CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

19 October 2016

Time 12.30 pm **Public Meeting?** YES **Type of meeting** Oversight

Venue Committee Room 3 - 3rd Floor - Civic Centre

Members of the Health and Wellbeing Board

Councillor Roger Lawrence	(Chair) Labour
Councillor Val Gibson	Labour
Councillor Sandra Samuels OBE	Labour
Councillor Paul Singh	Conservative
Councillor Paul Sweet	Labour
Ros Jervis	Service Director Public Health & Wellbeing
Dr Helen Hibbs	Wolverhampton Clinical Commissioning Group
Trisha Curran	Wolverhampton Clinical Commissioning Group
David Jamieson	West Midlands Police and Crime Commissioner
Tim Johnson	Strategic Director - Place
Linda Sanders	Strategic Director - People
Dr Alexandra Hopkins	University of Wolverhampton
David Loughton	The Royal Wolverhampton Hospitals NHS Trust
Jeremy Vanes	The Royal Wolverhampton Hospitals NHS Trust
Tracy Taylor	Black Country Partnership NHS Foundation Trust
Donald McIntosh	Healthwatch Wolverhampton
Alistair McIntyre	Locality Director NHS England (West Midlands)
Robin Morrison	Healthwatch Wolverhampton
Alan Coe	Wolverhampton Safeguarding Children Board

Information for the Public

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Some items are discussed in private because of their confidential or commercial nature. These reports are not available to the public.

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 as a correct record]

5 **Matters arising**

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 2016/17** (Pages 17 - 22)
[To consider and comment on the items listed on the Forward Plan]

8 **Child and Adolescent Mental Health Services (CAMHS) Local Transformation Plan** (Pages 23 - 74)
[Fred Gravestock, Whole Systems Transformation Director, (Wolverhampton Clinical Commissioning Group (CCG)), to present report]

9 **Wolverhampton Integrated End of Life Care Strategy** (Pages 75 - 78)
[Karen Evans, Solutions and Development Manager, (Wolverhampton CCG), to present report]

10 **Workshop "Living Well, Feeling Safe"** (Pages 79 - 82)
[Linda Sanders, Strategic Director – People, to present report]

11 **Wolverhampton CCG Commissioning Intentions 2017/18-2018/19** (Pages 83 - 90)
[Stephen Marshall, Director of Strategy and Transformation, (Wolverhampton CCG),to present report]

12 **Primary Care Strategy - update** (Pages 91 - 94)
[Steven Marshall, Director of Strategy and Transformation, (Wolverhampton CCG) to present report]

13 **Better Care Fund (BCF) update - report to follow**
[Steven Marshall, Director of Strategy and Transformation (Wolverhampton CCG) to present report]

14 **Public Health Lifestyle Survey 2016** (Pages 95 - 116)
[Ros Jervis, Service Director Public Health and Wellbeing, to present report]

15 **West Midlands Care Act Stock-Take - report to follow**
[Steve Cartwright, Transforming Adult Social Care Programme Manager, to present report]

PART 2 - EXEMPT ITEMS, CLOSED TO PRESS AND PUBLIC

16 **Exclusion of press and public**
Exclusion of press and public

To pass the following resolution:

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 falling within paragraph 3 of Schedule 12A of the Act

17 **Sustainability and Transformation Plans (STP) 2016/17 - 2020/2021**

[Steven Marshall, Director of Strategy and Transformation (Wolverhampton CCG) to present report]

Information relating to the financial or business affairs of any particular person (including the authority holding that information) Para (3)

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CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

Minutes - 20 July 2016

Attendance

Members of the Health and Wellbeing Board

Councillor Roger Lawrence	
Councillor Sandra Samuels	
Ros Jervis	Service Director Public Health and Wellbeing
Tim Johnson	Strategic Director - Place
Jeremy Vanes	Chair, The Royal Wolverhampton Hospitals NHS Trust
Linda Sanders	Service Director - People
Jan Sensier	Chief Executive, Engaging Communities, Healthwatch

Employees

Earl Piggott-Smith	Scrutiny Officer
Glenda Augustine	Consultant in Public Health, Community Directorate
Viv Griffin	Service Director - Disability and Mental Health
Tim Johnson	Strategic Director – Place

In Attendance

Alan Coe	Chair, Wolverhampton Safeguarding Children and Adult Board
Tracey Cotterill	Deputy CEO, Black Country Partnership, NHS FT
Mike Hastings	Associate Director of Operations, Wolverhampton CCG

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 the following member(s) of the Board

Cllr Paul Sweet
Dr Helen Hibbs, Wolverhampton City Clinical Commissioning Group

2 **Notification of substitute members (if any)**
There were no substitutes for this meeting.

3 **Declarations of interest (if any)**
No declarations of interest were made relative to items under consideration at the meeting.

