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning.

2.5 The table below provides a summary of the responsibilities for primary care functions across each level of co-commissioning:

| Primary Care Function | Greater Involvement | Joint Commissioning | Delegated Commissioning |
|---|---|---|---|
| General Practice commissioning | Potential for involvement in discussions but no decision-making role | Jointly with sub-regions | Yes |
| Pharmacy, eye health and dental commissioning | Potential for involvement in discussions but no decision-making role | Potential for involvement in discussions but no decision-making role | Potential for involvement in discussions but no decision-making role |
| Design and implementation of local incentive schemes | No | Subject to joint agreement with sub-region | Yes |
| General practice budget management | No | Jointly with sub-regions | Yes |
| Complaints management | No | Jointly with sub-regions | Yes |
| Contractual GP practice performance management | Opportunity for involvement in performance management discussions | Jointly with sub-regions | Yes |

| | | | |
|---|---|---|---|
| Medical performers' list, appraisal, revalidation | No | No | No |

## 3.0 Progress, options, discussion, etc.

3.1 From April 2015, 86 CCGs took up 'joint commissioning' responsibilities and 63 CCGs took up 'delegated commissioning' responsibilities.

3.2 Wolverhampton CCG applied in January 2015 for joint commissioning of primary care services, but the application was deferred by NHS England at regional level to allow the CCG more time to improve its financial stability. The ambition for applying for co-commissioning was:

- To promote the development of seamless, integrated out-of-hospital services through a shift of investment from acute to primary and community services
- To achieve greater alignment of primary and secondary care commissioning, improving efficiency across patient pathways and greater synergy between commissioning budgets
- To improve access to primary care and wider out-of-hospital services by bringing services closer to patients
- To facilitate opportunities to improve proactive care planning for patients (including self-management of chronic conditions), patient outcomes and experience
- To reduce unplanned hospital admissions as a result of exacerbations of long-term conditions
- Enhance the quality of decision-making and support to GPs in referral to secondary care

3.3 These ambitions for co-commissioning still hold true as the rationale for re-applying. However, following the review of the CCG's Practice Support Visit Programme in 2014/15, there is a measured need to strengthen the joint approach to improve the *quality* and *performance* of Practices, where identified as in need of development, against key deliverables eg. Access to care, care management and general performance to targets.

3.4 The functions of each level of co-commissioning are described below:

**3.4.1 Greater Involvement in Primary Care Decision-Making.** Under this model CCGs would be enabled to collaborate more closely with NHSE to ensure the strategic alignment of decisions across the local health economy. Both parties will also need to engage with local authorities, local Health & Wellbeing

Boards and communities in primary care decision-making. With no formal accountability for decision-making, CCG conflicts of interest are not increased.

**3.4.2 Joint Commissioning Arrangements** enables CCGs to assume responsibility for jointly commissioning primary medical services with NHSE via a joint committee. This model is designed to give CCGs and NHSE an opportunity more effectively plan and improve the provision of out-of-hospital care and enable pooling of funding for investment in primary care. The functions covered include:

- GMS, PMS and APMS contacts, monitoring contracts, taking contractual action such as issuing breach / remedial notices and removing a contract
- Newly designed enhanced services
- Design of local incentives schemes as an alternative to QOF
- The ability to establish new GP Practices in an area
- Approving practice mergers
- Making decision on discretionary payments (eg return / retainer schemes)

**3.4.3 Delegated Commissioning Arrangements** offers CCGs the opportunity to assume full responsibility for commissioning general practice services whilst NHSE will retain responsibility for the performance of primary care medical commissioning. The functions covered are similar to joint commissioning, with more autonomy.

## 4.0 Financial implications

4.1 Co-commissioning will have an impact on the workforce capacity of the CCG. There is no uplift in CCG running costs to accommodate the extra responsibilities of co-commissioning so any adjustment to staffing structures must be contained within the current running cost limits

## 5.0 Legal implications

5.1 Risks would need to be managed in respect of governance, conflicts of interest, workload vs staff capacity and engagement / liaison with NHSE

## 6.0 Equalities implications

6.1 None identified

## 7.0 Environmental implications

7.1 None identified

## 8.0 Human resources implications

8.1 Appropriat Staffinglevels need to be identified by the CCG

## 9.0 Corporate landlord implications

9.1 None

## 10.0 Schedule of background papers

10.1 N/A

**Agenda Item No. 9**

CITY OF WOLVERHAMPTON COUNCIL

# Health and Wellbeing Board

29 July 2015

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| **Report title** | **Update from the Wolverhampton Clinical Commissioning Group in response to the recommendations made by Francis Inquiry** | |
| **Cabinet member with lead responsibility** | Councillor Sandra Samuels<br>Chair Health and Wellbeing Board | |
| **Wards affected** | All | |
| **Accountable director** | Linda Sanders - People | |
| **Originating service** | Wolverhampton City Clinical Commissioning Group | |
| **Accountable employee(s)** | Manjeet Garcha | Tel: 01902 442476<br>Email:manjeet.garcha@nhs.net |
| **Report to be/has been considered by** | | |

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**Recommendation(s) for action or decision:**

The Health and Wellbeing Board is recommended to:
Note and support the steps Wolverhampton CCG (WCCG) is taking to address the findings of the Mid Staffordshire Inquiry. This report covers the wider system changes which have been implemented to address the recommendations.

## 1. Purpose

1.1 To provide a further assurance report to the Health and Wellbeing Board that the CCG continues to consider and reflect on the implications of the Mid Staffordshire NHS Trust reports and system wide change necessary to improve patient safety, clinical effectiveness and patient experience. The Health and Wellbeing Board requested this at the January meeting.

## 2.0 Background

2.1 Sir Robert Francis was commissioned in July 2009 to chair a non-statutory inquiry into the happenings at Mid Staffordshire. The primary purpose of this being to give a voice to those who had suffered and to consider what went wrong. This initial report was published in February 2010 and subsequent reports in 2013 and Governments Response in 2014.

## 3. Introduction

The Francis Report highlighted that despite monitoring systems being in place, there was still a failure to provide safe care over a sustained period of time, which, had sadly resulted in the avoidable demise of many patients. The immediate priority across the health and social care system was to identify if there were any similar quality and patient safety failures in other areas of patient care, and this was guided by several reports and responses following 2013.

## 4. Key Reports and Inquiries

Since 2001 there have been several reports and inquiries (Appendix 1) which have all highlighted a deficit in quality of care. They all made recommendations which have common themes;

- Preventing problems
- Detecting problems quickly
- Taking prompt action
- Robust accountability
- Staff training and motivation
- Safety and openness

## 5. CCG and Provider Work streams – Update

5.1 **Transparency of quality data and improved availability** – this includes

- Publishing data on mortality, per consultant for 10 medical specialties
- Publishing data on Friends & Family Test (FFT), which now includes A&E, inpatient, maternity and primary care. There is now also a Staff FFT. Further roll out to include community and mental health.

Assurance: Wolverhampton CCG agreed Commissioning for Quality and Innovation (CQUIN) incentive with RWT for 2014/15, this is now embedded practice and monitored monthly at the Clinical Quality Review Meetings (CQRM). Results are published nationally on NHS Choices and ongoing assurance is sought. This is also supported by the Care Quality Commission (CQC) appointment of three Chief Inspectors hospitals, adult social care and primary care.

CQC inspections are ongoing and RWT have recently (June 2015) received a 3 day inspection, (awaiting report) and BCPFTs inspection is planned for the autumn. There have also been several inspections across primary and health and social care. All ratings and reports are published on CQC and Trust website, including reports to Trust Boards and Governing Bodies. RWT, as an aspiring Foundation Trust, has to achieve 'outstanding' or 'good' to be authorised by Monitor.

### 5.2 Addressing 'Failing' Providers

The Government has extended greater powers of intervention to the CQC. Providers are put into 'special measures' and action plans are monitored jointly by CQC, CCG, NHSE and Trust Development Authority (TDA) as appropriate. All measures stated in this report serve as an 'alert' for the commissioner that services are of concern, whilst the commissioner or provider can take one serious issue on its own, best practice shows that triangulation with several other key areas will give a clearer picture and then a level of appropraite escalation and management can be agreed.

Quality failures are given the same importance as financial failures.

### 5.3 Leadership and Accountability/Oversight

Includes:

- CQC inspection and CCG Assurance Framework Domain includes 'well led organisation'
- Performance Management Frameworks
- Nursing and Midwifery Revalidation to commence approx. April 2016
- Revalidation for doctors has been strengthened
- Senior leadership programmes
- Fast track leadership programmes for clinicians to recruit external talent into top jobs in the NHS
- Named GP for all elderly/vulnerable patients in primary care
- Monthly oversight reports from all providers (safety, effectiveness and experience)
- Mandatory reporting of agreed indicators as per quality schedules included in contracts i.e. staff training, absence, appraisal, complaints, FFTs, agency usage, safer staffing, infection management
- Primary Care Quality Monitoring
- Nursing and care home sector improving quality schemes

Assurance- provider assurance via monitoring key performance indicators and remedial action plans. E.g. compliance to training plans and targets for training achieved at different levels i.e. safeguarding training at levels 1, 2, 3 and 4 for all including clinician and non-clinicians. CCG provides and monitors mandatory and all other training via individual staff appraisals on an annual basis. WCCG also provides training and update for primary care staff at bi monthly Team W events.

In addition, WCCG has worked with RWT to share learning on key patient safety issues which have seen a significant and sustained improvement as Never Events across the Birmingham, Black Country & Solihull NHSE foot print, which was evaluated very well and participants valued the opportunity to learn from other commissioners and providers as well as discuss learning from the incidents across various specialties.

The new measures as identified above and in response to the Francis Recommendations, go some way in identifying early failing services, measures to turn them around, accountability and when necessary, criminal sanctions. But it has to be recognised that these are only the beginning of the process to fundamentally change the culture to ensure safe and compassionate care across the whole of the NHS.

### 5.4 Commissioning for Quality

The CCG is committed to ensuring that there are appropriate processes in place to engage with the public and staff, gain views on services, use this information to inform service design or redesign, measure outcomes and inform our future commissioning intentions. We do this by several forums;

- Patient Participation Groups
- Locality Meetings
- ‘pop up’ shops
- Consultation/engagement events
- Children and Young People Forums
- Patient surveys
- Carers Support
- Complaint monitoring
- Staff surveys
- Joint engagement forums with key stakeholders
- Use of technology i.e. twitter, facebook, e-news letters etc

### 5.5 Performance management and standard setting

The policing of compliance with standards are very challenging and requires a robust policy and strategy which is supported by all stakeholders. In order to meet this standard there are robust performance management processes in place. In order to get a better understanding of the quality of care provided in various settings, WCCG has in place a series of scheduled and unscheduled quality visits to all providers of NHS commissioned care. These include acute, mental health, primary, local authority, third sector and independent sector. We work in collaboration with our stakeholders and regulatory partners i.e. CQC, TDA to conduct regular ‘walk rounds’ to ensure direct observation of care. Findings are shared with providers and regulators for transparency and over time this has fostered stronger working relationships. WCCG is working with Health watch to undertake some joint work. The visiting team is made up from clinicians, governing body members with specialist interest in Quality, lay members, expert patients and members from the quality team.

Assurance: is sought at monthly CQRM, performance and contract review meetings to monitor all agreed performance indicators. This is further supported by information from the quality visits and other softer data related to patient safety, experience and effectiveness.

NHSE chair a monthly Quality Surveillance Group for key issues to be discussed and escalated and the CCG has a quarterly Assurance Review meeting to monitor the system wide assurance.

### 5.6 Organisational Culture

Robert Francis recommended that all providers demonstrate commitment to reviewing organisational culture. Since 2013, all providers have had in place robust action plans to monitor their progress with the pertinent recommendations and evaluation to monitor effectiveness. As you can see from **appendix 1,** since Francis, there have been several other reports which all impact on safety and quality of services patients/carers receive.

Assurance - Each provider was tasked with providing assurance to its respective governing body/trust board on progress made with their action plans. Over time the action plans have matured and all actions completed. On ongoing basis principles of openness, transparency and candour are monitored, all action plans are sighted by WCCG and evidenced i.e. job descriptions have been reviewed and updated, provider and CCG Being Open policies are in place and human factors are considered for all significant event learning.

### 5.7 Workforce and Safer Staffing Levels

Since the last update, there has been much activity in this area, namely ward level data being published by each trust and whether they are meeting their staffing requirements, every six months trust boards receive assurance that a detailed review of staffing levels has been undertaken using evidence based tools. National Institute for Health and Care Excellence (NICE) also undertook a staffing review and made some recommendations for using key accredited tools. It was anticipated that NICE would endorse safe staffing levels, however, it did not.

Key changes in recruitment of student nurses, it is proposed that before entering NHS funded nurse training courses, each student nurse will have to demonstrate and evidence a yearlong placement in a health care setting as a health care assistant.

Training for Health Care Workers and Social Care Support Workers will be required to be certificated to assure the fundamental training and skills to give personal care to patients and service users. There is ongoing work with Health Education England and Skills Council to progress this.

Assurance – providers share their board reports at CQRMs, on an ongoing basis all soft or hard data related to patient safety incidents is correlated with staffing levels to get a better understanding of the whole picture i.e. information on pressure ulcers, falls and other harms is triangulated with ward dashboards to identify key issues with staffing and skills mixes. Wards that are a concern are supported through staffing, education, training and leadership. Further work is ongoing to extend this to other services i.e. maternity and community settings.

Workforce training, skills, absence management, bank/agency usage are all monitored.

### 5.8 Supporting staff to share concerns

Francis highlighted that one of the key areas which needed to be addressed immediately was the issue related to staff feeling supported and free from reprisal in the event they wished to 'whistle blow'. In his 2015 report, *Freedom to Speak Up,* Robert Francis identified 5 key overarching themes for which he made 20 recommended principles to put into practice. The five key themes were;

- Culture change
- Improve handling of cases
- Measures to support good practice
- Particular measures for vulnerable groups
- Extending legal protection

Assurance – whilst formal assurance is gained via policies and procedures being in place, WCCG place a greater emphasis on learning from staff on how things have changed/improved or not. This is obtained via several forums including: surveys, response rates, staff FFT, complaints, whistleblowing cases, engagement with vulnerable groups, walk around and sickness rates. All providers provide ongoing monthly assurance via the CQRM's.

### 6.0 Next Steps/Conclusion

It can be recognised that the CCG has taken a number of steps in meeting their responsibilities to address recommendations initially set out by Francis, but as demonstrated in appendix 1, maintained by several other reports which followed, which may have specific function but key themes remain consistent over safety, safeguarding, experience and effectiveness.

There are early discussions across the wider health and social care economy to lead on a provider led workshop what will bring together all WCCG providers and local commissioners to harness the learning and share good practice to further drive up standards of care across the whole of the health economy in the City.

WCCG remains committed to this important agenda; I would very much welcome the opportunity to return to Health and Well Being Board in six months to report on further progress and updates including the findings of the recent and pending CQC Inspections.

Report Author:

Manjeet Garcha
Director of Nursing and Quality
WCCG

Appendix 1

| Year | Key Report | No of Recommendations |
|---|---|---|
| 2001 | The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995 | 198 |
| 2002-5 | The Shipman Inquiry | 190 |
| 2009 | Mid Staffs Review- Dr David Colin Thome | 24 |
| 2009 | Mid Staffs Review- Professor Alberti | 23 |
| 2010 | Colin Norris Inquiry 2010 | 32 |
| 2010 | RF 1 March 2009 (Robert Francis QC) | 18 |
| 2010 | The Airedale Inquiry (Kate Thirwell QC) | 6 |
| 2012 | Winterbourne Review | 56 |
| 2012 | Morecambe Bay | 35 |
| 2013 | RF2 Feb 2013 (Robert Francis QC) | 290 |
| 2013 | Don Berwick- a promise to learn | 10 |
| 2013 | Bruce Keogh- Review of 14 NHS Trusts | 8 |
| 2013 | Ann Clwyd MP & Professor Tricia Hart- Review of NHS Hospitals Complaints Systems | 4 |
| 2013 | Cavendish Review- Healthcare assistants and support workers in NHS settings | 2 |
| 2014 | Hard Truths- Government Response to RF2 | 5 |
| 2014 | Kennedy Breast Care Review | 10 |
| 2014 | Independent Enquiry into Child Sexual Exploitation in Rotherham | 15 |
| 2015 | NHS Saville Legacy Unit; Oversight Report | 14 |
| 2015 | Robert Francis review of Whistleblowing: Freedom to Speak | 20 |
| Total | | 960 |

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**Agenda Item No. 10**

# Health and Wellbeing Board

29 July 2015

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|---|---|---|
| **Report title** | Obesity Call to Action – Update and progress made towards developing an Action Plan to tackle obesity in Wolverhampton | |
| **Cabinet member with lead responsibility** | Councillor Sandra Samuels<br>Health and Wellbeing | |
| **Wards affected** | All | |
| **Accountable director** | Ros Jervis - Public Health and Wellbeing | |
| **Originating service** | Public Health | |
| **Accountable employee(s)** | Ros Jervis<br>Tel<br>Email | Director of Public Health and Wellbeing<br>01902 551372<br>Ros.jervis@wolverhampton.gov.uk |
| **Report to be/has been considered by** | People Leadership Team (6 July 2015)<br>Cabinet (16 September 2015) | |

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**Recommendation(s) for action or decision:**

The Health and Wellbeing Board is recommended to:

1. Where appropriate, nominate representatives to be part of the obesity call to action programme board.

2. Discuss and consider the proposed content of the Action Plan to tackle obesity in Wolverhampton and identify areas where partners across the Board may add value.

## 1.0 Purpose

1.1 The Health and Wellbeing Board received an update in relation to progress made for the Obesity Call to Action on the 15 March 2015. The purpose of this report is to update the Board on the development of a whole systems obesity action plan and associated governance arrangements, promote an element of challenge to progress and stimulate ideas for contribution across the partnership.

## 2.0 Background

2.1 The Board has previously noted progress made since the publication of the 2013/14 annual report; Weight? We Can't wait. A call to action to tackle obesity in Wolverhampton including the organisation of an Obesity Summit, the launch of member champion and 'million' programmes. In addition, a number of project work streams have been established, a community call to action was launched and the City Council has implemented a series of workplace health interventions.

2.2 One of the things we did was ask ourselves the following questions:

- What have we been doing for years?
- Are these things having an impact?
- Do we know what works?
- What are the key high impact measures and who needs to be involved?

2.3 Using best practice examples from a range of sources, a detailed action plan has been formulated to use as a starting point to work with partners and associated work streams. This document has been summarised (appendix one) and in its current form is largely owned by public health. However, the intention is that as further work develops with key partners and stakeholders the action plan will be revised to reflect these essential relationships. Such is the complexity of the problem, a key challenge lies in developing a coherent, affordable action plan with relevant partners that are able to commit time and resources.

2.4 Specific work areas that require further exploration include the role of General Practitioners (GP's) in encouraging more health checks and having more conversations with patients about unhealthy weight levels. GP's also require more up to date quality information regarding suitable referral opportunities. New health policies and increased public health concerns present an opportunity for community pharmacists and their teams to have a developing role in tackling obesity and positively influencing weight management. This may be through through the dispensing of medication and the provision of supporting advice to patients to address their diet and lifestyles and of weight management services. Community pharmacies, through their accessibility to patients, are in a position to provide advice to patients on nutrition and encourage obese patients to attend a monitored weight loss programme. Further areas to explore include building upon the work within Primary and Secondary schools to increase the emphasis with special schools and those pupils with learning disabilities.

## 3.0 Wolverhampton Action Plan to tackle obesity

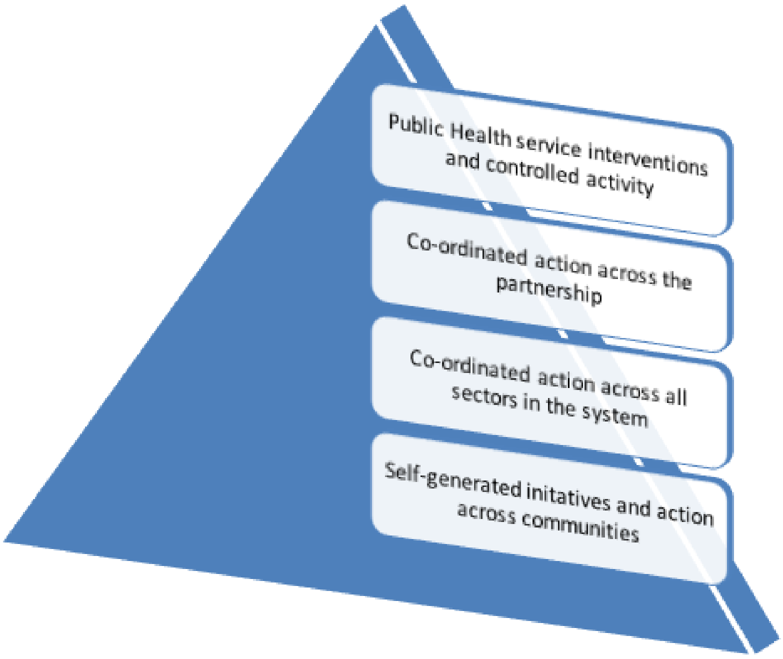
3.1 A five year draft plan (detailed in Appendix one) sets out the high level actions required to tackle obesity within the City. A more detailed technical plan has also been produced detailing the evidence base and interventions for work streams to implement over a five year period.

3.2 The overall aim of the action plan is:

'*To deliver a whole systems, asset based approach to make Wolverhampton a place that helps to prevent people of all ages from gaining weight and supports them to lose weight'.*

3.3 The action plan should not be seen as a finite response to this complex issue; rather, it is intended that the plan acts as a catalyst to motivate action across the whole system at all levels including self-generated activity in communities. The diagram below illustrates the proposed approach.

A whole systems approach to tackling obesity



3.4 The focus for the plan is a one year period with further work to be developed to achieve an overall strategic timeframe of five years. The plan aims to achieve the following overarching outcomes:

- To halt the rising trend in childhood obesity in reception year children
- To slow down the rapid rise in childhood obesity from reception year to year six

- To reduce the number of inactive adults in Wolverhampton so that those who do no physical activity begin to be more active
- To increase physical activity amongst children and young people

3.5 It is proposed that the action plan will become a dynamic working document which is refreshed and updated regularly in order to reflect the activity and commitment to change as more and more partners engage. It is envisaged that the Health and Well Being Board receive an annual update based on evaluation of evidence and lessons learnt.

3.6 The underpinning principles of the action plan will be based on and reflect the following:

- A whole systems approach – a city wide, inclusive plan
- An asset based approach - using our assets better and differently to achieve better outcomes
- A life course approach – to benefit all ages, sustained as people grow up and grow older
- Use behaviour change approaches – finding out what works for our residents

3.7 The action plan details a number of outputs and outcomes that are realistic within the timescale of 12 months, but set within the context of a five year strategic framework. The action plan includes measures, both qualitative and quantitative and focusses on the following:

- Increases in physical activity/ reducing levels of inactivity
- Weight loss and better health outcomes
- Childhood obesity and physical activity
- Indicators relating to work stream outcomes. This will include a range of intelligence and social marketing insights, including barriers and enablers related to each of the work streams

## 4.0 Governance arrangements

4.1 Four work streams have been established and have been instrumental in developing the draft action plan. However, further work is required to build upon the plan in order to achieve a whole systems approach to tackling obesity within the City. In addition, a programme board is to be established with high level representation from a number of agencies. A project management approach will be adopted and progress will be reported internally within Council and subsequently to the Health and Well Being Board and Cabinet.

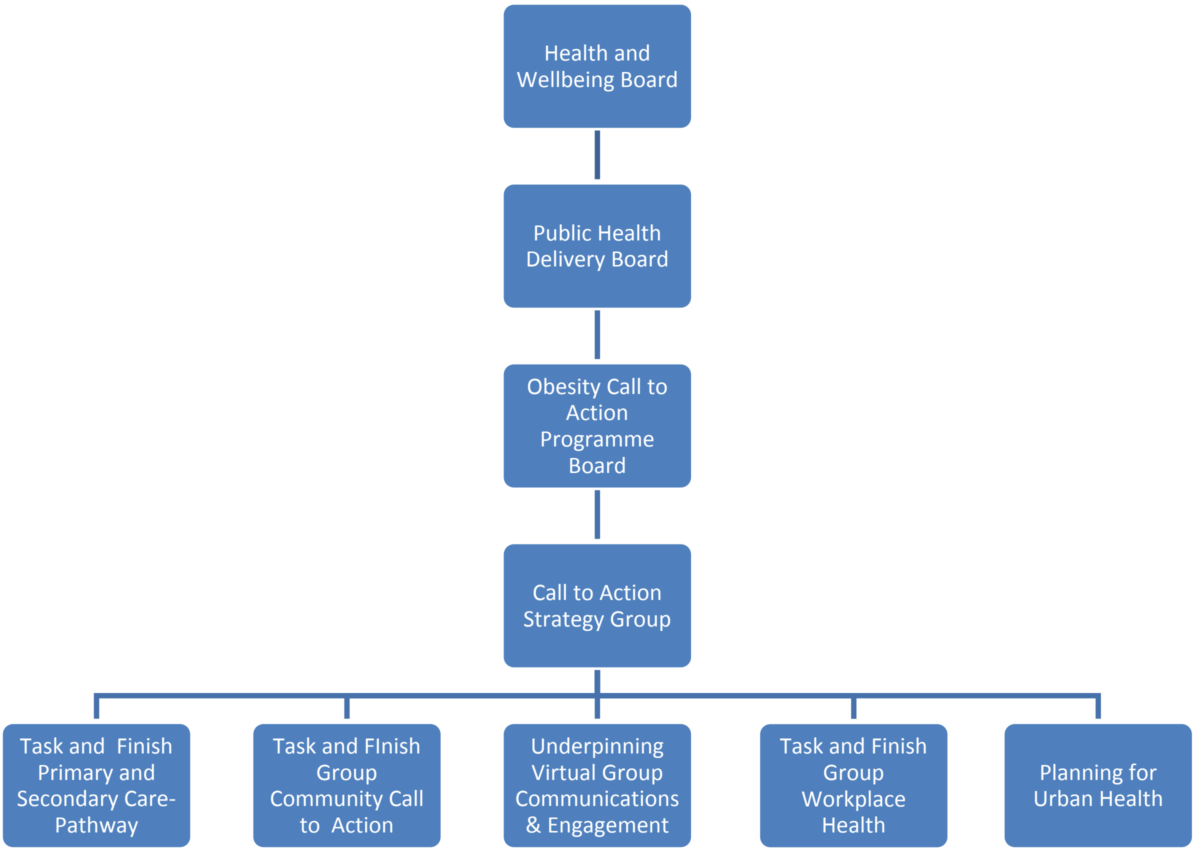
4.2 Work streams include those below and each will each be supported by a communications plan.

1. Workplace health
2. Planning for Urban health
3. Community call to action

4. Primary and Secondary Care - Development of a physical activity and weight management pathway across the life course.

4.3 The governance structure for the Call to Action programme is shown in Figure 1:

Figure 1:



## 5.0 Financial implications

5.1 Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The total funding settlement for Public Health for 2015/16 is £19.3 million.

5.2 Any costs incurred for the initiatives commissioned by Public Health in relation to obesity will be met from within this allocation.

[NM/14072015/N]

## 6.0 Legal implications

6.1 The report contains no legal implication.
(RB/14072015/O).

## 7.0 Equalities implications

7.1 The obesity priority will consider equalities implications and especially the impact of obesity on those in poverty, on different ethnic groups and social class. A full equality impact assessment is not considered necessary at this stage.

## 8.0 Environmental implications

8.1 The obesity action plan will consider the environmental implications of making Wolverhampton a less obesogenic place to live.

## 9.0 Human resources implications

9.1 There are no human resource implications.

## 10.0 Corporate landlord implications

10.1 There are no corporate landlord implications.

## 11.0 Schedule of background papers

11.1 Weight? We can't wait. A Call to Action to tackle obesity in Wolverhampton. Public Health Annual Report 2013/14 Health and Wellbeing Board, 9 July 2014

11.2 Obesity Call to Action, Health and Well Being Board, 4 March 2015.

**Obesity Call to Action – Action Plan**
**1. Children and Young People – Pre Conception, Early Years and School Age**

| Aim | Commentary | Year 1 Action | Medium Term Action (2/3 years) | Longer Term Action (4-5 years) | Targets | Measure of Success / Outcomes | Resource Implications |
|---|---|---|---|---|---|---|---|
| Support overweight and obese women to keep their weight gain during pregnancy to within the guidance of around 10kg. | Academic Public Health is beginning to research how our future weight is influenced by Mum's weight and weight gain during pregnancy. Women who are overweight and obese are encouraged to keep their weight gain during pregnancy to within the guidance of around 10kg. We are looking for ways to ensure the weight of all newly conceived Mums is recorded, this may be before their first midwife appointment and to refer to the relevant service. In the steps to deliver this, we also want to assess any other aspects of health which could be improved, such as smoking, smoking status in the home, alcohol or other substance misuse and make appropriate referrals to the Healthy Lifestyles Service (HLS). It could be as simple as dietary improvement too. | Establish a pilot in GP's receptions to survey all newly conceived women. BMI measurement to be taken on scales provided by pilot scheme. | Evaluate impact of pilot and roll out citywide if successful. | Monitor and review impact. | Increase the number of referrals made to HLS of newly conceived women by 10%.<br>Increase the number of overweight and obese women who restrict weight gain to 10kg by 10%.<br>Increase the number of women supported to improve their lifestyle during pregnancy, particularly smoking amongst the under 24 year olds (by 35%. | Data shows improvement in the targets identified | Budget of (30k) for pilot scales has been identified.<br>If successful, cost of providing scales in all GP practices would be required. Estimated budget of £50k . |
| Promote and support breastfeeding | Breast feeding is best for baby and best for Mum in terms of baby's current and future health, bonding and Mum's weight loss. | Revise data capture on feeding status, including at 6 months.<br>Support the work of the multi-agency infant feeding group to develop an infant feeding strategy. | Implement social marketing techniques to improve breast feeding rates. | Review and revise social marketing plan. | Improve breast feeding rates by 0.5%. | Increase reported by data return | Some provision --<br>Recurring costs may be incurred to support the infant feeding strategy and to support social marketing |

**Obesity Call to Action – Action Plan**

1. **Children and Young People – Pre Conception, Early Years and School Age**

| Aim | Commentary | Year 1 Action | Medium Term Action (2/3 years) | Longer Term Action (4-5 years) | Targets | Measure of Success / Outcomes | Resource Implications |
|---|---|---|---|---|---|---|---|
| Obesity prevention in the early years | To provide opportunities for the parents of children, younger than school age, to learn about the importance of a healthy lifestyle.<br>Key principles will be shared with local professionals so that health messages can be reinforced as they contact families.<br>The aim is to reduce the number of children who are overweight or obese when they start school, as recorded through the National Child Measurement Programme (NCMP) | Develop and deliver early years healthy lifestyle programmes based on local need. | Continue to monitor, develop and deliver the programmes to families and train staff | Evaluate the programme.<br>Share results | Programme to run 12 times per year. | Parents feel more confident and knowledgeable to follow advice about healthy lifestyles for the whole family.<br>Improvements in year R NCMP figures by September 2019 | Budget for Early Years programme identified.<br>£70,000. |
| Universal obesity prevention in schools | To develop and implement an obesity prevention framework for schools.<br>The framework will help to get Headteacher support for addressing obesity throughout the school day, as well as allowing children and young people opportunities to learn about the benefits of a healthy lifestyle in a school environment that supports positive health choices. School based healthy eating and physical activity projects included in the framework will provide children and young people opportunities to apply their knowledge to their health behaviours. | Work with local partners to develop the framework.<br>Recruit an initial phase of schools to participate.<br>Set up healthy eating and physical activity projects in these schools. | Evaluate phase 1 schools and make necessary changes.<br>Recruit a second and third phase of schools to participate in the framework | Evaluate phase 2 and 3 schools and make necessary changes.<br>Recruit hard to engage schools. | In the first year, 5 schools engage and implement at least 75% of the prevention strategy.<br>In years 2-3, 50% of schools engage and deliver at least 80%.<br>By year 4, 80% are delivering at least 80% of the strategy | More children lead healthier lifestyles- i.e. have better diets in and out of school and are more physically active.<br>This can be measured in the HRBS (Health Related Behaviour Survey) | £30,000 identified for year 1 projects<br>Year 2 onwards to be determined following evaluation of year 1 |

| Aim | Commentary | Year 1 Action | Medium Term Action (2/3 years) | Longer Term Action (4-5 years) | Targets | Measure of Success / Outcomes | Resource Implications |
|---|---|---|---|---|---|---|---|
| Early intervention with primary aged school children | Primary aged children identified as overweight or very overweight via the National Child Measurement programme (NCMP) receive support from the School Nursing Service. Identified children, with their families, are also referred to a local healthy lifestyle programme.<br>Vulnerable children are referred to the British Heart Foundation (BHF) 'Hearty Lives' programme – a one on one support programme that takes place in the family home. | From September 2015, 40 programmes each supporting 10 families will be commissioned<br>Delivery of the 'Hearty Lives' programme to vulnerable children and families | Expand the referral so that other local professionals and parents can refer children in to programmes.<br>Evaluate and review the effectiveness of the programme and look for alternative programmes | Implement new methods of programme delivery | It is forecasted that 20% of the children identified will participate in a family programme.<br>35% of participants to maintain or reduc e BMI at one year. | Participants to maintain weight during the family programme.<br>Follow up periods to monitor at 3/6/12 months | £60k identified within existing weight managements contracts. |
| Early intervention with children aged 11-18 | Secondary aged young people identified as overweight or obese (including those that are vulnerable) are referred to the British Heart Foundation 'Hearty Lives' programme. | Expand referrals into the Hearty Lives programme.<br>Extend delivery options, to better engage young people on programmes. | Implement new methods of programme delivery e.g. sessions for young people in community venues | Evaluate impact of year 1 to 3 activity | 50 overweight Young People to participate.<br>35% to maintain or reduce BMI after 3 months/6 months/1 year. | Increased engagement with young people.<br>A greater range of delivery options to suit multiple needs. | Currently funded by British Heart Foundation and Public Health £150k. |

**Obesity Call to Action – Action Plan**

**2. Early adulthood/ Adulthood**

| Aim | Commentary | Year 1 Action | Medium Term Action (2/3 years) | Longer Term Action (4-5 years) | Targets | Measure of Success / Outcomes | Resource Implications |
|---|---|---|---|---|---|---|---|
| Implement the Workplace Wellbeing Charter National Award for England to commitment, achievement and excellence within the city | Learning from national practice, promotion of the National Workplace Health award is an effective way of engaging and working with local businesses of all sizes to raise the profile of workplace health; as well as facilitating the improvement of the health and wellbeing of staff, the award allows businesses to begin to understand that improving workplace health contributes significantly to improvements in productivity, staff retention as well as the wellbeing of staff. | Engagement and sign up to of WCC, RWT and University to national charter. | Continued work towards higher levels of charter by first 3 organisations and wider engagements of local Small Medium Enterprises. | Using previous successes and promoting benefits, wider range of SME encouraged to sign and progress charter. | 3 large organisations reach achievement level in year 1<br>RWT, WCC and University complete excellence level, 5 SME commit to complete.<br>Further 10 SME completing national charter | Reduction in staff sickness absence by x in 3 large organisations<br>Measure for improved mental health and wellbeing of staff<br>Morale/staff satisfaction measure (via staff satisfaction survey) | Initial budget of £30k identified to engage 3 large organisations. Additional resource needs to be calculated following year one assessment. |
| Adult weight management | Weight management services for adults are delivered by a commercial company (weight watchers) and RWT's Healthy Lifestyle Service. Further work is required to understand the uptake of priority groups and associated long term impact of these programmes. | Review impact of current programmes and commission accordingly. | Increase uptake of weight management programmes by priority groups. | Monitor and review impact | Improvement in BMI outcomes at 1 year. Improvement in the numbers of men and those from BME backgrounds who attend the newly commissioned weight management service(s) and HLS. | Reduction in the numbers of type 2 diabetics: halt the rise in the proportion of type 2 diabetics who are from a BME background | |

| Aim | Commentary | Year 1 Action | Medium Term Action (2/3 years) | Longer Term Action (4-5 years) | Targets | Measure of Success / Outcomes | Resource Implications |
|---|---|---|---|---|---|---|---|
| Adults | Health Checks are the equivalent of your car’s MOT but for humans. Through various tests and by answering some questions about lifestyle, it can identify some conditions you may have, such as high blood pressure or cholesterol, or a risk of some health issues occurring in the next 10 years, such as type 2 diabetes or heart attack. The aim is to increase the number of adults who take up their invitation from their GP to have a health check and to support opportunistic testing with our known higher risk populations. | Work with Public Health England to understand how we can support their campaign “one you”, starting Jan 2016. Work with HLS on current activity and how this might be boosted by “One you”. Explore alternative IT options for Health Checks. | Increase the uptake of offered health checks | | To increase the uptake of Health Checks by 10% | Increased number of health checks. | Existing GP and Healthy Lifestyle Resources to be utilised.<br>£50k budget identified to improve Health Check IT system |

**Obesity Call to Action – Action Plan**
**3. All ages**

| Aim | Commentary | Year 1 Action | Medium Term Action (2/3 years) | Longer Term Action (4-5 years) | Targets | Measure of Success / Outcomes | Resource Implications |
|---|---|---|---|---|---|---|---|
| Increase participation in physical activity and encourage people to be healthier | Increased physical activity and leading a healthier lifestyle can significantly impact upon obesity levels at every life stage. Objective: Work with all ages across the City to increase participation in physical activity and encourage healthy behaviours through activities such as choosing better food options, being more active, promoting good mental health and health checks. More / improved facilities are required within the City to accommodate increased physical activity participation levels. | Promote national healthy lifestyle campaigns. Conduct an annual healthy lifestyles survey and mapping exercise to identify where physical activity and healthy lifestyles activity takes place. | Develop local healthy lifestyles campaign and work with partners to deliver a variety of activities that promote healthy behaviours. | Deliver local healthy lifestyles campaign and assess impact of intervention through outcomes outlined in project plan. | 1% increase in children's physical activity participation levels (baseline 35%).<br>0.5% increase in percentage of physically active people year on year (baseline 54.1%)<br>Reduce percentage of physically inactive people by 0.5% year on year (baseline 33.4%)<br>An increase of 1258 more people each year achieving 150 minutes of physical activity a week. | Percentage of school pupils reporting 5 or more times exercise per week.<br>Percentage of adults that are physically active / inactive (Sport England Active People Survey) | Physical activity interventions: £31k.<br>Current budget of £5 million allocated against facility planning and delivery:<br>Research (survey) budget identified: £50k. |
| **Community Call to Action: faith groups and community groups** | Reach out to faith groups and places of worship to support the communities they serve to encourage healthy behaviours such as choosing better food options and being more active | Build on the work of the British Heart Foundation social cooking programme with 15 places of worship | Build on the work with faith groups to reach out more broadly to community groups | Build on the work with faith groups to reach out more broadly to community groups; assess the impact on the health of the participants | 50 groups reached out to over 3 year period; showcase events at each annual working well week | Reduction in the rate of increase in levels of obesity amongst Asian and Black children | Not known yet: but intend to use the transformation fund project 'Self-Reliant Communities should the need arise |

| Aim | Commentary | Year 1 Action | Medium Term Action (2/3 years) | Longer Term Action (4-5 years) | Targets | Measure of Success / Outcomes | Resource Implications |
|---|---|---|---|---|---|---|---|
| **Community Call to Action: Community hubs** At the community hub level, increase participation in physical activity and encourage people to be healthier: | Reach out to hubs to support the communities they serve to encourage healthy behaviours such as choosing better food options and being more active. | Hold a community hub 'convention' to share good practice and develop ideas across the community hubs.<br>Commence implementation of ideas | Further implement the ideas and continue the dialogue of how community hubs can establish strong links with local community groups | Assess the impact of community hubs using measures of impact and outcomes as identified by the ideas identified and developed | Suite of initiatives in place in community hubs each with clear outcomes attached | Community Hubs lead on a suite of sustained programmes which improve health; Relationship with local community groups considerably strengthened; participants level of engagement increased | Not known yet but intend to use the transformation fund project 'Self-Reliant Communities should the need arise |
| **Reduce the obesogenic environment** | Different patterns of behaviour, including behaviour related to health and wellbeing are embedded in people's social and material circumstances as well their environment. Individuals, communities and agencies must be enabled to make the changes necessary to reduce the obesogenic environment in their homes, schools, workplaces and the environment. | Establish a Planning for Urban Health Group which considers policy change and interventions based on national good practice.<br>Establish an annual action plan. | Evaluate impact of action plan and revise accordingly.<br>Year two plan to be developed | Year three plan to be developed. | Public Health to become a statutory consultee on all significant developments within the City.<br>Research to be undertaken to develop a greater understanding of causal effects of childhood obesity within the city to include fast food takeaways and open space. | Reduction in the obesogenic environment. | Employee time estimated at two months. |

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**Agenda Item No. 12**

CITY OF WOLVERHAMPTON COUNCIL

# Health and Wellbeing Board

29 July 2015

| | |
|---|---|
| **Report title** | Wolverhampton City Council and Wolverhampton Clinical Commissioning Group Mental Health Strategy 2014-2016 |
| **Cabinet member with lead responsibility** | Councillor Sandra Samuels<br>Health and Wellbeing |
| **Wards affected** | All |
| **Accountable director** | Steven Marshall, Director of Strategy & Transformation, Wolverhampton Clinical Commissioning Group |
| **Originating service** | Commissioning – Wolverhampton CCG |
| **Accountable employee(s)** | Sarah Fellows Mental Health Commissioning Manager<br>Tel 01902 442573<br>Email sarahfellows2@nhs.net |
| **Report to be/has been considered by** | Wolverhampton Health and Well-Being Board - Wednesday 29th July 2015 |

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**Recommendation(s) for action or decision:**

The Health and Wellbeing Board is recommended to:

1. The purpose of this report is to provide members of the Health and Well-Being Board with recommendations regarding a proposal to increase capacity within CAMHS COMMISSIONING across NHS Wolverhampton Clinical Commissioning Group and Wolverhampton City Council. This is to deliver a dedicated whole systems project across CAMHS TIERS 1-4 that will deliver a sustainable model into 2020/21, deliver QIPP in the short, medium and longer term, deliver to the key strategic drivers and ambitions of Future in Mind and transform the lives of the children and young people of our city.

**Recommendations for noting:**

The Health and Wellbeing Board is asked to note the following key points:

- The development and implementation of the Mental Health Strategy, including ammendments made to address the needs and requirements of key vulnerable groups. HEADSTART: WOLVERHAMPTON pilots are delivering a range of resilience and self-efficacy building initiatives for children and young people aged 10-14 years to prevent common mental health conditions.

- Future in mind Promoting, protecting and improving our children and young people's mental health and well-being (HM GOVT 2015) outlines the NHS England Children and Young People's Task Force vision for CAMHS TIERS 1-4. Funding will follow the report which CCGs will utilize as agreed with local partners and to address the gaps / priorities outlined in Future in mind and in line with local levels and patterns of need.

- Wolverhampton Clinical Commissioning Group are leading the Black Country wide NHS England funded pilot regarding alternative models for CAMHS TIER 3 PLUS, CAMHS TIER 4 and Tri-partite funded placements.

- Wolverhampton Clinical Commissioning Group and Wolverhampton City Council are currently reviewing all children placed tri-partite funded placements including looked after children to inform commissioning intentions and support plans to reduce numbers of looked after children.

- All of the above provide an opportunity to develop and deliver a transformational plan with an aligned financial model into 2020/21that will recurrent and non-recurrent funds to deliver a service model across TIERS 1-4 realise sustainable benefits across the whole system, reduce numbers and levels of complex and enduring difficulties with regard to CAMHS presentations, deliver early intervention and prevention and deliver QIPP on a Wolverhampton and Black Country footprint.

## 1.0 Purpose

1.1 The purpose of this report is to provide members of the Health and Well-Being Board with recommendations regarding a proposal to increase capacity within CAMHS COMMISSIONING across NHS Wolverhampton Clinical Commissioning Group and Wolverhampton City Council. This is to deliver a dedicated whole systems project across CAMHS TIERS 1-4 that will deliver a sustainable model into 2020/21, deliver QIPP in the short, medium and longer term, deliver to the key strategic drivers and ambitions of Future in Mind and transform the lives of the children and young people of our city. This is to deliver the following key outputs:

- Delivery of an integrated whole systems transformation programme across CAMHS TIERS 1-4 that will deliver a sustainable model into 2020/21 with an aligned financial plan.

- Delivery of an aligned programme of QIPP in the short, medium and longer term.

- Delivery of the key strategic drivers and ambitions of Future in Mind across CAMHS TIERS 1-4 and therein transform the lives of the children and young people of our city by covering areas of recognised provision weakness, increase numbers of children and young people in early treatment and support and therein reduce levels of need and complexity.

- Re-design and delivery of a model of prevention, resilience, early intervention and personalisation at local level, employing the resilience and self-efficacy building facets of HEADSTART across the whole system.

- Re-design and delivery of improved care pathways and services across CAMHS Tiers 1-4 on a Black Country wide footprint in collaborative and / or consortium commissioning arrangements which will potentially include co-procurement with Black Country wide health and social care commissioning partners. This will involve asset mapping across CAMHS TIERS 1-4 including financial, human and other resources such as buildings and location of services etc. with the core purpose of increasing local provision, providing care close to home and increasing access to early intervention and prevention services at scale.

- Collaboration with specialised commissioning at the Birmingham, Solihull and Black Country NHS England Local Area Team regarding collaborative approaches to CAMHS TIER 4 commissioning and care pathways into and out of the local system into CAMHS TIER 4.

- Liaison with colleagues in Public Health to deliver a focused Joint Strategic Needs Assessment for children and young people resident in Wolverhampton.

## 2.0 Background

2.1 Mental health problems which begin in childhood and adolescence are common and can have multiple, wide-ranging and long-lasting effects. The economic case for investment is strong. Recent studies have estimated that mental illness costs the United Kingdom economy as much as £100 billion per year. In addition mental health problems can also have a terrible impact on people's physical health. People with schizophrenia are almost twice as likely to die from heart disease as the general population and four times more likely to die from respiratory diseases.

2.2 75% of mental health problems in adult life (excluding dementia) start by the age of 18. For young people, mental illness is strongly associated with behaviours that pose a risk to their health, such as smoking, drug and alcohol abuse and risky sexual behaviour. Mental health problems in children and young people are common and account for a significant proportion of the burden of ill health in this age range Failure to support children and young people with mental health needs costs lives and money. Early intervention avoids young people falling into crisis and avoids expensive and longer term interventions in adulthood.

2.3 Most mental health difficulties can be effectively treated. Many people can recover completely, whilst for others the severity and impact of the condition, and the lifetime cost can be significantly reduced. In general terms, the treatments for mental health problems can be as effective as those for physical illness.

2.4 Despite the high costs to individuals and society and the range of NICE approved interventions however, it is estimated that only a quarter of children and young people with mental health difficulties receive treatment. Nationally a history of underinvestment in CAMHS means that services are not currently able to offer all of the timely evidenced-based interventions that should be delivered across CAMHS TIERS 1-4.

2.5 There is a compelling moral, social and economic case for change and a growing evidence-base in terms of clinically effective and cost effective interventions. There is also growing evidence regarding rising levels of need - for example referral rates to Tier 3 CAMHS have increased greatly in recent years, with the number of cases rising by more than 40% between 2003 and 2009/10.

2.6 There are clear opportunities for a multi-agency / collaborative and integrated approach to commissioning CAMHS. This involves risks and interdependencies, but also opportunities to better meet the needs of the populations that we serve, reduce the impact of mental health difficulties upon statutory services in the longer term both CAMHS and AMHS and achieve wider system efficiencies, including upon the criminal justice system.

2.7 The wide ranging mental health difficulties addressed by CAMHS include:

- Conduct disorder
- Anxiety and depression
- ADD
- Psychosis
- Co-morbid substance misuse
- Eating Disorders
- Self-harm and suicidal behaviour
- Bullying
- Challenging Behaviour

2.8 The national programme to transform the outcomes and experience for service users and carers in receipt of CAMHS has been led by the NHS England Children and Young People’s Task Force based within the Department of Health which was established in September 2014. This follows the Child and Adolescent Mental Health Services Tier 4 Report, July 2014 which highlighted the Chief Medical Officer’s concerns regarding difficulties gaining access to appropriate treatment for mental health difficulties, and the Parliamentary Health Select Committee report regarding CAMHS of November 2014, which also highlighted difficulties in terms of access to appropriate community and hospital treatment care pathways. Improving access to and quality of patient experience and outcomes within CAMHS, to deliver parity of esteem with Adult Mental Health Services is therefore a key national driver.

2.9 Future in mind Promoting, protecting and improving our children and young people's mental health and well-being (HM GOVT 2015) is the report of the Children and Young People's Task Force. A copy of the report is provided as Appendix 1. The report outlines the NHS England Children and Young People's Task Force vision for CAMHS TIERS 1-4. In June guidance is expected regarding the funding that CCGs will utilise as agreed via Health and Well-Being Boards with local partners to address the gaps / priorities outlined in Future in Mind and in line with local levels and patterns of need. Each CCG will submit funding plans in a CAMHS TRANSFORMATIONAL PLAN. Key priorities for investment are likely to include:

- Children and young people's Improving Access to Psychological Therapies programme (CYPT IAPT), wherein it is estimated that talking therapy services can save £1.75 for the public sector for every £1spent.

- Improved crisis services and home treatment services, in line with the national and local Crisis Concordat/s, bridging the gap between hospital and community services and reducing the need for high cost CAMHS Tier 4 Services.

- Early Intervention in Psychosis Services, wherein it is estimated that if everyone who required Early Intervention in Psychosis services received a service the NHS could save £44 million annually.

- Local community Eating Disorder Services with better liaison with Acute, Paediatric and Primary Care services and again bridging the gap between hospital and community services and reducing the need for high cost Tier 4 Services.

2.10 Wolverhampton CCG is one of 8 areas across the Country that has been awarded a project grant by the Children and Young People's Task Force to scope potential to re-design / improve current CAMHS commissioning models, following an invitation to submit EOIs. The Wolverhampton project focuses upon CAMHS Tier 4 and TIER 3 plus model/s across the Black Country and this includes a focus on tri-partite funded placements for children and young people that are 'out of area'. This work is being lead by Wolverhampton CCG on behalf of all of the four CCGs (Dudley, Walsall, Sandwell and Wolverhampton) across the Black Country covering a population of 1,152,500 (ONS 2013 mid-year population estimates). Details of the eight successful EOIs including the Wolverhampton submission are included as Appendix 2.

2.11 A Black Country wide key stakeholder event was held in March. An initial high level findings event was hosted by NHS E in March for all 8 CYP Task Force Funded Projects. Many commonalities in terms of care pathways and outcomes regarding CAMHS TIER 4 and tri-partite funded placements are apparent with a number of areas of potential opportunity to develop local service models and improve patient experience and deliver QIPP.

2.12 From initial stakeholder findings there are initial clear messages regarding the need for whole systems change and this will feature in the Black Country recommendations element of the NHS England EOIs Report. It is the expectation of NHS England that the Black Country co-commissioning pilot continue via the four Black Country CCGs Future in Mind transformation plans. A meeting is in the planning stage for end June with all strategic commissioning health and social care leads to agree and plan next steps.

2.13 HEADSTART WOLVERHAMPTON is well established and currently funding pilots to deliver a range of resilience and self-efficacy building initiatives for children and young people aged 10-14 years to prevent common mental health conditions. The pilots include development and use of digital technology and social media apps and resources, resilience and self-efficacy training in schools and communities for parents, teachers and peer mentors and a variety of initiatives as part of 'a place to go', such as out of schools clubs and community groups with a focus on supporting children and young people to develop self-efficacy skills and attributes and receive support from strong and positive role models and peers whilst having fun.

2.14 Wolverhampton Clinical Commissioning Group and Wolverhampton City Council are currently reviewing all children placed tri-partite funded placements including looked after children to inform commissioning intentions, the local CAMHS transformation Plan and support plans to reduce numbers of looked after children.

2.15 There is a clear opportunity to use the impetus behind all of the above projects to redesign and re model local services to deliver a model for sustainable future provision across CAMHS TIERS 1-4 and to use programme funds from both HEADSTART and Future in Mind to employ a transformation director to align and deliver the whole systems transformation with an aligned financial plan and QIPP for 2015/16 – 2020/21.

## 3.0 Progress, options, discussion, etc.

3.1 Stakeholder consultation and engagement from all of the above initiatives have identified a number of key themes. These can be described as follows:

- Are the current commissioning and provider model/s for CAMHS TIER 3 PLUS LEVEL and TIER 4 and regarding Tri-partite funded placements fit for purpose?

- All areas are experiencing levels of chronicity and complexity in terms of CAMHS referrals and levels of need which are concerning.

- Across the Black Country the impact on Accident and Emergency Departments, Paediatric Wards and Departments and the police and West Midlands Ambulance Services (Section 136 / place of safety) is significant and at times profound. This includes / also applies to Learning Disability CAMHS. Street Triage is picking up a significant number of CAMHS cases across Wolverhampton and all areas of the Black Country (in some cases very young children, e.g. as young as 9 years).

- CCGs and Local Authority partners are funding significant numbers of high cost tri-partite funded placements which have poor connectivity with CAMHS local to the placement and CAMHS close to home / within home authority. In some cases the placements are understood to have direct correlation with capacity and capability within and absence of the correct local provision of Tier 2, TIER 3 PLUS and TIER 4 CAMHS, including regarding CAMHS LD and targeted interventions for looked after children and children on the edge of care.

- Across all areas of the Black Country and post the ending of TaMHS (Targeted Mental Health Service for Schools) CAMHS TIER 2 provision has gaps, is under resourced and lacks connectivity across education, health and social care. There are some examples of good practice across all areas such as HeadStart: Wolverhampton and Kooth Dudley, however there is an urgent and pressing need to develop this level of service provision to prevent escalation of difficulties and release economic, social and personal benefits of solution focussed and self-efficacy building initiatives across TIERS 1 and 2 and with clear care pathways into TIER 3 CAMHS.

- Parents are described as ‘not coping’, absent or ‘on their knees’, within education schools are providing pastoral care and other services to manage many types of mental health difficulties that are fuelled by issues such as bullying and gangs. Cyber-bullying, texting, sexting and use of many forms of social media provides an additional dimension to bullying and negative peer behaviour / influences.

- The traditional approach to describing, commissioning and delivering CAMHS TIERS are described as being not always helpful, particularly as specialist health skills are required are often required in targeted prevention work in TIERS 1 and 2. In addition the Health and Social Care interface provides challenges in terms of connectivity and / or whole systems working. This also applies to links with education and the youth offending / criminal justice system. Commissioning Tiers appears to be unhelpful as different organisations commission different tiers / services. This approach does not always lend itself well to early intervention and prevention or provide financial incentives to develop a whole systems approach to mental health and well-being.

- There are co-morbidities regarding substance misuse including alcohol and potent forms of cannabis including skunk which carry high risk in terms of psychosis and this is evident in terms of Early Intervention in Psychosis Services. Care pathways need strengthening across these services to reduce admissions and improve clinical outcomes and life chances.

- There are questions concerning whether or not we have the right capacity and / or capabilities, interventions and resources i.e. at the right places in the care pathway. This includes across health and social care and specifically regarding high end interventions. This includes the current service specifications, including at CAMHS TIER 4. Some encouraging evidence is emerging in the West Midlands area regarding DBT within CAMHS which needs exploration in terms of a Black Country wide model.

- There are many difficulties in terms of knowledge of services and care pathways, communication and information across the whole system. It appears that sometimes staff with limited knowledge of care pathways and services are trying to access appropriate levels of support and intervention with difficulty.

- Local providers report many difficulties in terms of serious delays regarding gate keeping assessments for and admissions to CAMHS TIER 4 and the impact of this apparent upon social care, paediatric services, local specialist CAMHS and patient and carer experience and outcomes. This impacts upon local delivery of the Crisis Concordat and Local Resilience Plans in terms of delays causing avoidable breeches and difficulties with patient flow in Acute Services and inappropriate use of police custody as highlighted nationally.

- In addition there are concerns regarding maintaining integrity of care pathways across the distance of CAMHS TIER 4 provision, and the lack of parity of esteem with Adult Mental Health (AMHS) in terms of local provision, connectivity with local crisis services, day services and assertive outreach provision and the need for a dynamic care pathway across these services which allows timely admission and discharge and avoids lengthy admissions.

- Critically it should also be noted that some Acute and Paediatric services have reported direct admissions to paediatric beds in the absence of an appropriate Tier 4 bed. Impact on paediatric wards generally includes safeguarding and safety issues in terms of other children on the ward and their vulnerabilities and disruption to and impact upon their care, lack of beds for physically sick children, delays due to lack of appropriate social care placements, and delays for appropriate TIER 4 beds or placements of up to 3 months. Delays for access to appropriate services appear worse for children with a learning disability in some cases.

- Current commissioning is complex, fragmented and money doesn’t flow from placements to the community. When children are placed out of area either in CAMHS Tier 4 beds or Tri-partite funded placements the locality of the service can cause connectivity and care pathway issues with local CAMHS, impacting on discharge plans and fluidity across interventions.

- The current CAMHS TIER 4 Service Specification requires review, to address issues such as parity of esteem with AMHS, changing levels and types of need and to improve access, experience, efficacy of interventions and outcomes.

- Re-admission rate to CAMHS TIER 4 across the Black Country is in excess of 40% currently.

- The impact of difficulties accessing care pathways into CAMHS TIER 4 have an impact on paediatric wards and funding of tri-partite funded placements that is not wholly visible across the commissioning and policy making landscape.

3.2 In addition to the above challenges there are a number of opportunities for improving provider and commissioning arrangements including:

- Improved care pathways regarding Earlier Intervention in Psychosis including substance misuse, as highlighted in recent national guidance.

- Developing enhanced community services across the Black Country including Crisis Resolution Home Treatment, Assertive Outreach, Day Services and the potential to develop a hybrid – bridging model between Tier 3 PLUS and TIER 4 with for example crisis beds and Section 136 MHA / Place of Safety, to develop parity of esteem with Adult Mental Health Services and comply with NICE Clinical Guidance, regarding self-harm for example and re-using local estate.

- Opportunities for some collaborative commissioning and procurement opportunities regarding the above with value for money opportunities regarding for example economies of scale.

- Opportunities regarding pooled budgets, specifically regarding cost efficiencies in terms of tri-partite funded placements which could deliver QIPP and allow for investment in TIER 2 and 3 services – supporting early intervention and prevention and improving waiting times and connectivity of pathways across and with education, and criminal justice.

- Opportunities to bring children and young people back into the Black Country by co-commissioning specialist residential placements locally using available estate.

- Opportunities for improved, focussed and targeted case management of all types of services with regular scheduled reviews and improved connectivity with local CAMHS and CAMHS close to home.

- Opportunities to pump prime change at TIERS 1 and 2 to reduce levels of need at TIERS 3 and 4 and Tri-partite funded arrangements and deliver QIPP. This includes use of and learning from the HEADSTART ‘Ordinary Magic’ at TIERS 1-2 can provide alternative and innovative solutions and prevent escalation into TIERS 3 and 4. CYP IAPT and use of social media and digital technology could play key roles here, as could resilience and self-efficacy training and building interventions in schools and communities providing early help and innovative and stigma reducing solutions wherever possible.

- Schools are key players regarding all of the above, both in terms of delivery of initiatives and child and family support and referral into services and there is therefore enormous potential to transform care pathways and services and initiatives across education, health and social care and opportunities to explore and develop a more strategic and partnership role for schools and establishments for children alternatively engaged or disengaged should be explored.

- There are opportunities to align system change with Adult Services to support parents either in terms of coping with their child’s mental health difficulties and / or their own individual needs, including troubled families and mental health and substance misuse services for adults.

- Across the Black Country there are significant co-commissioning opportunities, including regarding CAMHS TIER 4, improved co-commissioning and procurement of tri-partite funded placements, aligned and integrated local service models, better use of existing assets and pooled budgets, potentially across the whole system.

3.3 In addition to the above local priorities and next steps Future in Mind identifies the following key themes:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

3.4 In addition to the above key themes Future in Mind identifies the following key priorities:

- Place the emphasis on building resilience, promoting good mental health, prevention and early intervention.

- Simplify structures and improve access: by dismantling artificial barriers between services by making sure that those bodies that plan and pay for services work together, and ensuring that children and young people have easy access to the right support from the right service.

- Deliver a clear joined up approach: linking services so care pathways are easier to navigate for all children and young people, including those who are most vulnerable so people do not fall between gaps.

- Harness the power of information: to drive improvements in the delivery of care, and standards of performance, and ensure we have a much better understanding of how to get the best outcomes for children, young people and families/ carers and value from investment.

- Sustain a culture of continuous evidence-based service improvement delivered by a workforce with the right mix of skills, competencies and experience.

- Make the right investments: to be clear about how resources are being used in each area, what is being spent, and to equip all those who plan and pay for services for their local population with the evidence they need to make good investment decisions in partnerships with children and young people, their families and professionals.

3.5 In addition to the above key themes Future in Mind identifies the following key priorities for investment:

- Mental health awareness / resilience training in schools and support for schools.
- Support for parents.
- Harnessing digital technology.

- Reducing the impact of bullying.
- Improving the mental health and physical health interface.
- Getting more numbers of children and young people into treatment,
- Responding early to self-harm.
- Improving Crisis support.
- Developing CYP Integrated Access to Psychological Therapies.

3.6 The above challenges, opportunities and key local and national drivers should be formatted into a **Wolverhampton CAMHS Transformation Plan 2015-2020** which presents an opportunity for whole system transformation and change, with aligned QIPP and Financial Plan. Financial and resource implications within the Wolverhampton Plan will include:

- Use of HEADSTART funds to further develop and evaluate pilot initiatives and to align HeadStart Stage Two and Three developments and service model delivery with sustainable system efficiencies achieved via the local and wider Black Country transformation plans.

- Wolverhampton and potentially wider Black Country use of recurrent NHS England CAMHS Transformation funds. Guidance regarding allocation of this is expected imminently and will include release of some very early funds for programme management and infrastructure costs to deliver transformation of resources. (This will also include a specified sum for Eating Disorder Services).

- Re-alignment of existing resources across CAMHS TIERS 1-4 as described above from 2015-2020, with a potentially strong Black Country wide case to locally commission CAMHS TIER 4 with NHS England funds, and commission local services that reduce the need for tri-partite funded placements out of the Black Country.

- Some potential re-alignment of budgets and resources locally and across the Black Country where service model and re-procurement opportunities indicate that this is viable and sustainable and will improve patient outcomes and offer value for money.

3.7 It is recommended that HEADSTART and Future in Mind infrastructure and programme management funds are used to fund a fixed term transformation director post for a minimum period of one year to realise the benefits for our health and social care economy described above and initiate and deliver the required commissioning changes and developments across the whole system. Salary scale is indicative of the required skills, experience, responsibilities and deliverables over the post which will be complex and challenging and require considerable experience of transformation and track record of delivery across providers and to national drivers. CAMHS experience will be essential. Key facets of the role will be to deliver the outputs described in section 1.1.

3.8 Very recent contact with the CAMHS National Programme Lead at NHS England confirms that some funds will be available very shortly for CCGs. Very strong support was given to the Wolverhampton proposal to align HeadStart with CAMHS Transformation Plans and Black Country co-commissioning EOI outputs moving forward.

3.9 Recommended Next steps are as follows:

- Swift recruitment to Transformation Associate Director to develop Wolverhampton wide CAMHS commissioning capacity across CAMHS TIERS 1-4 and to commence delivery of next steps as described below. Wolverhampton CCG to develop local CAMHS Transformation Plan utilising release of early summer and them later autumn funds as per NHS England guidance working with all local partners and the Area Team.

- Black Country commissioning strategic workshop is planned for end July 2015 as described in the body of this report following local commissioning meetings to agree next steps and plan any collaborative options regarding wider system change and collaborative commissioning arrangements for CAMHS TIER 4 and tri-partite funded placements especially.

- Review of commissioning intentions following release of the NHS England Co-commissioning pilot report will be received shortly including details out puts and recommendations of the Black Country Pilot.

- Analysis of HEADSTART Pilots learning to inform commissioning intentions and transformation plan and prepare for Stage 3 Bid writing and submission demonstrating sustainability beyond 2021 on withdrawal of HeadStart funding via local whole system model.

- Review of commissioning intentions following completion of reviews of Wolverhampton tri-partite funded placements to inform commissioning intentions and plan.

- Delivery of model regarding CAMHS Whole System Re-design and Sustainable Change 2015-2020 with financial plan, QIPP Plan and implementation plan to be delivered to Commissioning Committee, HEADSTART PROGRAMME BOARD and Health and Well-Being Board.

- Align all of the above with targeted JNSA refresh.

- Continued feedback to and monitoring by the above key forums is essential.

3.10 The above next steps are essential in terms of developing a WOLVERHAMPTON model that will re-align resources to provide:

- resilience and self-efficacy building
- prevention and early intervention and early help
- improved clinical outcomes
- prevent crisis and relapse
- provide care closer to home
- reduce numbers of Looked After Children

- delivery of  QIPP
- delivery of appropriate local response to current and future levels and types of complexity and need and changing types and pattern of need

## 4.0 Financial implications

4.1 A financial plan will be developed as part of the proposed next steps and service model options. Pump priming and infrastructure and programme support funds are available from HEADSTART and Future in Mind and it is proposed that these are utilised to employ a camhs transformation programme director on  a fixed term basis to deliver whole systems change.

## 5.0 Legal implications

5.1 There are currently no outstanding legal implications that should be highlighted in relation to this report.

## 6.0 Equalities implications

6.1 Section 149 of the Equality Act 2010 outlines the Public Sector Equality Duty to engage with relevant individuals regarding key decisions. A period of consultation will be required regarding any proposed changes to mental health services locally, with a requirement to take the revised Strategy to Health Scrutiny Panel.

## 7.0 Environmental implications

7.1 There are currently no outstanding environmental implications that should be highlighted in relation to this report.

## 8.0 Human resources implications

8.1 There are currently no outstanding environmental implications that should be highlighted in relation to this report.

## 9.0 Corporate landlord implications

9.1 There are currently no corporate landlord implications that should be highlighted in relation to this report.

## 10.0 Schedule of background papers

10.1 Appendices 1-2 are attached.

Department of Health

NHS England

# Future in mind

## Promoting, protecting and improving our children and young people's mental health and wellbeing

NHS England Publication Gateway Ref. No 02939

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

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# Contents

<u>The Report</u>

# Foreword from Norman Lamb, Minister of State for Care and Support

Our childhood has a profound effect on our adult lives. Many mental health conditions in adulthood show their first signs in childhood and, if left untreated, can develop into conditions which need regular care.

But, too often, children and young people's emotional wellbeing and mental health is not given the attention it needs. Far too many families have experienced poor children's and adolescent mental health care. This isn't endemic, and we have made great progress in the last few years, but it remains unacceptable that not every child or young person gets the help they need when and where they need it. Some don't get any care at all, and their problems escalate to a crisis point. This isn't due to lack of good will – there are many highly skilled and highly valued staff working with children and young people who want to make a real and lasting difference to their lives but there are barriers in the system itself which prevent change.

I have been changing that system. Since 2011, my Department and NHS England have invested over £60 million in the Children and Young People's Improving Access to Psychological Therapies programme. We have funded the development of MindEd – giving more advice to health professionals about how to help young people with mental ill-health. We have put more mental health beds for young people in the system, as well as training new case workers to offer help where it is needed. But this isn't enough – we need to be ambitious if we want children and young people to live happy, healthy lives.

This is why I set up the Children and Young People's Mental Health and Wellbeing Taskforce. I wanted to identify what the problems were, what was stopping us from providing excellent mental health care for young people. The Taskforce brought together professionals from across the education, health and care system to figure this out. They also worked with charities and community organisations and, importantly, they brought in young people and their families, too. We needed a comprehensive view to understand the wide-ranging issues affecting our mental health service.

This is the Government report of the work of the Taskforce and it sets out what we need to do to overcome the status quo. We need a whole child and whole family approach, where we are promoting good mental health from the earliest ages. We need to improve access to interventions and support when and where it is needed, whether that's in schools, GP practices, hospitals or in crisis care. We mustn't think about mental health in a purely clinical fashion. We need to make better use of the voluntary and digital services to fill the gaps in a fragmented system. Crucially, we must make it much easier for a child or young person to seek help and support in non-stigmatised settings. This is where the voluntary sector can be so valuable. We need a simpler system, breaking down the barriers which tiers create, looking at some of the innovative practices which are already happening in this country and abroad.

Anyone who works with or for young people knows that this isn't just about funding. What is needed is a fundamental shift in culture. A whole system approach is needed focusing on prevention of mental ill health, early intervention and recovery. We owe this to young people. It is with their future in mind that we must all commit to, and invest in this challenge.

# Foreword from Sam Gyimah, Parliamentary Under Secretary of State, Department for Education

In the Department for Education we want all children and young people to have the opportunity to achieve and develop the skills and character to make a successful transition to adult life. Good mental health is a vital part of that. The challenges young people face are hugely varied – from stress and anxiety about exams to incredibly serious and debilitating long-term conditions. Everyone who works with children and young people has a role in helping them to get the help they need.

That is why I am so pleased to be the first minister in the Department for Education with a specific responsibility for child and adolescent mental health. And why I wanted the department to work closely with the Taskforce to look at how we can make a better offer to children and young people. I believe success in this area comes from Government departments working closely together. We want to make sure young people no longer feel that they have to suffer in silence, that they understand the support that's available for them and that they see mental health services as something that can make a real difference to their lives.

Many schools already support their pupils' mental health. But we can do more to help schools develop knowledge about mental health, identify issues when they arise and offer early support. That is why we have been working alongside the Taskforce to develop work on teaching about mental health with the PSHE Association, and develop a new strategy to encourage more and better use of counselling in schools.

Support can come from other places too. The voluntary sector can be especially effective in reaching out in a way that makes sense to children and young people. That is why DfE has, for the first time, identified mental health as a specific priority within its £25m voluntary sector grant scheme – from April we will be supporting a range of exciting projects. Children's services are also looking for innovative ways to make mental health an integral part of support for the most vulnerable, and our Social Care Innovation Programme will continue to fund projects developing this work.

But not every adult who works with children and young people can be a mental health expert. Schools and children's services often raise with me the problems with access to specialist support for children who need it, when what they can provide reaches its limits. That is why I welcome the drive to put the needs of children and young people at the heart of specialist mental health services, to break down the complex tiers of services and to establish clear responsibility for putting in place a coherent offer of services.

This report shows that real success comes from collaboration and sets a challenge to all those working with children and young people. Only by working in partnership, sharing expertise, and making best use of finite resources can we achieve the improvements in mental health outcomes that we all want to see, and make a reality of the vision.

# Foreword from Simon Stevens, CEO of NHS England

There is now a welcome national recognition of the need to make dramatic improvements in mental health services. Nowhere is that more necessary than in support for children, young people and their families. Need is rising and investment and services haven't kept up. The treatment gap and the funding gap are of course linked.

Fortunately that is now changing. However in taking action there are twin dangers to avoid. One would be to focus too narrowly on targeted clinical care, ignoring the wider influences and causes of rising demand, overmedicalising our children along the way. The opposite risk would be to diffuse effort by aiming so broadly, lacking focus and ducking the hard task of setting clear priorities. This document rightly steers a middle course, charting an agreed direction and mobilising energy and support for the way ahead. I'm pleased to give it NHS England's full support.

# Your future in mind – an open letter to children and young people

A few months ago, we were asked by the Government to work out what needs to be done to improve children and young people's mental health and wellbeing. Growing up is meant to be one of the very best times in anyone's life but it can also be tough. There are many pressures and some young people, such as looked-after children and those leaving care, are exposed to situations and experiences that can make them particularly vulnerable.

Experiencing mental health concerns is not unusual. At least one in four of the population experience problems at some point in their lives. Over half of mental health problems in adult life (excluding dementia) start by the age of 14 and seventy-five per cent by age 18. Although mental health issues are relatively common, it is often the case that children and young people don't get the help they need as quickly as they should. As a result, mental health difficulties such as anxiety, low mood, depression, conduct disorders and eating disorders can stop some young people achieving what they want in life and making a full contribution to society.

**We were asked to work together and see how your mental health and wellbeing could best be supported to give you the best start in life.**

That means we want to help you acquire the resilience and skills you need when life throws up challenges. We want you to know what to do for yourself if you are troubled by emotions or problems with your mental health. That includes knowing when and how to ask for help and, when you do, to receive high quality care. We want services to be able to respond quickly, to offer support and, where necessary, treatment that we know works, to help you stay or get back on track. We believe that asking people who use services what they think about what happens now is vital. They are the ones who know what needs to change. So our first thought was to ask you – children, young people and those who care for you – how things could work better.

We also knew that lots of good work had been done in the past, so we looked at previous reports and reviewed all the evidence we have. We asked a group of people with a mix of experience and expertise that included young people, parents, people working in schools, in the voluntary sector, and in services as well as people who work for the Government to come together as a 'Taskforce' to help look at all the information we have and think about how we could improve.

**What we have come up with is a vision that we hope reflects what you as well as your parents, carers and professionals told us was needed, with ideas about how to make it happen.**

We have set out the vision by describing how we think the system should work for young people. The report lays out a map of how we could make those ambitions a reality. In this report, we tell you what we think can change now, but also what we think will take more time. Not all the changes can be made straight away, some are longer term ambitions. But we believe substantial progress can be made over the next five years if we act now to make children and young people's mental health a priority.

Do let us know what you think about this report. You can add your comments to our blogs (see links below) and also share your opinions on Twitter using **#youngmentalhealth**.

And finally let's remember that there is one change that we can all contribute to. We can all look out for those children and young people who might be struggling right now. We can confront bullying and we can make it OK to admit that you are struggling with your mental health. We can end stigma. And we can support our friends in their treatment and recovery.

Let's make a start.

**Dr Martin McShane, NHS England**

J Rouse

**Jon Rouse, Department of Health**

Useful links:

Taskforce website: www.gov.uk/government/groups/children-and-young-peoples-mental-health-and-well-being-taskforce

Jon Rouse's blog: https://jonrouse.blog.gov.uk/

Dr Martin McShane's blog: www.england.nhs.uk/category/publications/blogs/martin-mcshane

# Our vision for children and young people's mental health

**You have goals and ambitions you want to achieve. We want you to grow up to be confident and resilient so you can develop and fulfil these goals and make a contribution to society. To do this we must make sure:**

Your parents and carers get the help they need to support you through your childhood and into adult life. Other adults such as GPs, midwives, health visitors, teachers and other people who work in schools, should understand emotional and mental health in children and young people, and know what to do and where to go if they are worried about you or those who care for you.

If you are having difficulty, you shouldn't have to wait until you are really sick to get help, and those around you should be understanding. Asking for help shouldn't be embarrassing or difficult and you should know what to do and where to go.

**When you need help, you want to find it easily and to be able to trust it. To make sure this happens, we need to make sure that:**

There are websites and apps that you know you can trust and use to help yourself and find out information on how to get more help.

You have a choice about where you can get advice and support from a welcoming place. You might want to go somewhere familiar, such as your school or your doctor. Or you might want to go to a drop-in centre, or access the help you need online. But wherever you go, the advice and support you are offered should be based on the best evidence about what works. All the professionals you meet should treat you as a whole person, considering your physical and mental health needs together.

**You are experts in your care and want to be involved in how mental health services are delivered and developed, not just to you and those who support you, but to all the children, young people and families in your area. To do this we must make sure that:**

All services give you the opportunity to set your own treatment goals and will monitor with you how things are going. If things aren't going well, the team providing your care will work with you to make changes to achieve your goals. You have the opportunity to shape the services you receive. That means listening to your experience of your care, how this fits with your life and how you would like services to work with you. It means giving you and those who care for you the opportunity to feedback and make suggestions about the way services are provided. Services should tell you what happened as a result.

**When you need help, you want it to meet your needs as an individual and be delivered by people who care about what happens to you. This means that:**

You should only have to tell your story once, to someone who is dedicated to helping you, and you shouldn't have to repeat it to lots of different people. All the services in your area should work together so you get the support you need at the right time and in the right place.

If you have a crisis, you should get extra help straightaway, whatever time of day or night it is. You should be in a safe place where a team will work with you to figure out what needs to happen next to help you in the best possible way.

If you need to go to hospital, it should be on a ward with people around your age and near to your home. If you need something very specialised, then you and your family should be told why you need to travel further, and the service should stay in touch to get you home as soon as possible. And while you are in hospital, we should ensure you can keep up with your education as much as you can.

Throughout your care, there are likely to be changes so that you get the right care at the right time. You'll have the opportunity to make informed choices about your treatment and care. You'll keep getting help until you're confident that you're well enough to no longer need it.

If you need help at home, your care team will visit and work with you and your family at home to reduce the need for you to go into hospital. If you do need to go in to hospital, the team should stay in touch and help you to get home quickly.

If you need to move from one service to another, you'll be involved in conversations to prepare you for this and to agree exactly what is happening and when. You'll make the move when you feel ready for it. If you have to move from one area to another, the people responsible for your care will sort this out and involve you, so that you do not have to start from scratch.

You'll keep getting help until you're confident that you're well enough to no longer need it, even if sometimes you can't or don't want to attend appointments. If you don't keep your appointments, someone should get in touch to find out what they can do to help, not just leave you to it.

**You want to know that, whatever your circumstances, you get the best possible care, support and treatment when you need it. You'll be able to get help wherever you are in the country, and the help you get where you live won't be worse than if you lived somewhere else. To make this happen we will need to make sure:**

The people responsible for organising and delivering services to you know which services to provide to best help you and other children, young people and families in your community. The people who fund and provide your service should be dedicated to offering the best mental health services possible, and will be honest and open about how they do that as well as about how they are working to improve it.

# 1. Executive summary and key proposals

1.1 The Children and Young People's Mental Health and Wellbeing Taskforce[1] was established in September 2014 to consider ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided.

1.2 Key themes emerged which now provide the structure of this report. Within these themes, we have brought together core principles and requirements which we consider to be fundamental to creating a system that properly supports the emotional wellbeing and mental health of children and young people.

1.3 **In summary, the themes are:**

- **Promoting resilience, prevention and early intervention**
- **Improving access to effective support – a system without tiers**
- **Care for the most vulnerable**
- **Accountability and transparency**
- **Developing the workforce**

## The case for change

1.4 Mental health problems cause distress to individuals and all those who care for them. One in ten children needs support or treatment for mental health problems. These range from short spells of depression or anxiety through to severe and persistent conditions that can isolate, disrupt and frighten those who experience them. Mental health problems in young people can result in lower educational attainment (for example, children with conduct disorder are twice as likely as other children to leave school with no qualifications) and are strongly associated with behaviours that pose a risk to their health, such as smoking, drug and alcohol abuse and risky sexual behaviour.

1.5 The economic case for investment is strong. 75% of mental health problems in adult life (excluding dementia) start by the age of 18. Failure to support children and young people with mental health needs costs lives and money. Early intervention avoids young people falling into crisis and avoids expensive and longer term interventions in adulthood. There is a compelling moral, social and economic case for change. We set this out in full in **Chapter 3.**

1.6 Evidence presented to the Taskforce also underlined the complexity and severity of the current set of challenges facing child and adolescent mental health services. These include:

i. **Significant gaps in data and information and delays in the development of payment and other incentive systems.** These are all critical to driving change in a co-ordinated way.

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[1] *Children and Young People's Mental Health and Wellbeing Taskforce: Terms of Reference.* Available at: www.gov.uk/government/groups/children-and-young-peoples-mental-health-and-well-being-taskforce

ii. **The treatment gap.** The last UK epidemiological study[2] suggested that, at that time, less than 25% – 35% of those with a diagnosable mental health condition accessed support. There is emerging evidence of a rising need in key groups such as the increasing rates of young women with emotional problems and young people presenting with self-harm.

iii. **Difficulties in access.** Data from the NHS benchmarking network and recent audits reveal increases in referrals and waiting times, with providers reporting increased complexity and severity of presenting problems.

iv. **Complexity of current commissioning arrangements.** A lack of clear leadership and accountability arrangements for children's mental health across agencies including CCGs and local authorities, with the potential for children and young people to fall though the net has been highlighted in numerous reports.[3]

v. **Access to crisis, out of hours and liaison psychiatry services are variable** and in some parts of the country, there is no designated health place of safety recorded by the CQC for under-18s.

vi. **Specific issues facing highly vulnerable groups of** children and young people and their families who may find it particularly difficult to access appropriate services.

1.7 These issues are addressed in considering the key themes that form the basis of this report and the proposals it makes.

## Making it happen

1.8 The Taskforce firmly believes that the best mental health care and support must involve children, young people and those who care for them in making choices about what they regard as key priorities, so that evidence-based treatments are provided that meet their goals and address their priorities. These need to be offered in ways they find acceptable, accessible and useful.

1.9 Providers must monitor, and commissioners must consider, the extent to which the interventions available fit with the stated preferences of young people and parents/carers so that provision can be shaped increasingly around what matters to them. Services need to be outcomes-focused, simple and easy to access, based on best evidence, and built around the needs of children, young people and their families rather than defined in terms of organisational boundaries.

1.10 Delivering this means making some real changes across the whole system. It means the NHS, public health, local authorities, social care, schools and youth justice sectors working together to:

- **Place the emphasis on building resilience, promoting good mental health, prevention and early intervention** (Chapter 4)

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[2] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). *Mental health of children and young people in Great Britain, 2004*. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.

[3] National CAMHS Review (2008). *Children and young people in mind: the final report of the National CAMHS Review*. National CAMHS Review; HM Government (2011). *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages.* London: Department of Health; Department of Health (2012). *Annual Report of the Chief Medical Officer 2012*. London: Department of Health; CAMHS Tier 4 Report Steering Group (2014). *CAMHS Tier 4 Report*. London: NHS England.

- **Simplify structures and improve access**: by dismantling artificial barriers between services by making sure that those bodies that plan and pay for services work together, and ensuring that children and young people have easy access to the right support from the right service (Chapter 5).
- **Deliver a clear joined up approach**: linking services so care pathways are easier to navigate for all children and young people, including those who are most vulnerable (Chapter 6), so people do not fall between gaps.
- **Harness the power of information**: to drive improvements in the delivery of care, and standards of performance, and ensure we have a much better understanding of how to get the best outcomes for children, young people and families/carers and value from our investment (Chapter 7).
- **Sustain a culture of continuous evidence-based service improvement** delivered by a workforce with the right mix of skills, competencies and experience (Chapter 8).
- **Make the right investments**: to be clear about how resources are being used in each area, what is being spent, and to equip all those who plan and pay for services for their local population with the evidence they need to make good investment decisions in partnerships with children and young people, their families and professionals. Such an approach will also enable better judgements to be made about the overall adequacy of investment (Chapter 9).

1.11 In some parts of the country, effective partnerships are already meeting many of the expectations set out in this report. However, this is by no means universal, consistent or equitable.

## A National ambition

1.12 This report sets out a clear national ambition in the form of key proposals to transform the design and delivery of a local offer of services for children and young people with mental health needs. **Many of these are cost-neutral, requiring a different way of doing business rather than further significant investment.**

1.13 **There are a number of proposals in this report which require critical decisions, for example, on investment and on local service redesign, which will need explicit support from the next government, in the context of what we know will be a very tight Spending Review.** We are realistic in this respect. At both national and local level, decisions will need to be taken on whether to deliver early intervention through an ‘invest to save’ approach and/or targeted reprioritisation, recognising that it will take time to secure an economic return for the nation.

**The Government's aspirations are that by 2020 we would wish to see:** *(The numbers in brackets refer to the proposals in and at the end of each chapter)*

1. **Improved public awareness and understanding, where people think and feel differently about mental health issues for children and young people where there is less fear and where stigma and discrimination are tackled.** This would be delivered by:
   - a hard hitting anti-stigma campaign which raises awareness and promotes improved attitudes to children and young people affected by mental health difficulties. This would build on the success of the existing Time to Change campaign; (3)
   - with additional funding, we could also empower young people to self-care through increased availability of new quality assured apps and digital tools. (5)
2. **In every part of the country, children and young people having timely access to clinically effective mental health support when they need it.** With additional funding, this would be delivered by:
   - a five year programme to develop a comprehensive set of access and waiting times standards that bring the same rigour to mental health as is seen in physical health. (17)
3. **A step change in how care is delivered moving away from a system defined in terms of the services organisations provide (the 'tiered' model) towards one built around the needs of children, young people and their families.** This will ensure children and young people have easy access to the right support from the right service at the right time. This could be delivered by:
   - joining up services locally through collaborative commissioning approaches between CCGs, local authorities and other partners, enabling all areas to accelerate service transformation; (48)
   - having lead commissioning arrangements in every area for children and young people's mental health and wellbeing services, responsible for developing a single integrated plan. We envisage that in most cases the CCG would establish lead commissioning arrangements working in close collaboration with local authorities. We also recognise the need for flexibility to allow different models to develop to suit local circumstances and would not want to cut across alternative arrangements; (30)

- transitions from children's services based on the needs of the young person, rather than a particular age. (15)

4. **Increased use of evidence-based treatments with services rigorously focused on outcomes.** With additional funding, this would be delivered by:
    - building on the success of the CYP IAPT transformation programme and rolling it out to the rest of the country. (44)
5. **Making mental health support more visible and easily accessible for children and young people.** With additional funding, this would be delivered by:
    - every area having 'one-stop-shop' services, which provide mental health support and advice to children and young people in the community, in an accessible and welcoming environment. This would build on and harness the vital contribution of the voluntary sector; (16)
    - improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools. This would include integrating mental health specialists directly into schools and GP practices. (16)
6. **Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible.** This would be delivered by:
    - ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented; (12)
    - no young person under the age of 18 being detained in a police cell as a place of safety; (19)
    - implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care. (13)
7. **Improving access for parents to evidence-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour.** With additional funding, this would be delivered by:
    - enhancing existing maternal, perinatal and early years health services and parenting programmes. (4)
8. **A better offer for the most vulnerable children and young people, making it easier for them to access the support that they need when, and where they need it.** This would include:
    - ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to the services that they need, including specialist mental health services. (24)
9. **Improved transparency and accountability across the whole system, to drive further improvements in outcomes.** This would be delivered by:
    - development of a robust set of metrics covering access, waiting times and outcomes to allow benchmarking of local services at national level; (36)
    - clearer information about the levels of investment made by those who

commission children and young people’s mental health services; (38)

- subject to decisions taken by future governments, a commitment to a prevalence survey for children and young people’s mental health and wellbeing, which is repeated every five years. (39)

10. **Professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support for those who need it.**

## Local Transformation Plans

1.14 Delivering the national ambition will require local leadership and ownership. We therefore propose the development and agreement of **Transformation Plans for Children and Young People’s Mental Health and Wellbeing** which will clearly articulate the local offer. These Plans should cover the whole spectrum of services for children and young people’s mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.

1.15 In terms of local leadership, we anticipate that the lead commissioner, in most cases the Clinical Commissioning Group, would draw up the Plans, working closely with Health and Wellbeing Board partners including local authorities. All these partners have an important role to play in ensuring that services are jointly commissioned in a way that promotes effective joint working and establishes clear pathways. Lead commissioners should ensure that schools are given the opportunity to contribute to the development of Transformation Plans.

1.16 To support this, NHS England will make a specific contribution by prioritising the further investment in children and young people’s mental health announced in the Autumn Statement 2014 in those areas that can demonstrate robust action planning through the publication of local Transformation Plans.

1.17 What is included in the Plan should reflect the national ambition and principles set out in this report and be decided at a local level in collaboration with children, young people and their families as well as providers and commissioners. Key elements will include commitments to:

### Transparency

- A requirement for local commissioning agencies to give an annual declaration of their current investment and the needs of the local population with regards to the full range of provision for children and young people’s mental health and wellbeing.
- A requirement for providers to declare what services they already provide, including staff numbers, skills and roles, waiting times and access to information.

### Service transformation

- A requirement for all partners, commissioners or providers, to sign up to a series of agreed principles covering: the range and choice of treatments and interventions available; collaborative practice with children, young people and families and involving schools; the use of evidence-based interventions; and regular feedback of outcome monitoring to children, young people and families and in supervision.

### Monitoring improvement

- Development of a shared action plan and a commitment to review, monitor and track improvements towards the Government's aspirations set out in this Report, including children and young people having timely access to effective support when they need it.

## Next steps in 2015/16

1.18 **At a national level, we will play our part to deliver the ambition by:**

- delivering waiting times standards for Early Intervention in Psychosis by April 2016;
- continuing development of new access and waiting times standards for Eating Disorder;
- commissioning a new national prevalence survey of child and adolescent mental health;
- implementing the Child and Adolescent Mental Health Services Minimum Dataset, which will include the new CYP IAPT dataset;
- continuing to focus on case management for inpatient services for children and young people, building on the response to NHS England's Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report;[4]
- testing clear access routes between schools and specialist services for mental health by extending the recently established co-commissioning pilots to more areas;
- improving children's access to timely support from the right service through developing a joint training programme to support lead contacts in mental health services and schools. This will be commissioned by NHS England and the Department for Education and tested in 15 areas in 2015/16. DfE will also support work to develop approaches in children's services to improve mental health support for vulnerable children;
- improving public awareness and understanding of children's mental health issues, through continuing the existing anti-stigma campaign led by Time to Change and approaches piloted in 2014/15 to promote a broader national conversation;
- encouraging schools to continue to develop whole school approaches to promoting mental health and wellbeing through a new counselling strategy for schools, alongside the Department for Education's other work on character and resilience and PSHE.

1.19 **In the medium to longer term, the Taskforce would like a future government to consider formalising at least some parts of this national ambition to ensure consistency of practice across the country.** This would also give a more precise meaning to what is meant by the existing statutory duties in respect of parity of esteem between physical and mental health, as they apply to children and young people.

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[4] CAMHS Tier 4 Report Steering Group (2014). *CAMHS Tier 4 Report*. London: NHS England.

# 2. Introduction

2.1 Children and young people's mental health really matters, not only for the individual and their family, but for society as a whole. The evidence tells us that treating different, specific health issues separately will not tackle the overall wellbeing of this generation of children and young people. Their mental and physical health are intertwined, and at the heart of health and wellbeing are their relationships with others. They want an integrated child, youth and family friendly approach that recognises their particular needs, makes them feel supported, emphasises the positives and helps them to cope.

2.2 Over half of all mental ill health starts before the age of fourteen years, and seventy-five per cent has developed by the age of eighteen.[5] The life chances of those individuals are significantly reduced in terms of their physical health, their educational and work prospects, their chances of committing a crime and even the length of their life. As well as the personal cost to each and every individual affected, their families and carers this results in a very high cost to our economy.

2.3 A great deal of work has been done in recent years to try to address the emotional wellbeing and mental health needs of children and young people. There is a wealth of evidence and good practice to build on. Key strategies, reports and initiatives include the National Service Framework[6] in 2004, Every Child Matters in 2003 and the work of the National Advisory Council in 2008.[7] More recently, the Children and Young People's Health Outcomes Forum[8] and Chief Medical Officer's Annual Reports in 2012 and 2013 have maintained the focus on improving children's mental health outcomes at national level.

2.4 The Government has made clear its commitment that mental health services for people of all ages should have parity of esteem with physical health services[9] and called on all parts of the health system to put children, young people and their families right at the heart of decision-making and improve every aspect of health services – from pregnancy through to adolescence and beyond.[10] A major programme of investment

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[5] Murphy M and Fonagy P (2012). *Mental health problems in children and young people.* In: Annual Report of the Chief Medical Officer 2012. London: Department of Health.

[6] Department of Health (2004). *National Service Framework for Children, Young People and Maternity Services.* London: Department of Health.

[7] National Advisory Council (2011). *Making children's mental health everyone's responsibility.* London: National Advisory Council.

[8] Department of Health (2012). *Report of the Children and Young People's Health Outcomes Forum*. London: Department of Health.

[9] HM Government (2011). *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages.* London: Department of Health.

[10] Department of Health (2013). *Improving Children and Young People's Health Outcomes: a system wide response*. London: Department of Health.

and standard-setting has laid the groundwork for significant improvements in the care that children and young people with mental health problems receive.

2.5 Good progress is being made on this agenda with the investment of:

- £60m into the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme over 2011-15/16;
- £7m in an extra 50 CAMHS specialised Tier 4 beds for young patients in the areas with the least provision (as identified by the NHS England CAMHS Tier 4 Report, July 2014);
- £150 million over the next five years in England to improve services for children and young people with mental health problems, with a particular emphasis on eating disorders; and
- £3 million in the MindEd e-portal launched in March 2014. The e-portal provides clear guidance on children and young people's mental health, wellbeing and development to any adult working with children, young people and families.
- NHS England is investing £15 million in health provision in the Children and Young People's Secure Estate.

2.6 Achieving Better Access to Mental Health Services by 2020[11] outlines the first waiting time standards for mental health and includes a standard which will ensure that by 2016, at least 50% of people of all ages referred for early intervention in psychosis services will start treatment within two weeks. This is backed by £40 million investment.

2.7 Wider cross-government service transformation initiatives such as the Troubled Families programme aimed at turning around the lives of 120,000 families with a broad range of problems have provided further traction and levers for local areas to make progress. Problems in these families often include mental health issues in either the children or the parents. In response, local authorities are working with families using integrated whole family approaches to address problems collectively for all members of the family.

2.8 The Department for Education (DfE) is leading work to improve the quality of teaching about mental health in Personal, Social, Health, and Economic (PSHE) lessons in schools, and is developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools. In addition, DfE has invested £36 million to develop and sustain evidence-based interventions for children in care, on the edge of care or custody and adopted children and their families, such as multisystemic therapy.[12]

2.9 Since 2011, the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme for children and young people has supported the transformation of local services. However, there remain significant and unacceptable gaps and variations in consistency and coherence within and across services and how they are commissioned. Services have worked hard to try to keep up with increasing demand, but this has been against a backdrop of fiscal constraint, particularly for local government.

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[11] Department of Health (2014). *Achieving Better Access to Mental Health Services by 2020.* London: Department of Health.

[12] Edward Timpson MP on better support for vulnerable adolescents. Addressed to the second European Multisystemic Therapy Conference. London, 12 May 2014. Transcript available at: www.gov.uk/government/speeches/edward-timpson-on-better-support-for-vulnerable-adolescents

2.10 At a service level, we know the importance of directly involving children, young people and their parents and carers in their own treatment, setting goals that have a meaning for them and using their feedback to guide their treatment and overall service development: it pays dividends in making services effective and efficient. Our knowledge about the evidence base has grown, and we have a much clearer picture of good models of care and how best to integrate services through strong collaborative working across the statutory, independent and voluntary and community sectors.

2.11 We therefore have some good work on which to build. However, this has to be set against a context of many local and specialist services struggling to cope with what benchmark surveys[13] demonstrate is increasing demand in a very tight financial environment. The Taskforce also found a lack of consistency in local systems' approach to, and prioritisation of child mental health. The next chapter of the report sets out the case for change in some detail, but we would want to make clear from the outset that there is an urgent need for change.

2.12 Last autumn, the publication of the NHS Five Year Forward View[14] brought statutory organisations together around a vision for the future of health and care in England that emphasises prevention, new models of care and local determination within national frameworks.

2.13 Nowhere could these principles be more relevant than in supporting the mental health and wellbeing of children and young people. To this end, the Minister for Care and Support, supported by colleagues in other government departments, set up the Children and Young People's Mental Health and Wellbeing Taskforce, co-chaired by the Department of Health and NHS England, to gather insights and evidence and inform this report.

2.14 The core group met five times, with a membership of over 60 participants from across health, social care, youth justice and education. Four working groups were formed, involving Taskforce members and others with specialist expertise, to look at the issues in more detail. 1600 children, young people, parents and carers were also involved through engagement activity led by YoungMinds. It is their voice and their experience which have been central to guiding and shaping this report.

2.15 This report has taken feedback from the working groups in the Taskforce, the engagement with children and young people, parents, carers and professionals and collated it with the established evidence base and previous reports. The work of the Taskforce was characterised from the outset by a shared sense of purpose that real change is necessary and, over time, achievable.

2.16 A number of key themes rapidly emerged. There is a need for good, transparent, regular data and information that is collected nationally. Prevention and early intervention are not only desirable but cost-effective. Support and treatment, especially in a crisis, need to be coordinated to make sure that different organisations and professionals know where responsibility lies and how to act effectively together. In addition, the needs of the more vulnerable should be recognised and addressed so they are not neglected or marginalised. Finally, interventions need to be evidence-based or contribute to research and evaluation so that the finite resources available are used to best effect.

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[13] NHS Benchmarking Collaborative 2014 – see www.nhsbenchmarking.nhs.uk/index.php

[14] NHS England (2014). *Five Year Forward View.* London: NHS England.

2.17 These themes form the basis of this report and guide the principles it sets out and the changes it proposes.

2.18 Some of the most significant decisions will require consideration by an incoming Government with a full term ahead of them. But there is also much that can be started now. The Taskforce has found examples of existing best practice from around the country and there is plentiful scope for further local as well as national innovation.

2.19 There is no time to waste.

# 3. The context and case for change

3.1 The prevalence of mental health problems in children and adolescents was last surveyed in 2004. This study estimated that:[15]

- 9.6% or nearly 850,000 children and young people aged between 5-16 years have a mental disorder
- 7.7% or nearly 340,000 children aged 5-10 years have a mental disorder
- 11.5% or about 510,000 young people aged between 11-16 years have a mental disorder
- This means in an average class of 30 schoolchildren, 3 will suffer from a diagnosable mental health disorder[16]

3.2 The most common diagnostic categories were conduct disorders, anxiety, depression and hyperkinetic disorders.

**Common mental health issues affecting children and young people**

Conduct disorders:

- 5.8% or just over 510,000 children and young people have a conduct disorder.

Anxiety:

- 3.3% or about 290,000 children and young people have an anxiety disorder.

Depression:

- 0.9% or nearly 80,000 children and young people are seriously depressed.

Hyperkinetic disorder (severe ADHD):

- 1.5% or just over 132,000 children and young people have severe ADHD.

3.3 Children with mental health problems are at greater risk of physical health problems; they are also more likely to smoke than children who are mentally healthy. Children and young people with eating disorders and early onset psychosis are particularly at risk, but it is important to note that many psychotropic drugs also have an impact on physical health.

3.4 Children with physical health problems also need their mental wellbeing and health supported.

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[15] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). *Mental health of children and young people in Great Britain, 2004*. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.

[16] YoungMinds Mental Health Statistics. Available at: www.youngminds.org.uk/training_services/policy/mental_health_statistics

### The interface between mental and physical health

- 12% of young people live with a long-term condition (LTC) (Sawyer et al 2007).
- The presence of a chronic condition increases the risk of mental health problems from two-six times (Central Nervous System disorders such as epilepsy increase risk up to six- fold) (Parry-Langdon, 2008; Taylor, Heyman & Goodman 2003).
- 12.5% of children and young people have medically unexplained symptoms, one third of whom have anxiety or depression (Campo 2012). There is a significant overlap between children with LTC and medically unexplained symptoms, many children with long term conditions have symptoms that cannot be fully explained by physical disease.
- Having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50%[17] and doubles the risk of coronary heart disease in adults.[18]
- People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population.[19]

## Economic argument

3.5 The economic case for addressing child and adolescent mental wellbeing is a strong one.

3.6 Mental health problems not only cause distress, but can be associated with significant problems in other aspects of life and affect life chances.

3.7 Despite this burden of distress, it is estimated that as many as 60-70% of children and adolescents who experience clinically significant difficulties have not had appropriate interventions at a sufficiently early age.[20] Evidence shows that, for all these conditions, there are interventions that are not only very effective in improving outcomes, but also good value for money, in some cases outstandingly so, as measured by tangible economic benefits such as savings in subsequent costs to public services.[21]

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[17] Mykletun A, Bjerkeset O, Overland S, Prince M, Dewey M, and Stewart R (2009). Levels of anxiety and depression as predictors of mortality: the HUNT study. *British Journal of Psychiatry* 195: 118-125.

[18] Hemingway H and Marmot M (1999). Evidence based cardiology: psychosocial factors in the aetiology and prognosis of coronary heart disease. A systematic review of prospective cohort studies. *British Medical Journal* 318: 1460–1467; Nicholson A, Kuper H and Hemingway H (2006). Depression as an aetiologic and prognostic factor in coronary heart disease: a meta-analysis of 6362 events among 146 538 participants in 54 observational studies. *European Heart Journal* 27: 2763–2774.

[19] Parks J, Svendsen D, Singer P, Fonti ME, and Mauer B (2006). *Morbidity and Mortality in People with Serious Mental Illness (Thirteenth in a Series of Technical Reports)*. Alexandria, Virginia: National Association of State Mental health Program Directors (NASMHPD) Medical Directors Council.

[20] Children's Society (2008) *The Good Childhood Inquiry: health research evidence.* London: Children's Society

[21] Fonagy P, Cottrell D, Phillips J, Bevington D, Glaser D, and Allison E (2014). *What works for whom? A critical review of treatments for children and adolescents* (2nd ed.). New York, NY: Guilford Press.

3.8 The evidence base, both clinical and economic, for other conditions, such as eating disorders, self-harm or autistic spectrum disorders is not as strong, but the moral and ethical arguments to care, research and build an evidence base are undeniable.

3.9 The B-CAMHS surveys of mental health of children and adolescents show all forms of mental disorder are associated with an increased risk of disruption to education and school absence.[22,23] Research on the longer-term consequences of mental health problems in childhood adolescence has found associations with poorer educational attainment and poorer employment prospects, including the probability of 'not being in education, employment or training' (NEET).[24]

3.10 There is a strong link between parental (particularly maternal) mental health and children's mental health. Maternal perinatal depression, anxiety and psychosis together carry a long term cost to society of just under £10,000 for every single birth in the country (see paragraph 4.4).

3.11 Social relationships can be affected both in childhood and adolescence and in adult life. Other increased risks include drug and alcohol use. Conduct disorder and ADHD are also both associated with an increased risk of offending and conduct disorder in girls with an increased risk of teenage pregnancy.

3.12 Bullying is reported by 34-46% of school children in England in recent surveys. A dose-response relationship exists, which means that children who are exposed to frequent, persistent bullying have higher rates of psychiatric disorder. Exposure to bullying is also associated with elevated rates of anxiety, depression and self-harm in adulthood.[25]

3.13 As well as the impact on the individual child and family, mental health problems in children and young people result in an increased cost to the public purse and to wider society. Those with acute conduct disorder incur substantial costs above those with some conduct problems, but not conduct disorder. A study by Friedli and Parsonage[26] estimated additional lifetime costs of around £150,000 per case – or around £5.3bn for a single cohort of children in the UK. Costs relating to crime are the largest component, accounting for 71% of the total, followed by costs resulting from mental illness in adulthood (13%) and differences in lifetime earnings (7%). More widely, in 2012/13, it was estimated the total NHS expenditure on dedicated children's mental health services was £0.70bn.

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[22] Meltzer H, Gatward R, Goodman R, Ford T (1999). *The mental health of children and adolescents in Great Britain.* The report of a survey carried out in 1999 by Social Survey Division of the Office for National Statistics on behalf of the Department of Health, the Scottish Health Executive and the National Assembly for Wales. London: The Stationery Office.

[23] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). *Mental health of children and young people in Great Britain, 2004*. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.

[24] Goodman A, Joyce R, Smith JP (2011). The long shadow cast by childhood physical and mental health problems on adult life. *Proc Natl Acad Sci* 108(15): 6032-6037.

[25] Copeland WE, Wolke D, Angold A, Costello EJ (2013). Adult psychiatric outcomes of bullying and being bullied by peers in childhood and adolescence. *JAMA Psychiatry* 70(4): 419-426.

[26] Friedli L, Parsonage M (2007). *Mental Health Promotion: Building an Economic Case.* Northern Ireland Association for Mental Health.

3.14 In straitened financial times, ensuring best value for the taxpayer investment is vital. The Centre for Mental Health has analysed the return on investment from addressing the four common disorders in childhood.[27] For instance, it has been estimated that children with early conduct disorder are 10 times more costly to the public sector by the age of 28 than other children.[28]

3.15 The impact of mental health disorders extends beyond the use of public services. Taking this wider societal viewpoint, it has been estimated that the overall lifetime costs associated with a moderate behavioural problem amount to £85,000 per child and with a severe behavioural problem £260,000 per child.[29]

> "The strength of the mental health of our future adult population is the responsibility of all departments of society – health, education, policing etc… children and young people with mental health difficulties cost all of these departments more money – it is in everyone's best interest to invest in the children and young people of today."
>
> A family support worker who took part in the Taskforce engagement exercises

3.16 The National Institute for Health and Care Excellence (NICE) documents a wide range of well-evidenced interventions that can be used to treat children and young people with mental health disorders effectively.[30] For example, the table below details the impact of group cognitive behavioural therapy for depressed adolescents.

3.17 It is important to note that this does not include wellbeing gains, but does measure the financial benefit to an individual due to improved employment opportunities as a result of managing their condition.

3.18 The benefits included in a benefit:cost ratio are *in addition to* the mental health and wellbeing improvements associated with evidenced interventions. In general, measured benefits include two main elements: (i) reductions in the use of public services because of better mental health, and (ii) increases in earnings associated with the impact of improved mental health on educational attainment. In the case of conduct disorder, there are also benefits to society resulting from reduced offending, including costs to victims and the community.

3.19 The inescapable fact is that failure to prevent and treat children and young people's mental health problems comes at a heavy price, not only for the wellbeing of the children concerned and their families, but also for taxpayers and society because of increased future costs.

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[27] Khan L, Parsonage M, Stubbs J for CentreForum's Mental Health Commission (2015). *Investing in children's mental health: a review of evidence on the costs and benefits of increased service provision*. London: Centre for Mental Health.

[28] Scott S, Knapp M, Henderson J, Maughan B. (2001). Financial cost of social exclusion: follow-up study of antisocial children into adulthood. *British Medical Journal* 323(7306): 191.

[29] Parsonage M, Khan L, Saunders A (2014). *Building a better future: the lifetime costs of childhood behavioural problems and the benefits of early intervention*. London: Centre for Mental Health.

[30] National Institute for Health and Care Excellence. Mental health and wellbeing guidance. Available at: http://www.nice.org.uk/guidance/lifestyle-and-wellbeing/mental-health-and-wellbeing

| **Group Cognitive Behavioural Therapy (CBT) for depressed adolescents**[31] | |
|---|---|
| **Aim** | Group CBT for depressed adolescents aims to improve general functioning and prevent the risk of a major depressive episode from occurring. It is a series of group sessions lead by a therapist, involving exploring ideas related to the condition and how to handle it. There is a suggested duration of three months of weekly meetings. |
| **Unit Cost** | £229 |
| **Total lifetime benefit** | £7,252 |
| **Lifetime benefit to taxpayers** | £3,520 |
| **Lifetime benefit to participants** | £3,455 |
| **Lifetime benefit to others** | £277 |
| **Lifetime benefit-cost ratio (benefits/costs)** | 31.67 |

## Levels of Investment

3.20 In 2012/13, NHS expenditure on child and adolescent mental health disorders was estimated to be £700 million (ie £0.70bn) or 6% of the total spend on mental health. Between 2006/7 and 2012/13, the proportion of mental health spending on children and young people has fallen.

3.21 NHS England is taking forward work on collecting comprehensive spending data on mental health services in the NHS.

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[31] Investing in Children. Group Cognitive Behavioural Therapy (CBT) for Depressed Adolescents. Available at: http://investinginchildren.eu/interventions/group-cognitive-behavioural-therapy-cbt-depressed-adolescents

## NHS expenditure on mental health

3.22 There is no national level information on current local authority social care or education spend on children and young people's mental health. However, from a number of surveys there would appear to be a pattern of increasing demand that local mental health services in many areas are struggling to meet.

3.23 The Department of Health and NHS England are working on improvements to overall mental health data and intelligence across the full life course.

## Issues to address

3.24 Evidence presented to and discussions in the Taskforce have underlined the complexity and severity of the current set of challenges facing child and adolescent mental health services.

3.25 These include:

i. **Significant gaps in data, information and system levers.** There has been significant delay in national collection of outcomes metrics, access standards, development of payment and other incentive systems and their alignment across the health, education and social care systems, which are all critical to driving change in a co-ordinated way. Although there is locally collected data, there is a general lack of clarity about what is provided by whom, for what problem, for which child.

ii. **Investment levels.** The lack of data, information and system drivers have made Child and Adolescent Mental Health services (CAMHS) financially vulnerable. Historically, mental health services have suffered when the public sector is under financial pressure. NHS England and the Department of Health have initiated action to address this for health services for 2014/15 and 2015/16 but local government continues to face significant financial challenges and more work is needed.

iii. **The treatment gap.** The last UK epidemiological study[32] suggested that, at that time, less than 25% – 35% of those with a diagnosable mental health condition accessed support. There is emerging evidence of a rising need in key groups such as the increasing rates of young women with emotional problems and young people presenting with self-harm. In addition, there are some groups with additional vulnerabilities (see below) who, due to a range of issues, are not given the priority they need.

iv. **Difficulties in access.** NHS benchmarking data and recent audits reveal increases in referrals and waiting times, with providers reporting increased complexity and severity of presenting problems and a consequent rising length of stay in inpatient facilities. Since 2011, our best evidence is that these difficulties are the result of financial constraints accompanied by rising demand.[33]

v. **Complexity of current commissioning arrangements.** A lack of clear leadership and accountability arrangements for children's mental health across agencies with the potential for children and young people to fall though the net has been highlighted in numerous reports.[34] Co-ordination across the system, particularly for those children and young people with complex needs, is challenging where there is no lead agency accountable for the child or young person, despite the large number involved in providing services.

vi. **Access to crisis, out of hours and liaison psychiatry services are variable**. There are variations in access to appropriate or age-appropriate inpatient care close to home and available when needed. In some parts of the country, there is no designated health place of safety recorded by the CQC for under-18s.

vii. **Specific issues facing highly vulnerable groups**. All children and young people may experience adverse life events at some time in their lives, but some are more likely to develop mental health disorders eg following multiple losses and/or trauma in their lives, as a result of parental vulnerability or due to disability, deprivation or neglect and abuse. These children, young people and their families may find it particularly difficult to access appropriate services, or services may not be configured to meet their psychosocial needs. In addition, they sometimes find it more

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[32] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). *Mental health of children and young people in Great Britain, 2004*. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.

[33] Department of Health (2013). *Annual Report of the Chief Medical Officer 2013. Public Mental Health Priorities: Investing in the Evidence.* London: Department of Health.

[34] National CAMHS Review (2008). *Children and young people in mind: the final report of the National CAMHS Review*. National CAMHS Review; HM Government (2011). *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages.* London: Department of Health; Department of Health (2012). *Annual Report of the Chief Medical Officer 2012*. London: Department of Health; CAMHS Tier 4 Report Steering Group (2014). *CAMHS Tier 4 Report*. London: NHS England.

difficult to access services they may find alienating and may have a lifestyle that is not conducive to meeting regular appointments.

3.26 These issues are addressed in considering the key themes that form the basis of this report and the proposals it makes.

# 4. Promoting resilience, prevention and early intervention

4.1 We need to value the importance of recognising and promoting good mental health and wellbeing in all people, not just focusing on mental illness and diagnosis. There is evidence that supporting families and carers, building resilience through to adulthood and supporting self-care reduces the burden of mental and physical ill health over the whole life course, reducing the cost of future interventions, improving economic growth and reducing health inequalities.[35]

4.2 It is therefore crucial that, locally, there is an integrated, partnership approach to defining and meeting needs. A wide range of professionals should be involved across universal, targeted and specialist services, through:

- **promoting** good mental wellbeing and resilience, by supporting children and young people and their families to adopt and maintain behaviours that support good mental health;
- **preventing** mental health problems from arising, by taking early action with children, young people and parents who may be at greater risk;
- **early identification** of need, so that children and young people are supported as soon as problems arise to prevent more serious problems developing wherever possible.

## Prevention and support from birth

4.3 If we are to have the greatest chance of influencing the determinants of health and wellbeing, we should focus efforts on actions to improve the quality of care for children and families. We should start by making efforts to ensure a safe and healthy pregnancy, a nurturing childhood and support for families in providing such circumstances in which to bring up children.

4.4 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.

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[35] Annual Report of the Chief Medical Officer: *Health in Scotland 2011, Transforming Scotland's Health* (Chapter 3). Scottish Government: December 2012.

[36] Bauer A, Parsonage M, Knapp M, Iemmi V, and Adelaja B (2014). *The costs of perinatal mental health problems.* London: Centre for Mental Health.

**Current action to improve early support for parents, carers and children from birth (1** and **4)**

- The Mandate between the Government and NHS England sets an objective to work with partner organisations to ensure that the NHS reduces the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support.
- The Mandate between Health Education England (HEE) and the Government recognises the importance of maternal mental health during pregnancy and after birth – by 2017, every birthing unit should have access to a specialist perinatal mental health clinician.
- The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives.
- Public Health England is publishing an update of the evidence base for the Healthy Child Programme[37] (0-5 years) that will guide professionals including supporting early attachment between infant and parent(s).
- Ensuring progress with these mandate requirements and workforce capability will support better mental wellbeing for children and young people into the future. In addition, Achieving Better Access to Mental Health Services by 2020 sets out that DH and NHS England will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the postnatal period with a known or suspected mental health problem.
- In the 2014 Autumn Statement to Parliament, the Chancellor announced a 0-2 year old early intervention pilot to prevent avoidable problems later in life. The Pilots will be run jointly by DfE and DH. They will complement the work of the Early Intervention Foundation, and link closely with other activity such as the Healthy Child Programme and the Troubled Families Programme. Details of how and where the pilots will operate will be made available shortly. Government will consider the emerging evidence in relation to prevention and intervening early with mental health problems.

4.5 The transfer of commissioning of 0-5 public health services to local government in October 2015 provides a great opportunity for local authorities, working through Health and Wellbeing Boards, to create a stronger focus on mental health in the early years and beyond. Public Health England's rapid review of the evidence base for the Healthy Child Programme (0-5) will help local services make use of the most up-to-date evidence base.

4.6 There is strong evidence of the benefits of evidence-based parenting programmes in intervening early for children with behavioural problems. These are benefits to the individual child and family, as well as producing significant cost saving to the system as a whole. Such programmes should remain

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[37] Shribman S and Billingham K (2009). *Healthy Child Programme – Pregnancy and the First Five Years of Life.* London: Department of Health.

a priority for local authorities and better links developed with specialist services to work jointly on cases where families have difficulty engaging in groups or need intensive individual support before they are ready to join a group.

## The role of universal services in mental health promotion, prevention and early intervention

4.7 Universal services, including health visitors, Sure Start Children's Centres, schools, school health services including school nurses,[38] colleges, primary care and youth centres, play a key role in preventing mental health problems. Universal services support children and young people's wellbeing through delivering mental health promotion and prevention activities, which work best when they operate on a whole-system basis.

4.8 In our discussions with young people, they emphasised the difficulties many of them had faced in discussing their problems with their GP. Many of them also reported that their school was not an environment in which they felt safe to be open about their mental health concerns.

4.9 For their part, GPs, schools and other professionals such as social workers and youth workers often feel as frustrated as the children and their parents. They want to do the right thing, but have not necessarily been equipped to play their part or been provided with clear access routes to expertise and for referring to targeted and specialist support. Professionals working in child and adolescent mental health services are equally aware of the challenges that come from balancing identified need with available resource.

4.10 There is also a need for greater clarity about the core attributes that underpin mental health and resilience throughout life. The Department for Education is leading work to help schools ensure more pupils develop the character traits, attributes and behaviours, which, alongside academic achievement, underpin future success. The Department will work closely with all key stakeholders as this work develops, informed by insights and evidence on effective practice from its investment in character education projects and research, due in autumn 2016. Alongside this, Public Health England should continue to strengthen its work on core attributes that underpin mental health and resilience and the application of this by commissioners and service providers.

## GPs

4.11 General Practice and the primary care team have an important part to play in supporting families, children and young people to develop resilience and in identifying and referring problems early. GPs take a holistic approach to the whole family registered with them and are responsible for primary physical and mental health. There is significant potential in that the GP practice is a less stigmatising environment than a mental health clinic. Many GPs have improved accessibility to young people by using the 'You're Welcome' standards and self-audit.[39] Practices such as Herne Hill Group Practice in London, working with the voluntary sector organisation Redthread Youth, have gone further by creating the Well Centre with drop-in clinics for young people where they can discuss a range of issues and have access to specialist mental health support.

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[38] Chief Nursing Officer's Professional Leadership Team (2012). *Getting it right for children, young people and families.* London: Department of Health.

[39] Department of Health (2011). *You're Welcome – Quality criteria for young people friendly health services*. London: Department of Health.

4.12 There is also scope for GPs and other professionals with children and young people to consider referring for a wider range of interventions and services to support their mental health and wellbeing. The local offer could include commissioning approaches that support the ability for GPs to offer social prescribing, where activities such as sport are used as a way of improving wellbeing.

## Schools

4.13 Many schools are already developing whole school approaches to promoting resilience and improving emotional wellbeing, preventing mental health problems from arising and providing early support where they do. Evidence shows[40] that interventions taking a whole school approach to wellbeing have a positive impact in relation to both physical health and mental wellbeing outcomes, for example, body mass index (BMI), tobacco use and being bullied.

4.14 The vast majority of secondary schools surveyed in recent CentreForum research[41] reported that they implement programmes to promote positive mental health universally across the student population, with 93% doing this within the context of Personal, Social, Health, and Economic (PSHE) education. The research also indicates that pupils in 86% of secondary schools surveyed have access to a trained/qualified counsellor(s), and almost all secondary schools (98%) have pastoral care services. While counselling services within schools are not intended as a substitute for other community and specialist mental health services, they can be a valuable complement to them.

4.15 We encourage all schools (including those in the independent sector) to continue to develop whole school approaches to promoting mental health and wellbeing (**2**). This will build on the Department for Education's current work on character building, PSHE and counselling services in schools (see box for details). The named mental health lead for schools proposed in chapter five would also make an important contribution to leading and developing whole school approaches.

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[40] Brooks F (2012). Life stage: School Years. In: *Annual Report of the Chief Medical Officer 2012. Our Children Deserve Better: Prevention Pays*. London: Department of Health.

[41] Taggart H, Lee S, McDonald L (2014). *Perceptions of wellbeing and mental health in English secondary schools: a cross sectional study*. London: CentreForum Commission.

**Current action to support schools in promoting resilience and prevention of mental health problems**

- The Department for Education (DfE) is leading work to improve the quality of teaching about mental health within Personal, Social, Health, and Economic (PSHE) lessons in schools, and has commissioned the PSHE Association to produce guidance for schools in teaching about mental health safely and effectively, which will be available in spring 2015. Alongside the guidance will be a series of lesson plans covering key stages 1-4 (5-16 year olds). For older pupils, they will address such topics as self-harm and eating disorders, as well as issues directly concerned with school life, such as managing anxiety and stress around exams.
- DfE is developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools, with practical and evidence-based advice to ensure quality provision, that improves children's outcomes and achieves value for money. This will be published in spring 2015.
- DfE has invited schools, colleges and organisations to bid for a £3.5 million character education grant fund for local projects.
- School nurses lead and deliver the Healthy Child Programme (HCP) 5-19 and are equipped to work at community, family and individual levels. They can play a crucial role in supporting the emotional and mental health needs of school-aged children. School nursing services are universal and young people see them as non-stigmatising.[42]
- Inspection is a key lever to drive improvement. The new draft Ofsted inspection framework 'Better Inspection for All' includes a new judgement on personal development, behaviour and welfare of children and learners.

4.16 It is important that schools tackle bullying, including cyberbullying, robustly. The Government has continued to take action when required. By law, all schools must have a behaviour policy which includes measures to tackle all forms of bullying and they are held to account by Ofsted. The best schools create an ethos of good behaviour where pupils treat each other, and staff, with respect, understand the value of education, and appreciate the impact that their actions can have on others. The Department for Education has produced advice to help schools support pupils who are severely affected by bullying.[43]

4.17 Schools can help to contain cyber-bullying during the school day by banning or limiting the use of personal mobile phones and other electronic devices. Schools also have the power to search for, and if necessary delete, inappropriate images (or files) on electronic devices, including mobile phones.

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[42] Department of Health and Public Health England (2013). *Promoting emotional wellbeing and positive mental health of children and young people.* London: Department of Health.

[43] Department for Education (2013). *Departmental advice on preventing and responding to bullying.* London: Department for Education.

## Developing a national conversation

4.18 We need to create the space for an open national conversation about children and young people's mental health. Children, young people and their parents/carers need clearer awareness of what is good mental health and what is poor mental health, as well as better information about how to keep mentally and emotionally healthy.

4.19 To this end, the Taskforce proposed there could be a major national branded social marketing campaign with a mechanism for dialogue so it is a genuine two-way conversation – driven by children, young people, parents and carers (**3**). Options include building on the Time to Change campaign (www.time-to-change.org.uk/youngpeople) as well as looking for opportunities to address mental health and wellbeing issues with the Public Health England Rise Above[44] campaign. The Time to Change programme has already been associated with greater mental health literacy as well as less stigmatising attitudes.[45] In the last year or two, we have seen remarkable progress in reducing levels of stigma towards mental health conditions. It is now time we did the same for children and young people, to create a climate where there is as much interest in their emotional and cognitive development as there is in their academic development.

## Harnessing digital technology

4.20 The digital world has become of utmost importance with its potential to protect and enhance the mental health and wellbeing of our children and young people. We are raising a generation of 'digital natives' who differ from previous generations in the way they communicate. Electronic media has some positive influences, such as improved faster information processing; conversely, there are widespread concerns about potential negative effects, including decreased attention, hyperactivity, and excessive use.[46] There is high risk that children and young people are subject to harmful exposure to inappropriate material, to the risks of cyber-bullying, to potential grooming and exploitation[47] and to websites that reinforce negative behaviour, such as those encouraging excessive weight loss.

4.21 We recognise there is already a significant amount of work as part of the Government response on tackling child sexual exploitation as well as more broadly under the auspices of the National Group on Sexual Violence against Children and Vulnerable People. The need to influence and protect young people has a wide reach. Thus in the new computing programmes of study, which were introduced in September 2014, e-safety will be taught at all four key stages of school. It covers responsible, respectful and secure use of technology, as well as ensuring that pupils are taught age-appropriate ways of reporting any concerns they may have about what they see or encounter online.

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[44] Public Health England (2014). *Public Health England Marketing Strategy*. London: Public Health England.

[45] Evans-Lacko S, Malcolm E, West K, Rose D, London J, Rusch N, Little K, Henderson C, Thorniscroft G (2013). *Influence of Time to Change's social marketing interventions on stigma in England 2009-2011.* British Journal of Psychiatry 2012: 77-88.

[46] Department of Health (2013). *Annual Report of the Chief Medical Officer 2013. Public Mental Health Priorities: Investing in the Evidence.* London: Department of Health.

[47] National Crime Agency. CEOP Command. Available at: www.nationalcrimeagency.gov.uk/about-us/what-we-do/child-exploitation-online-protection-ceop

4.22 We also recognise the positive role of digital technology, which provides new opportunities to deliver the right information to children and young people and reduce stigma. For example, Mind has unveiled YouTube star and teen icon Zoe Sugg as its new Digital Ambassador, who has used her blog to share open and honest accounts of her own battles with anxiety and panic attacks, and launched the initiative **#DontPanicButton**.

4.23 The use of apps and other digital tools can empower self-care, giving children and young people more control over their health and wellbeing and empowering their parents and carers. Harnessing the potential of the web to promote resilience and wellbeing aligns with the principles set out in Personalised Health and Care 2020[48] and the priority it has already given to young people. Children and young people's mental health and wellbeing should be given the priority it deserves and the system should build on existing resources to support the intentions set out in this report – signalling the promise indicated by the National Information Board's Framework for Action.

4.24 We propose that the Government asks the National Information Board to work in close partnership with the Government Digital Service and young people themselves to develop a single framework for harnessing the power of digital technology and protecting young people from mental harm (**5**). Within this framework, we propose that Government considers incentivising the development of new apps and digital tools; and also whether there is a need for some form of kite-marking scheme based on research evidence to guide young people and their parents on quality.

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[48] National Information Board and Department of Health (2014). *Personalised Health and Care 2020: using data and technology to transform outcomes for patients and citizens.* London: Department of Health.

**Resilience, prevention and early intervention for the mental wellbeing of children and young people – chapter 4 summary**

Our aim is to act early to prevent harm, by investing in the early years, supporting families and those who care for children and building resilience through to adulthood. Strategies should be developed in partnership with children and young people to support self-care. This will reduce the burden of mental and physical ill health over the whole life course.

Much of what is needed can be done now by:

1. Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots.
2. Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.
3. Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.

With additional funding, a future government should consider:

4. Enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence-based programmes of intervention and support.
5. Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kitemarking scheme in order to guide young people and their parents in respect of the quality of the different offers.

# 5. Improving access to effective support – a system without tiers

> *"You have to fit into their paths and none of their paths fit you."*
>
> *"Mental health isn't a one size fits all treatment, it really depends on the person."*
>
> Young people who took part in the Taskforce engagement exercises.

5.1 Our discussions with professionals who work with children and young people revealed a strong, common theme – that it is essential that children and young people are at the heart of the work they do and the services that are provided for them. However, the tiers model,[49] a reasonable construct at its inception in 1995, defines the system in terms of the services that provide the care. In practice, this means that children and young people have to fit the services, rather than the services fitting the changing needs of the child or young person.

5.2 Furthermore, the tiers model has been criticised for unintentionally creating barriers between services, embedding service divisions and fragmentation of care. It often results in children or young people falling in gaps between tiers and experiencing poor transitions between different services. At its worst, it can even lead to commissioners and providers of different tiers of service effectively passing the buck to one another.

5.3 Many areas across the UK, such as Liverpool and Leeds, are already working to move away from the tiered structure by designing new local models which create a seamless pathway of care and support, and which address the need for the diversity of circumstances and issues with which families and young people approach mental health services. Alternative models can also be seen internationally. A further example of a more flexible needs-based model for structuring children and adolescent mental health services is the recently proposed 'Thrive model'.[50] We consider this model to have potential and that it should be evaluated and debated further.

5.4 The advantage of these models is that they have the potential to move away from an inflexible and restrictive system, towards one which enables agencies to commission and deliver support to allow children and young people to move more easily between services and to make collaborative choices about what would work best for them at given points in time. It obliges providers to place expertise at the front end of delivery systems to establish with children, young people and families, the intervention most appropriate to their current need. However, it is also important to note that there is no

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[49] The report on the Thrive model (see below) contains a description of the tiers model (page 5).

[50] Wolpert M, Harris R, Jones M, Hodges S, Fuggle P, James R, Wiener A, Mckenna C, Law D, Fonagy P (2014). THRIVE: *The AFC-Tavistock Model for CAMHS*. London: CAMHS Press. Available at: www.tavistockandportman.nhs.uk/sites/default/files/files/Thrive%20model%20for%20CAMHS.pdf

one size fits all. Models could and should be different in different types of locality; for example, a model which works well in rural Devon may fail to meet need if applied in inner-Manchester, and vice versa. This is why we have not dictated the local offer but been clear about the national ambition (**6**).

## Right time, right place, right offer

> *"There needs to be one point of access between patients and services that the patient can approach to find out anything they wish to know about the rest of the services involved and out there."*
>
> A young person who took part in the Taskforce engagement exercises.

5.5 The starting-point is that children and young people and their parents/carers need clearer awareness of how to recognise when they might have a mental health problem as well as where and how to get help, clarity about what help is available, what might happen when they access it, and what to do while they are waiting.

5.6 Therefore, at the heart of any good local system should be cross-sector agreement to ensure clarity in respect of how services are accessed. Many areas are already using a **single point of access** to targeted and specialist mental health services through a multi-agency 'triage' approach, including areas working within the CYP IAPT programme such as Liverpool. There is a pressing need to develop these approaches more widely (**7** and **16**). Common features of a single point of access system include:

- One point of contact for a wide range of universal services to access a team of children and young people's mental health professionals for advice, consultation, assessment and onward referral.
- Initial risk assessment to ensure children and young people at high risk are seen as a priority.
- Prompt decision-making about who can best meet the child/young person's needs (including targeted or specialist services, voluntary sector youth services and counselling services).
- Young people and parents are able to self-refer into the single point of access.

5.7 We propose the following to improve communication and access:

i. Create an expectation that there is a **dedicated named contact point in targeted or specialist mental health services** for every school and primary care provider, including GP practices (**8** and **16**). Their role would be to discuss and provide timely advice on the management and/or referral of cases, including consultation, co-working or liaison. This may include targeted or specialist mental health staff who work directly in schools/GP practices/voluntary sector providers with children, young people and families/carers.

ii. Create an expectation that there should be a **specific individual responsible for mental health in schools,** to provide a link to expertise and support to discuss concerns about individual children and young people, identify issues and make effective referrals (**8** and **16**). This individual would make an important contribution to leading and developing whole school approaches.

iii. Develop a joint **training programme** for named individuals in schools and mental health services to ensure shared understanding and support effective communications and referrals (**9**).

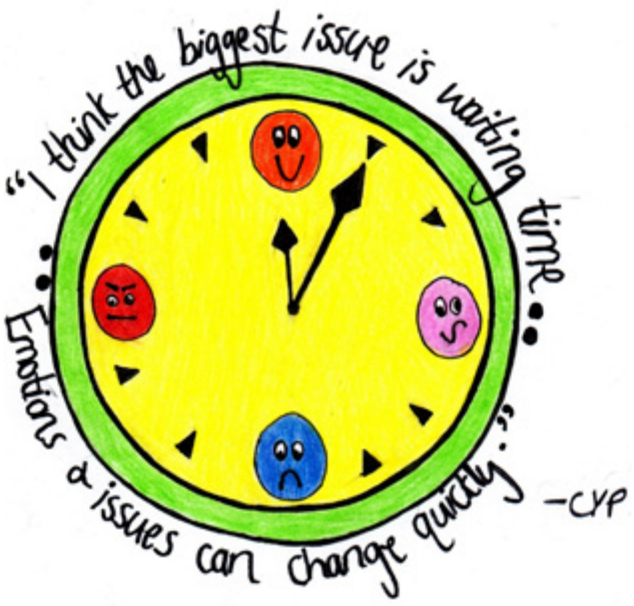
iv. Provide a key role for the voluntary and community sector to encourage an increase in the number of **one-stop-shop services**, based in the community (**7** and **16**). They should be a key part of any universal local offer, building on the existing network of YIACS (Youth Information, Advice, and Counselling Services). Building up such a network would be an excellent use of any identified early additional investment. There may also be a case in future for developing national quality standards for a comprehensive one-stop-shop service, to support a consistent approach to improving outcomes and joint working.

v. Enable greater access to **personal budgets** for children and young people (and their families) who have a longer term condition or disorder, to give them more choice and control over when and how they access which services

vi. Ensuring there is a strategic link between children's mental health services and services for children and young people with **special educational needs and disabilities** (SEND) (**10**). This should be matched by involvement, where necessary, of mental health professionals in co-ordinated assessment and planning (for children and young people with and without Education, Health and Care Plans.)

## Use of standards

5.8 NHS England has committed to developing access and waiting time standards in mental health. By 2020, the aim would be to provide a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services. This applies to children and young people who will benefit in the first year with the introduction of the first ever waiting time standards in respect of early intervention in psychosis. It is important that children and young people are taken fully into account as further access and waiting time standards are considered, subject to resource availability. Careful consideration will need to be given to which conditions are prioritised, working with experts, services and commissioners and building on current work to develop standards for eating disorders and the introduction of the standard for early intervention in psychosis. (**17**)



## A welcoming environment

> *"The fact that they showed human qualities helped me feel comfortable sharing."*
>
> A young person who took part in the Taskforce engagement exercises.

5.9 There are some changes that have little cost which could be implemented straightaway. Examples include a warm

**and** encouraging welcome for children, young people and parents/carers when they walk through the door; enabling and encouraging their involvement in their own treatment plans and reviews; having a positive attitude and culture within services and promoting effective participation. Young people say that these interactions make an enormous difference to how they feel, to their confidence in participating, and to counteracting the stigma associated with accessing mental health services.

5.10 Some children, young people and families find the formal setting of a clinic off-putting and are unwilling to attend. This can lead to them saying that they do not wish to be referred or not turning up – particularly for some highly vulnerable groups, such as those involved with gangs or those who have been sexually exploited. As a consequence, some services experience high rates of children, young people and families not attending appointments. It is important that services monitor attendance and actively follow up families and young people who miss appointments and inform the referrer (see also paragraph 6.2). It may be necessary to find alternative ways to engage the child, young person or family.

5.11 Mental health practitioners and staff such as youth workers delivering interventions should follow existing good practice and give young people and families the choice to receive treatment away from traditional NHS mental health settings. This might mean that staff see them in public places, such as cafes and restaurants, or in schools, or home-based treatment and there are a number of areas where staff, including consultants, do so successfully. This may also help to re-engage the young person with clinical staff and to be able to attend clinical settings at a later stage. This is likely to lead to a better result than young people or families failing to attend and receiving no support.

## Peer Support

> *"Peer mentoring is a fantastic idea as young people should be able to feel like they aren't the only one going through these problems."*
>
> A young person who took part in the Taskforce engagement exercises.

5.12 Young people, as well as parents or carers, also have an important role to play in informing and supporting other young people and families about mental health prevention and access. Consultations carried out through YoungMinds' Engagement Survey and other engagement activities have shown that young people have a strong desire to hear from other young people who have accessed mental health services and CYP IAPT reports suggest this is also a priority for parents and carers. Peer support schemes should be led and designed by children and young people or by parents or carers, with careful professional support to reduce and manage risk both to peer mentors and the young people and families they are involved with. It is proposed that further work should be done with relevant education and third sector partners to audit where peer support is currently available and evaluate it, building on existing work such as the Royal Society for Public Health Youth Health Champions. Local areas can then consider closing gaps in provision. (**11**)

## Digital access

> *"I particularly like websites that have in depth resources on conditions and treatments eg Mind and Rethink. They talk about issues objectively so sufferers don't feel patronised, but also offer supportive information. They allow me to access information easily and whenever I want."*
>
> A young person who took part in the Taskforce engagement exercises.

5.13 As we established in the previous chapter, children and young people and many parents and carers are digitally literate and told us they wanted better and more use made of the web. This could be expressed in a number of ways, but must be informed by the views and preferences of children and young people to be effective. The Taskforce believes a future government should look at options enabling children, young people, parents and carers to access high quality and reliable online information and support. One such option could be a national branded web based portal established using NHS Choices, in line with the recently published National Information Board framework.[51] (**18**) It could build on the successful MindEd website (www.minded.org.uk) aimed at professionals to provide national information about mental health and wellbeing in an engaging and reliable format. The NHS Choices content on adult mental health should link to the children and young people equivalent – the Youth Wellbeing Directory (youthwellbeingdirectory.com) and services are encouraged to register with the Directory.

## Community mental health provision

5.14 The availability and adequacy of the right mix of specialist community health services is critical to the success of THRIVE and similar needs based 'triage' models. Under these models, community mental health is not just a set of services to be referred into. It becomes a joined-up team, working proactively to support other professionals in their settings as well as managing caseloads in terms of higher level interventions. This can identify children and young people who may not present until they are in crisis at an early stage and improve support after discharge.

5.15 The shape and structure of these local teams cannot be defined at national level. However, national agencies can help by providing tools and best practice guidance which enable commissioners and providers to work together to assess the capacity and

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[51] National Information Board and Department of Health (2014). *Personalised Health and Care 2020: using data and technology to transform outcomes for patients and citizens.* London: Department of Health.

capability they require, and to enable efficient and effective prioritisation of resources, for example via www.chimat.org.uk.

## Dealing with crisis

5.16 The litmus test of any local mental health system is how it responds in a crisis. For children and young people experiencing mental health crisis, it is essential that they receive appropriate support/intervention as outlined in the Crisis Care Concordat,[52] including an out-of-hours mental health service (**12**). The challenge of supporting a child or young person in a crisis includes ensuring that there is a swift and comprehensive assessment of the nature of the crisis. There are examples around the country of dedicated home treatment teams for children and young people, but these are not universally available. Some children and young people end up in A&E, where access to appropriate and timely psychiatric liaison from specialist child and adolescent mental health services is not always available. Some are placed (not always appropriately) on paediatric or general adult hospital wards. The national development of all-age liaison psychiatry services in A&E Departments with targeted investment over this and the next financial year, as set out in the joint Department of Health and NHS England publication, Achieving Better Access to Mental Health Services by 2020, should mean that appropriate mental health support in A&E is more readily available. This needs to be carefully monitored.

5.17 For some children and young people, their route into specialist services is more extreme and is through detention by the police, under Section 136 of the Mental Health Act. Those who exhibit such distress and risk to themselves or others that a section 136 detention becomes warranted will need further support, which may not be purely from mental health services. There is broad support for legislating to ensure that no child or young person under-18 would be detained in a police cell as a place of safety, subject to there being sufficient alternative places of safety.[53] (**19**) It is also important to develop improved data on the availability of crisis/home treatment for under-18 year olds and the use of section 136 for children and young people under-18 to support better planning. CQC should be asked to carry out routine assessments of places of safety with a focus on their age-appropriateness for children and young people.

## Inpatient care

5.18 While community-based mental health services have a significant role in supporting children and young people in great need, there will always be some children and young people who require more intensive and specialised inpatient care. These must be age-appropriate and as close to home for the child or young person as possible.

5.19 The access and utilisation of specialised beds is a signal of how the whole system is working and therefore cannot be addressed in isolation. As the recent NHS England Tier 4 review[54] has demonstrated, there have been gaps in provision that NHS England is addressing. The key to commissioning the right type of care, in the right places is to adopt a whole system

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[52] Department of Health and Concordat signatories (2014). *Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis*. London: Department for Health.

[53] Department of Health and Home Office (2014). *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983*. London: Department of Health and Home Office.

[54] CAMHS Tier 4 Report Steering Group (2014). *CAMHS Tier 4 Report*. London: NHS England.

commissioning perspective compatible with the type of model we describe in this chapter. This should address the role of pre-crisis, crisis, and 'step-down' services alongside inpatient provision. We return later in the report to the question of how we achieve a planning and commissioning framework, and information systems that can enable the system to make much better decisions about what inpatient capacity is required and to improve outcomes for children and young people for whom inpatient care cannot be avoided. There is strong support for investing in effective targeted and specialist community provision, including admission prevention and 'step-down' provision. This can provide clear pathways for young people leaving inpatient care to help avoid unnecessary use of inpatient provision and shorten duration of stay by easing the transition out of inpatient care (**13**). In line with the NHS 5 Year Forward View, NHS England is exploring a range of options for future commissioning and more collaborative work.

## Use of residential care

5.20 If we are to improve outcomes for young people, especially those with learning disabilities, we must all learn from the lessons arising from the terrible events at Winterbourne View hospital, as to how people can become institutionalised. Children and young people with challenging behaviour can too easily be admitted to residential care unsuited to supporting their long-term health and wellbeing, and which does not support preparation for transition to adulthood and independent living. This is a group of vulnerable children and young people who already face the poorest outcomes, both in terms of their health and long-term independence and security. Sir Stephen Bubb's recent report highlighted the specific pressures which combine to force a young person into a residential setting: the lack of awareness of the individual's needs and wishes; the complexity of joint commissioning to deliver service transformation; the absence of viable alternative community-based provision; and the resource issues which inhibit its development.[55]

5.21 As highlighted in the Government's response to the Bubb report, in 2015/16 NHS England will lead partners in developing ways to strengthen the assurance that an admission is the best approach to care. This work will involve people with learning disabilities and their families and include:

- robust admission gateway processes for those with learning difficulties;
- a challenge process to check that there is no alternative to admission; and
- the agreement of a discharge plan on admission.[56]

5.22 Children and young people's mental health services must draw on this methodology and apply similar principles. (**14**)

5.23 There are likely to be some children and young people with mental health needs, usually those at risk of crisis, for whom an inpatient setting will be the most suitable. The effectiveness of care provided to children and young people in crisis can be assessed by the extent to which it meets their immediate needs, whilst providing a basis for long term support and improvement. There should be systemic safeguards in place to prevent it becoming their permanent home which include:

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[55] Transforming Care and Commissioning Steering Group (2014). *Winterbourne View – Time for Change. Transforming the commissioning of services for people with learning disabilities and/or autism*. London: ACEVO.

[56] NHS England (2015). *Transforming Care for People with Learning Disabilities – Next Steps*. London: NHS England.

i. ongoing strategic audits of admissions;

ii. a co-ordinated outcome focused care plan for each inpatient (this could be part of an Education, Health and Care plan where the child was eligible because of their learning disability);

iii. regular, comprehensive reviews of the suitability of the placement, against criteria focused on transition outcomes for the child or young person; and

iv. engagement with the young person and their family.

## Managing transitions

> *"I had a very bad transition from CAMHS to adult services. One day I was in CAMHS with plenty of support and then the next, the only support I knew of was a crisis number. It took over 6 months for me to have a proper assessment and be assigned a care co-ordinator, by which time I had suffered a complete relapse in my condition."*
>
> A young person who took part in the Taskforce engagement exercises.

5.24 The issue of transition for young people is longstanding, but focusing on a moment in time masks the real issue, which is how we ensure better co-ordination of mental health services for young adults.

5.25 All young people face multiple and often simultaneous transitions as they move to adulthood. This can be from school to higher or further education or work. They may be in the process of leaving home or care. The families of those in the armed forces may be particularly affected by multiple moves. Young people transferring from children and young people's mental health services differ from those leaving physical services in that, for many, adult mental health services are either not available or not appropriate. Adult mental health services are not universally equipped to meet the needs of young people with conditions such as ADHD, or mild to moderate learning difficulties or autistic spectrum disorder.

5.26 For some young people, the nature of adult mental health services and their emphasis on working with the individual rather than a more holistic approach including the family means that young people prematurely disappear from services altogether despite needing further support.[57,58]

5.27 Youth Information Advice and Counselling Services (YIACs) usually operate over the age of transition, often up to the age of 25. We also note that in some parts of the country, such as Birmingham and Norfolk, there is a move to develop mental health services for 0-25 year olds. This new development will be watched with considerable interest.

5.28 The key components of best practice transition which are valued by both young people and clinicians should be built into Joint Strategic Needs Assessments (JSNAs), joint strategies for young people's and adult services and into all contracts between commissioners and providers of

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[57] Singh SP, Paul M, Ford T, Kramer T, Weaver T (2008). Transitions of Care from Child and Adolescent Mental Health Services to Adult Mental Health Services (TRACK Study): A study of protocols in Greater London. *BMC Health Services Research* 8: 135.

[58] McLaren S, Belling R, Paul M, Ford T, Kramer T, Weaver T, Hovish K, Islam Z, White S, Singh SP (2013). 'Talking a different language': an exploration of the influence of organizational cultures and working practices on transition from child to adult mental health services. *BMC Health Services Research* 13: 254.

young people's and adult services.[59,60,61] NHS England has published a model specification[62] based on best practice for transitions and a transfer/discharge protocol that can be used by local areas to support better transition planning and delivery.

5.29 The Taskforce does not wish to be prescriptive about the age of transition, but does recognise that transition at 18 will often not be appropriate. We recommend flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age, with joint working and shared practice between services to promote continuity of care. (**15**)

5.30 Vulnerable young people, such as care leavers and children in contact with the youth justice system, may also be especially vulnerable at points of transition and local strategic planning on transition should take their needs into account.

> *"My university GP was wonderful and made the effort to contact my GP at home, along with former services I had used for treatment, to get full information on my history of mental health problems… this is the experience that I think everyone should be having."*
>
> A young person who took part in the Taskforce engagement exercises

5.31 We also acknowledge the difficulty of transitions for university students as having extra complexity due to geographical relocation and transience of residence. Students may need access to mental health support both at home and at university, both from primary and secondary care services. We support the production of best practice guidance for CCGs and GPs around student transitions which encourages close liaison between the young person's home-based and university-based primary care teams and promotes adherence to NHS guidelines on funding care for transient populations.

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[59] Joint Commissioning Panel for Mental Health (2012). *Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services*. UK: Joint Commissioning Panel for Mental Health.

[60] Hovish K, Weaver T, Islam Z, Paul M, Sing SP (2012). Transition Experiences of Mental Health Service Users, Parents, and Professionals in the United Kingdom: A Qualitative Study. *Psychiatric Rehabilitation Journal* 35(3): 251-257.

[61] McLaren S, Belling R, Moli P, Ford T, Kramer T, Weaver T, Hovish K, Islam Z, White S, Singh SP (2013). 'Talking a different language': an exploration of the influence of organizational cultures and working practices on transition from child to adult mental health services. *BMC Health Services Research* 13: 254.

[62] NHS England. Resources for CCGs. Available at: www.england.nhs.uk/resources/resources-for-ccgs/

## Improving access to effective support – chapter 5 summary

Our aim is to change how care is delivered and build it around the needs of children and young people and families. This means moving away from a system of care defined in terms of the services organisations provide to ensure that children and young people have easy access to the right support from the right service at the right time.

Much of what is needed can be done now by:

6. Moving away from the current tiered system of mental health services to investigate other models of integrated service delivery based on existing best practice.
7. Enabling single points of access and One-Stop-Shop services to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector.
8. Improving communications and referrals, for example, local mental health commissioners and providers should consider assigning a named point of contact in specialist children and young people's mental health services for schools and GP practices; and schools should consider assigning a named lead on mental health issues.
9. Developing a joint training programme to support lead contacts in specialist children and young people's mental health services and schools.
10. Strengthening the links between children's mental health and learning disabilities services and services for children and young people with special educational needs and disabilities (SEND).
11. Extending use of peer support networks for young people and parents based on comprehensive evaluation of what works, when and how.
12. Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented.
13. Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.
14. Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour.
15. Promoting implementation of best practice in transition, including ending arbitrary cut-off dates based on a particular age.

With additional funding, a future government should consider:

16. Improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools, single points of access and one-stop-shop services, as a key part of any universal local offer.
17. Putting in place a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services.
18. Enabling clear and safe access to high quality information and online support for children, young people and parents/carers, for example through a national, branded web-based portal.
19. Legislating to ensure no young person under the age of 18 is detained in a police cell as a place of safety.

# 6. Care for the most vulnerable

6.1 There are some children and young people who have greater vulnerability to mental health problems but who find it more difficult to access help. If we can get it right for the most vulnerable, such as looked-after children and care leavers, then it is more likely we will get it right for all those in need.

6.2 The aim is to support staff who work with vulnerable groups by providing access to high quality mental health advice when and where it is needed. Co-ordinated services should be provided in ways in which children and young people feel safe, build their resilience, so that they are offered evidence-based interventions and care, drawing on the expertise and engagement of all the key agencies involved. Children, young people and their families who have additional vulnerabilities and complex mental health needs should not have to fight for services, nor be offered services that are well-meaning, but are not evidence-based or which fail to meet their needs. The Taskforce members heard of cases where, if vulnerable young people had been able to access specialist advice and support more rapidly, it would have resulted not only in earlier and better outcomes, but also a significant saving to the public purse. In addition, not attending appointments should not lead to a family or young person being discharged from services, but should be considered as an indicator of need and actively followed up (this can apply to all children and young people – see also paragraph 5.10) (**20**).

## A flexible, integrated system to meet the needs of vulnerable children and young people

6.3 Mental health services need to work effectively within and in partnership with existing service delivery structures to help vulnerable children and young people – such as Early Help Services, services for Troubled Families, Child Protection and Safeguarding Services, as well as education, youth justice services and Multi-Agency Safeguarding Hubs. Staff in mental health services need to utilise and build on existing opportunities where agencies are already working with the child – for instance, looked-after care review meetings, child protection case conferences or youth justice assessments and the Common Assessment Framework.

6.4 There is a clear need for appropriate and bespoke care pathways that incorporate new models of providing effective, evidence-based interventions to vulnerable children and young people to provide a social and clinical response to meeting their needs (**21**). The provision of mental health support should not be based solely on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern (**22**). Some children and young people will benefit from services which tackle problems across all family members, including adult mental health, substance misuse issues or complex cases that do not have a clear clinical diagnosis.

6.5 The most effective multi-agency arrangements have in place a clear sense of purpose shared by all agencies, together with shared assessment, case management and regular multi-agency case review processes overseen by multi-agency governance boards. The fact that mental health support is required does not necessarily mean that it is mental health services that are responsible overall for managing the case.

## Trauma-focused care

6.6 Experiencing or witnessing violence and abuse or severe neglect has a major impact on the growing child and on long term chronic problems into adulthood. Many mental health service users of all ages have problems directly attributable to severe neglect and/or trauma in the early years. Some vulnerable children and young people – including those who are adopted, looked-after children, those in contact with the youth justice system and substance misusing young people – are more likely to have been affected during childhood and adolescence.

6.7 Enhanced training for staff working with children and young people would lead to greater professional awareness of the impact of trauma, abuse or neglect on mental health (**27**). This should be coupled with effective treatment, including:

- Ensuring assessments carried out in specialist services include sensitive enquiry about neglect, violence and physical, sexual or emotional abuse. For young people aged 16 and above, as part of the Government's response to the concerns arising about child sexual exploitation, routine enquiry in line with NICE guidelines[63] (whereby every young person is asked during the mental health assessment about violence and abuse) will be introduced from 2015-16[64] (**23**).
- Those children and young people who have been sexually abused and/or exploited should receive a comprehensive specialist initial assessment, and referral to appropriate services providing evidence-based interventions according to their need. There will be a smaller group who are suffering from a mental health disorder, who would benefit from referral to a specialist mental health service (**24**).
- Specialist services for children and young people's mental health should be actively represented on Multi-Agency Safeguarding Hubs which should be used more extensively to identify those at high risk who would benefit from referral at an earlier stage (**25**).

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[63] National Institute for Health and Care Excellence (2014). *NICE public health guidance 50*. Available at: www.nice.org.uk/guidance/ph50/

[64] Casey L (2015). *Report of inspection of Rotherham metropolitan borough council.* London: Department for Communities and Local Government.

## Delivering care to vulnerable groups

6.8 There are some specific models of provision that the Taskforce considered to be particularly helpful to these groups. Whatever models are adopted, the professionals involved need to specifically address the need to seek out, listen to, and respond to the voices of vulnerable children and young people.

## A consultation and liaison mental health model:

6.9 Applying an approach whereby specialist services are available to provide advice, rather than to see those who need help directly to advise on concerns about mental health or neurodevelopmental difficulties is already best practice in some areas, for some very specific and highly vulnerable groups. Consultation and liaison teams can be used to help staff working with those with highly complex needs which include mental health difficulties – such as those who have been adopted or those with harmful sexual behaviour, and those in contact with the youth justice system – based on the complexity of the issues involved. These services would offer advice, troubleshooting, formal consultation and care planning, or assessment and intervention in cases where this is required above and beyond the level of existing cross-agency provision (including specialist services). There would need to be an identified specialist point of reference, including a senior clinician with specific expertise within mental health services. The roll-out of such teams could be piloted and, if successful, implemented at a sub-regional level (**28**).

## Embedding mental health practitioners in teams responsible for groups of vulnerable children and young people

6.10 Young people who are amongst the most excluded from society, such as those involved in gangs, those who are homeless and/or looked-after children, need support from people they trust. This is a small number of young people, who may not even recognise that they have mental health problems. They benefit from having a mental health practitioner embedded in teams that have relationships with, and responsibility for such groups, such as a youth club or hostel (**29**). The embedded worker can develop a relationship with the young people through youth-led activities so that they are then able to respond as a familiar, trusted adult as the need arises, working with more specialist or intensive services as required. They can also impart basic mental health skills to frontline staff. This approach has been successfully developed by MAC-UK's INTEGRATE model (see www.mac-uk.org) which also incorporates the necessary governance structures essential for success. INTEGRATE requires a highly flexible team structure which includes the regular mapping of each young person's needs, informing a consistent and psychologically-informed approach across the team members.

6.11 A case study, Jay's story, highlighting this approach and the value of a familiar, trusted professional in engaging the most vulnerable and difficult to reach children and young people is set out in the Vulnerable Groups and Inequalities Task and Finish group report.

## Designated professionals

*"We need services that understand we need to stick with young people who DNA and assertively engage them, instead of being pushed to close cases due to pressures on throughput. We also need services that can be responsive to risk and windows of opportunity for engagement, and to use these for long term work"*

A CAMHS psychologist who took part in the Taskforce engagement exercises.

*"I should be able to reach out to someone in any of the settings when I need, but for it all to be coordinated by one person."*

A young person who took part in the Taskforce engagement exercises.

6.12 Children and young people in vulnerable groups are amongst the most complex seen in specialist services. Systems such as appointing a lead professional through a Common Assessment Framework (CAF), Team Around the Child or Family, or the Care Programme Approach (for those with severe mental health problems) already exist in many places. For some, the consistent application of these needs to be improved – particularly for vulnerable children and young people with complex needs who require care that is well-planned and co-ordinated with information shared effectively. A designated or lead professional should be identified and their role strengthened – someone who knows the family well – to liaise with all agencies and ensure that services are targeted and delivered in an integrated way (**26**). This role could be allocated through a number of multi-agency processes, including the CAF or Team Around the Child or Family processes.

6.13 The decision about which plan to use will depend on the needs of the child and family, but the lead professional or Care Co-ordinator's role is to co-ordinate support and services from across agencies to meet the needs, for example, of children and young people in contact with the youth justice system, whose care may otherwise fall between several different agencies. For young people with more severe mental health difficulties or those transitioning to adult mental health services, the Care Programme Approach may be the most appropriate approach.[65]

## Reducing Health Inequalities and Promoting Equality

6.14 The Taskforce was told that some groups, for example, learning disabled children find it difficult to access specialist services. In addition, studies have shown marked health inequalities in relation to children and young people's mental health, with correlations between poor mental health and disadvantage – for example, children in low income families having a three-fold increased risk of developing mental health problems.[66] We know that improving children and young people's mental health and their access to mental health services will require solutions that are tailored to the needs of children and young people from all backgrounds, of all characteristics, and from all sectors of the community.

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[65] Department of Health (2008). *Refocusing the Care Programme Approach – Policy and Positive Practice Guidance.* London: Department of Health.

[66] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). *Mental health of children and young people in Great Britain, 2004*. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.

6.15 The Equality Act 2010 requires all public and voluntary sector organisations to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people. In addition, the Health and Social Care Act 2012 introduced duties on the Secretary of State for Health, NHS England and on CCGs to have regard to the need to reduce health inequalities.[67]

6.16 For NHS England and CCGs, the health inequalities duties mean they must consider the need to reduce inequalities in access and outcomes for patients. In meeting these duties, they will wish to demonstrate that they have considered how policies and services for children and young people vulnerable to, or receiving support for, mental health problems take account of need, not just demand, and give appropriate focus to those groups in the population which have poorer access or outcomes.

6.17 Whilst the health inequalities duties apply only to the Health Secretary and NHS, the Taskforce encourages all those involved in commissioning mental health and wellbeing services for children and young people to give the same consideration to the need to reduce health inequalities in access and outcomes (**21**).

**Caring for the most vulnerable – chapter 6 summary**

Current service constructs present barriers making it difficult for many vulnerable children, young people and those who care for them to get the support they need. Our aim is to dismantle these barriers and reach out to children and young people in need.

Much of what is needed can be done now by:

20. Making sure that children, young people or their parents who do not attend appointments are not discharged from services. Instead, their reasons for not attending should be actively followed up and they should be offered further support to help them to engage. This can apply to all children and young people.
21. Commissioners and providers across education, health, social care and youth justice sectors working together to develop appropriate and bespoke care pathways that incorporate models of effective, evidence-based interventions for vulnerable children and young people, ensuring that those with protected characteristics such as learning disabilities are not turned away.
22. Making multi-agency teams available with flexible acceptance criteria for referrals concerning vulnerable children and young people. These should not be based only on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern.
23. Mental health assessments should include sensitive enquiry about the possibility of neglect, violence and abuse, including child sexual abuse or exploitation and, for those aged 16 and above, routine enquiry, so that every young person is asked about violence and abuse.

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[67] Equality and Health Inequalities Team (2014). *Guidance for NHS commissioners on equality and health inequalities legal duties.* Leeds: NHS England.

24. Ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to appropriate evidence-based services. Those who are found to be more symptomatic who are suffering from a mental health disorder should be referred to a specialist mental health service.
25. Specialist services for children and young people's mental health should be actively represented on Multi-Agency Safeguarding Hubs to identify those at high risk who would benefit from referral at an earlier stage.
26. For the most vulnerable young people with multiple and complex needs, strengthening the lead professional approach to co-ordinate support and services to prevent them falling between services.

With additional funding, a future government should consider:

27. Improving the skills of staff working with children and young people with mental health problems by working with the professional bodies, NHS England, PHE and HEE, to ensure that staff are more aware of the impact that trauma has on mental health and on the wider use of appropriate evidence-based interventions.
28. Piloting the roll-out of teams specialising in supporting vulnerable children and young people such as those who are looked after and adopted, possibly on a sub-regional basis, and rolling these out if successful.
29. Improving the care of children and young people who are most excluded from society, such as those involved in gangs, those who are homeless or sexually exploited, looked-after children and/or those in contact with the youth justice system, by embedding mental health practitioners in services or teams working with them.

# 7. Accountability and transparency

7.1 We have a wealth of information and many examples across the country of services moving towards greater integration and offering greater choice of evidence-based outcomes focused treatments working collaboratively with children and young people. However, this is not consistent and there is unacceptable variation.

7.2 Agreeing better models of care is not enough. Right now there are too many barriers to have confidence that such models would succeed because:

- the system of commissioning services is fragmented, with money often sitting in different budgets, in different organisations, in different parts of the system and without clear lines of accountability;
- there is limited access to the necessary information to know how a local system is working in respect of access and waiting times, how outcomes are achieved or if they provide value for money;
- there is poor information sharing within the system which hampers joint working; and
- the best practice standards, agreed as quality markers for accreditation systems, are not universally applied.

7.3 These are ingrained and systemic problems facing children and young people's mental health services that require strong leadership right across the whole system and at every level.

7.4 The recent changes to the national statutory framework for children and young people with special educational needs and disabilities (SEND) establish a platform for significant potential improvements over time for a cohort which includes some children and young people in need of mental health services. It is not possible to simply copy this model in respect of mental health, as support and treatment are quite different, but there are key features that are relevant:

- access to a wider range of local services through a transparent 'local offer';
- clarity over points of access and decision-making processes for more specialist support, including use of triage processes;
- co-ordination of assessment and planning around the individual child, involving all relevant services, facilitated by information sharing and a lead professional or key worker; and
- giving young people and parents more control, including greater use of personal budgets.

## Securing the best possible service for children and young people with mental health problems

7.5 We consider that there are a number of issues that need to be addressed in the organisational and accountability frameworks if we are to achieve transformation in the service offer.

7.6 There was strong support from many members of the Taskforce to make it a requirement at the local level for there to be **a lead accountable commissioning body** to co-ordinate commissioning and the implementation of evidenced-based care (**30**). Many members of the Taskforce also favour the creation of **a single, separately identifiable budget for children's mental health services.** These proposals build on the learning from those areas which are already jointly commissioning children's mental health services between Clinical Commissioning Groups and local authorities, in some cases with pooled budgets. We envisage in most cases the CCG would establish lead commissioning arrangements working in close collaboration with local authorities. We also recognise the need for flexibility to allow different models to develop to suit local circumstances and would not want to cut across alternative arrangements.

> *"If we are all working towards the same outcomes, planning in an integrated way to meet them, using clear accountability structures and a person-centred planning approach, then joint ownership of outcomes is inevitable. This is not easy to do – but… we can start."*
>
> A community services manager who took part in the Taskforce engagement exercises.

7.7 There is a need to address the ambiguity in **local authorities' role and responsibilities** in respect of child mental health commissioning. Although the statutory lever under the Children Act 1989 remains in place, along with responsibilities regarding looked-after children and care leavers, the financial position that local authorities are facing is challenging and there is no longer any ring-fenced budget for this provision within local authorities. As a result, we are seeing very different patterns of commitment and contribution across both public health and children's social care budgets. At the least, there should be full transparency in terms of individual local authorities' contribution.

7.8 The work of the lead commissioner should be based upon an agreed **local plan** for child mental health services, agreed by all relevant agencies and with a strong input from children, young people and parents/carers (**30**). The local plan itself should be derived from the local Health and Wellbeing Strategy which places an onus on Health and Wellbeing Boards to demonstrate the highest level of local senior leadership commitment to child mental health. Health and Wellbeing Boards have strategic oversight of the commissioning of the whole pathway or offer regarding children and young people's mental health and wellbeing. As some individual commissioners and providers, including schools, are not statutory members of Health and Wellbeing Boards, they should put in place arrangements to involve them in the development of the local plan, drawing on approaches already used in some areas such as Mental Health Advisory Panels or Children's Partnership Boards.

7.9 Key drivers for the quality of any local offer should be the local Health and Wellbeing Board's Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy. The JSNA should address children and young people's health and wellbeing, including mental health (**31**). Health and Wellbeing Boards, supported by the local government-led health and wellbeing system improvement programme and Public Health England, should ensure that both the JSNA and the Joint Health and Wellbeing Strategy address children and young people's mental health needs effectively and comprehensively.

7.10 As well as drawing on the local plan, we consider that the local offer should be guided by a **national ambition** that clearly sets out the expectations and requirements for securing the best possible outcomes for children and young people's mental wellbeing. This will avoid the dangers of a postcode lottery while still ensuring a high degree of local flexibility. Over time, Government should consider whether elements of the national ambition should be placed on a more formal footing to ensure consistency of practice across the country.

7.11 Developing **an effective local system of care and support** requires access to diverse and flexible services. In adult social care, there is a now a statutory duty on local authorities to shape the market to ensure adequacy of local provision. While the situation is not precisely analogous in children and young people's mental health our assessment is that those local areas exhibiting best practice have access to a range of providers, and, in particular, have harnessed the strength of the voluntary and community sector.

7.12 There is a particular need to **co-ordinate the commissioning of community health and inpatient services** (**32**). Within the current statutory system, the former is the responsibility of local commissioners and the latter the responsibility of the national commissioner, NHS England. If we are serious about moving away from a tiered model, then this commissioning needs to be joined up. This need for co-commissioning has been recognised by NHS England. At the same time, however, we want to avoid the mistakes of the past where we ended up with a patchwork quilt of intensive community crisis support and inpatient services.

7.13 The National Institute for Health and Care Excellence has a crucial role to play in framing a national ambition through the development of **Quality Standards** as well as guidance for health and social care, which are commissioned by the Secretaries of State for Health and Education (**33**). The quality standards will need to describe cost-effective evidence-based practice. They should provide clear descriptions of high priority areas for quality improvement. They will help organisations by supporting comparison of current performance, using measures of best practice to identify priorities for improvement. Though not mandatory, they are an important driver for change in the new arrangements for commissioning and service delivery in health and social care. It would be helpful if their recommendations could include further advice regarding implementation across the whole care pathway.

7.14 In supporting implementation and delivery of high quality care, we consider that CQC and Ofsted – with their distinct roles and responsibilities in health and education – should develop **a joint cross inspectorate view** of how the health, education and social care systems are working together to improve children and young people's mental health outcomes and how this area should be monitored in future (**34**).

## Access to information

7.15 However, this is still not enough without access to information. Measurement is crucial to support continuous improvement. Support and services should be based on high quality, accurate data, but there are significant gaps in relation to children's mental health. The last children and young people's mental health prevalence survey was done over a decade ago, although the Department of Health has just started the process of commissioning the next one (**35**). We propose the commissioning of a regular prevalence survey of child and adolescent mental health every 5 years, giving particular consideration to including under-5s and ages over 15 (**39**). In addition, and in response to the growing international evidence base, the survey should be expanded to cover:

- New disorder codes (DSM 5, ICD-11) and conditions or issues that have grown in prominence since 2004, eg eating disorders, self-harm and the impact of social media and experience of cyberbullying; and
- The ability to analyse data by characteristics such as ethnicity and deprivation or whether a child is adopted or in care.

> *"If data collects meaningful information that can be useful for clinicians and patients alike to monitor their progress, data collection becomes part of the therapy."*
>
> A CAMHS psychologist who took part in the Taskforce engagement exercises.

7.16 At the same time, levels of investment in mental health services for children and young people should be transparent. Accurate information on current levels of spend on children's mental health across agencies is a key gap. NHS England is working to improve the quality of data on adult mental health spend from April 2015 so that it will be able to identify the overall spend in primary and community care as well as mental health services and specialist commissioning. This has been built into the NHS planning process at CCG level. We propose that, in the future, this activity is extended to cover children's mental health spend by the NHS. It is also proposed that further work is undertaken to improve understanding of child and adolescent mental health funding flows across health, education, social care and youth justice to support a transparent, coherent, whole system approach to future funding decisions and investment (**38**).

7.17 The CAMHS Minimum Dataset, already in development, will allow specific outcome metrics by condition, activity and evidence-based interventions to support evaluation of the effectiveness of the care commissioned (**35**). To build on this work, it is important that routine data collection of key indicators of child and adolescent mental health service activity, patient experience and patient outcomes are properly co-ordinated and incentivised.

7.18 Data from the CAMHS Minimum Data Set will begin to flow no later than January 2016. It is likely that early data will be flawed and will take time for data completeness and quality to be such that conclusions can be drawn about access and waiting times. The Minimum Data Set does not cover investment levels. The implementation in 2015 and central flow of data through the Health and Social Care Information Centre (HSCIC) must be a key priority for implementation at a national and local level. This includes ensuring that commissioners are placing into contracts the requirements for meaningful data collection, including outcomes monitoring.

7.19 NHS England has committed to developing access and waiting time standards in mental health. This applies to children and young people who will benefit in the first year with the introduction of the first ever waiting time standards in respect of early intervention in psychosis. In developing any access and waiting time standards, it should be a requirement that access to services is reported as time to different events in a pathway of care linked to delivery of NICE concordant treatment and measurement of outcomes (**36** and **37**).

7.20 In the meantime, many providers are already collecting data that can be used by commissioners, for instance:

- Members of the NHS Benchmarking Collaborative.
- Outcomes data collected by members of Children's Outcomes Research Consortium (CORC).
- The CYP IAPT datasets and outcome measures.
- Data collected for CAMHS Currencies.
- Health and Justice data.

7.21 Commissioning Support Units and Academic Health Science Networks should therefore be supporting commissioners to analyse local data collections, share best practice and pool knowledge and skills, mentoring new commissioners and delivering learning sets. This should include promoting the use of existing benchmarking tools by commissioners, for example, the Fingertips tool on the Mental Health Intelligence Network and the service snapshots and other information supplied by Public Health England.

**To be accountable and transparent – chapter 7 summary**

Far too often, a lack of accountability and transparency defeats the best of intentions and hides the need for action in a fog of uncertainty. Our aim is to drive improvements in the delivery of care, and standards of performance to ensure we have a much better understanding of how to get the best outcomes for children, young people and families/carers and value from our investment.

Much of what is needed can be done now by:

30. Having lead commissioning arrangements in every area for children and young people's mental health and wellbeing services with aligned or pooled budgets by developing a single integrated plan for child mental health services in each area, supported by a strong Joint Strategic Needs Assessment.
31. Health and Wellbeing Boards ensuring that both the Joint Strategic Needs Assessments and the Health and Wellbeing Strategies address the mental and physical health needs of children, young people and their families, effectively and comprehensively.
32. By co-commissioning community mental health and inpatient care between local areas and NHS England to ensure smooth care pathways to prevent inappropriate admission and facilitate safe and timely discharge.
33. Ensuring Quality Standards from the National Institute for Health and Care Excellence (NICE) inform and shape commissioning decisions
34. By Ofsted and CQC working together to consider how to monitor the implementation of the proposals from this report in the future.
35. The Department of Health fulfilling its commitment to complete a prevalence survey for children and young people's mental health and wellbeing, and working with partner organisations to implement the Child and Adolescent Mental Health Services dataset within the currently defined timeframe.
36. Developing and implementing a detailed and transparent set of measures covering access, waiting times and outcomes to allow benchmarking of local services at national level, in line with the vision set out in Achieving Better Access to Mental Health Services by 2020.
37. Monitoring access and wait measurement against pathway standards – linked to outcome measures and the delivery of NICE-concordant treatment at every step.
38. Making the investment of those who commission children and young people's mental health services fully transparent.

And subject to decisions taken by future governments:

39. Committing to a prevalence survey being repeated every five years.

# 8. Developing the workforce

8.1 Professionals working with and supporting children and young people want to make a real and lasting difference to their lives.

8.2 The national vision is for everyone who works with children, young people and their families to be:

- ambitious for every child and young person to achieve goals that are meaningful and achievable for them;
- excellent in their practice and able to deliver the best evidenced care;
- committed to partnership and integrated working with children, young people, families and their fellow professionals;
- respected and valued as professionals.

**There is consistency in children and young people's views about the workforce qualities and behaviour they would like to see:**

- A workforce which is equipped with the skills, training and experience to best support children and young people's emotional and mental wellbeing.
- Staff who are positive, have a young outlook, are relaxed, open-minded, unprejudiced, and trustworthy.
- Behaviour that is characterised by fairness, and a willingness to listen to, trust and believe in the child or young person.
- Everybody should work from a basis of asking and listening, being prepared to be helpful in creating understanding among other members of the workforce.
- Their processes should be transparent, honest, and open to being both inspected and clearly explained. Visible actions should result from such scrutiny, enabling children to voice their opinions.
- The workforce should provide real choice of interventions supported by enough resources to follow through, whilst remaining honest and realistic.

## A workforce with the right mix of skills, competencies and experience

8.3 Professionals across health, education and social care services need to feel confident to promote good mental health and wellbeing and identify problems early, and this needs to be reflected in initial training and continuing professional development across a range of professions (**40**). Professionals need to be trained to be able to:

- Recognise the value and impact of mental health in children and young people, its relevance to their particular professional responsibilities to the individual and how to provide an environment that supports and builds resilience.
- Promote good mental health to children and young people and educate them and their families about the possibilities for effective and appropriate intervention to improve wellbeing.
- Identify mental health problems early in children and young people.
- Offer appropriate support to children and young people with mental health problems and their families and carers, which could include liaison with a named appropriately trained individual responsible for mental health in educational settings.
- Refer appropriately to more targeted and specialist support.
- Use feedback gathered meaningfully on a regular basis to guide treatment interventions both in supervision and with the child, young person or parent/carer during sessions.
- Work in a digital environment with young people who are using online channels to access help and support.

## Universal settings

8.4 Anybody who works with children and young people in universal settings such as early years provision, schools, colleges, voluntary bodies and youth services, should have training in children and young people's development and behaviours, as appropriate to their professional role.

8.5 This does not mean that professionals working in universal services should step in where a more specialised service is needed. But it does mean that, for example, a teacher who sees that a child is anxious, in a low mood, not eating or socialising as children and young people usually do, is withdrawn or behaving uncharacteristically, understands this child may need help. MindEd (www.minded.org.uk) is a useful resource for promoting this level of awareness in all staff who work with children and young people.

## Targeted and specialist services

8.6 Staff who work in targeted and specialist services come from a range of professional backgrounds: social work, occupational therapy, nursing, clinical and educational psychology, psychotherapy, child and adolescent psychiatry and, with a growing number of 0-25 services, general adult psychiatry.

8.7 Staff in paediatric services make an important contribution to targeted and specialist mental health services for children and young people. Their role is likely to increase with a move towards greater integration between children's mental health provision and community paediatrics. The move towards 0-25 service models and integrated services means that, although discipline-specific training will remain the core of most professionals' training, interdisciplinary training and practice and cross-agency working will become increasingly important.

8.8 Basic training in all disciplines should include an understanding of the interface between physical and mental health. These interactions indicate the need for: greater awareness of mental health problems amongst paediatric staff; greater awareness of physical health problems amongst mental health staff and the development of services models (such as paediatric liaison) which recognise the interaction and overlap between physical and mental health. A paediatric nurse working with young people with diabetes, for example, should be able to identify whether that young person also requires emotional or mental health support. All of these recommendations have significant implications for the training of staff in the children and young people's workforce. Enhanced, multi-professional training across the physical and mental health interface will be a key part of improving the experience of children and young people with physical and mental health problems.

8.9 Effective access to support requires improved communication between universal, targeted and specialist services, backed by a clear shared understanding of roles and responsibilities across all those involved in the system, so that children and young people do not fall between services, and receive timely and appropriate support. This implies the use of local reciprocal multi-agency and multi-professional training programmes for those involved in children and young people's services. A good example is the reciprocal training programme between practice nurses and local community mental health trust nurses in Health Education England North Central & East London which is now available to be rolled out nationally.

8.10 The workforce in targeted and specialist services need a wide range of skills brought together in the CYP IAPT Core Curriculum. All staff should be trained to practise in a non-discriminatory way with respect to gender, ethnicity, religion and disability. This was considered in detail by the Vulnerable Groups and Inequalities Task and Finish Group. In addition, there are skills gaps in the current workforce around the full range of evidence-based therapies recommended by NICE. The CYP IAPT programme was commissioned with a modest budget to deliver training for a limited range of therapies to a prescribed group as a part of its transformation role. There are gaps in the training of staff working with children and young people with Learning Difficulties, Autistic Spectrum Disorder, and those in inpatient settings. Counsellors working in schools and the community have asked for further training to improve evidence-based care (**43**).

8.11 Skills and capabilities audits in the North West have shown not only deficits in terms of competencies but also gender and age issues that need to be addressed. 48% of staff in the survey were found to be due to retire in the next 10 years, and 90% were female.

8.12 The Taskforce highlighted a number of initiatives in progress which could and should contribute to supporting professional capabilities.

**Current action to develop workforce skills and competencies includes:**

For schools, the **Carter Review of Initial Teacher Training**[68] (ITT) reported in January. It recommended commissioning a sector body to produce a framework of core content for ITT which would include child and adolescent development (**41**).

The revised **Foundation Programme curriculum for doctors** (covering the first two years of postgraduate training for doctors qualifying in the UK) will give increased prominence to mental health, and 45% of foundation trainees will rotate through a psychiatry post during their two years from 2016 to ensure that more doctors (many of whom will become GPs) have experience of working with patients with mental health issues. The opportunity should be taken to review whether a greater emphasis on children and young people's mental health could be incorporated.

The **CYP IAPT programme** currently works with partnerships covering 68% of the 0-19 population. The Service Transformation programme includes training for existing service leaders, supervisors and therapists in the NHS, social care and voluntary sector in a range of evidence-based programmes, with a Mandate commitment for both Health Education England and NHS England to plan further roll-out (**44**).

The **social work reform programme** is placing a much stronger focus on the skills and competencies needed by child and family social workers. This includes identifying child development, physical and mental health and education needs and working in partnership with other professionals and organisations to provide the help a child or young person needs.

The **Think Ahead initiative** will provide a new cadre of top graduates training to specialise in adult mental health social work, including work with young adults.

The sector skills councils such as **Skills for Care & Development** will also play an important role in shaping education and training for the workforce in support of the children and young people's mental health agenda.

## Developing a strategic approach to workforce planning

8.13 Adopting new commissioning arrangements with new models of contracting and performance monitoring would be a key driver to securing collaborative and co-ordinated working across local areas.

8.14 The established and proven CYP IAPT transformation initiative gives a platform on which to build and align the creation of a children and young people's mental wellbeing workforce across agencies that is fit for purpose.

8.15 Planning for mental health services for children and young people in the future requires a bottom-up consideration of the current competencies and capabilities of the existing workforce as well as an understanding of the capacity that will be required to deliver a workforce fit for the future. The role of Health Education England and Local Education and Training Boards will be crucial to establish local requirements and local practice through locally led needs assessments of current workforce capability and capacity.

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[68] Carter A (2015). *Carter review of initial teacher training.* London: Department for Education.

> *"[We need] designated leaders to drive change across service and agency boundaries, and trained commissioners who know and understand how this would work and what they need to be commissioning. The Health Select Committee CAMHS report showed that many local authorities still do not consider children's emotional health and wellbeing and mental health as their core business. But of course it is! Their activity and priorities are the very foundation of building resilience and emotional intelligence in children."*
>
> Office of the Children's Commissioner as part of the Taskforce engagement exercises.

8.16 It is proposed that the Department of Health and Department for Education should work together with HEE, the Chief Social Worker for children and others, to design and commission a census and needs assessment of the current workforce working across the NHS, local authorities, voluntary sectors and independent sector as the first stage in determining a comprehensive cross-sector workforce and training strategy (**45**).

## Training for commissioners

8.17 Traditionally, especially in the NHS, investment in training has focused on the provision of services. There is, however, no recognised standard training programme for commissioners of children's services or mental health services for children and young people. The recent mental health commissioning and leadership programme developed by NHS England and Academic Health Science Networks is organised around the principles of: data for commissioning, the use of the evidence base and leadership. All programmes include a module on child and adolescent mental health provision, and attendance at these accredited courses should be a requirement for all those working in commissioning of children and young people's services (**42**).

**Developing the workforce – chapter 8 summary**

It is our aim that everyone who works with children, young people and their families is ambitious for every child and young person to achieve goals that are meaningful and achievable for them. They should be excellent in their practice and able to deliver the best evidenced care, be committed to partnership and integrated working with children, young people, families and their fellow professionals and be respected and valued as professionals themselves.

Much of what is needed can be done now by:

40. Targeting the training of health and social care professionals and their continuous professional development to create a workforce with the appropriate skills, knowledge and values to deliver the full range of evidence-based treatments
41. Implementing the recommendations of the Carter Review of Initial Teacher Training (ITT) to commission a sector body to produce a framework of core content for ITT which would include child and adolescent development.
42. By continuing investment in commissioning capability and development through the national mental health commissioning capability development programme.

With additional funding, a future government should consider:

43. Extending the CYP IAPT curricula and training programmes to train staff to meet the needs of children and young people who are currently not supported by the existing programmes.
44. Building on the success of the CYP IAPT transformation programme by rolling it out to the rest of the country and extending competencies based on the programme's principles to the mental wellbeing workforce, as well as providing training for staff in schools.
45. Developing a comprehensive workforce strategy, including an audit of skills, capabilities, age, gender and ethnic mix.

# 9. Making change happen

9.1 This report sets out a vision for a comprehensive approach to promoting, supporting and treating our children and young people's mental health, and to supporting their families. We have made a set of proposals to enable this vision to be translated into national and local frameworks. There is undoubtedly an urgency to act and in this section we set out how we might make a start.

## Building the evidence base

9.2 Throughout the report, we have emphasised the paucity of good quality national information about meaningful outcomes as well as outputs in respect of child mental health services and how this can be corrected over the next few years, building on the early successes of the CYP IAPT programme.

9.3 If we are continuously to improve the mental health care and wellbeing of children and young people, we need data and evidence with which to do so (**49**). Good information is the foundation for commissioning; to understand need, to plan, secure and monitor services. In some areas, evidence is weak or entirely lacking as to the best interventions. Although lack of evidence should not be used as an excuse for lack of care, it is unethical and a waste of taxpayers' money to invest in interventions that have no evidence base – unless they are subject to rigorous evaluation.

9.4 This is one of the hardest challenges the system has: to secure acknowledgment of the limitations of our knowledge and not assume that interventions are without harm. There is good evidence that well-meaning interventions, with the best of intentions, can do more harm than good. A classic paper illustrating this is the McCord study of a multi-disciplinary approach to child delinquency. In the 30 year follow up of the two groups, control versus active, every outcome was worse in the active group.[69] Another was the mixed impact of suicide prevention in adolescents.[70] These examples illustrate the necessity to use an evidence base wherever possible and, if one is lacking, to ensure that research capacity is deployed to fill the gap.

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[69] McCord J (1978). A thirty year follow-up of treatment effects. *American Psychologist* 33: 284-289.

[70] Ploeg J, Ciliska D, Dobbins M, Hayward S, Thomas H, Underwood J (1996). A systematic overview of adolescent suicide prevention programs. *Canadian Journal of Public Health* 87(5): 319-324.

9.5 This re-emphasises the importance of NICE guidance and Quality Standards for those who plan, commission or provide services, and also the need for a world class research programme in child mental health and wellbeing supported by regular detailed prevalence surveys and reliable routinely collected comprehensive outcomes data.

## Making a start

9.6 There are a number of proposals in this report directed at a national level that can only be properly considered during the next Parliament. However, we are keen that progress is made during 2015/16. **Many of our proposals require a different way of doing business rather than further significant investment.**

9.7 National organisations must play their part but we believe that even more progress can be made rapidly at the local level.

9.8 This will require local leadership and ownership. We therefore propose the development and agreement of **Transformation Plans for Children and Young People's Mental Health and Wellbeing** which will clearly articulate the local offer (**46**). These Plans would cover the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.

9.9 We would anticipate that the lead commissioner, in most cases the Clinical Commissioning Group, would draw up the Plans, working closely with Health and Wellbeing Board partners including local authorities. All these partners have an important role to play in ensuring that services are jointly commissioned in a way that promotes effective joint working and establishes clear pathways.

9.10 To support this, and in line with the announcement at the time of the Autumn Statement 2014, NHS England can make a specific contribution by prioritising further investment in those areas that can demonstrate robust action planning through the publication of local Transformation Plans that accord with the principles and ambitions set out in this report.

9.11 What is included in the Plan should be decided at a local level in collaboration with children, young people, families as well as provider and commissioner representatives and should address as many of the principles and proposals set out in the report as possible.

9.12 At the same time, NHS England and the Department of Health have recently invited proposals from CCGs to lead and accelerate co-commissioning arrangements for children and young people's mental health. The national response to this invitation was hugely encouraging and indicative of the potential to be harnessed by this report. Although only a limited number of areas could be chosen, as these projects develop, they will provide good examples of what can be achieved, alongside other relevant initiatives such as the Social Care Innovation Fund and the Department for Education's Voluntary and Community Sector Fund (**48**).

9.13 Lead commissioners should ensure that schools are given opportunities to contribute to the development of local Transformation Plans. The Department for Education is already leading work to improve the quality of teaching about mental health in Personal, Social, Health, and Economic (PSHE) lessons in schools, and is developing an evidence-based outcomes focused schools counselling strategy to encourage more and better use of counsellors in schools. This should equip schools to contribute to the development of the local Transformation Plans.

## Seeing it through

9.14 The transformation of our national and local approach to children and young people's mental health and wellbeing will take time, at least the period of the next Parliament, aligning with the timescales of the Five Year Forward View. Change at the national level will need co-ordination across policy, investment, commissioning, regulation, training and inspection. Local areas will need ongoing support and guidance. It represents a complex and difficult journey and it will need strong political will combined with senior level leadership to see it through and be successful. Our closing proposal is therefore that there should be some clear governance at the national level to oversee the transformation of children's mental health with clear accountability for progress to the relevant Accounting Officers and Ministers (**47**).

### Making Change Happen – chapter 9 summary

Much of what is needed can be done now by:

46. Establishing a local Transformation Plan in each area during 2015/16 to deliver a local offer in line with the national ambition. Conditions would be attached to completion of these Plans in the form of access to specific additional national investment, already committed at the time of the Autumn Statement 2014.
47. Establishing clear national governance to oversee the transformation of children's mental health and wellbeing provision country-wide over the next five years.
48. Enabling more areas to accelerate service transformation.

With additional funding, a future government should consider:

49. The development of an improved evidence base, on the safety and efficacy of different interventions and service approaches, supported by a world class research programme.

# 10. Conclusion

10.1 The work of the Taskforce has revealed great potential to meet the desire for children and young people to have better support and care for their mental health. The economic argument and evidence for effective interventions make a strong case for putting national energy and effort into supporting the expectations that have emerged.

10.2 We have described a vision for our country in which child mental health and wellbeing is everybody's business, where our collective resilience and mental strength is regarded as an asset to the nation in the same way as we prize our levels of attainment, creativity and innovation.

10.3 We can start by doing what we know works, indeed already is working in some areas of the country, but is not being applied consistently.

10.4 The second step is to deliver the commitments already made and the initiatives already started that give us the fundamental building blocks that will help justify securing the third element.

10.5 With better data, transparency and accountability, the value of investment in mental wellbeing and care for child and young people can, and we believe will, be demonstrated and justified. A cycle of virtue can be created where, for each taxpayer's pound invested, the benefit for the individual and society can be realised with confidence.

10.6 In the meantime, there are targeted opportunities if resources can be identified through re-prioritisation and/or on an 'invest to save' basis. These have been set out clearly in the report and are illustrated by the additional money already identified for eating disorder services from April this year. And, of course, any local area can make a decision to re-prioritise its resources in favour of child mental health on the basis of existing national and local evidence of need and efficacy.

10.7 The work of the Taskforce has reconfirmed that we are by no means alone in the international community in grappling with how to give our children and young people a better start, to keep them safe and to help their mental health and resilience. It would be a hallmark of our progress if by 2020 we could truly say that England is leading the world in improving the outcomes for children and young people with mental health problems. We know that it is possible. But it will only happen if we decide with resolve and determination to place such a goal at the heart of the economic and social vision for our nation.

# Glossary and Acronyms

| | |
|---|---|
| A&E | Accident and Emergency |
| ADHD | Attention Deficit Hyperactivity Disorder<br>Neurodevelopmental disorder identified by behavioural symptoms that include inattentiveness and impulsiveness. |
| CAMHS | Child and Adolescent Mental Health Services |
| CBT | Cognitive Behavioural Therapy |
| CCGs | Clinical Commissioning Groups<br>Statutory bodies clinically led that include all of the GP practices in their geographical area. The aim of this is to give GPs and other clinicians the power to take commissioning decisions for their patients. Each CCG has a constitution and is run by its governing body, and is overseen by NHS England. |
| CORC | CAMHS Outcomes Research Consortium |
| CQC | Care Quality Commission<br>Independent regulator of all health and social care services in England. |
| CYP IAPT | Children and Young People's Improving Access to Psychological Therapies Programme |
| DfE | Department for Education |
| DH | Department of Health |
| DSM-5 | Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition<br>Psychiatric classification and diagnostic tool, published in May 2013. The Fifth Edition superseded the Fourth Edition which had been in use since 2000. |
| HCP | Healthy Child Programme |
| HEE | Health Education England |
| HSCIC | Health & Social Care Information Centre |
| H&WBs | Health and Wellbeing Boards<br>Statutory bodies based on upper-tier and unitary authorities in England drawing together members of CCGs, local HealthWatch and the Local Authority. They are charged with assessing the needs of their local population producing Joint Strategic Needs Assessments and agreeing a Joint Health and Wellbeing Strategy. The board also has responsibility for promoting integration of health and care services. |

| | |
|---|---|
| ICD-10 | International Classification of Diseases, 10th Revision<br>The World Health Organization's medical classification list, in use since 1994. The 11th revision is due to be released in 2017. |
| ITT | Initial Teacher Training |
| JSNAs | Joint Strategic Needs Assessments<br>Process of reviewing and describing the current and future health and wellbeing needs of a local population. |
| LTC | Long Term Condition<br>A health problem for which there is currently no cure, but the symptoms of which may be managed with medication and other treatment. Examples include asthma and diabetes. |
| MUS | Medically Unexplained Symptoms<br>Persistent physical complaints for which medical examination does not reveal an obvious cause. |
| NICE | National Institute for Health and Care Excellence |
| Ofsted | Office for Standards in Education, Children's Services and Skills |
| PHE | Public Health England |
| PSHE | Personal, Social and Health Education<br>Programme of learning that aims to equip young people with the knowledge, understanding and skills they need to manage their lives healthily, safely, productively and responsibly. |
| SEND | Special Educational Needs and Disabilities |
| YIACS | Youth Information, Advice and Counselling and Services |

# Taskforce Membership

| **Name** | **Job Title** |
|---|---|
| Dr Martin McShane | Co-Chair & Director (Domain 2) Improving the quality of life for people with Long Term Conditions, NHS England. |
| Jon Rouse | Co-Chair & Director General for Social Care, Local Government & Care Partnerships, Department of Health. |
| Dr Pru Allington-Smith | Consultant Psychiatrist in Learning Disability Coventry & Warwickshire NHS Trust. |
| Matthew Ashton | Assistant Director of Public Health (Knowsley) Liverpool. |
| Dr Maggie Atkinson | Children's Commissioner for England. |
| Mick Atkinson | Head of Commissioning, Place2Be. |
| Prof Sue Bailey | Chair of Children & Young Peoples Mental Health Coalition. |
| Dr Laurence Baldwin | Royal College of Nursing. |
| Johnny Benjamin | Expert by Experience. |
| Sarah Brennan | Chief Executive, Young Minds. |
| Sally Burlington | Head of Programmes Local Government Association. |
| Prof Mick Cooper | Prof of Counselling Psychology, CYP IAPT National Adviser for Counselling, University of Roehampton. |
| Dr Jacqueline Cornish | National Clinical Director for Children, Young People & Transition to Adulthood, NHS England. |
| Karen Cromarty | Senior Lead Advisor for Children & Young People, British Association for Counselling & Psychotherapy. |
| Margaret Cudmore | Vice Chair of the Independent Mental Health Service Alliance. |
| Rebecca Cotton | Director of Mental Health Policy, NHS Confederation. |
| Dr Max Davie | Community Paediatrician. |
| Dr Eustace DeSousa | Deputy Director, National Team for Children, Young People & Families, NHS England. |
| Keith Douglas | Managing Director, NHS South Commissioning Support Unit. |
| Julia Faulconbridge | Consultant Clinical Psychologist (Children, Young People & Families), British Psychological Society. |
| Prof Peter Fonagy | National Clinical Lead CYP & IAPT, NHS England, & Chief Executive of the Anna Freud Centre. |

| Name | Job Title |
|---|---|
| Charlotte Gatherer | Expert by Experience. |
| Vivienne Griffin | Service Director, Disabilities and Mental Health, Wolverhampton City Council. |
| Peter Gibb | Policy Lead, Prevention & Access, Children & Young People's Mental Health & Wellbeing Taskforce, Department of Health. |
| Flora Goldhill | Director, Children, Families & Social Inclusion, Department of Health. |
| Ann Gross | Director, Special Needs & Children's Services Strategy, Department for Education. |
| Sharon Gray | Head Teacher, Netherfield Primary School. |
| Dr Nick Hindley | Consultant Child & Adolescent Forensic Psychiatrist, Associate Medical Director & Oxford Health Lead, Named Doctor for Children's Safeguarding, Thames Valley Forensic CAMHS, Oxon FASS, & Oxon & Bucks CAHBS Teams. |
| Dr Peter Hindley | Consultant Child & Adolescent Psychiatrist, Chair, Faculty of Child & Adolescent Psychiatry, Royal College of Psychiatrists. |
| Netta Hollings | Health & Social Care Information Centre. |
| Mathew Hopkinson | Assistant Director, 0-25 SEN & Disability Unit, Department for Education. |
| Cathy James | MST Programme Lead, NHS England. |
| Paul Jenkins | Chief Executive, Tavistock & Portman NHS Foundation Trust. |
| Dr Stephanie Lamb | General Practitioner, Member of Adolescent Health Group, Royal College of GPs. |
| Dr Warren Larkin | Consultant Clinical Psychologist, Lancashire Early Intervention in Psychosis Service & Clinical Director Children & Families Network Lancashire Care NHS. |
| John Lees | Associate Director of Commissioning, Birmingham South Central Clinical Commissioning Group. |
| Christine Lenehan | Director of Council for Disabled Children & Co-Chair of Child Health Outcomes Forum. |
| Terence Lewis | Ministerial Advisory Group for Mental Health Users & Carers. |
| Sarah-Jane Marsh | Chief Executive, Birmingham Children's Hospital. |
| Nick McGruer | Deputy Director Health, Disability & Employment Directorate, Department of Work & Pensions. |
| Paul Melody | Social Media Communication Expert. |
| Dr Jane Mischenko | Commissioning Lead, Children & Maternity Services,<br>NHS Leeds Clinical Commissioning Groups. |
| Karl Mittlestadt | Development Manager, Youth Justice Board for England & Wales. |

| Name | Job Title |
|---|---|
| Dr Paul Mitchell | Senior Clinical Nurse, Adult & Youth Specialised Services, Greater Manchester West NHS Trust. |
| Zoe Mulliez | Public Policy Advisor, Healthwatch England. |
| Dr Margaret Murphy | Consultant Child and Adolescent Psychiatrist; Clinical Chair of the Secure & Specialised Mental Health Programme NHS England & Chair of Tier 4 CAMHS Clinical Reference Group. |
| Kath Murphy | Head of Mental Health, Specialised Services, NHS England. |
| Wendy Nicholson | Public Health Nursing, Department of Health. |
| Anne O'Herlihy | Extended Scope Programme Manager CYP IAPT, NHS England. |
| Alison O'Sullivan | Vice President, Association of Directors of Children's Services & Director for Children & Young People, Kirklees Council. |
| Nick Page | Chief Executive, Solihull Metropolitan Borough Council. |
| Claire Phillips | Deputy Director, Children & Young People's Mental & Wellbeing Taskforce, Department of Health. |
| Kathryn Pugh | Children & Young People's Improving Access to Psychological Therapies (CYP IAPT) Programme Lead. |
| Dr Sandeep Ranote | CAMHS Psychiatrist, Lead for Specialist Clinical Networks, NHS England. |
| Barbara Rayment | Director, Youth Access. |
| Emma Rigby | Chief Executive, Association for Young People's Health. |
| Wendy Russell | Head of Policy & Operations, Health Education England. |
| Eileen Scott | Expert by Experience. |
| Anne Spence | Policy Lead, Children & Young People's Mental Health & Wellbeing Taskforce, Department of Health. |
| Dawn Taylor | Deputy Director, Children & Young People's Mental Health, Department for Education. |
| Isabelle Trowler | Chief Social Worker for Children & Families, Department of Education. |
| Teresa Tunnadine CBE | Head Teacher, The Compton Secondary School. |
| Karen Turner | Head of Delivery, Parity & Esteem, NHS England. |
| Kate Ward | Policy Lead, Children & Young Peoples Mental Health & Wellbeing, Department of Health. |
| Dr Jon Wilson | Clinical Lead, Norfolk Youth Service. |
| Miranda Wolpert | Director of CAMHS Evidence based Practice Unit, National Advisor on data for CYP IAPT programme. |
| Dr Ann York | Professional Adviser on CAMHS, Care Quality Commission. |

# Acknowledgements

During its work, the Children and Young People's Mental Health and Wellbeing Taskforce has consulted and learned from a wide range of people and organisations, including health, education and care professionals, academics, young people, parents and carers and policy experts. We have benefited greatly from their expertise and we would like to thank them all for their input and contributions to the report.

We would also like to thank Leanne Walker, GIFT Young Sessional worker, for providing illustrations.

Department
of Health

2903393 Produced by Williams Lea for the Department of Health

NHS
England

# Accelerating and sharing good practice in co-commissioning arrangements for child and adolescent mental health services (CAMHS) : successful pilot areas

## A. Co-commissioning a comprehensive care pathway from Tier 1 – 4* (See note below)

- **NEW Devon - £75k**

Builds on NEW Devon CCG and Plymouth City Council integrated working. This will involve working closely with Plymouth Teaching School Alliance to develop whole systems approach for children and young people who may not meet specialist CAMHS criteria but who have significant issues such as self-harm or substance misuse. The pilot will work with education to develop a co-commissioned "Single Point of Contact" for professionals and parents that will identify family risk factors and enable whole family care planning and early help.

**Other partner agencies involved in the application**

Plymouth City Council

- **Derbyshire - £40k**

This pilot will provide commissioning capacity to enable schools to identify and manage emotional wellbeing and behaviour through early help and will be piloted with five schools as co-commissioners. The commissioned pilot service will build on good practice in integrated working, including 'team around the school', with multi-agency meetings to support children, young people and families. The pilot will test a single point of access, with a set of referral and threshold criteria which has been drafted for targeted and specialist services. The aim is to improve appropriateness and timeliness of access to specialist services.

**Other CCGs involved in the application**

Southern Derbyshire CCG
Erewash CCG
North Derbyshire CCG
Hardwick CCG

**Other partner agencies involved in the application**

Derbyshire County Council
Derby City Council
Local schools
Primary care
Voluntary and community sector
Children and Young People Derbyshire Healthcare NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust
Derby Hospitals NHS Foundation Trust

- **Newcastle - £75k**

A joint bid across Newcastle and Gateshead LAs and CCGs. They have already established a joint project to design a whole system approach to family mental health including wellbeing promotion, early support and evidence based practice. The pilot will create new commissioning arrangements by mapping CAMHS services and exploring a variety of contracting and payment methods, including personal budgets. It will build on the existing local waiting times initiative and Targeted Mental Health in Schools project. A group of children, young people and parents will be trained to be involved in the commissioning process.

**Other CCGs involved in the application**
Newcastle West CCG, Gateshead CCG

**B. Joint commissioning across health, social care and education at Tier 2/3.**

- **Tameside and Glossop - £75k**

The pilot will equip all front line staff to be able to identify and respond to mental health issues within an agreed framework for intervention providing clear pathways and access supported by consultation, advice and guidance model. The pilot will review existing thresholds for Tier 2 and Tier 3 Child and Adolescent Mental Health Services (CAMHS), benchmarked with other similar partnership services. They will ensure open consultation into developing thresholds and a service 'core offer' at Tiers 2 – 3, with all partners including children, young people and families.

**Other CCGs involved in the application**
Through co-commissioning partners of the CAMHS contract and as wider partners of the Pennine Care contract, Stockport, Oldham, Bury and HMR.

**Other partner agencies involved in the application**
Tameside Metropolitan Borough Council (including Public Health and Education)
Derbyshire County Council
Tameside and Glossop CAMHS (Pennine Care Foundation Trust)
42nd Street (voluntary sector organisation)

- **Norfolk - £40k**

This is a consortium of Norfolk CCGs and the County Council. The pilot will focus on the learning disabilities pathway. This will allow specialist time to be dedicated to reviewing and jointly commissioning more robust pathways, from a range of agencies, with piloting of how CAMHS and LA outreach teams jointly manage a number of cases.

**Other CCGs involved in the application**
North Norfolk CCG, Norwich CCG, West Norfolk CCG, Great Yarmouth & Waveney CCG
**Other partner agencies involved in the application**
Norfolk County Council, Norfolk CAMHS Strategic Partnership (members include a range of Norfolk’s statutory and voluntary sector providers and commissioners)

- **Southampton - £45k**

Currently Southampton City Council and Southampton City CCG undertake joint commissioning within an Integrated Commissioning Unit. The Headstart Project covers 21 schools within the city and includes Emotional First Aid training, school counselling and mindfulness training. The pilot will develop a framework for extending joint commissioning and integrated services to help young people address a range of inter-related personal, practical, emotional, health, social welfare and legal needs simultaneously. The pilot will also identify future opportunities for re-commissioning services looking at all resources currently spent on children and young adults in order to support improved transitions, including extending to a 0-25 service.

**Other partner agencies involved in the application**
Southampton City Council
No Limits (Southampton) Ltd

**C. Co-commissioning by clusters of CCGs with NHS England for Tier 4 CAMHS.**

- **Wolverhampton - £75k**

Bid from Black Country CCGs and Wolverhampton LA to scope, map and analyse commissioning of CAMHS Tier 4 and other health funded out of area placements, with the aim of preventing the large numbers of children from the Black Country being placed 'out of area'. The pilot will develop specialist care pathways, improving early intervention and prevention to reduce the use of Tier 4 provision. It will include commissioning urgent care at Tier 3 / Tier 3+ to include focus upon delivering a Black Country wide solution to children and young people requiring admission to a place of safety (under Section 136 of the Mental Health Act).

**Other CCGs involved in the application**
NHS Sandwell and West Birmingham CCG
NHS Dudley CCG
NHS Walsall CCG
Specialised Commissioning within the Birmingham Black Country and Solihull NHS England Area Team

**Other partner agencies involved in the application**
The Black Country Partnership NHS Foundation Trust
Wolverhampton City Council
The Children's Society

**D. Collaborative commissioning across the transition age span to 25.**

- **South Sefton - £75k**

Wide consortium bid including LA and VCS partners. Builds on DfE-funded BOND project (which focused on VCS role in brokering and co-ordinating youth-focused emotional wellbeing services in the community). The pilot will build on existing mapping to enable clearer support pathways for 5-25 year olds, and will work with children, young people and families to design the process. The pilot will use voluntary sector services within the partnership to deliver specific services that meet the needs of young people currently being referred to Tier 3 CAMHS but do not meet the threshold.

**Other CCGs involved in the application**
Southport and Formby CCG

***CAMHS tiers:**

***Tier 1 (Universal services)***

These are services whose primary remit is not that of providing a mental health service, but as part of their duties they are involved in both assessing and/or supporting children and young people who have mental health problems. Universal services include GPs, health visitors, schools, early years' provision and others. Universal services are commissioned by CCGs and Local Authorities and schools themselves, and may be provided by a range of agencies.

***Tier 2 (Targeted services)***
These include services for children and young people with milder problems which may be delivered by professionals who are based in schools or in children's centres. Targeted services also include those provided to specific groups of children and young people who are at increased risk of developing mental health problems (e.g. youth offending teams and looked after children's teams, paediatric psychologists based in acute care settings). Targeted services are commissioned by CCGs and Local Authorities and schools, and are provided by a range of agencies.

***Tier 3*** (***Specialist services***)
These are multi-disciplinary teams of child and adolescent mental health professionals providing a range of interventions. Access to the team is often via referral from a GP, but referrals may also be accepted from schools and other agencies, and in some cases self-referral. These services are commissioned by CCGs although there may be a contribution from Local Authorities.

***Tier 4 (Specialised CAMHS)***
These include day and inpatient services and some highly specialist outpatient services including services for children/young people.

ENDS

**Agenda Item No. 13**

CITY OF WOLVERHAMPTON COUNCIL

# Health and Wellbeing Board

29 July 2015

| | | |
|---|---|---|
| **Report title** | Report on Equality Analysis<br>Joint Strategy for the Provision of Urgent & Emergency Care for Patients using Services in Wolverhampton 2016/17 | |
| **Cabinet member with lead responsibility** | Councillor Sandra Samuels<br>Health and Wellbeing | |
| **Wards affected** | All | |
| **Accountable director** | Steven Marshall – WCCG Director of Strategy & Transformation | |
| **Originating service** | Health, Wellbeing & Disability | |
| **Accountable employee(s)** | Steven Marshall<br>Tel<br>Email | Director of Strategy & Transformation<br>01902 445797<br>steven.marshall3@nhs.net |
| **Report to be/has been considered by** | | |

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**Recommendation(s) for action or decision:**

The Health and Wellbeing Board is recommended to:

1. The Health and Wellbeing Board is recommended to note the steps taken by the Clinical Commissioning Group to implement recommendations 8, 10, 11, 19, 20 and 21 in the Equality Analysis document.

## 1.0 Purpose

1.1 To update The Health and Wellbeing Board with action taken following the equality analysis report on the Joint Strategy for the Provision of Emergency and Urgent care on Wolverhampton

## 2.0 Background

2.1 The Quality Analysis report has already been presented to the health and wellbeing board on 3rd September 2015 and the following recommendations were agreed

## 3.0 Progress,

### 3.1 Consultation & Engagement

3.1.1 Recommendation 8 - All agencies - opportunities to engage across the protected characteristic groups should be built in to proposed engagement and consultation as the implementation phase of the urgent care strategy progresses including specific outreach work where response rates show low engagement with particular groups.

3.1.2 *The CCG are currently working with the CSU to develop a robust and fully inclusive Communication and Engagement plan which will incorporate a generic engagement with the public through the usual varied routes and methods and will also target the protected characteristic groups. These groups will be specifically targeted with tailored engagement/involvement.*

### 3.2 Partnership Work

3.2.1 Recommednation 10 - All agencies - because of the trend in homelessness in Wolverhampton and the disproportionate impact of homelessness on the costs of health provision – particularly skewed towards urgent and emergency care – the implementation plans for urgent and emergency care should involve social housing providers and homelessness organisations as part of an integrated approach. Further work may be required to identify any geographical disparities in the location of homelessness people; to research the health experiences of homeless people; and to explore the potential for more effective and earlier interventions to prevent or reduce ill-health and to respond more appropriately to their healthcare needs.

3.2.2 *The CCG recognise the disproportionate cost impact caused by homelessness. As a result, the Communication and Engagement plan for urgent and emergency care will have a specific focus on homeless patients. Social housing providers and homeless charities will be specifically targeted to ensure this client group is aware of the planned changes, along side the wider Choose Well campaign. The CCG are developing a frequent service user project where a patients lack of a fixed abode will be noted and will play a part in the development of the targeted individualised intervention plan. In addition, the System Resilience Group has funded P3 (homeless charity) to support 75 patients throughout 2015/16, who have been discharged from hospital with no fixed abode. The aim is to find them suitable* *accommodation and register with a GP and short term monitoring to ensure compliance with medical appointments. With reference to researching the experiences of homeless people, P3 have provided the CCG with a suite of reports including numerous case studies and hospital discharge needs assessment. WVSC are a key stakeholder on the SRG*

3.2.3 Recommendation 11 - The Health and Wellbeing Partnership to explore ways to better understand the health needs of the Wolverhampton based travelling communities and how they access healthcare. However, any such work and the resource commitment will need to be proportionate. Anecdotal information about healthcare demands may offer an appropriate starting point on which to build more targeted studies.

3.2.4 The *Health and Wellbeing partnership no longer exists therefore it is assumed this recommendation becomes the responsibility of the Health and Wellbeing Board. As detailed within the Equality Analysis report, statistics for 'gypsy or travelling communities' are difficult to estimate. The CCG will ensure that information is captured by the new Urgent Care Centre in relation to how patients access the service (i.e. ambulance, self present, NHS 111 referral). however this will be limited to those who are already accessing services. The CCG has factored this into the communication and engagement plan for urgent and emergency care so that we can be sure that the travelling community are aware of service provision and the expected changes.*

3.2.5 Recommendation 19 - The Health and Well-Being Board consider specific support being identified within the suicide prevention strategy for Lesbian, Gay, Bisexual and Transgender people.

3.2.6 *CCG response: Through the joint commissioning portfolio the CCG have committed funds from February 2015 to support Wolverhampton LGBT. This element of the suicide prevention plan is now being taken forward by Public Health who are leading on the planned delivery overall.*

### 3.3 Staff Training

3.3.1 Recommendation 20 - All agencies to ensure that equality and diversity training is included in the mandatory training elements for each organisation. Where possible, agencies are recommended to share training opportunities, particularly where patient pathways necessitate involvement with different organisations. This would allow for consistency of approach, and highlight areas of complementary (or dissonant) practice. For all, training content should include information about all the protected characteristic groups; the public sector equality duty and the three aims; the significance and importance of equality monitoring; and the values, principles and pledges within the NHS Constitution as a minimum.

3.3.2 *This has been picked up by key stakeholders (RWT and CCG) who now included equality and diversity training as mandatory. The CCG have built this into existing contractual arrangements with current provider.*

3.3.3 Recommendation 21 - Staff involved in the design of surveys or questionnaires; in their distribution or completion with respondents should receive a comprehensive and timely briefing beforehand which covers: the significance and value of equality questions; the importance in ensuring a high % of completion from respondents; and how to confidently respond to respondents' questions in a way which is tactful, sensitive, and reassures people about the confidentiality of the information they share.

3.3.4 *All staff within the CCG who are involved in designing surveys/questionnaires now include basic equality information alongside the general demographic information.*

## 4.0 Financial implications

4.1 None identified

## 5.0 Legal implications

5.1 None identifed

## 6.0 Equalities implications

6.1 Covered in content

## 7.0 Environmental implications

7.1 None identifed.

## 8.0 Human resources implications

8.1 None identifed.

## 9.0 Corporate landlord implications

9.1 None identifed.

## 10.0 Schedule of background papers

10.1 Report on Equality Analysis - Joint Strategy for the Provision of Urgent and Emergency Care for Patients using Services in Wolverhampton to 2016/17.

Midlands and Lancashire
Commissioning Support Unit

Wolverhampton
Clinical Commissioning Group

# Report on Equality Analysis

## Joint Strategy for the Provision of Urgent and Emergency Care for Patients using Services in Wolverhampton to 2016/17

# Contents

# Summary

Midlands and Lancashire Commissioning Support Unit (CSU) is contracted to provide equality and diversity support to Wolverhampton Clinical Commissioning Group. As part of this support, the Equality and Diversity Team of the CSU was asked to undertake an equality analysis of the 'Joint Strategy for the Provision of Urgent and Emergency Care for Patients using Services in Wolverhampton to 2016/17'. The analysis is focused on the impacts for Wolverhampton residents.

This document presents the analysis along with reasons for the conclusions reached, and makes evidence based recommendations to inform equality approaches in the procurement, operation, and continuous improvement of urgent and emergency care services.

The Equality Analysis considers two distinct, but related areas:

1. The equality impact of the reconfiguration of services, and particularly the relocation of the Walk-in Centre facility from Showell Park to a new Primary Care Centre at New Cross Hospital.

## Assessment 1

**The relocation of the Walk-in-Centre from Showell Park to New Cross Hospital will benefit some residents and disadvantage others. Although it is not possible to quantify the balance between 'winners' and 'losers', the demographic information available suggests that the health inequality gap between different groups is unlikely to be widened by the proposals. Proxies for deprivation discussed in the report such as no car ownership or receipt of Disability Living Allowance suggest that a greater proportion of low income households with mobility disadvantages may benefit from the re-siting. Furthermore, if the proposed improvements in primary and secondary care are realised, all protected characteristic groups should benefit from more accessible and responsive services. Urgent care for other distinct groups such as homeless people and migrants also has potential to improve.**

2. A consideration of how *operationally*, urgent and emergency care services can adopt an equality approach towards different protected characteristic groups.

## Assessment 2

**Commissioners can ensure that robust equality considerations, sensitive to the particular needs of each protected characteristic group, are built into procurement in pre-qualification questionnaires (PQQs), and service specifications. Contracts can require providers to conduct further equality analyses on their service operations. Contractual information requirements can also be established which consider equality in the provider workforce and in the delivery of services. All NHS Trusts and private sector providers commissioned by the CCG will be required to demonstrate compliance with the general duty under s149 Equality Act 2010 (the Public Sector Equality Duty).**

Recommendations are offered in the analysis as part of a specific equality action plan for services as they are developed **(at section 7)**.

# 1. Introduction

## Urgent and Emergency Care – the case for change

1.1 The increase in demand for urgent and emergency care services, and the pressures this creates in the health economy of Wolverhampton have been clearly articulated in the strategy itself:

> **"It is understood that there is no single cause to the increased pressure nor is there a single solution. The existing system of providing urgent care in Wolverhampton is unsustainable and was not designed to cope with the significant and unpredicted increased levels of activity. Our patients are experiencing long waits and have told us that they are confused on how and where to access appropriate services. Doing nothing is not an option....The system has become complicated for patients and their expectations have led to immediate demands to be seen and treated for conditions that are not always urgent, with the default often being the ambulance service or the Emergency Department (ED)."**
>
> Joint Strategy (Wolverhampton CCG, 2013a; p6)

1.2 The intention is set out in the vision for the strategy:

> **"Our vision is for an improved, simplified and sustainable 24/7 urgent and emergency care system that supports the right care in the right place at the right time for all of our population. Our patients will receive high quality and seamless care from easily accessible, appropriate, integrated and responsive services. Self-care will be promoted at all access points across the local health economies and patients will be guided to the right place for their care and their views will be integral to the culture of continuous improvement."**
>
> Joint Strategy (Wolverhampton CCG; 2013a;p7)

1.3 'Access points' will include 'easy to access' 24 hours a day, seven days a week services, urgent GP appointments, Walk in Centres, Emergency Department, the Ambulance Service and emergency admissions to hospital. The crux of the reconfiguration is described as:

> **The new urgent & emergency care system will be improved and simplified for patients with access to general practice, community teams, a walk in centre at the Phoenix Centre, the ambulance service and a new Primary Care Centre and ED at New Cross Hospital. Patients will be encouraged to self-care or seek advice from pharmacy services or to be guided to the right place for their care through telephone access with NHS 111. The out of hours service and the Showell Park Walk in Centre (only the service, the building and GP practice will remain) will be relocated to become fundamental parts of the new Primary Care Centre which will offer care to primary care patients 24 hours a day, 7 days per week whether they walk in or are directed there by a healthcare professional.**
>
> Joint Strategy (Wolverhampton CCG, 2013a; p23-24)

1.4 The Consultation document *'Plans for Urgent and Emergency Care Services in Wolverhampton'* summarised the proposals for change for residents and invited respondents to indicate if they were supportive of them:

> **"At the heart of our plans is the move to bring together some of the city's urgent and emergency care services into one building, which is expected to open in early 2016. This will be a brand new purpose-built centre that will be open 24 hours per day and 365 days per year at New Cross Hospital"**
>
> Plans for Urgent and Emergency Care Services (Wolverhampton CCG; 2013b)

## The timetable for change

1.5 The strategy for urgent and emergency care services outlines the 'what', 'where' and 'when', and explains that the 'how' will be detailed within the *implementation plans*. There are 4 distinct phases for implementation:

**Phase 1 – December 2013 – December 2014**
Consultation, and development of implementation plans. This phase will include a new Emergency Department with a co-located Primary Care Centre, and supporting ambulatory and diagnostic facilities. Subsequent developments are proposed and include a second and third floor housing Emergency Admissions Units for Children (PAU), Medical Patients (AMU), Surgical Patients (SAU) and a proposed Clinical decisions Unit (CDU). The new ED Business case is tightly linked to the emerging Urgent and Emergency Care Strategy and work has been undertaken to provide assurance to the CCG's that the new ED will improve quality.

**Phase 2 – November 2013 – December 2016**
Improve Primary Care

**Phase 3 – November 2013 – December 2016**
Improve Secondary Care

**Phase 4 – December 2016 – December 2017**
Review and amend

## Responses to the proposals so far

1.6 The methodology for the consultation, and a summary of patient responses are included in a 'Feedback Report' ' (Wolverhampton CCG; 2013) The consultation was undertaken between 2 December 2013 and 2 March 2014. 94% of respondents to the survey expressed support for the plans for urgent care.

1.7 Key themes emerging from patients included issues around access to services: especially GP appointments; transport and parking at urgent care facilities; and reducing confusion about the sytem through education and communication. Healthwatch Wolverhampton has said it agrees with the principle of creating a simple system with fewer options, layers and improved information, and that this will be better for the people of Wolverhampton. It also stressed the importance of on-going involvement of patients and residents in the development of the service specification.

1.8 There was a demand for information on the impact of the proposed changes for the Eye Infirmary, including its connectivity to the new centre. There is an expectation that the services should be linked or co-located in order to make it easier for eye care patients to travel between the two. This should be supported with clear and accessible information.

1.9 Healthwatch Wolverhampton has expressed the view that more needs to be done to clarify care pathways for ophthalmology urgent care patients.

1.10 Healthwatch Wolverhampton has also expressed the view that the current pharmacy provision is not effective.

## Equality and diversity research methodology

1.11 204 individuals responded to the consultation survey which was, given the reach of the consultation process, a low response level. Responses to specific equality questions included on the survey form (questions on disability, ethnicity etc) were not well completed, and there are lessons here for improving the confidence of questioners when asking for equality information, and too for the reassurances given to the public about why the information is being collected, and how it is to be used. The minority ethnic completion percentage for respondents was much lower than for the Wolverhampton population overall, suggesting that different venues, and specific outreach approaches need to be identified in the future. Both these points are included in the recommendations arising from this analysis and should help to influence implementation plans.

1.12 However there was significant coverage, and a very wide range of stakeholders included in the consultation process, and so it is reasonable to conclude that the vast majority of Wolverhampton residents had an opportunity to access the materials and to respond if desired.

### Survey of organisations

1.13 A separate short survey was undertaken, targeted at voluntary and community organisations who work with protected characteristic groups as defined by the Equality Act 2010. This survey was kindly distributed by both the Wolverhampton Equality and Diversity Forum (EDF) to their membership list, and by the Wolverhampton Voluntary Sector Council using their organisational database. This survey was designed to be complementary to the consultation questionnaire, and to capture any currency of information, through the knowledge and understanding of representative groups, about how urgent and emergency care services are operating. The questions asked about:

- Positive experiences of urgent care health services?
- Any difficulties experienced?
- Improvements which could be made?
- Whether services understand (or don't understand) the particular needs of different groups?
- Whether people feel listened to?
- Whether privacy and dignity are respected by services?

1.14 The survey ran over a six week period from early January through to 21st February 2014. 23 organisational responses were received. The findings from this survey have been used to inform the local issues included in the analysis of protected characteristic groups from **section 4** . In general the responses have been positive and focussed on patient experiences of urgent care. Some concerns were expressed about the needs of people with mental health problems, and patients with learning disabilities. These echo some of the concerns highlighted about Accident and Emergency services by the CQC Quality Report following the recent inspection of New Cross Hospital (CQC, November 2013).

1.15. Issues were not raised in this survey concerning the rationale for the proposed changes to urgent and emergency care, nor for the proposed re-siting of urgent care facilities in Wolverhampton.

1.16 Wolverhampton CCG will work with provider organisations to ensure that as plans for re-modelled urgent and emergency care services develop and are implemented, that thorough consideration is given to the appropriate collection of equality monitoring information, and that equality analyses (impact assessments) help to inform the receptiveness and sensitivity of services to diverse needs.

# 2 The Context for Equality Analysis

## Strategic Commitment

2.1 There are explicit commitments to equality and diversity in the strategy itself:

> **"The Urgent and Emergency Care Board is fully committed to promoting equality of opportunity, eliminating unlawful and unfair discrimination and valuing diversity, so that we can remove or minimise disadvantages between people who share a protected characteristic and those who do not. All Urgent and Emergency Care services will ensure that services are appropriate and do not discriminate on the basis of the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or beliefs, sex and sexual orientation...The rights and pledges contained in the NHS Constitution will be upheld at all stages of the patient journey through Urgent and Emergency Care (p9)**
>
> Joint Strategy (Wolverhampton CCG, Royal Wolv'hampton NHS Trust; 2013; p9)

2.2 To ensure this, a regular Equality report has been considered by the Board (on a bi-monthly basis) submitted by the Midlands and Lancashire Commissioning Support Unit which has sought to identify improvements in the equality approaches adopted by the process – especially to consultation methods, and to data collection systems.

## The Public Sector Equality Duty

2.3 Clinical Commissioning Groups (CCGs) are now listed as public authorities in Part 1 of Schedule 19 to the Equality Act 2010. This means that Wolverhampton CCG is subject to the general Public Sector Equality Duty required by s.149 of the Act. S.149 states that the CCG must ***"have due regard to the need to***:

i. Eliminate discrimination, harassment, victimisation, and any other conduct prohibited by the Act;
ii. Advance equality of opportunity between persons who share a relevant protected characteristic***** and persons who do not share it;
iii. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it."

*****Protected characteristic groups' are described in paragraph 2.7 below.

2.4 Having ***due regard*** for advancing equality (2nd aim) involves:

- **Removing or minimising disadvantages** experienced by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low

2.5 In the case of *R (Brown) v Secretary of State for Work & Pensions [2008] EWHC 3158 (Admin).*the Court set out some principles for public bodies to guide them in compliance with the duty to give due regard to relevant equality needs. These include that:

- When a public authority makes decisions that do or might affect a protected characteristic group, it must be made aware of its duty to have due regard to the aims in the Equality Duty. An incomplete or mistaken appreciation of the Duty will mean that 'due regard' has not been paid.
- The 'due regard' must be exercised with rigour and with an open mind. It is not a question of 'ticking boxes'. The Duty has to be integrated within the discharge of the public functions of the CCG. **It involves a conscious and deliberate approach to policy-making** and needs to be thorough enough to show that 'due regard' has been paid before any decision is made.
- If the CCG has not specifically mentioned the relevant general Equality Duty when carrying out a particular function, this does not mean that the Duty to have 'due regard' has not been performed. However, it is good practice for the policy itself, or the CCG, to make reference to the Duty and any code or other non-statutory guidance. This will reduce the chance of someone successfully arguing that 'due regard' has not been paid to equality considerations. This is also likely to enable a public authority to ensure that factors relevant to equality are taken into account when developing a policy.
- It is good practice for public organisations to keep an adequate record showing that they have actually considered the Equality Duty and pondered relevant questions. Appropriate record-keeping encourages transparency and will discipline those carrying out the relevant function to undertake their Equality Duties conscientiously.

## The role of Midlands and Lancashire Commissioning Support Unit

2.6 Midlands and Lancashire Commissioning Support Unit (MAL CSU), as part of its support to Wolverhampton Clinical Commissioning Group, was asked to help facilitate an Equality Analysis on the Joint Strategy for Urgent and Emergency Care services. The aims in producing this report were to:

i. Establish a baseline on current usage of urgent and emergency care services within Wolverhampton with regard to **protected characteristic groups**.
ii. Assess the equality impact on the local population of potential changes as part of the plans in Wolverhampton.
iii. To use the process of Equality Analysis, as guided by the route map (Appendix 1) to inform decision-making.
iv. Identify opportunities to promote equality
v. Recognise the potential risks to the strategy from not addressing inequalities.
vi. To suggest ways to mitigate these risks

2.7 The **'protected characteristic groups'** are defined in Part 1 of the Equality Act 2010 and cover people who are specifically offered protection by the Act. Before the Equality Act, all NHS organisations already had to demonstrate that they were treating people of different races, people with a disability, and men and women fairly and equally. The 2010 Act has added groups of people to the equality duty. These are set out in Table 1 below:

## Table 1: Definition of Protected Characteristics

| Protected Characteristic | Definition |
|---|---|
| Age | This refers to a person having a particular age (for example, 52 years old) or being within an age group (eg 18-30 year olds; 'older people' or 'children and young people'. Specific discussions about age will usually be given context by the nature of the services under consideration. |
| Sex | Someone being a man or a woman |
| Disability | A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. |
| Race | Race refers to a group of people defined by their colour, nationality (including citizenship), ethnic, cultural or national origins. 'Ethnic group' is another descriptive term often used. This may refer to a long, shared history and common cultural traditions; a common geographical origin, language, literature, or religion may also be factors to consider. |
| Sexual Orientation | Whether a person's sexual attraction is towards their own sex (homosexuality), the opposite sex (heterosexuality), or to both sexes (bisexuality). The terms 'Lesbian', 'Gay', 'Bisexual' (LGB) are commonly used when describing the particular health experiences, prejudices, and challenges encountered by people whose sexuality differs from the majority heterosexual state. |
| Gender reassignment | People who are transitioning from one gender to another. A person who is Transgender is someone who expresses themselves in a different gender to the gender they were assigned at birth. Although the legislation covers gender reassignment, the term 'trans' better encompasses the wider community and has wide currency. Gender reassignment may also include people who are considering a sex change, but an intention to change sex is not a necessary requirement to be considered as trans. |
| Religion or belief | People with a religious or philosophical belief, (or people without a religion or belief e.g. Atheism). Generally a belief should affect your life choices or the way you live for it to be included in the definition. Political beliefs are not afforded protected characteristic status. |
| Pregnancy and maternity | Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in an employment context. In the non-work context, protection against maternity discriminatiion is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding. |
| Marriage and Civil Partnership | People who are in a civil partnership or are married. Marriage is currently defined as a 'union between a man and a woman'. Same-sex couples can have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same way as married couples on a wide range of legal matters |

## Scope of the Equality Analysis

2.8 The Equality Analysis considers two distinct but related areas:

i. The equality impact of the reconfiguration of services, and particularly the relocation of the Walk-in Centre facility from Showell Park to a new Primary Care Centre at New Cross Hospital.

ii. A consideration of how operationally, urgent and emergency care services can adopt an equality approach towards different protected characteristic groups as users of services.

2.9 The focus of the analysis has been on the impact for residents of Wolverhampton, but not for visitors from neighbouring CCG areas seeking healthcare within Wolverhampton. Each CCG should consider the equality impact for its own population.

2.10 The impact on staff working for provider organisations has not been considered as part of this analysis. This work would need to form part of the equality analysis of specific implementation plans for each provider.

## Method

2.11 Wolverhampton CCG at its inception in April 2013, adopted a process for Equality Analysis for many key areas of its work. This includes an equality analysis tool comprising a template and guidance. The CCG's Equality and Diversity Strategy and Action Plan (available at this link) sets out in detail how the CCG seeks to comply with its Public Sector Equality Duty.

2.12 For the Joint Strategy, in anticipation that a much wider group of stakeholders would be engaged in the process, an equality analysis 'route map' was produced by the CSU to illustrate how each stage could progress. A summary of this route map is attached at Appendix 1. The case for change set out in the Joint Strategy is focused on the issues which necessitate a reconfiguration of urgent care services and facilities. This equality analysis has therefore considered the potential impact of the case at an early stage and considers the information from the listening exercise carried out early in 2013, the formal public consultation held in early 2014, and a targeted survey of voluntary and community organisations which deal with protected characteristic groups (early 2014) [Discussed more fully in section 4]

2.13 A wide range of reports, statistical information, and transferable learning from equality analyses of urgent care services in other parts of the country were used as part of this analysis. A full list of these appears at the end of this document. In addition, equality information statistical returns from provider organisations were compiled, and additional service information was requested from those organisations directly involved in providing urgent and emergency care. These were used to try to understand the provision for protected characteristic groups as well as for non-statutorily protected groups who have significant healthcare needs (eg: homeless people; migrants; travelling communities). The conclusions and inferences made in this analysis have been made using these materials.

## Assumptions

2.14 We have assumed:

i. No planned diminution of service has been identified either by withdrawing services, or restricting eligibility for existing services. The drivers for change emphasise the intention to enhance services and improve efficiencies by reducing unnecessary duplication, and offering clinicians and patients alike greater clarity along the treatment pathway.

ii. Provider organisations, in pursuance of meeting their own Public Sector Equality Duty under s149 Equality Act 2010 will conduct their own equality analyses to cover workforce and service impacts arising from implementation plans. These will form an important part of the implementation phase.

iii. Further engagement opportunities for patients and their families, and other stakeholders will continue throughout the strategy period (to 2017) and be effected through the joint partners to the strategy. These opportunities will be receptive to the perspectives of different protected characteristic groups.

# 3. Equality Impact of the reconfiguration of services

## Relocation of Showell Park

3.1 Evidence considered by the Joint Urgent and Emergency Care Strategy Board found that:

> **“Further to the analysis of Walk-in-Centre use by patients, based on their registered GP Practice, it is clear that the proximity of the Walk-in-Centre to a patient’s home or GP Practice has a significant impact on their use of walk-in-centre – ie the closer they are based to the walk-in-centre, the more significant their use”**
>
> (Wolverhampton City Council, 2012)

3.2 As well as high use from people living close to the walk-in-centre, the evidence also showed that the walk-in-centre was in higher demand when GP Practices are shut (evenings and weekends), and that for Showell Park walk-in-centre in particular, activity is localised around the physical location of the services. However there is also a significant duplication of Accident and Emergency use where patients visit Showell Park and then go on to visit A&E. This pattern of activity is shown in Figures 1 and 2 below

**Figure 1: Showell Park activity in 2011/12 (Wolverhampton City Council, Public Health Intelligence Team 2013) – figures in brackets refer to the number of geographical 'lower super output areas' (LSOAs) that demonstrate each level of activity.**

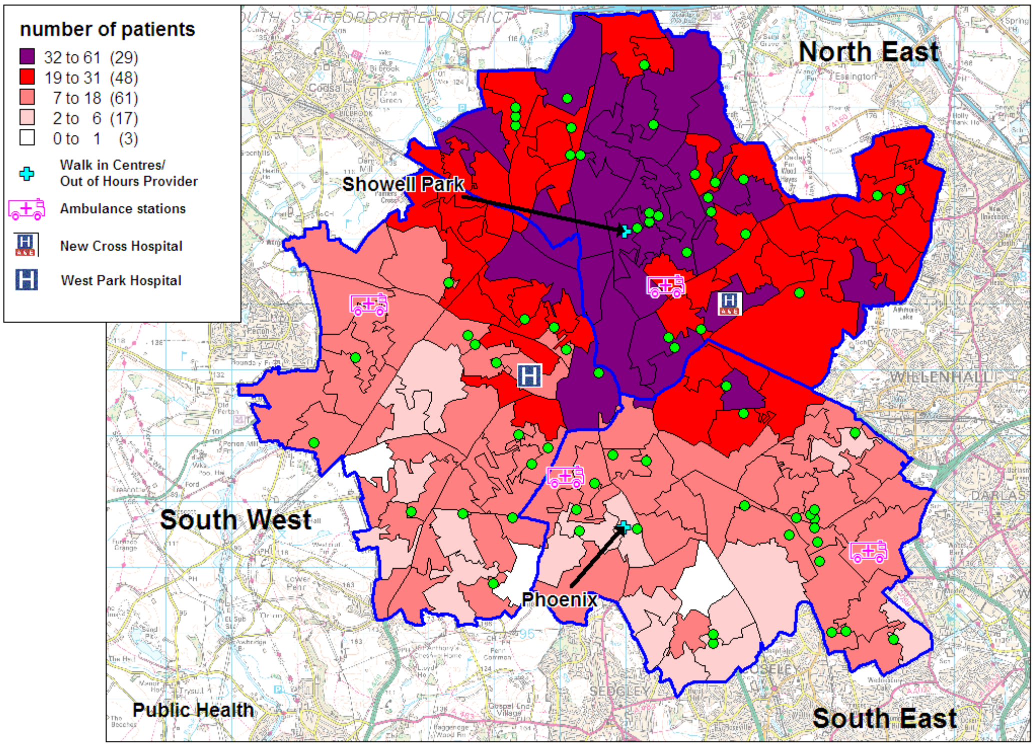
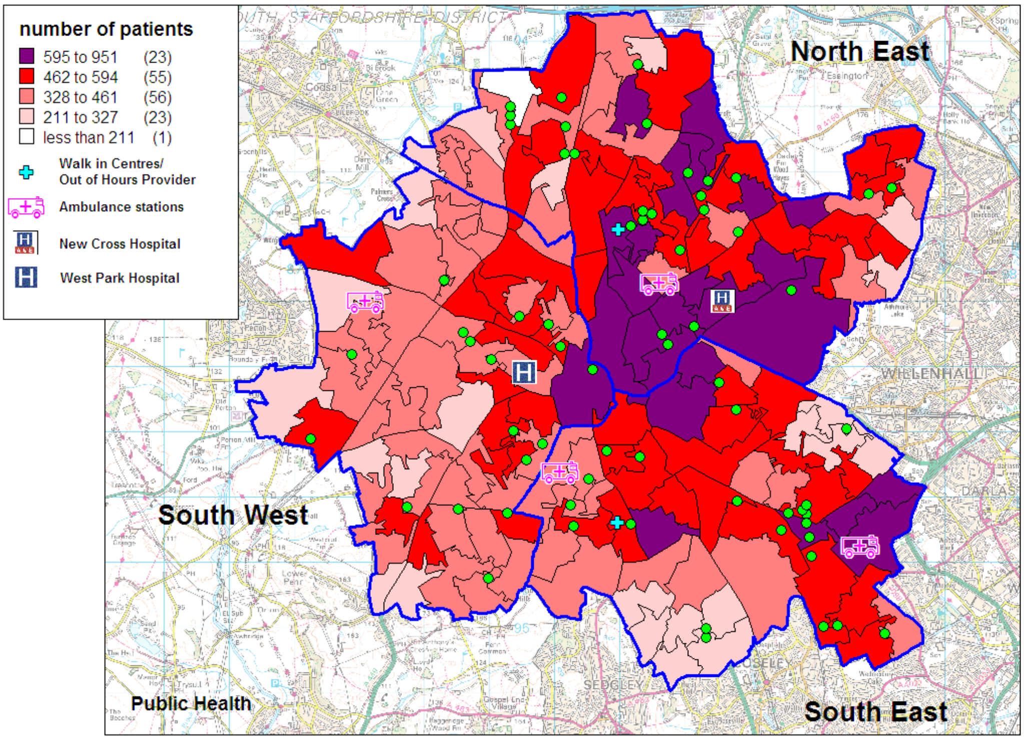


**Figure 2: A&E attendances in 2011/2012 (Wolverhampton City Council Public Health Intelligence Team 2013)**

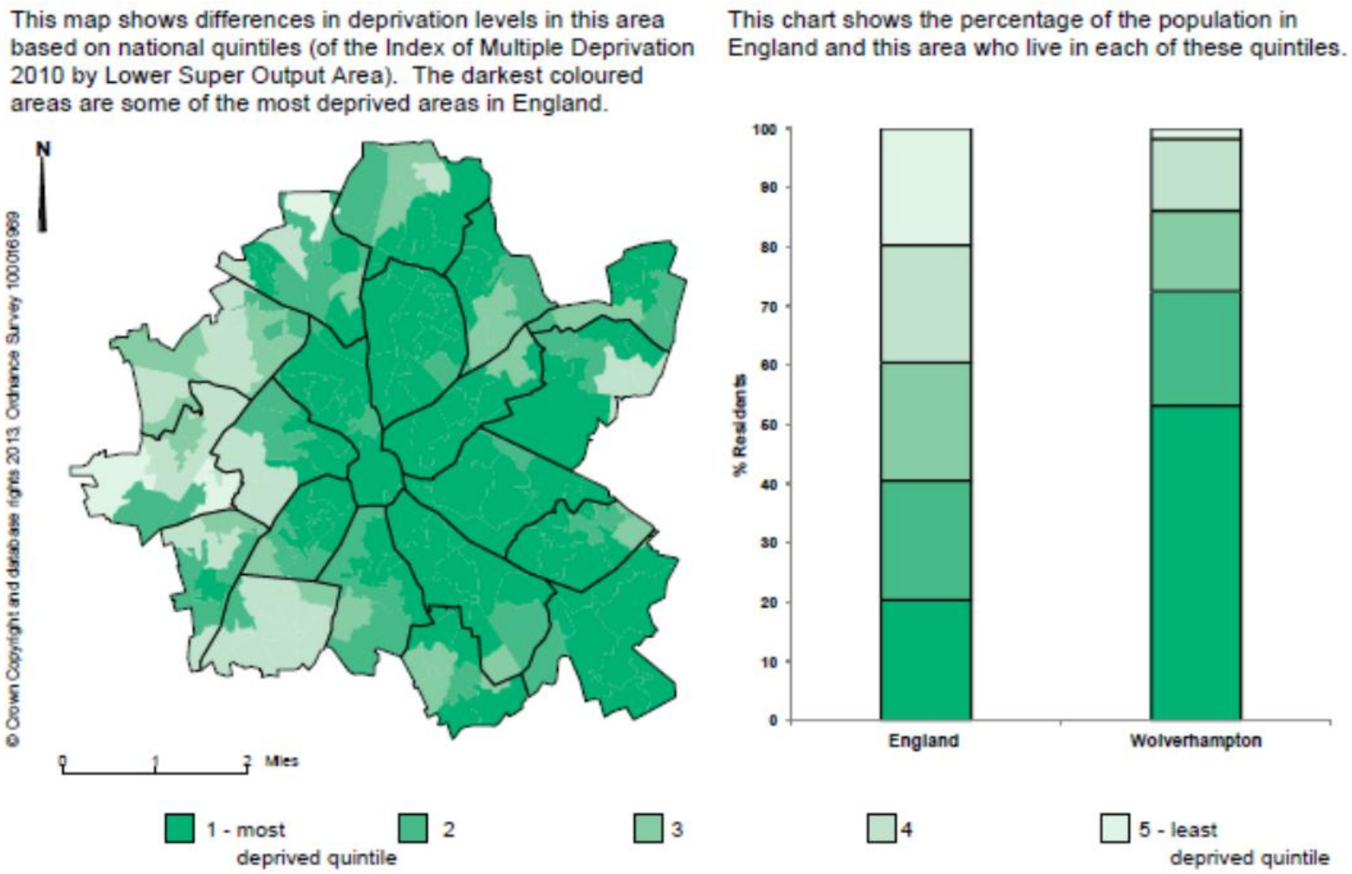


3.3 This suggests that the relocation of Showell Park walk-in-centre to a facility at New Cross (also shown on the map) will have a disadvantageous impact on residents living in the vicinity, and to the immediate North and West of Showell Park. Residents living to the South and East of Showell Park will be closer to the new facility. The question then arises, what is the magnitude of this impact? A definitive answer can not be given, but we can look for some clues in the demographic information we have available.

## Demographic Information

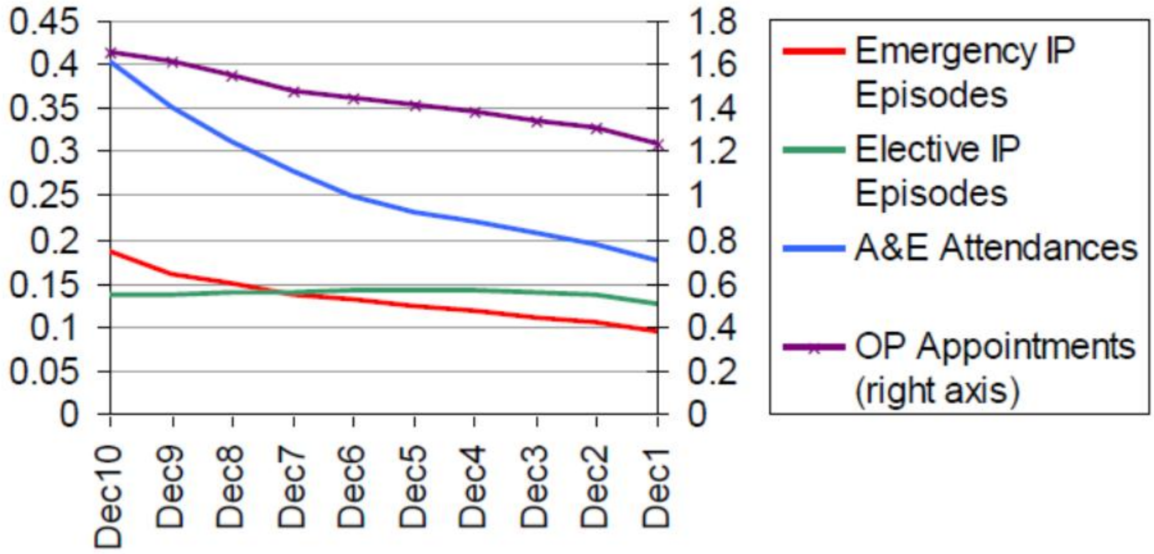
3.4 The use of urgent and emergency healthcare services is inextricably linked to socio-economic factors and particularly to deprivation. Wolverhampton has high numbers of people living in deprived areas when compared to the figures for England – Figure 3.

**Figure 3 – Map of Deprivation in Wolverhampton (Public Health England 2013)**



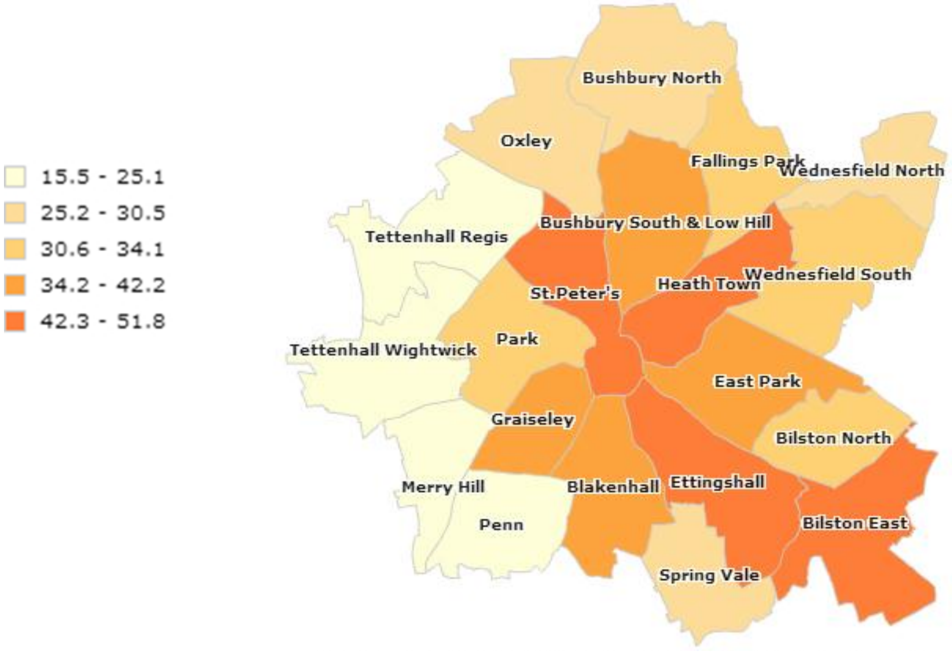
3.5 Figure 4, below, shows that while the number of elective admissions per head is broadly similar across all deprivation deciles, more deprived areas have more emergency inpatient admissions per head than less deprived areas. In this national study, A&E attendances from Decile 10 were more than double that from Decile 1 and show a steeper incline from Deciles 6 through to 10. Although these figures are for England in 2012 the authors contend that this finding is stable year on year, and it is reasonable to conclude that the pattern in Wolverhampton is highly likely to be similar. Monitor (2014;p39) has found from primary research that “*people from lower socio-economic groups tend to be the most common users of walk-in centres*”. The significance for the analysis is that geographic variation in deprivation will influence the use, not only of A&E, but the new Primary Care Centre and the retained Phoenix Walk-In-Centre.

**Figure 4**
**Emergency and elective inpatient episodes for England, A&E attendances and outpatient appointments per head of population by deprivation decile (10 is most deprived, 1 is least deprived), patients of all ages (McCormick et al; 2012)**



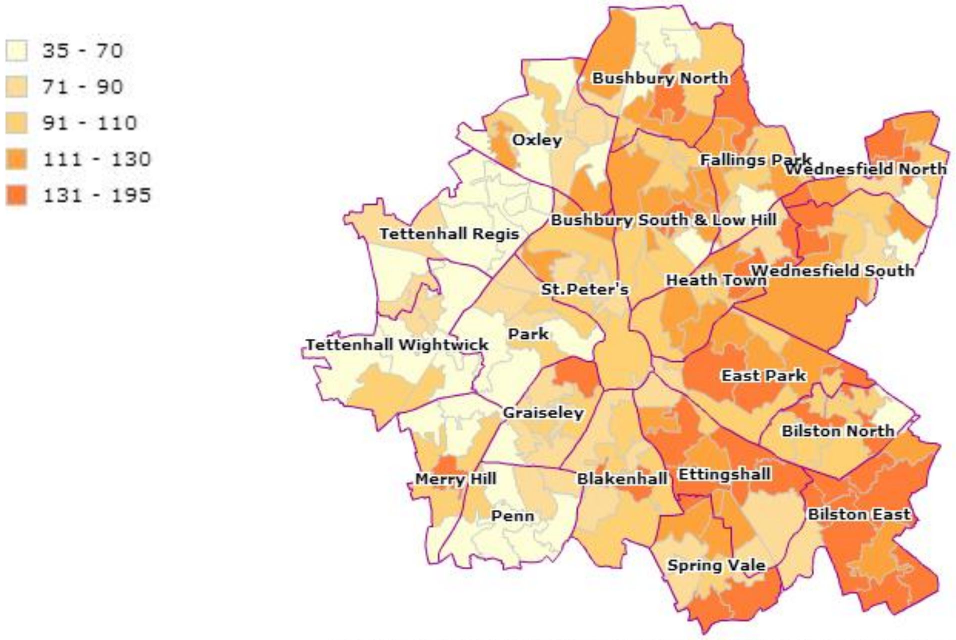
3.6 The following maps highlight some of the indicators of health and wellbeing which may have a contributory effect on the impact of relocating Showell Park.

**Figure 5: % of households with no car or van – 2011 (Wolverhampton City Council 2013)**



3.7 Figure 5 patterns of car ownership suggests that people living in St Peter's, Bushbury South and Low Hill wards are likely to experience most disbenefit because of an apparent reliance on other people for their transport needs – either public transport or lifts from friends, relatives. People in Heath Town and Wednesfield South (where car ownership is low) will be closer to the new Primary Care Centre at New Cross. Implementation plans should consider access to public transport networks for those people who need to travel further from these and other wards in the North of the City, particularly during the transition to discernible improvements in primary care.

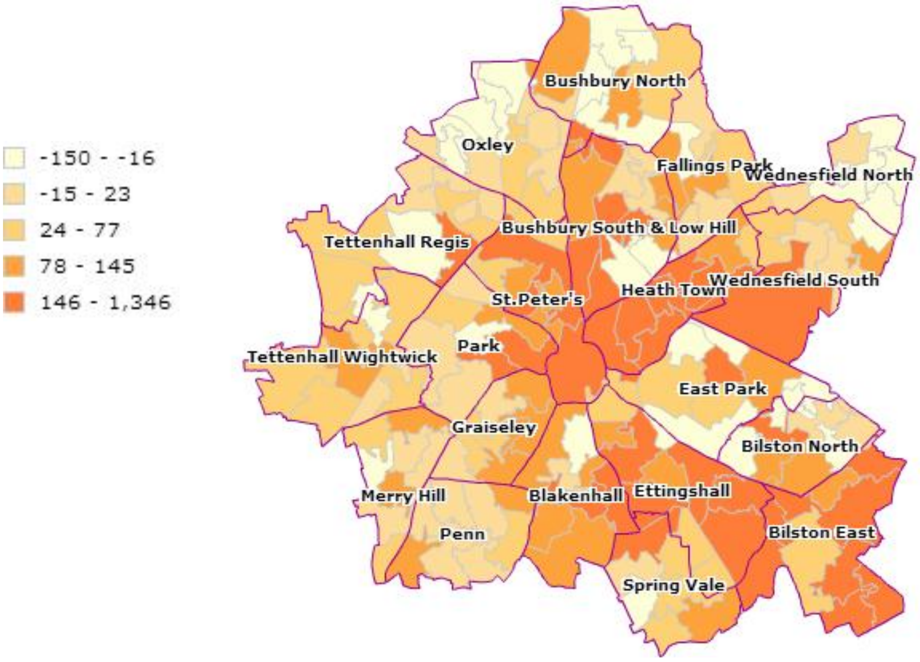
**Figure 6 – Number of people who claim Disability Living Allowance (DLA) (Feb 2013) (Wolverhampton City Council 2013)**



3.8 Figure 6 shows that the pattern for people who claim DLA (now being replaced by Personal Independence Payment (PIP) for over 16s and under-65s). DLA provides some money to eligible claimants as a contribution to extra costs caused by long term ill-health or disability. People needing DLA are less likely to be independently mobile, and more reliant on carers. The distinct skew of the pattern for higher levels of DLA claimants in the East of the Borough suggests that the relocation of the Walk-In-Centre facility to New Cross will be closer to a greater proportion of people with mobility difficulties and their carers.

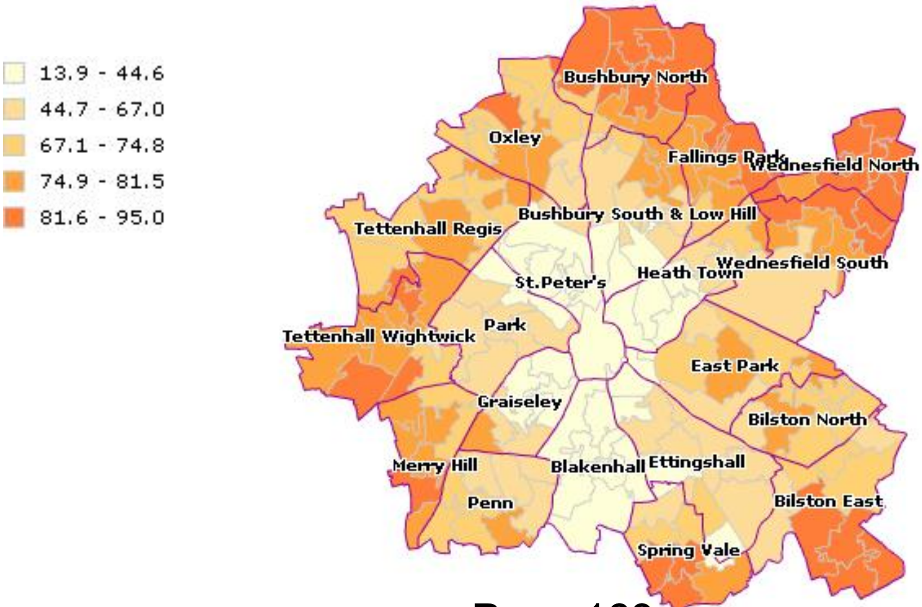
3.9 Figure 7 below shows the total change in population in the 10 years between the last two censuses (in 2001, and 2011) and indicates significant increases in the south-east and the east of the City. The relocation and siting of Urgent and Emergency Care services at a new purpose built centre at New Cross is consistent with the strategic intention to increase accessibility for patients – certainly if the proximity to the changing demographic of Wolverhampton residents is taken into account.

**Figure 7: Change in total population between 2001 and 2011 (Censuses 2001, 2011)**



3.10 Figure 8 shows the pattern of minority ethnic groups in the City area, based on Census 2011 information and using the descriptor of ‘the % of residents who are White British’. In this map therefore, the ***darker*** the shaded area, the greater the proportion of White British people who are resident in the area. The pattern for minority groups correlates closely to the map of deprivation in Figure 3 above. The relocation of the Walk-In-Centre from Showell Park will mean that the facility is further away from patterns of residence for minority ethnic groups and there are likely to be people in these groups who are inconvenienced because of the move. It has not been possible to quantify this disbenefit however, nor to estimate any compensating benefits – eg those arising from the reduced duplication between Showell Park and A&E patient visits. Residency analysis also ignores any in-borough mobility for work, volunteering, or social visits.

**Figure 8: Population % of residents who are White British (Census 2011)**



## Conclusion on the relocation of Showell Park

3.11 Because of the complexity of variables arising in the statistics and data available, it is difficult to make a cogent and assured assessment of the overall impact on protected characteristic groups and whether, on balance, the impact is differentially negative, or positive. There are competing claims – eg the closure of Showell Park will definitely inconvenience some people and extend travel times. Patterns of residency suggests that this will impact more negatively on poorer and minority ethnic groups in the City. However, it has not been possible to quantify this. Furthermore patterns of residency do not offer information about where people are located day-to-day – in work for example – and where they are most likely to access urgent care facilities from? The discussion above has also offered some possible arguments for benefits for some groups. And the apparent reduction in duplication between sites (which impacts negatively on other patients through less available consultation/treatment time) is an obvious benefit of co-locating facilities.

3.12 Offering conclusions on the magnitude of benefits and disbenefits would be speculative. Disbenefits may well be out-weighed by improvements in the system – especially if primary care improvements mean that people will be able to access their GP and attendant primary care services more easily, in their own locality and with a wider range of services available.

3.13 **Conjecture and uncertainty in modelling means that it can not be argued that there is any discernible differential impact overall (positive or negative) on any protected characteristic groups. Because of limited data collected by providers about usage patterns [see section 6 below] it is not possible to detect any spikes or gaps in service reach. If the vision for urgent and emergency care (including primary care improvements) is realised then all patients should benefit from improvements**.

# 4. Equality considerations for services

## Introduction

4.1 Urgent and emergency care services should be prepared to provide for all citizens. Because services here are often provided at a time of heightened distress, and imminent danger to the wellbeing of patients, it is right that the focus of attention should be on the immediate health care needs of each person, and that healthcare staff (and patients) do not feel encumbered by unnecessary burdens of bureaucracy and form-filling, or in undertaking equality assessments which prove to be irrelevant to the ‘core business’ of patient care.

4.2 This section of the report – set out in **Table 2** below - considers the operation of services and how these impact distinctly on different protected characteristic groups to demonstrate how a consideration of diverse needs in planning and organising urgent and emergency healthcare can offer much improved experiences and outcomes for patients, as well as improving the working environment for staff.

4.3 Following a consideration of the challenges for service provision for each protected characteristic group in an urgent care context, this section then considers the challenges in the care of other groups not covered by the Equality Act 2010, and the key structural challenges to service reconfiguration which have an impact on all patients.

**Key to Table 2**

<table>
<tr><th colspan="2"><b>Protected Group =</b> <i>Group as defined by the Equality Act 2010</i></th></tr>
<tr><th>Potential Impact</th><th>Opportunity/Risk Mitigation</th></tr>
<tr><td><i>Impact as discerned from available evidence. Full reference list given at back of this document</i>.</td><td><i>The opportunities available in service design and operations, and the potential for reducing risks through acknowledgement of the needs of different protected characteristic groups.</i></td></tr>
<tr><td colspan="2"><b>Local Issues</b></td></tr>
<tr><td colspan="2"><i>The issues arising from the consultation, the equality survey of organisations, local research or studies, and stakeholder comments received</i>.</td></tr>
</table>

**Table 2 - Protected Characteristic Groups**

| **Protected Group** | **AGE – Older People** |
|---|---|
| **Potential Impact** | **Opportunity/Risk Mitigation** |
| The number of older people (65 year and above) living in the city has increased to 40,600 from 40,000 in 2001, a +1.5% increase. This represents 16.2% of the population, close to the English average of 16.5% but lower than that for the West Midlands (17.2%).<br>The growing elderly population and the prevalence of long term conditions represents a significant challenge to health and social care services. Older people are significantly high users of A&E.<br>**No discernible negative impact, but important issues to consider at implementation for improvements in service delivery. Positive impacts are contingent on improvements to primary/secondary care.** | Opportunity to consider accessibility to specific facilities as they are developed for **older people**; and to consult. NHS 111 pilots' usage data indicates high use of the service for patients aged over 80 when compared to the average use (DH 2012; p18). This is a potential beneficial use of technology as part of the overall integration of services. However please note that Older people also appear to be reluctant to use the telephone to access out-of-hours care (DH 2012; p20).<br>Standards and recommendations for the care of older people in urgent care settings are set out in the 'Silver Book' (2012) along with specific recommendations for primary care, Emergency Departments and Urgent Care units. Example recommendations from the Silver Book are:<br>**Rec 15**. There should be a distinct area in Emergency Departments which is visibly and audibly distinct, that can facilitate multidisciplinary assessments.<br>**Rec 16** All units should have ready access to time critical medication used commonly by older people such as Levo-Dopa.<br>**Rec 17** If a procedure is required for a person who is confused, two health care professionals should perform the procedure, one to monitor, comfort and distract, and the other to undertake the procedure; carers and/or family members should be involved if possible; cutaneous anaesthetic gel should be considered prior to cannulation, particularly if the person is confused.<br>**Rec 18**. All urgent and emergency care units should have accessible sources of information about local social services, falls services, healthy eating, staying warm, benefits and for carers of frail older people.<br>**Recommendation: Provider organisations should consider adoption of the Silver Book recommendations as appropriate for their areas of service**. |
| **Local Issues** | |
| Feedback from respondents to the Urgent Care Equality Survey (Appendix 2) offered issues for consideration by provider organisations. These include – Long waits for ambulances (sometimes two arrive); Triage phone management for access to ambulances needs to be more responsive to the needs of older people; Some issues of dignity – overly familiar use of first names without seeking permission first; concerns over inadequate facilities for the care of elderly patients; concerns that elderly people are not given appropriate priority and appropriate, timely care; long waiting times in A&E are particularly difficult for elderly patients, especially when having to sit for long periods when they need to lie down; communication with community services requires improvements; a suggestion that understanding of palliative care in A&E would help to ensure a safe discharge for patients; generally recognition that staff are caring but that time constraints force a focus on the presenting problem without seeing the whole picture for patients. | |

| Protected Group | AGE – Younger People |
|---|---|
| **Potential Impact** | **Opportunity/Risk Mitigation** |
| Monitor (2014, p39) found that younger people are the predominant users of Walk-in Centres, with people between 16 and 45 attending at higher rates than other age groups and those in the 25 to 34 year age bracket (23%) and the 16 to 24 age bracket (16%) were the most commonly attending patients. (Monitor patient survey report)<br>Local figures for Showell Park in 2011/2012 show that the 0-5 age group were the largest group of users. Walk-In-Centre analysis in 2012 showed a significant increase in use by the 0-5 and 21-25 age groups.<br>**No discernible negative impact, but important issues to consider at implementation for improvements in service delivery. Positive impacts are contingent on improvements to primary/secondary care.** | Opportunity to consider accessibility to specific facilities as they are developed for young people and parents with young children and to consult. NHS 111 pilots' usage data indicates high use of the service for patients aged 0 to 4, when compared to the average use (DH 2012; p18). This is a potential beneficial use of technology as part of the overall integration of services.<br>The Royal College of Paediatrics and Child Health RCPCH (2012) have published 'Standards for Children and Young People in Emergency Care Settings' developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings. Example standards set are:<br>**Section 6 - Staffing and Training issues**<br>**Standard 1:** Nurses working in emergency care settings in which children are seen require a minimum level of knowledge, skill and competence in both emergency nursing skills and in the care of children and young people.<br>**Standard 9:** Emergency care settings seeing more than 16,000 children per annum employ a consultant with sub-specialty training in paediatric emergency medicine<br>**Section 4 - Environment in emergency care settings**<br>**Standard 1:** Emergency care settings accommodate the needs of children, young people and accompanying families and comply with DH 'You're welcome' and HBN 22 standards' (NB now superceded by HBN 15-01: Accident and Emergency Departments Planning and design guidance (Department of Health, April 2013)<br>**Recommendation: Provider organisations should consider adoption of the Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings (as appropriate) for their areas of service** |

## Local Issues

Difficulties reported in obtaining same-day GP appointments for young people; some young people reporting that they feel that they are not listened to by their GP, and that some issues are pre-judged (eg: self-harm); privacy and dignity is not always respected. Suggestions for improvements include: more accessible appointments with GPs; more support for issues such as self-harm; and an idea for specific surgeries once a month for young people to discuss issues and access treatment. View expressed that it is a myth that young people do not want to access services. This needs to be broken.

| **Protected Group** | **DISABILITY GENERAL ISSUES** |
|---|---|
| **Potential Impact** | **Opportunity/Risk Mitigation** |
| The coherent integration of pathways across health and social care is a recurring concern nationally for patients with a disability and for carers.<br>Physical access to facilities, and the availability of suitable equipment to meet the specific needs of people with different disabilities (particularly when emergency treatment is required) also figures prominently.<br>**No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase.** | There is an opportunity to consult people with disabilities – both directly and through representative organisations as part of the continuing consultation and particularly during the implementation phase; to consider accessibility improvements for people who have mobility problems, and/or who use mobility aids; for visually impaired people (colour schemes, and signage); Hearing impaired people and communication options generally.<br>**Recommendation: Both commissioner and provider organisations should ensure that representatives from the Wolverhampton People's Parliament (part of the Changing Our Lives charity which supports people with disabilities of all ages) see www.changingourlives.org** |

## Local Issues

There was a demand during the consultation for information on the impact of the proposed changes on the Eye Infirmary, including its connectivity to the new emergency centre. There is an expectation that the services should be linked or co-located in order to make it easier for eye care patients to travel between the two. This should be supported with clear and accessible information. Healthwatch Wolverhampton expressed the view that more needs to be done to clarify care pathways for ophthalmology urgent care patients.

**CQC (2013)** commented "We found that the Trust had recently introduced good systems so that most patients could now be treated in A&E without having to be sent to the eye department to access specialist eye care for treatment. **This is an example of effective treatment for patients in the A&E department.**"

| Protected Group | DISABILITY – LEARNING DISABILITY |
|---|---|

| Potential Impact | Opportunity/Risk Mitigation |
|---|---|
| Having a learning disability can increase anxiety and distress (adding to the patient’s vulnerability) as the individual may not understand why they are there or what to expect. Therefore it helps to make the situation as predictable as possible for the person – always letting them know what is happening. Consideration should be given to the appropriate reception and treatment for patients with a learning disability who arrive at an urgent care facility and to whether staff are sufficiently trained to safely discern the person’s needs; to communicate effectively with the patient and their carer(s); and to ensure the best possible patient experience.<br>**No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase, and specific consideration given to pathways for people with a Learning Disability.** | **Royal College of Nursing (2013); Dignity in Health Care for People with Learning Disabilities (2nd edition) [London]**<br>**“I was in a ward and a patient was screaming. Nobody did anything. I was scared” p14**<br>The RCN publication offers excellent and useable examples of good practice. Commonly reported experiences for people with learning disabilities include:<br>• Discrimination<br>• Assumptions being made about individuals with no assessment<br>• Lack of communication with the individual and their carers<br>• Difficulty in accessing services<br>• Staff with a lack of knowledge and skills in learning disabilities<br>• Abuse and neglect<br>This document can be used to pose questions for the urgent and emergency care pathways for people with a learning disability and to consider scenario testing.<br>**GAIN (Guidelines and Audit Implementation Network, June 2010): Guidelines on Caring for people with a Learning Disability in General Hospital Settings (Northern Ireland)**<br>This document proposes that: ‘Staff within emergency care departments should develop a specific care pathway/protocol for identifying and caring for patients with a learning disability.<br>**Bradley and Lofchy (2005) ‘Learning Disability in the accident and emergency department Advances in Psychiatric Treatment 2005, 11:45-57**<br>“An A&E department is generally a strange and unfamiliar environment for anyone. For people with learning disabilities, the experience may be particularly frightening because they may understand even less what is happening around them. Getting to A&E may also have been traumatic, for both the person and the family or care providers. Waiting can be anxiety provoking and contribute to behavioural disturbance” (p 47) |

| Protected Group | DISABILITY – LEARNING DISABILITY - CONTINUED |
|---|---|

| Potential Impact | Opportunity/Risk Mitigation |
|---|---|
| **No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase, and specific consideration given to pathways for people with a Learning Disability** | Work undertaken in Lincolnshire in 2011 demonstrated that people with learning disabilities, although a small percentage of the population (0.3%), accounted for 6% of the Accident and Emergency budget. Over the next 20 years we will see a doubling in the number of people with learning disabilities. (ADASS 2013; p6**)**<br>**Public Health England (2013a) Learning Disabilities profile for Wolverhampton**<br>This document explains (at page 3) that the emergency hospital admissions (in 2009) for people with a learning disability were significantly worse than the England average. Identification of people with a learning disability in general hospital statistics was similarly poor. Administrative changes in access to hospital episode statistics means that PHE were unable to update these indicators for 2013. Adults with a learning disability known to GPs was significantly higher than the national average however the proportion having a GP health check was significantly worse.<br>**Recommednation: Commissioner, and Provider organisations should work collaboratively to improve the data collection mechanisms for use of emergency care by people with Learning Disabilities and publish these regularly. Providers should consider using the RCN and the GAIN publications (particularly where these offer recommendations for emergency settings) as part of their equality analysis of facility design and pathway development.** |

## Local Issues

The lack of current, accurate statistical information about emergency care for people with a learning disability means that further exploration is required, with the objective of improving data collection mechanisms. At the time of preparing this report the local Learning Disability Self Assessment Framework (LD SAF) for Wolverhampton 2013 was not available.

CQC (2013) refer (p18) to a listening event conducted with patients during the September 2013 inspection of New Cross Hospital: "..people spoke to us about delays in treating family members with learning difficulties and autism." This echoes the feedback received from the equality survey of organisations. The hospital has recognised this and the CQC reported that staff now prioritise these patients to reduce any distress caused by waiting.

**Recommendation: Commissioner and Provider should monitor the effectiveness of this prioritisation and evaluate through further listening events to inform improved practice.**

| Protected Group | DISABILITY – MENTAL HEALTH |
|---|---|

| Potential Impact | Opportunity/Risk Mitigation |
|---|---|
| Concern has been expressed in a number of reports regarding national reconfigurations about mental health emergency care and the joint working between services not receiving adequate attention – please see this link .<br>**No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase, and specific consideration given to pathways for people with mental health problem.** | **The College of Emergency Medicine (Feb 2013); 'Mental Health in Emergency Departments – A toolkit for improving care' [College of Emergency Medicine, London]**<br>The core principle of Mental Health in the Emergency Department:<br>**"A patient presenting to ED with either a physical or mental health need should have access to ED staff that understand and can address their condition, and access to appropriate specialist services, regardless of their postcode, GP, or time of arrival." (p2)**<br>**"Does the education and clinical knowledge of your staff in mental health match that for major trauma, cardiac arrest…?" (p2)**<br>CEM standards for mental health are set out at page 15 and include: 1. Patients who have self-harmed should have a risk assessment in the ED; 2. Previous mental health issues should be documented in the clinical record; 6. From the time of referral, a member of the mental health team will see the patient within one hour...". Plus strong links with Community Mental Health Teams are advocated including **"Involvement in each other's induction programme really helps to improve response times and flow of service. For the pure psychiatry trainees or staff grades, they may have no knowledge of the ED's clinical standards or time requirements. Equally, we need to understand the competing pressures that exist in mental health"** (CEM, p11).<br>Care plan management involving multi-disciplinary teams for substance and mental health for patients who will benefit from a consistent response.<br>**Recommendation: Commissioner and providers consider a planned move towards adoption of the CEM standards over an agreed and realistic period of time.** |

## Local Issues

CQC (2013) expressed concern about the safety of mental health patients at New Cross Hospital and the deprivation of liberty. There were also concerns about the delays in mental health trust staff reaching A&E.

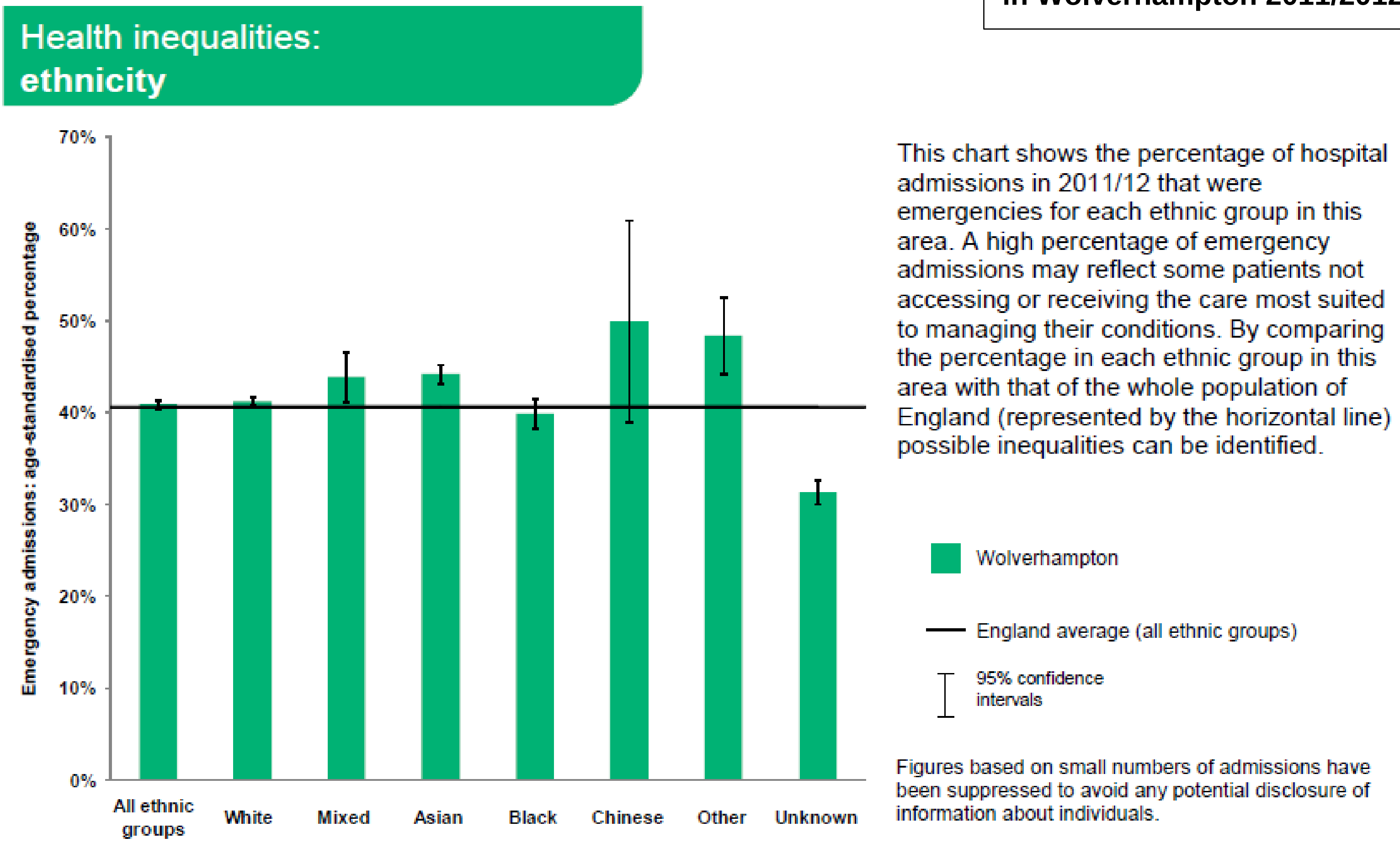
The Equality Survey of organisations identified concerns about practitioners being unable to "differentiate between psychosis and being under the influence" (ie of drugs or alcohol, particularly following self-medication). Requests for better mental health training for front line staff, but also timely follow up through after care services are seen as wanting.

Bishop (2013) recommends that the Local suicide prevention strategy needs to include specific support for Lesbian,Gay, Bisexual and Transgender people

Survey response from The Haven (which supports individuals who have been victims of violence and abuse) strongly advocating the long term funding of an Independent Domestic Violence Advisor to be based within the local emergency department and offer valuable preventive and cost effective support.

| Protected Group | RACE |
|---|---|
| **Potential Impact** | **Opportunity/Risk Mitigation** |
| Wolverhampton's Black and Asian Minority Ethnic (BAME) population has increased significantly since the 2001 Census and now represents over one third of the population at 35.5%.<br>Nationally, the Afiya Trust *s*uggests that "many minority ethnic communities have poor access to health and social care services for a variety of reasons including language barriers, lack of awareness/information, social isolation, lack of culturally sensitive services and negative attitudes about communities". (Afiya Trust 2010)<br>Impact analysis is hampered by the lack of good equality monitoring information for ethnicity.<br>**No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase..** | **Hull, S; Mathur,R; Boomla,K (May 2011):**<br>**"For general practice this means developing robust counts of ethnicity at practice level and using the data to monitor access and service utilisation. This is particularly important in urban areas which tend to be most ethnically diverse and where population mobility is greatest…At the local level one of the primary purposes of collecting ethnic category data about patients is to establish whether services are meeting the needs of different ethnic groups in the community and to assist future planning of service provision."**<br>Monitoring of ethnicity locally, in Wolverhampton, is poor and can be improved.<br>The figures for minority ethnic respondents to the urgent care consultation were low and so there are opportunities to consult different minority ethnic groups as part of the urgent and emergency care implementation phase – both in 'mainstream' consultation events and through dedicated outreach work. This should include a review to consider if appropriate interpreting facilities are available at some consultation events for patients whose first language is not English. Commissioner's service specifications and procurement process may wish to highlight public sector equality duty and set contractual information requirements on providers to demonstrate how they comply with statutory provisions. Provider opportunities to consider workforce development and talent management, recruitment , and promotion of equal opportunity policies.<br>**DH (June 2011) A&E Clinical Quality Indicators; Best Practice Guidance for Local Publication**<br>"25. Organizations are also encouraged to use the richness of their A&E data to analyse and present data that can be disaggregated by the equality protected characteristics defined by the Equality Act 2010 (for example, presenting data for different age, gender and ethnic groups where available); and to explore presenting their data in a way that aids understanding of the issues affecting particular clinical groups (for example, investigating attendances for patients with mental health issues)."<br>**NHS Scotland Information Services Division (ISD)  in their AE2 'A&E data recording reference manual (October 2013 v2.0) includes as potential data items: ethnicity, religion, sexual orientation.**<br>**Butler, Christina, Hatzidimitriadou, Eleni and Psoinos, Maria (2010)** put a cogent case for the benefits of ethnic monitoring. |

**Figure 9: emergency hospital admissions in Wolverhampton 2011/2012.**

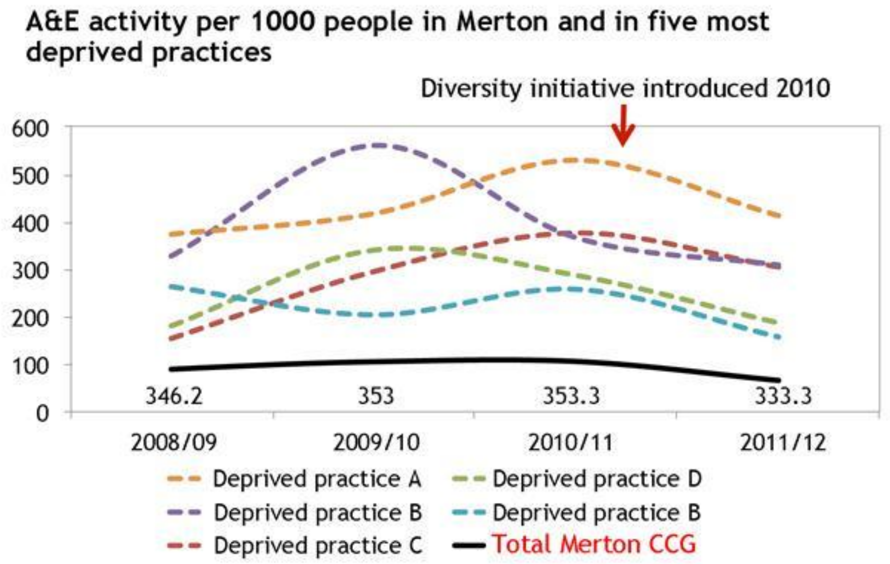


This chart shows the percentage of hospital admissions in 2011/12 that were emergencies for each ethnic group in this area. A high percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. By comparing the percentage in each ethnic group in this area with that of the whole population of England (represented by the horizontal line) possible inequalities can be identified.

Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

FROM: **Public Health England (2013b) Wolverhampton Health Profile** (published 24th September 2013) available at: http://www.apho.org.uk/resource/view.aspx?RID=127042

This chart also emphasises the need for better equality monitoring and work to advance the issues identified by the Joint Urgent and Emergency Care Board around gaps in equality monitoring **(please see the Recommendations for DATA in section 7)**



A&E activity per 1000 people in Merton and in five most deprived practices

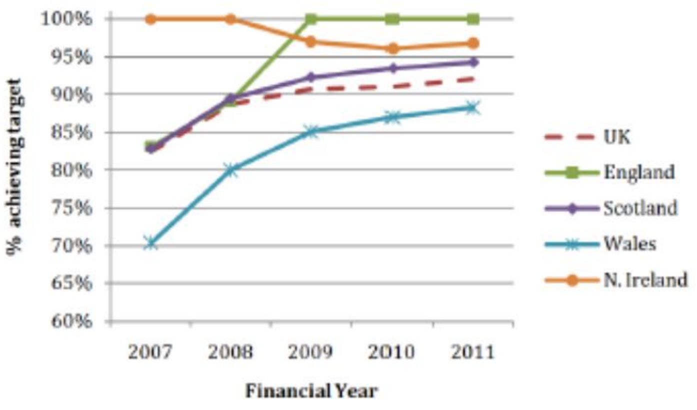
**Ford A et al (2013) Cutting A&E use and health inequalities. Nursing Times; 109: 24, 14-16**

People from migrant communities may not use primary care because the services , expectations and payment requirements are very different in their country of origin. They may not feel comfortable communicating in English or they may feel embarrassed about health issues. 2 strangers in the room can accentuate these feelings (Health Care Professional and an interpreter). They may think that using A&E or urgent care services is easier or more appropriate without realising that there are other options.

The work in Merton (see adjacent figure) has been successful, breaking into the cycle of inequality and changing the way in which A&E services are used including reduced A&E activity in the 5 most deprived ward areas.

In Wolverhampton, the health profile shows that, at the very least the statistics suggest that there are cues for further exploration.

Figure 1. Proportion of UK practices achieving 100% ethnicity recording for all newly registered patients



*Graph produced using freely available NHS data[87], Data for UK and Wales missing values for 2010

**NCRM – National Centre for Research Methods (March 2013) 'Availability and use of UK based ethnicity data for health research (Working Paper 1/13)**

P9 'When hypothesising about and interpreting the mechanisms through which ethnicity is related to health, it is essential to be clear that health outcomes are determined by factors associated with ethnicity, not ethnicity itself. The distribution of these factors, such as genetic influences, socio economic deprivation, migration status, cultural practices, and lifestyle manifest unequally in different population groups and can be conceptualised, broadly, as ethnic differences."

P13 The recording of ethnicity was removed from the programme in 2011(QOF under GMS) and now relies on an expectation that this will be recorded by GPs.

| Protected Group | RACE - CONTINUED |
|---|---|

| Potential Impact | Opportunity/Risk Mitigation |
|---|---|
|  | **Lawrenson,R et al (1998)** offers a useful general conclusion that ethnic origin is recorded but not on every patient; recruitment of staff from ethnic minorities may require positive action; formal training in place for staff to gain an appreciation of issues facing patients from ethnic minorities; interpreters and written materials. Although this paper is from 1998, the issues it identifies are still pertinent to the situation now. |

## Local Issues

No specific local issues have been identified around race (ethnicity) and urgent and emergency care services. The Equality Survey of organisations did not express any concerns around discriminatory practice. However equality monitoring of ethnicity for service use is poor, and ethnicity recording for complaints information is similarly weak.

**Recommendation: Equality monitoring mechanisms need to be improved.**

| Protected Group | RELIGION |
|---|---|
| **Potential Impact** | **Opportunity/Risk Mitigation** |
| **No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase** | Opportunity for providers to consider workforce composition and planning as local populations change, and to consider the cultural sensitivity of services provided.<br>Religion is increasingly being recognised as an important signifier of customs and traditions which may have a bearing on health and prevalence of ill-health (for example dietary habits). It can also help, in consideration alongside data on race (ethnicity), to identify physical, cultural, or behavioural barriers to accessing health and social care services. There are sometimes concerns expressed about the work required to capture and analyse such information and whether or not it is proportionate. However, provider organisations are subject to the public sector equality duty and need to demonstrate that they are eliminating discrimination, and minimising disadvantage across all protected characteristic groups. This information can also usefully be compared to a provider's workforce data (for race and religion) to demonstrate if the composition of the workforce reflects the communities it serves? The absence of any robust local data here does not allow for any form of analysis.<br>Useful resources include:<br>**Northern Ireland inter-Faith Forum (2005) 'Check up - A guide to the special healthcare needs of ethnic-religious minority communities' and the guide by the Department of Health (January 2009).** The DH guide identifies the important role that Chaplains and spiritual care givers have in the planning (as well as the delivery) of urgent care. |

## Local Issues

None identified but caveat that information collection mechanisms are poor.

**Recommendation – included in a general recommendation about equality monitoring and data collection.**

| Protected Group | SEXUAL ORIENTATION |
|---|---|

| Potential Impact | Opportunity/Risk Mitigation |
|---|---|
| Although no specific issues have been identified with the case for change in Wolverhampton; Issues have been identified nationally with same sex partners not having easy access to loved ones in emergency/urgent circumstances, or not being included in consultations in the same way that heterosexual couples/married partners would.<br>**No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase** | Opportunity to gather further evidence from Lesbian, Gay, and Bisexual and Transgender (LGBT) groups locally/regionally to see if anecdotal reports of poor experiences can be addressed.<br>**Bishop, M (2013) ‘Out in the City – exploring the experience and needs of Lesbian, Gay, Bisexual and Trans People in Wolverhampton’ [LGBT Network Wolverhampton and Wolverhampton City Council, Wolverhampton]**<br>Section 2.11- “Just over 34% respondents did not feel Wolverhampton hospitals were meeting the needs of LGB and T people; 11% felt they did, 55% had never used hospital services in Wolverhampton.”<br>Section 2.12 – significantly higher numbers of LGB and T people who self harm, contemplated suicide, or attempted suicide. **(NB link this finding to the College of Emergency Medicine (2013) p 15 – CEM standards for mental health included 1. Patients who have self-harmed should have a risk assessment (in the ED).**<br>**Stonewall (2008) ‘Serves You right: Lesbian and gay people’s expectations of discrimination [Stonewall, London]**<br>Stonewall describes staff comments and antagonistic attitudes in response to current affairs stories or radio news openly discussed in front of patients:<br>**“The surgeon said he thought it ridiculous that gays could now get married and what on earth was the world coming to recognising this type of union. He went on to ask his assistant if she realised gays could adopt as well, he thought it outrageous.”**<br>[Conversation overheard by a lesbian patient during treatment to reattach nerves in her finger (Stonewall, 2008;p15).<br>**Stonewall recommendations: dignity and respect. ‘Health providers should inform all staff that discrimination on the grounds of sexual orientation is unlawful and that the GMC can stop Doctors from practising if they discriminate against lesbian and gay people (Stonewall, 2008, p20).** |

## Local Issues

The work by Bishop (2013) and the LGBT network offers the most recent and comprehensive survey of LGBT service users although no specific questions are included about urgent and emergency care. There are however important cues for further exploration including treatment of LGBT people in primary care; professional attitudes towards LGBT people; and staff training.

| **Protected Group** | **GENDER REASSIGNMENT** |
|---|---|
| **Potential Impact** | **Opportunity/Risk Mitigation** |
| **Patients who have stigmatising conditions can end up in urgent and emergency departments partly because of limited access to other health care services. Therefore inclusive policies, awareness and training are key to all provider operations.**<br>No specific issues have been identified in Wolverhampton, but anecdotal issues raised nationally with trans groups around courtesy of treatment, respect and dignity issues for a person's preferred identity.<br>**No negative differential impact identified at this stage. However this will need to be reviewed further at the implementation phase** | There are concerns in trans communities about recording gender reassignment status and the potential for identifying people where postcode information is also identified. Opportunity to engage further and for Providers to review policies for reception and treatment for patients and carers; and training for staff**.**<br>**ICD 10 (WHO International Statistical Classification of Diseases and Related Health Problems 10th Revision ICD-10 )** still lists at **F64 Gender identity Disorders** including F64.0 Transexualism and F64.1 Dual-role transvestism, whereas the APA DSM-V - the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders ' which may well influence the release of ICD-11 in 2017 has now moved away **from 'disorder' to 'dysphoria'**. This may have a positive impact on the treatment of transgendered individuals by removing the stigmatism of individuals having a 'disorder'.<br>A diagnosis of Gender identity Disorder implies that the problem lies within the patient, suggesting and setting a context for treatment that the patient needs to be cured or 'fixed' emotionally or mentally. The reclassification in DSM-V recognises the mental state that accompanies being transgendered within a society that stigmatises the condition. – ie the problem to be addressed is not the person's identity but rather the distress that is often experienced by those who need access to medical transition care.<br>**Transgender Patients: Implications for Emergency Department Policy and Practice (Journal of Emergency Nursing 2005; 31: 405-407)**<br>**"A young woman trauma patient has arrived in the emergency department. When her clothes are cut off, her breasts and male genitalia are apparent. Will the care she receives be influenced by this discovery? Ideally gender expression and identity should not make a difference in health providers' care delivery. But in reality negative attitudes and lack of knowledge can compromise the care of transgender patients."** (p405)<br>This scenario acts as a useful cue to ask an appropriate question of providers – how would such an individual be treated in your organisation? How do you know? |

## Local Issues

The work by Bishop (2013) and the LGBT network offers the most recent and comprehensive survey of LGBT service users although no specific questions are included about urgent and emergency care. There are however important cues for further exploration including treatment of LGBT people in primary care; professional attitudes towards LGBT people; and staff training.

| Protected Group | SEX |
|---|---|

| Potential Impact | Opportunity/Risk Mitigation |
|---|---|
| **No negative differential impact identified** | |

| Protected Group | PREGNANCY AND MATERNITY |
|---|---|

| Potential Impact | Opportunity/Risk Mitigation |
|---|---|
| **No negative differential impact identified** | **Recommendation: Access and mobility issues should be considered for visitors and ability for mothers to breastfeed; for parents to change babies as part of Providers' consideration of service use.** |

| Protected Group | MARRIAGE AND CIVIL PARTNERSHIP |
|---|---|

| Potential Impact | Opportunity/Risk Mitigation |
|---|---|
| **No negative differential impact identified** | No specific issues with plans for change. Issues have been identified nationally with same sex partners not having easy access to loved ones in emergency/urgent circumstances, or being included in consultations in the same way that heterosexual couples/married partners would. |

# 5. Groups not protected by the Equality Act 2010

5.1 There are some key groups which are not covered by the Equality Act but are vulnerable, often marginalised, and have a significant impact on health services.

## Homeless people

5.2 Wolverhampton City Council's Homelessness Strategy 2011-2014 identified that:

- 1 in 5 people suffer from mental health problems
- The suicide rates of homeless people are 34 times greater than the population as a whole.
- 80% of street homeless people are addicted to drugs or alcohol
- The life expectancy of someone who is street homeless is 42.
- Rough sleepers are 13 times more likely to be a victim of violent crime.

5.3 The number of homeless households in Wolverhampton is significantly worse than the England average (Public Health England Community Mental Health and general Health profiles 2013) despite successful homelessnes intervention strategies adoopted by the City Council.

5.4 Homeless people attend A&E up to six times as often as the general population; are admitted four times as often and once admitted, tend to stay three times as long in hospital as they are invariably more sick. As a result, acute services are four times, and unscheduled hospital costs are eight times those of general patients. Nearly 90% of all 'NFA – No Fixed Abode' admissions are emergency admissions compared to around 40% for the general population. (Deloitte Centre; p5)

5.5 Because of the trend in homelessness in Wolverhampton and the disproportionate impact of homelessness on the costs of health provision – particularly skewed towards urgent and emergency care – the implementation plans should involve social housing providers and homelessness organisations as part of an integrated approach. Further work may be required to identify any geographical disparities in the location of homelessness people; to research the health experiences of homeless people; and to explore the potential for more effective and earlier interventions to prevent or reduce ill-health and to respond more appropriately to their healthcare needs.

## Travelling Communities

5.6 The Equality and Human Rights Commission has stated:

> **"There is evidence that groups about whom very little research has been conducted, notably Gypsies and Travellers, asylum seekers and refugees, have particularly low levels of health and wellbeing. Those without fixed addresses, such as Roma, gypsies and travellers, asylum seekers and refugees, have difficulty in accessing services and their needs are often different and unknown."**
>
> (EHRC 2010)

5.7 Statistics for ‘gypsy or travelling communities’ are difficult to estimate. The Department of Communities and Local Government count of ‘Gypsy and Traveller Caravans’ from January 2013 suggests that 58 caravans are located within the City boundary – 40 are ‘socially rented’ and 18 are on land owned by traveller’s themselves. Reliable estimates of the number of individuals and their age profile have not been secured for this report.

5.8 It would be useful, through the Health and Wellbeing Partnership to explore ways to better understand the health needs of the Wolverhampton based travelling communities and how they access healthcare. However, any such work and the resource commitment will need to be proportionate. Anecdotal information about healthcare demands may offer an appropriate starting point.

## Migrants and Asylum Seekers

5.9 The Faculty of Public Health briefing (2008) states that:

> **“Asylum seekers are one of the most vulnerable groups within our society, with often complex health and social care needs. Within this group are individuals more vulnerable still, including pregnant women, unaccompanied children and people with significant mental ill-health” (p1)**

5.10 Newall (2013) explains that information on migrant populations can be obtained from a range of data sources, “however no one source is able to provide a detailed picture of all new migrants to the UK that have settled in the City.” He suggests that 3.8% of Wolverhampton’s population arrived from outside the UK in the past 5 years. This compares to 2.9% for the West Midlands Region. In 2011, 22.9% of primary school aged children and 18.5% of secondary school pupils in the City have a non-English first language (Regional averages are 18.9% and 13.8% respectively).

### Migrants registering for health services

5.11 Newall provides a useful summary for Wolverhampton:

> **“Migrant patients who have never previously registered with the NHS are given a marker for their first patient registration, known as a flag 4. Flag 4 registrations in the City are equivalent to 13 per 1000 of the resident population for 2010. This represents 3228 new migrant patient registrations in 2010-11, a negligible change from of from 2009-10 (3224), however it is an increase of over 700 new registrations per year from 2008-9. The Clinical Commissioning Group or Public Health department may be able to break this information down further info nationality, gender and age profiles by analysing patient registration data. The City has a higher level of new GP registration per 1000 residents than the West Midlands Region as a whole for 2010, which was 8 per 1000 of the resident population.”**

5.12 Understanding the process of GP registration for migrants, and for asylum seekers, and collating the statistics can offer useful information about the likely demands on primary care, and on urgent and emergency care. As Newall suggests, the CCG or Public Health Department may analyse patient registration data, and obtain more contemporary figures than those presented in this summary.

5.13 The Social Care Institute for Excellence (2010) publication 'Good Practice in social care for asylum seekers and refugees' though targeted at social care, has a useful set of principles from which urgent and emergency health care services could learn:

- A humane, person-centred, rights-based and solution-focused response to the [health] care needs of asylum seekers and refugees
- Respect for cultural identity and experiences of migration.
- Non-discrimination and promotion of equality
- Decision-making that is timely and transparent and involves people, or their advocates, as fully as possible, in the process.

# 6. Data Considerations

6.1 The collation of equality data is a pivotal stage in developing any equality analysis work in support of strategic decision making because from this, we can begin to build a picture of how responsive urgent and emergency care services are to patients from the different protected characteristic groups. Initial concerns were raised by the lack of equality information returned to Wolverhampton CCG (See **Table 3 below**), and so a letter was sent out to key provider organisations on 23rd October 2013, seeking replies by 25th November 2013. The tone of the letter acknowledged that there would undoubtedly be gaps in equality information but sought at this stage to explore with each provider organisation what was available, and any barriers they felt there were to collecting information. The letter (and its purpose) was discussed at the Joint Urgent and Emergency Care Strategy Board on 8th November 2013.

6.2 From the replies received from 3 provider organisations we have identified specific difficulties in the collection and analysis of equality information The main issues can be summarised as:

i. Partial information only about protected characteristics is collected – typically for age, gender and ethnicity only – although some limited information is available on Learning Disability. High 'not stated' returns (ie where patients have chosen not to state ethnicity) render analysis of some of this information as unreliable.
ii. No consistency in the type of equality questions being collected (eg for ethnicity one provider simply asks 'White', 'Black', 'Asian' 'Other').
iii. Providers have tended to be guided by the contractual requirements set by previous commissioners, rather than by any conviction that such information offers useful business or strategic information. Historically, Wolverhampton PCT did not ask for equality information returns as part of the contractual information requirements. This has led to a situation where minimal equality information is collected by rote, and analysis is very rarely undertaken.
iv. Where information is collected, it resides in several different systems, which makes collation and analysis, and consideration of 'whole system' services time consuming.
v. Concerns by Providers that a move to collect information about a wider range of protected characteristic groups will impinge on precious staff time and impact on waiting times for patients.

vi. Where there has been consistently high ‘not stated’ numbers from patients, there has not been any promotion among patients (or indeed healthcare staff) to explain to patients the rationale for collection, and to offer assurances about anonymity of information and use of aggregated (not individual) data. Among staff the value of equality monitoring does not appear to have been discussed, nor any support in helping staff to feel confident about asking for such information in a sensitive manner, and at an appropriate time.

6.3 In short, it appears that equality monitoring information is not being used, and is not considered, organisationally, to be useful.

6.4 Providers have valid concerns about the potential resource commitment required to collect, collate and analyse equality monitoring data and the impact on waiting times. It is also the case however that NHS Trusts, and 3rd party suppliers are bound by the public sector equality duty in s149 Equality Act 2010 which requires them to eliminate discrimination and show due regard to minimising disadvantage for the protected characteristic groups: age; disability; race; religion/belief; sex; sexual orientation; gender reassignment; pregnancy and maternity; and marriage and civil partnership. In order to demonstrate compliance with these provisions, each organisation will need to understand something about the different patients it serves, and so collection of equality information is a necessary first step. As stated in the letter to providers:

> **“Wolverhampton CCG and the Joint Urgent and Emergency Care Board ... recognise that such information may not be readily available and that a number of information repositories may need to be interrogated in a variety of ways. We also understand that extracting such information may be considered to require disproportionate effort when compared to how useful it is. We do not wish to create unnecessary burdens on our partner organisations. If you consider that acquiring some information would be too onerous, then please share with us what these barriers are.”**

6.5 To develop these issues further, the Senior Equality and Diversity Manager of Midlands and Lancashire Commissioning Support Unit is working with the Head of Contracting and Procurement at Wolverhampton CCG on the following:

i. Reviewing the equality information and assurances offered by intending providers in PQQs (Pre Qualification Questionnaires); service specifications, and contractual information requirements.
ii. A standing item of ‘equality monitoring’ at each Data Quality Review Meeting.
iii. Once barriers have been addressed - seeking to secure an agreement across Joint Commissioning partners and Provider organisations to collect equality information in a consistent way which offers comparative analysis between organisations, and with population data (for example using Census 2011 categories as a starting point, but adapted to reflect local needs and demands

**Table 3 - Summary of equality data received by WolverhamptonCCG from providers**

| | Admissions | A & E | Phoenix Centre | Showell Park | Primecare | PALS | 111 | WMAS |
|---|---|---|---|---|---|---|---|---|
| **Age** | Y | Y | Y | Y | Y | N | N | N |
| **Sex** | Y | Y | Y | N | Y | N | N | N |
| **Race/Ethnicity** | S | S | S | N | N | N | N | N |
| **Religion or Belief** | N | N | N | N | N | N | N | N |
| **Sexual Orientation** | N | N | N | N | N | N | N | N |
| **Gender Reassignment** | N | N | N | N | N | N | N | N |
| **Pregnancy and Maternity** | N | N | N | N | N | N | N | N |
| **Marriage and Civil Partnership** | N | N | N | N | N | N | N | N |
| **Disability** | N | N | N | N | N | N | N | N |
| **Non-Statutory** | | | | | | | | |
| **Homeless people** | N | N | N | N | N | N | N | N |
| **Sex workers** | N | N | N | N | N | N | N | N |
| **Travellers** | N | N | N | N | N | N | N | N |
| **Migrant workers** | N | N | N | N | N | N | N | N |
| **Asylum seekers** | N | N | N | N | N | N | N | N |

PALS – Patient Advice and Liaison Service
WMAS – West Midlands Ambulance Service

| **Key** | |
|---|---|
| Y | Yes, available |
| S | Yes, available but not well completed |
| N | Not available in current data |

## Data it would have been helpful to consider

6.6 The Public Health Observatory (PHO) creates a “deprivation score” for each lower super output area (LSOA) from 1-10 with 1 being the most deprived and 10 being the least deprived. It would be useful to organise the geographical location of GP Practices into each of these deciles and to identify usage of urgent and emergency care servcies by decile and by GP Practice. We would expect to find higher use from more deprived areas. Unfortunately this data has not been collated.

6.7 Further analysis of the trends in deprivation scores (as evidenced by IMD figures) for example for health, income and employment, were outside the scope of this analysis but could yield useful information to advise partnership approaches – through the health and wellbeing Board, which are receptive, say, to housing and regeneration challenges; changes in the welfare system, and to patterns of employment.

## Summary of usage data

6.8 Because of the significant gaps in data collected, it is difficult to draw any reliable conclusions about the use of Urgent Care facilities in Wolverhampton, and in some cases, no analysis is possible. Establishing a baseline in line with our first aim (**see paragraph 2.6 (i)**) has therefore not proved to be possible at this stage in the project. However it has been very useful to discover that there are data gaps. Wolverhampton CCG has already begun work with its provider organisations to improve on the routine collection of equality information, and to harmonise the collection methodologies so that comparative statistics are available. We understand that this will need to be proportionate, and may need to be accompanied by appropriate training for staff so that questions are asked confidently, with sensitivity to patients’ circumstances (not when a person is in pain, discomfort or anxious about waiting to be seen), and with promotion among patients so that they can be reassured of the reasons why data is being collected, how it will be used, and the anonymous nature of aggregated data.

# 7. Recommendations

## DATA

1. **The CCG works with its Provider organisations to improve on the routine collection of equality information from patients, and by staff, and to harmonise the collection methodologies between providers so that comparative statistics are available (eg by using Census 2011 classifications but with flexibility to enable patients to self-define where this is possible). This should include staff training approaches (see Recommendation 21), and the joint promotion (across health and social care agencies) of equality monitoring with users of services.**

2. **The CCG explores the availability of benchmark data for similar services in other CCG areas. to help establish baseline positions.**

3. **The CCG and provider organisations work collaboratively to improve the data collection mechanisms for the use of emergency care by people with a learning disability and publish these regularly. Providers should consider using the RCN (2013) and the GAIN (2010) publications, particularly where these offer recommendations for emergency settings, as part of their equality analysis of facility design and pathway development.**

4. **'Equality monitoring progress' becomes a standing item at each Data Quality Review Meeting.**

## CONTRACTS

NB: all NHS Trusts and private sector providers commissioned by the CCG will be required to demonstrate compliance with s149 (the Public Sector Equality Duty), and this requirement is included within the standard form of NHS Contract.

5. **CCG to ensure that robust equality considerations are built into pre-qualification questionnaires (PQQs); service specifications; and by requiring providers to conduct further equality analyses on their service operations.**

6. **Provider organisations to implement and publish internal reviews of their use of equality information for services, and for their workforce and to assess their compliance with the Public Sector Eequality Duty (s.149 Equality Act 2010). Action plans to be published which allow for discernible improvement in equality approaches.**

7. **CCG to establish contractual information requirements which consider equality in the provider workforce and in the delivery of services, with a requirement to report on these and demonstrate compliance with s.149 of the Equality Act 2010.**

## CONSULTATION AND ENGAGEMENT

8. **All agencies - opportunities to engage across the protected characteristic groups should be built in to proposed engagement and consultation as the implementation phase of the urgent care strategy progresses including specific outreach work where response rates show low engagement with particular groups.**

9. **CCG and Provider organisations should ensure that representatives from the Wolverhampton People's Parliament (part of the Changing Our Lives charity which supports people with disabilities of all ages see www.changingourlives.org) and the Wolverhampton Equality and Diversity Forum are consulted and involved in any planned engagement work.**

## PARTNERSHIP WORK

10. **All agencies - because of the trend in homelessness in Wolverhampton and the disproportionate impact of homelessness on the costs of health provision – particularly skewed towards urgent and emergency care – the implementation plans for urgent and emergency care should involve social housing providers and homelessness organisations as part of an integrated approach. Further work may be required to identify any geographical disparities in the location of homelessness people; to research the health experiences of homeless people; and to explore the potential for more effective and earlier interventions to prevent or reduce ill-health and to respond more appropriately to their healthcare needs.**

11. **The Health and Wellbeing Partnership to explore ways to better understand the health needs of the Wolverhampton based travelling communities and how they access healthcare. However, any such work and the resource commitment will need to be proportionate. Anecdotal information about healthcare demands may offer an appropriate starting point on which to build more targetted studies.**

12. **The CCG and Public Health Department of Wolverhampton City Council should consider an analysis of patient registration data to understand current processes for the GP registration for migrants, and for asylum seekers, and how these statistics can be effectively and economically collated at regular intervals.**

## OPERATIONS and STANDARDS

13. **Provider organisations should consider adoption of the Silver Book (2012) recommendations - 'Quality Care for Older People with Urgent and Emergency Care Needs - as appropriate for their areas of service**

14. **Provider organisations should consider adoption of the Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings - RCPCH (2012) - (as appropriate) for their areas of service.**

**15. The CCG and Royal Wolverhampton NHS Trust should monitor the ongoing effectiveness of the prioritisation plans reported to CQC in September 2013 for people with learning difficulties and autism, and evaluate through further listening events to inform improved practice.**

**16. The CCG and Provider organisations consider a planned move towards adoption of the College of Emergency Medicine (2013) standards for mental health in a phased manner over an agreed and realistic period of time.**

**17. Providers to conduct equality analyses (equality impact assessments) on the proposed operations of their services at an early stage of planning, and to include user groups in this planning. CCG to require evidence of these contractually.**

**18. As informed by Recommendation 17 - Access and mobility issues should be considered for all visitors to urgent care facilities including the topography of the area (eg to avoid inclines for people with mobility difficulties); internal colour schemes (to enable visually impaired users of services to discern between different surfaces); internal fire doors (to enable wheelchair users to move independently through public areas of a building); appropriate signage; facilities for parents to change babies and ability for mothers to breastfeed – all as part of a Provider’s consideration of service use.**

**19. The Health and Well-Being Board consider specific support being identified within the suicide prevention strategy for Lesbian, Gay, Bisexual and Transgender people.**

## STAFF TRAINING

**20. All agencies to ensure that equality and diversity training is included in the mandatory training elements for each organisation. Where possible, agencies are recommended to share training opportunities, particularly where patient pathways necessitate involvement with different organisations. This would allow for consistency of approach, and highlight areas of complementary (or dissonant) practice. For all, training content should include information about all the protected characteristic groups; the public sector equality duty and the three aims; the significance and importance of equality monitoring; and the values, principles and pledges within the NHS Constitution as a minimum.**

**21. Staff involved in the design of surveys or questionnaires; in their distribution or completion with respondents should receive a comprehensive and timely briefing beforehand which covers: the significance and value of equality questions; the importance in ensuring a high % of completion from respondents; and how to confidently respond to respondents’ questions in a way which is tactful, sensitive, and reassures people about the confidentiality of the information they share.**

# 8. Conclusion

8.1 Marmot’s (2010a; 2010b) concern was with the ‘social determinants’ of ill-health or the ‘causes of the causes’ of health inequalities – those fundamental social and economic conditions which have been shown to have an impact on how healthy a person will be during the course of their life. This includes the conditions in which people are born, grow, live, work and age. It includes an individual’s education and employment opportunities in life and their earning potential; it can include belonging to a minority group or being socially excluded from mainstream society. Inequalities in the social determinants of health act as barriers to addressing health disparities. The equality approaches identified in this analysis, and explicitly included in the 21 recommendations above, are crucial complementary elements to any Health and Well Being strategy which is concerned with a person’s ’life course’, and in minimising the disadvantages each citizen may encounter during this life course.

8.2 The clinical case for a change in urgent and emergency care services in Wolverhampton has been clearly articulated. The strategy is designed to improve health outcomes for residents and visitors to Wolverhampton. The intention to rehabilitate facilities, improve access and navigability for patients, to remove unnecessary duplication and significantly enhance patients’ experiences of urgent care (including primary care) should offer a positive and beneficial impact for all patients, including the statutorily protected characteristic groups. There is no planned diminution of existing services. In this context there are no negative differential impacts identified at this stage for any of the protected characteristic groups covered by the Equality Act 2010.

8.3 A more detailed assessment of urgent care services ***operationally*** can be made by ensuring that equality considerations are built into pre-qualification questionnaires (PQQs), and specifications, and by requiring providers themselves to conduct further equality analyses on their service operations where these are not already a systemic part of service planning. Contractual information requirements can also be established which consider equality in the provider workforce and in the delivery of services, with regular (eg quarterly) reports submitted to the commissioner which are required to demonstrate statutory compliance with s.149 of the Equality Act 2010. All NHS Trusts and private sector providers commissioned by the CCG will be required to demonstrate compliance with s149 (the Public Sector Equality Duty).

# References

ADASS (2013) [with NHS England] - Joint Health & Social Care Self-Assessment Framework 2013 - 2014 Guidance and Resource toolkit
http://www.improvinghealthandlives.org.uk/uploads/doc/vid_18782_130806%20JHSCSAF%202013%20Guidance%20FINAL.pdf

Afiya Trust (2010): 'Achieving Equality in Health and Social Care' (www.afiyatrust.org.uk )

Bishop, M (2013) 'Out in the City – exploring the experience and needs of Lesbian, Gay, Bisexual and Trans People in Wolverhampton' [LGBT Network Wolverhampton and Wolverhampton City Council, Wolverhampton]

Black Country Cluster of PCTs (2013) Equality Act Information Summary January 2013

Bradley and Lofchy (2005) 'Learning Disability in the accident and emergency department Advances in Psychiatric Treatment 2005, 11:45-57

Butler, Christina, Hatzidimitriadou, Eleni and Psoinos, Maria (2010) Managing equality and diversity in health care: the case of ethnic monitoring at St George's NHS trust. *In: EAWOP Small Group Meeting - Managing diversity in organisations;* 23-24 Sep 2010, Birmingham, U.K.

Care Quality Commission (Nov 2013): 'The Royal Wolverhampton NHS Trust - New Cross Hospital; Quality Report [Care Quality Commission]

College of Emergency Medicine (Feb 2013); 'Mental Health in Emergency Departments – A toolkit for improving care' [College of Emergency Medicine, London]

Deloitte Centre for Health Solution (2012); 'Healthcare for the Homeless – Homelessness is bad for your Health' (Deloitte LLP; UK)

Department of Health (January 2009) 'Religion or Belief: A Practical guide for the NHS' [London, DH]

Department of Health (June 2011) A&E Clinical Quality Indicators; Best Practice Guidance for Local Publication [London, DH]

Department of Health (2012) NHS 111 Public Sector Equality Duty (PSED) Analysis of Impact on Equality (AIE):
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213148/NHS111AnalysisOfImpactOnEquality20121.pdf

Department of Health (April 2013) 'Health Building Note 15-01: Accident and emergency departments (Planning and design guidance)

EHRC (2010) [and Centre for Health Research, Sheffield Hallam University], *Life and Health: An Evidence Review and Synthesis for the EHRC's Triennial review 2010*,

Faculty of Public Health (2008); 'The Health Needs of Asylum Seekers – Briefing Statement' [London, FPH]

Ford A et al (2013) Cutting A&E use and health inequalities. *Nursing Times*; 109: 24, 14-16

Frontier Economics Ltd (2010) *Estimating the costs of health inequalities: A report prepared for the Marmot Review* (London, Marmot Review)

GAIN (Guidelines and Audit Implementation Network, June 2010): Guidelines on Caring for people with a Learning Disability in General Hospital Settings (Northern Ireland)

Hull, S; Mathur,R; Boomla,K May 2011): Recording ethnicity in primary care: assessing the methods and impact Br J Gen Pract.; 61(586)

House of Commons (July 2013) Health Select Committee report on Urgent and Emergency Services

Kingsfund (May 2013): Urgent and Emergency Care: http://www.kingsfund.org.uk/projects/urgent-emergency-care?gclid=CJu1lKGTlrgCFeXItAod230AGg

Lawrenson,R et al (1998) 'Are we providing for ethnic diversity in accident and emergency departments?' Ethnicity and Health Vol 3 Issue 1-2 1998 pp 117-123

Marmot M (2010a) *Fair Society Healthy Lives* Strategic Review of Health Inequalities in England post-2010 (The Marmot Review)

Marmot M (2010b) *Fair Society, Healthy Lives* The Marmot Review Executive Summary (The Marmot Review)

McCormick, B; Hill, PS, Poteliakhoff, E; (March 2012): – Are hospital services used differently in deprived areas? Evidence to identify commissioning challenges. Working Paper No 2.[ Centre for Health Service Economics and Organisation, London]

Monitor (February 2014): 'Walk in Centre review' Final Recommendations [London]

NCRM – National Centre for Research Methods (March 2013) '*Availability and use of UK based ethnicity data for health research*' (Working Paper 1/13)

NHS Central Midlands Commissioning Support Unit (June 2013); *The Causes of Urgent Care Pressures in Birmingham, Black Country and Solihull during the winter 2012/13* [Steven Wyatt Head of Strategic Analytics]

NHS England, (June 2013a) Emerging Principles from the Urgent and Emergency Care Review

NHS England, (June 2013b); Evidence Base from the Urgent and Emergency Care Review

NHS Scotland Information Services Division (ISD) AE2 'A&E data recording reference manual' (October 2013 v2.0).

Newall, D (December 2013); West Midland Migration Summaries Set 1 (Birmingham; Public Health England, West Midlands Strategic Migration Partnership)

Northern Ireland inter-Faith Forum (2005) 'Check up - A guide to the special healthcare needs of ethnic-religious minority communities'

Public Health England (2013a) Learning Disabilities profile for Wolverhampton

Public Health England (2013b) Wolverhampton Health Profile (published 24th September 2013) available at: http://www.apho.org.uk/resource/view.aspx?RID=127042

RCPCH (2012) 'Standards for children and Young People in Emergency Care Settings' Developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings

Royal College of Nursing (2013); Dignity in Health Care for People with Learning Disabilities (2nd edition) [London]

Shaffer, N (2005) Transgender Patients: Implications for Emergency Department Policy and Practice (Journal of Emergency Nursing 2005; 31: 405-407)

Silver Book (2012) 'Quality Care for Older People with Urgent and Emergency Care Needs [RCGP, RCN, ADASS, AACE, Age UK and others]

SCIE – Social Care Institute for Excellence (2010) 'Good Practice in social care for asylum seekers and refugees.

Stonewall (2008) 'Serves You right: Lesbian and gay people's expectations of discrimination [Stonewall, London]

Trafford SPB (June 2012) A New Deal for Trafford Pre-Consultation business case June 2012

UCL Institute of Health Equity (2012): The Role of The Health Workforce in Tackling Health Inequalities: Action on the social determinants of health (Published online at www.instituteofhealthequity.org  Website updated 22nd May 2012)

West Midlands Strategic Migration Partnership (March, 2011) 'How many Migrants are there in the West Midlands and who are they?' (Joint WMSMP, DoH and WMPHO Publication) – available from WM Employers at: http://www.wmemployers.org.uk/media/upload/Library/Migration%20Documents/Publications/WMPHO_WM_MigrantHealth.pdf

Wolverhampton City Council (2012) Walk in Centres Discussion Paper.(Public Health Intelligence Team)

Wolverhampton City Council (2013) Urgent Care Activity Slides.(Public Health Intelligence Team)

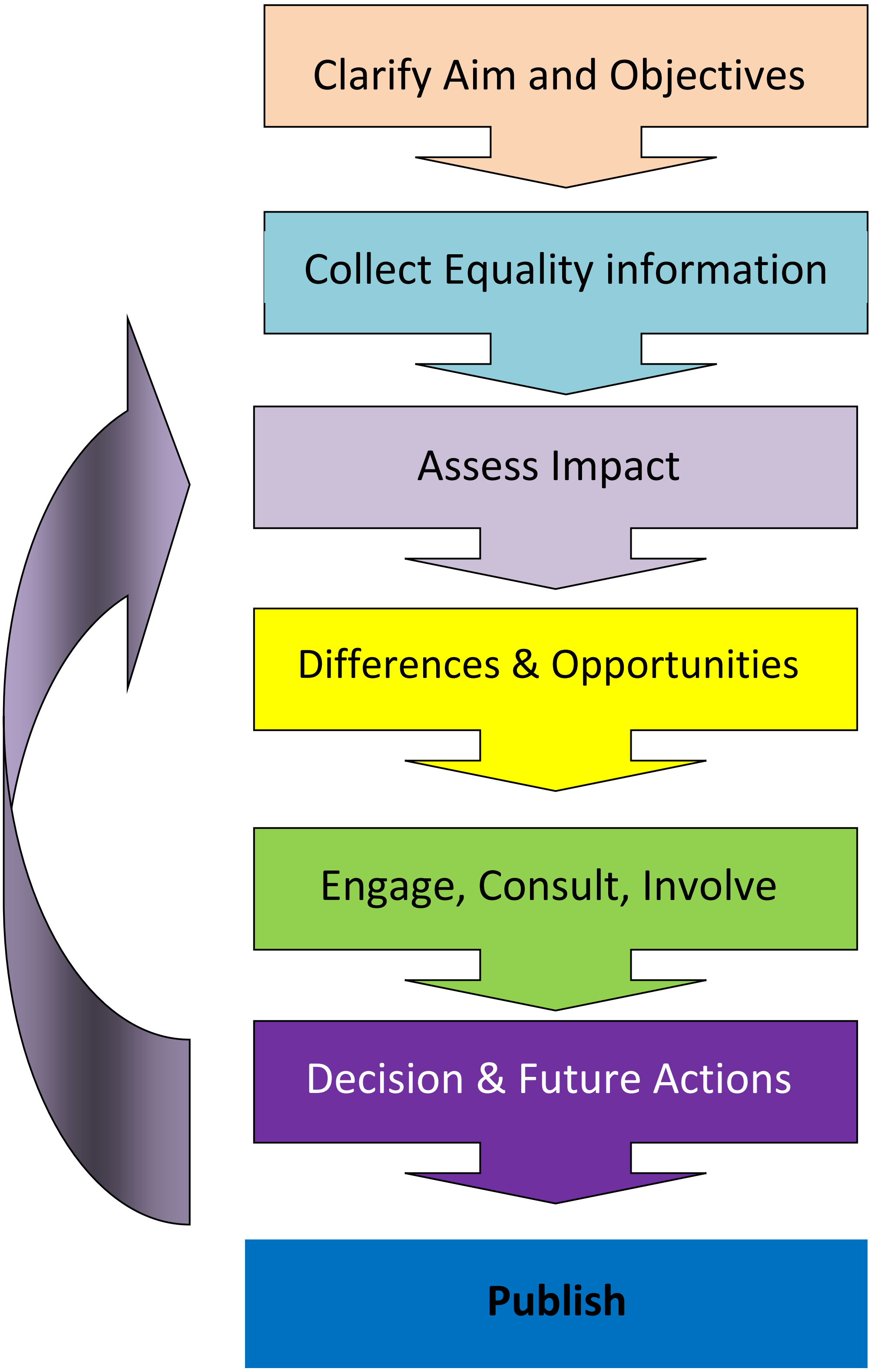
Wolverhampton CCG (2013) Consultation Feedback Report (CMCSU for Wolverhampton CCG)

Wolverhampton CCG, Royal Wolverhampton NHS Trust (October 2013): *A Joint Strategy for the Provision of Urgent and Emergency Care for Patients using Services in Wolverhampton to 2016/17; v.13.1*

World Health Organisation ICD 10 (WHO International Statistical Classification of Diseases and Related Health Problems 10th Revision ICD-10 )

**Appendix 1**

# Wolverhampton CCG
# Plans for Urgent and Emergency Care Services 2014
# Route Map for Equality Analysis



Clarify Aim and Objectives

Collect Equality information

Assess Impact

Differences & Opportunities

Engage, Consult, Involve

Decision & Future Actions

**Publish**

# Appendix 2

## Summary of Questions asked in the Urgent Care Equality Survey January – February 2014

NB. These are shortened forms of the questions asked. The original survey was piloted with several organisations before wider distribution.

**Q1: Name and address of your organisation (please include website if any).**

**Q2: Contact details for someone we can keep informed of progress**

**Q3: Please tell us a little about what your organisation does and who it helps?**

**Q4: Which protected characteristic groups do you work with/represent?**

**Q5: Positive experiences of urgent care health services provided in Wolverhampton?**

**Q6. Difficulties experienced?**

**Q7. Improvements you would wish to see?**

**Q8. Do providers of services understand the needs of the people you work with?**

**Q9. Does the group/community feel that their views are listened to by providers?**

**Q10. Does the group feel that their privacy/dignity as patients is respected**

**Q11. Please tell us three things you would like the NHS in Wolverhampton to change for the better for this group?**

# Three things?
# (from the equality survey, Q11 – see Appendix 2)

## Please tell us three things you would like the NHS in Wolverhampton to change for the better for this group/community?

**Group providing support to recipients of direct payments**
- Gender specific support on A&E
- Safe space to come down if high or drunk
- Quicker access to mental health support while in urgent care

**Counselling and support group for children and young people aged 6-25**
- Appointments at GPs more accessible – same day
- More support for issues such as self harm
- Specific surgeries once a month for young people to discuss issues and access treatment, break the myth that young people do not want to access services.

**A hospice**
- Improved communication with commnity services
- Access to health care professional that has an understanding of palliative care patients.
- Better discharge planning

**A nursery and children's centre**
- More community based provision

**A residents and tenants association**
- Keep the local walk-in-centre

**Residents in the vicinity of Prestwood Road**
- [The Hospital] to be concerned about being a better neighbour to us
- Try looking at the issues from our viewpoint too
- Realise that by trying to put a quart in a pint pot something gets spilled [reference to traffic congestion]

**A community association**
- Better care for the elderly
- More suppoprt in the community
- Better support for carers

**A support agency for people with mental health problems**
- Educate GPs in mental health awareness
- Educate hospitals/A&E in mental health awareness

**An organisation which supports victims of violence and abuse**

- To fund the posts of [currently] volunteer Domestic Violence staff in place
- To advertise the [Domestic Violence Advice] service within their own departments and literature
- To integrate Domestic Violence training with Safeguarding Training and make it compulsory attendance.

**A church based welfare project**

- Support services
- More staff
- Time management [context not explained]

**A church**

- Improved facilities at New Cross for elderly patients
- Speedier access to ambulance care – triage phone management needs to be more responsive to the particular needs of older people.
- 24 hour GP care.

**Agenda Item No. 14**

CITY OF WOLVERHAMPTON COUNCIL

# Health and Wellbeing Board

29 July 2014

| | | | |
|---|---|---|---|
| **Report title** | Better Care Fund Update | | |
| **Cabinet member with lead responsibility** | Councillor Sandra Samuels<br>Health and Wellbeing | | |
| **Wards affected** | All | | |
| **Accountable director** | Linda Sanders, People Directorate | | |
| **Originating service** | Adult Health and Social Care | | |
| **Accountable employee(s)** | Steven Marshall<br>Tel<br>Email | Transformation Director<br>01902 441 775<br>steven.marshall3@nhs.net | |
| **Report to be/has been considered by** | BCF Programme Board<br>Integrated Commissioning Board | | 15 July 2015*<br>15 July 2015*<br>(*Both Boards Cancelled) |

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**Recommendation(s) for action or decision:**

1. None – information only update

**Recommendations for comment:**

The Health and Wellbeing Board is asked to:

1. Note the progress update provided in this report in relation to two of the Better Care Fund Workstreams – Intermediate Care and Primary and Community Care
2. Feedback comments to the report author.

## 1.0 Purpose

1.1 The purpose of the report is:

- To brief the Board on the development and progress of the Better Care Fund, in particular the Intermediate Care and Primary and Community Care workstreams.
- To appraise the Board of next steps
- To secure continuing support from the whole Health and Social Care Economy to facilitate the successful delivery of the Better Care Programme

## 2.0 Background

2.1 Following a successful submission and considerable design and planning the Better Care Fund Programme is transitioning into implementation phase. The Better Care fund has to achieve six Outcomes:-

- Reduced delayed transfers of Care
- Reduction in avoidable emergency admissions
- Reduce admissions to residential and nursing homes
- Ensure effectiveness of reablement
- Improve patient/Service user experience
- Improve dementia Diagnosis rates

There are four work streams within the Better Care Fund. This report provides an update on two of those workstreams, Intermediate Care and Primary and Community Care as requested.

## 3.0 Progress, options, discussion, etc.

### 3.1 Intermediate Care

### 3.1.1. Financial

Financial value of this workstream is £32,168,889
Financial efficiencies targets are £528,651 (non-elective) and £228,960 in relation to Nursing, Residential, Reablement and DTOC. Totalling £757,611.

### 3.1.2 Key Milestones and Progress

- The Home In Reach Team (HIT) Pilot has been operational for some time; however the BCF programme redesign will expand HIT from a five day service to a seven day service and will increase the number of homes it supports to 21. This will increase the efficiencies already demonstrated by this service.

- A joint community reablement service pilot is now operational. The Community Intermediate Care Team (CICT) and Home Assisted Reablement Team HARP are jointly triaging referrals and working together to develop joint pathways of care that will enable seamless processes for patients/service users. An evaluation of the pilot will be undertaken in October and a future action plan and workforce plan for an integrated team will be developed. The pilot is focussing on Integrated pathways and models of delivery as opposed to organisational integration. This will enable more timely impact upon the delivery of care and subsequent efficiencies.

- An overarching service specification is being developed between health and social care colleagues to specify the joint reablement service in order to enable the formalising of the Joint Community reablement service following the pilot stage.

### 3.2 Primary and Community Care

### 3.2.1 Financial

Financial value of this workstream is £22,054,368
Financial efficiencies target are £963,007 (non-elective) and £66,250 in relation to Nursing, Residential, Reablement and Delayed Transfer of Care (DTOC), totalling £1,029,257

### 3.2.2 Key Milestones and progress

- **Community Neighbourhood teams-** This is the development of three Integrated Health and Social care teams. Core team members will be District nurses, Community matrons, Social workers and support workers all working closely with to meet the needs of individual patients and service users and carers and families. The core team will have access to specialist teams; the aim of the teams is to prevent emergency admissions by risk stratification, prevention, promoting self-management of conditions, developing personalised management plans, rapid response to patients with an urgent need. The teams will be co-located in order to enable integrated working, multi-disciplinary team meetings and joint care planning.

- **Point of Access –** This is the co-ordination of referrals and calls into the services via integrated pathways and working models. Health and social care access points will work collaboratively to ensure a seamless route into services for individuals. Health and social care will not be co-located but joint working will be achieved through regular meetings and the sharing of information.

- **End of Life -** The Rapid Discharge project at Royal Wolverhampton Hospital Trust (RWHT) has now gone live. This enables patients identified as end of life to be discharged promptly and appropriately back to their usual place of residence. This facilitates early discharge and enables the patients to die in their own home where this is their preference. The development of a hospice as a hub is underway. The project has secured funding from Macmillan to provide project management support during implementation of this project.

- **Urinary Tract Infection (UTI) Pathway –** the UTI pathway went live on the 6 July. Patients with a UTI that previously may have been admitted to hospital are now referred to the Community Matron and social care teams in order to manage the patients in their own home. Patients who are discharged from hospital or attend Accident and Emergency (A&E) with a UTI can also be referred to the team with the aim of preventing a re-admission. The pathway is being supported by a similar project being run by West Midlands Ambulance Service enabling the hours of the scheme to be extended until 8 p.m. in the evening.

- **GP Care Homes -** A service specification and business case has been approved in principle by Clinical Commissioning Group (CCG) Commissioning Committee and is in the process of being finalised. The project will see GPs allocated to residential homes in the City with the highest admission rates. Regular ward rounds and medication reviews will be undertaken and personalised management plans put in place for residents in order to reduce the number of emergency admissions from these homes.

## 4.0 Financial implications

4.1 The BCF revenue pooled fund for 2015/16 is £69.6 million. Of which, £22.9 million are budget held by the Council and the balance held by the CCG. The funds includes the £6.3 million representing the NHS transfer to social care (Section 256 funding).

4.2 A significant financial risk is the delivery of the reduction of 1048 emergency admissions. This is the metric aligned to Payment for Performance (P4P). Early indications show that there was a reduction in April of 111 admissions which puts the programme above plan. However it should be recognised that this is just one months' data and therefore gives a position at a moment in time as opposed to a trend in activity.

4.3 A further risk is the pooled budget identifing efficiencies to fund the demographic growth (£2 million) and care act implementation (£964,000). The Section 75 agreement specifies the basis in which this financial risk will be shared in the event that sufficient efficiencies are not identified by the work streams. The work streams are currently modelling their plans which will identify the extent to which these efficiencies will be realised. [AS/20072015/H]

## 5.0 Legal implications

5.1 A S.75 agreement is in place for the delivery of the BCF plan, which was approved in December 2014.

5.2 Section 75 of the NHS Act 2006 (the "Act") allows local authorities and NHS bodies to enter into partnership arrangements to provide a more streamlined service and to pool resources, if such arrangements are likely to lead to an improvement in the way their functions are exercised. Section 75 of the Act permits the formation of a pooled budget made up of contributions by both the Council and the CCG out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS body and prescribed health-related functions of the local authority. The Act precludes CCGs from delegating any functions relating to family health services, the commissioning of surgery, radiotherapy, termination of pregnancies, endoscopy, the use of certain laser treatments and other invasive treatments and emergency ambulance services. RB/17072015/W

## 6.0 Equalities implications

6.1 Each individual project within the workstreams would identify any Equality implications

## 7.0 Environmental implications

7.1 Each individual project within the workstreams would identify any Environmental implications, such as the need to review Estate for colocation of teams and services..

## 8.0 Human resources implications

8.1 Each individual project within the workstreams would identify HR implications. HR departments from both Local Authority and Acute Providers are already engaged in discussion regarding potential HR issues such as integrated working and change of base for staff.

## 9.0 Corporate landlord implications

9.1 Each individual project within the workstreams would identify implications

## 10.0 Schedule of background papers

10.1 None

WOLVERHAMPTON CHILDREN'S TRUST

# CHILDREN'S TRUST BOARD

Minutes of meeting held on 18th March 2015
Civic Centre

| Item | Notes | **Action** |
|---|---|---|
| | **Present**<br>Councillor Val Gibson (Chair) – WCC<br>Steven Marshall (Vice – Chair) – CCG<br>Councillor Pete O'Neill<br>Councillor Claire Darke<br>Ros Jervis – WCC, Public Health<br>Andrea Dill Russell– Wolverhampton College<br>Emma Bennett – WCC<br>Mary C Keelan – Secondary Representative, Wolverhampton School Improvement Partnership<br>Cathy Higgins – Consultant Paediatrics<br>Steve Dodd- (On behalf of Ian Darch)<br>Lesley Writtle – Black Country Partnership Foundation Trust<br>James McElligott – WCC<br>**Officers:**<br>Kush Patel - SIDO<br>Hannah Finch (Minute Taker) - WCC<br>**In Attendance:**<br>Kali Lewis – Locality Manager , Area 2<br>Carole Bourne – Head of Children's Commissioning | |
| 1. | **Welcome, Apologies, Introductions**<br>Apologies were received from:<br>Tim Johnson - WCC<br>Helena Kucharczyk– WCC<br>Linda Sanders – WCC<br>Lynn Law – Primary Representative, Wolverhampton School Improvement Partnership.<br>Jeremy Vanes – RWT<br>Chief Superintendent Simon Hyde – West Midlands Police<br>Gillian Ming - Safeguarding Board | |

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| 2. | **Declarations of interest:**<br>• None. | |
| 3. | **Minutes of the meeting held on 17th December 2014**<br>• Agreed as a true record<br>**Action:** Cllr Gibson stated she would raise the issue of escalation to Ministers in regards to absence of information sharing protocol. | |
| 4. | **Matters Arising**<br>• Discussion took place in regards to definitions of Tier 1,2,3 and 4 support.<br>• Photos for the Children's Trust Board Newsletter are still outstanding and need to be sent to Kush as a priority.<br>• Discussion around Mary Keelan's new role within the Children's Trust Board. Emma informed the board that Mary is now a Secondary Head Representative.<br>• Kush shared the annual report. Cllr Gibson agreed this was a positive move forward. Action: Approved | |
| 5. | **CYP and F Performance Plan.**<br>Kush Patel<br>• Kush Patel presented a summary of the report provided regarding key developments of the CPP and F Performance Plan. She stated that the group will receive a performance update in September.<br>Cllr Gibson<br>• Cllr Gibson stated this was a working document which was currently in development. She felt that the terms deprived school, used on page 11, was not a standard measure which should be used.<br>Steven Marshall<br>• Steven questioned how we work out the numerators and denominators for the working out of percentage across the document. Kush stated Helena Kucharczyk who has developed this document would be able to give greater clarity on this.<br>James McElligott<br>• James stated that he felt some changes may need to be made within the document in terms of Page 5, 1.2, What is the measure of a deprived child or a deprived school and Page 9 2.5, the document misses key A level outcomes, further on page 12, 2.5, these points need to be separated into Primary and Secondary school points.<br>**Action:** Helena Kucharczyk to discuss with James McElligott in regards to usage of term deprived school.<br>**Action:** Addition of A level outcomes to page 9.<br>**Action:** Separation of outcomes to reflect Primary and Secondary Schools on Page 12. | |

6. **School Readiness – Kali Lewis**

**Kali Lewis**

- Kali shared with the group the School Readiness proposal report and its key focus on stages before schooling in terms of social and emotional development.
- The report has a spot light on providing support for parents in providing correct parenting skills to ensure their child is school ready.
- Kail stated that the population of 0-5 children across the city was growing rapidly, with 33% of the current population aged less than 5.
- An NSPCC video was outlined to show the importance of school readiness and collaborative working between services to ensure provision is made for parents to help them achieve this.
- She further stated that EYFS characteristics of school readiness are quoted within this report however the reports key focus is on Parents and their readiness to help their children achieve.

**Ros Jervis**

- Ros stated she felt some of this work had already been undertaken by the Infant mortality group and was concerned about an overlap in development with this report.
- Questions and queries then arose around a previous Bump-start programme which had been implement but had finished its pilot stage and had not been continued due to a lack of evaluation.

**Cllr Peter O'Neill**

- Cllr O'Neill was concerned about the definition of school readiness and wanted to know if a definition existed to be shared with parents.

**James McElligott**

- James agreed a definition needed to be used and suggested those taken from the Early Years Framework, in terms of the Early Years Learning Goals.
- He further suggested he could condense these and present them to members of the group.

**Carole Bourne**

- Carole suggested that School Readiness was not actually a helpful title as this report had move of a focus on the social, emotional and behavioural impact that parents can have upon their young children.

**Mary Keelan:**

- Mary felt the report needed to be more visual and appealing, then to be circulated to schools.

**Cllr Gibson:**

- Cllr Gibson felt that this was a good report however it had drawn out many questions which need to be addressed in the form of a Task and Finish group.

**Actions:**

James McElligott to create booklet in regards to Early Learning Goals, to be distributed to members.

EB to discuss with Andrew Wolverson about creating a Task and Finish group in regards to this report, with a view to include Public Health and Education.

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| | KL to check with RJ to check no overlap has taken place between this work and projects run previously by Public Health. | |
| 7. | **Participation Plan:**<br>**Kush Patel**<br>• Kush stated that across Wolverhampton we undertake a good level of participation with service users shaping the services they interact with.<br>• The plan outlines how we collate the information we receive from the performance management comments across services.<br>• Further to this from a Commissioning perspective Kush suggested that Quality Assurance Compliance Officers visit services and ask to see how participation effects and develops these services. Kush hoped this would be something that could be developed further, similar to a national framework of participation<br>**Emma Bennett:**<br>• Emma stated that in regards to the participation plan, it is the principles of the plan that the Children's Trust Board are looking to sign up to.<br>**Steven Marshall**<br>• Steve queried how we currently monitor participation across services to which KP stated that we currently monitor this via Performance Management and a needs analysis. This should form a key part of the performance framework.<br>• He further felt that plan this needed to show the evidence of enabling the outcomes of participation.<br>**Lesley Writtle**<br>• Lesley stated if required she could provide the measures used across Health to monitor participation.<br>**Emma Bennett:**<br>• Emma felt that the plan was not clear about how participation was evidenced within the plan in terms of an audit.<br>**Action:** Kush Patel to consider how participation will be evidenced in the performance framework. | |
| 8. | **MASH Update – Information only.**<br>• Emma Bennett presented a summary of the progress of the MASH. She stated this was in early stages of development<br>• Cathy Higgins asked what input the MASH required from Health.<br>• Emma stated a representative had been asked from via Clair Boliver. She felt this needed to be further investigated. Emma suggested to Leslie Writtle that she needed to discuss this with her safeguarding representative to find out more about the MASH. Emma stated she would liaise with Leslie further in regard to this. | |
| 9. | **AOB**<br>• Nothing was reported. | |

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| 10. | **Date of Next Meeting:**<br>**Friday 18th September 2015, 2 pm – 4 pm. Committee Room 2 Civic Centre.**<br>The Chair thanked everyone for their attendance and authors of reports and the case study.<br>Meeting closed at 3:05pm. | |

| **Action** | **Responsibility** |
|---|---|
| Escalation letter to Ministers in regards to absence of information sharing protocol. | Cllr Gibson |
| Discussion in regards to usage of term deprived school. | Helena Kucharczyk<br>James McElligott |
| CY&F Performance Plan edits | Helena Kucharczyk |
| Creation of a Task and Finish group in regards to School Readiness, with a view to include Public Health and Education. | Emma Bennett |
| Definition of Early Learning Goals to be distributed to members. | James McElligott |
| Checks to ensure no overlap has taken place between School Readiness report and projects run previously by Public Health. | Kali Lewis<br>Ros Jervis |
| To consider how participation will be evidenced in the performance framework. | Kush Patel |

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# WOLVERHAMPTON HEALTH AND WELLBEING BOARD

# INTEGRATED COMMISSIONING & PARTNERSHIP BOARD

Minutes of meeting held on Thursday 11th June 2015
at the Civic Centre

**PRESENT:**

**Linda Sanders** - WCC Strategic Director, People **(Chair)**
**Viv Griffin** - WCC Service Director
**Helen Hibbs** - WCCG
**Steven Marshall** - WCCG
**Alison Shannon** - WCC, Head of Finance
**Donald McIntosh** - Healthwatch Wolverhampton
**Tony Ivko** - WCC Service Director
**Emma Bennett** - WCC Service Director
**Andrea Smith** - WCCG
**Ros Jervis** - WCC Service Director
**Sarah Fellows** - WCCG
**Kathy Roper** - WCC
**Tony Marvell** - WCC

**IN ATTENDANCE:** **Emma Dart** - WCC Quality Assurance & Business Support Officer

| | | **ACTION** |
|---|---|---|
| **1.** | **Apologies**<br>**Claire Skidmore** - WCCG. | |
| **2.** | **Minutes of previous meeting**<br>Notes of the meeting held on the 21st May 2015 were accepted as a true and accurate record of the meeting.<br>Actions arising from the meeting on 21st May 2015 will be picked up during the agenda for this meeting. | |
| **3.** | **CAMHS System Transformation**<br>• Discussions have been held outside of the Board and VG presented the conclusions to the Board.<br>• Future in Mind published the national future direction on CAMHS services. It has had media attention and has been high on the government agenda.<br>• The HeadStart project in Wolverhampton looks at the mental health of 10-14 year olds in the City especially at T1/2 level and focuses on prevention of issues and building resilience for young people.<br>• Young people from 18 schools are involved in the project.<br>• A successful funding bid to Big Lottery was made.<br>• There is a recognition that pathways are incomplete and on the back of HeadStart additional resources have been offered to look at gaps in the pathways. | |

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| | • It was suggested that additional money from CCG funding could be used to look at a 12 month piece of work in terms of the systems transformation of CAMHS and match funding to invest in high level CAMHS commissioning.<br>• The conclusion was brought to the group for approval in principle to work in an integrated way and pull resources through.<br>• Subject to final verification by Big Lottery, an amount of £50k each was suggested to be put forward for systems transformation.<br>• SF said that she thought it was a big opportunity, and that she had spoken to the CAMHS task force lead at NHS England who was aware of the HeadStart pilot in Wolverhampton.<br>• LS congratulated representatives for their work to get to this point.<br>• SM questioned the draft job advertisement and the overheads / on-costs – further work is required to be clear about the role and where it will be accommodated.<br>• The proposal was approved by the group. | **VG & SM** |
| **4.** | **Governance Structure Chart**<br>• VG circulated the draft Commissioning Governance Structure chart for WCC.<br>• DMcI questioned the timescales for a decision turnaround.<br>• VG explained that there are no big delays but stressed the importance of pre-planning work to aid the decision making process. As long as work is planned ahead, decisions can be reached quite quickly.<br>• The dotted lines on the chart represent where executive decisions cannot be made.<br>• The extra committees sitting under the cabinet means that fewer decisions are required to go to cabinet.<br>• Further work is needed on the structure chart, although too much detail would make the chart too complex. Detail around the layer below the People Leadership Team and more integrated groups is required, as well as ensuring both logos appear on the chart. | **VG** |
| **5.** | **Review of the Pooled Budget Arrangements for Children Placed out of City**<br>• EB gave an overview of what has been an in depth piece of work which has provided a quality assurance review of providers.<br>• An appointment has been made of an individual with a CAMHS background to focus on therapeutic needs and to ascertain whether placements meet the needs of the children.<br>• This work is ongoing and will inform future pooled budget and criteria.<br>• The number of children has been reduced from 29 to 20.<br>• An overspend of £500k was stated in January, which was reduced to an overspend of £250k at year end and now the forecast is an underspend of £185K.<br>• SM discussed the need to formalise future funding arrangements to ensure clarity on the pooled budget. The pooled fund covers education, | **EB** |

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| | health and social care needs. Going forward, a full review of children being placed out of the city is required, to look at the social, health and education needs, to lead to a reconfiguration and formalisation of arrangements.<br>• The pooled budget is inclusive of children with disabilities; out of 21 placements, 9 are appropriate for children with disabilities.<br>• LS asked what the commissioning implications are with bringing children into the city and how good we are at managing challenging behaviour locally.<br>• A number of children have been placed outside of the city because the there is no suitable education provision, for instance there is a gap in terms of catering for children with complex high end autism. Despite the level of special school provision in the city, schools cannot manage the requirements of some of the children.<br>• Some children are placed out of the city for specific reasons e.g. CSE or welfare grounds. | |
| **6.** | **AOB**<br>**BCF Mental Health and Dementia Interface**<br>• SF will prepare a paper to seek approval around a potential opportunity to transfer financial resource, to deliver services in a new way and to accommodate individuals in pathways more innovatively.<br>• AI expressed an interest to get involved.<br>**Discharge to Assess**<br>• SM discussed the frail elderly pathway and explained discharge to assess.<br>• BCF has taken a resource based approach regarding provision in primary care settings.<br>• There is a challenge to work in a more integrated way with frail elderly and there is a four step pathway including assessing to admit, so that individuals may not need to go to hospital, if they do need to go to hospital they are seen by a geriatrician rather than on a medical ward, discharge to assess, where elderly are assessed e.g. in their own homes and then comprehensive re-ablement.<br>• The driver is patient quality of life.<br>• A programme has been set up in Warwickshire.<br>• A community emergency response team should be able to be set up to divert individuals to a separate location. At the end of the process, the individual is assessed not in a hospital but in a place of non-dependency.<br>• If this programme is to be delivered in Wolverhampton, there must be alignment of agencies and it must be delivered together. It was proposed that the discharge to assess in Wolverhampton reflected the core components of Warwickshire and SM is looking for sponsorship and commitment from the Local Authority to redesign the pathway and an evolutionary approach to cohesively work together; to be able to | **SF & AI** |

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|  | meet the challenge of moving the frail and elderly through the system with speed and dignity.<br>• LS said that she was not sure that it was the right model to adopt and how to ensure that work was not duplicated.<br>• DMcI said that it would be useful to share further information about the model with the group to aid the decision making process.<br>***[DMcI left the meeting]***<br>**Delayed Discharge**<br>• HH and AI discussed delayed transfers of care (Detocs) figures and that the figures appeared to be better before the teams were integrated.<br>• The change may be down to the terminology used.<br>• Allocations figures are circulated daily, showing how many patients are awaiting discharge.<br>• Figures are agreed at 8.30am daily, however this is prior to the consultant completing their rounds.<br>• AI has agreed to increase management capacity to ensure that all workers are productive.<br>• Managers are encouraged to challenge the decisions of the wards, for example whether Social Services involvement is required or not.<br>• LS suggested commissioning an expert to work towards obtaining a solution.<br>• Greater understanding of the issues and terminologies are required. AI will talk to a colleague in Walsall where some analysis has been carried out. SM and AI to look into possible solutions.<br>**Independent Living Fund**<br>• VG will circulate a briefing note regarding the ILF.<br>• | **SM & AI**<br>**AI & SM**<br>**VG** |
| **10.** | **Date of Next Meeting**<br>13th August 2015, 15.30 – 16.30, People Board Room - Civic Centre |  |

# ADULT DELIVERY BOARD

# ACTIONS LOG

**[Appendix.1]**

**Summary of key Actions**

| Ref | Date | Action | Owner | Status | Notes |
|---|---|---|---|---|---|
| **063** | 10.9.14 | Update on the development of the refreshed Autism Strategy to be presented to future meeting of the Board. | **KR** | **OPEN** | **29/1/15** – Agreed refreshed Autism Strategy be presented to next Board meeting. |
| **066** | 29.01.15 | A small group to be created to connect and drive system change to support initiatives around National CAMHS task forces. | **VG** | **OPEN** | |
| **067** | 29.01.15 | A performance dashboard will be brought to the next meeting. The board have been asked to forward their thoughts on any business critical measures they would like to see included. | **All** | **OPEN** | |
| **068** | 29.01.15 | Members of the Board to re-group on the 2nd March 2015 to further evaluate the governance proposals and consider feedback from commissioners involved in the delivery of the BCF programme. | **SC/VG** | **OPEN** | |
| **069** | 21.05.15 | Outstanding actions from the Transformation Commissioning Board to be cross checked against the BCF Programme Board to ensure all actions are captured. | **LG** | **OPEN** | |
| ~~**070**~~ | ~~21.05.15~~ | ~~A governance structure chart which involves commissioners is required, along with mapping the governance structure across the Partnership. VG will map the LA part and pass to SM to complete the CCG section.~~ | ~~**VG & SM**~~ | **Closed** | Discussed at 11 June 2015 meeting. |
| ~~**071**~~ | ~~21.05.15~~ | ~~VG and SG to bring the proposals from their discussion of system transformation around CAMHS to the next meeting.~~ | ~~**VG & SM**~~ | **Closed** | Discussed at 11 June 2015 meeting. |
| **072** | 21.05.15 | Paper on public health commissioning strategy to be brought to the next meeting | **RJ** | **OPEN** | Deferred. |
| **073** | 11.06.15 | Further work is required to be clear about the draft advertisement for the CAMHS role and where it will be accommodated. | **VG / SM** | **OPEN** | |

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| **074** | 11.06.15 | Further work is needed on the structure chart, although too much detail would make the chart too complex. Detail around the layer below the People Leadership Team and more integrated groups is required, as well as ensuring both logos appear on the chart. | **VG** | **OPEN** | |
| **075** | 11.06.15 | A full review of children being placed out of the city is required, to look at their social, health and education needs, to lead to a reconfiguration and formalisation of future funding arrangements. | **EB** | **OPEN** | |
| **076** | 11.06.15 | SF and AI will prepare a paper to seek approval around a potential opportunity to transfer financial resource, to deliver services in a new way and to accommodate individuals in pathways more innovatively. | **SF & AI** | **OPEN** | |
| **077** | 11.06.15 | Further information about the Discharge to Assess model to be shared with the group to aid the decision making process. | **SM & AI** | **OPEN** | |
| **078** | 11.06.15 | AI will talk to a colleague in Walsall about their research into delayed discharge. SM and AI to look into possible solutions. | **AI & SM** | **OPEN** | |
| **079** | 11.06.15 | Briefing note regarding the ILF to be circulated. | **VG** | **OPEN** | |