4 **Minutes of the previous meeting**

The minutes to be amended to show Alan Coe and Linda Sanders as being in attendance at the meeting on 27 April 2016.

Resolved:

That the minutes of the meeting held on 27 April 2016 be confirmed, subject to the agreed changes, as a correct record and signed by the Chair.

5 **Matters arising**

There were no matters arising from the minutes.

6 **Summary of outstanding matters**

The Scrutiny Officer apologised for not including a written report in the papers for the meeting.

Viv Griffin, Service Director-Disability and Mental Health, gave a brief verbal report on matters previously considered by the Board.

Resolved:

The summary of outstanding matters be noted.

7 **Health and Wellbeing Board Forward Plan 2016/17**

Viv Griffin, Service Director - Disability and Mental Health, presented the Board's Forward Plan of items to be considered during the current year.

The Service Director emphasised the importance of effectively managing the Board's workload and suggested that items requiring priority focus be included at the top of agendas.

The Service Director added that partner agencies were undertaking a trial aimed at ensuring that the appropriate bodies were made aware of upcoming priority areas with a view to enabling them to schedule timely consideration.

Resolved:

The Board's Forward Plan 2016/17 is noted.

8 **How can the Council, hospital and CCG work more effectively together? verbal report (Chair)**

The Chair commented on the range of health issues facing the City and the work being done to improve the situation. The Chair commented on the successful bid for HeadStart programme and congratulated everyone involved for their efforts. The Chair commented on the benefits of the programme.

The Chair commented on the need for a joined up approach in tackling health issues and finding workable solutions that can improve the lives of local people.

9 **Making prevention everyone's business - Public Health Overview**

Ros Jervis, Service Director Public Health and Wellbeing, presented a report highlighting the importance of prevention being part of every member of the Board's work as part of efforts to promote good health. The members of the Board were invited to comment on the report.

Linda Sanders, Strategic Director, Community, welcomed the report and the importance given to supporting behaviour change and its focus on disease. The Strategic Director commented on the challenges presented by less generous funding for adult care social services. The Strategic Director commented on the introduction of the Telecare initiative as an example of work being done to contribute to improving health through prevention.

Resolved

That the report be received and comments noted.

10 **Merit Vanguard - Black Country Partnership NHS Foundation Trust**

Jo Cadman, Associate Director of Strategy, Black Country Partnership NHS Foundation Trust, gave a short PowerPoint presentation on work of the MERIT (Mental Health Alliance for Excellence, Resilience, Innovation and Training) programme.

The Associate Director commented that the scale of the programmes matches the size of the West Midlands Combined Authority, with only a few exceptions. The Associate Director outlined the rationale behind the initiative and the intended benefits, for example the opportunity to share good practice and a centralised bed management system. The Associate Director commented on the development of evidence based models across the partnerships and work done to improve skills and help reduce costs as part of the initiative.

The Associate Director commented on the opportunity to use the findings of the peer review to improve preventative services and clinical work streams outlined in the presentation. The Associate Director commented on the governance structure intended to deliver the shared vision across the seven national bodies.

The Chair commented on the need to support people with mental health needs to find employment and also to help people with mental issues to stay employed. The Board commented on the low level of funding for mental health services when compared to other services.

The Board were advised that each partner organisation is responsible for meeting their own responsibilities to handle personal information appropriately – it was accepted that not everything has be shared but the report highlighted the opportunity to share good practice.

The Board discussed the analysis of population figures compared the income summarised in the report and the difference in funding levels. The panel commented on the need for specialist mental health services.

The Board discussed the issue of sharing of personal data and records across the different agencies in the West Midlands region to improve health care.

Resolved:

That the report be received and noted.

11 **Wolverhampton Local Digital Map**

Mike Hastings, Associate Director of Operations, NHS Wolverhampton CCG, presented a report for approval by the Board of plans for Wolverhampton Local Digital Roadmap (LDR) as a requirement by NHS England in order to access funding.

The Associate Director explained that the proposal is an agreement between different health partner agencies who have each contributed to the drafting of the plan. NHS Wolverhampton CCG is the lead organisation responsible for the development of Wolverhampton LDR. The Associate Director explained that the plan was presented to the regional panel meeting in Birmingham. The plans will then be presented to national body for approval. The Board were advised that this is a condition of getting funding to invest in technology intended to transform the delivery of health services. Claire Skidmore is leading on the IT infrastructure and will be represented on the LDR Board.

The Associate Director explained the work being done with GPs to create longitudinal clinical records and progress for the sharing of patient data between primary and secondary care. The Associate Director commented that new system would allow access by The Royal Wolverhampton NHS Trust (RWT) to patient records, with patient permission. The Associate Director explained that RWT plan to make all correspondence electronic to support the plans. The Associate Director commented that the all the partner agencies are working well together and are very supportive of the programme aims.

The Board queried the reference in the report to the development of a shared care record across the whole health and social care economy and progress to date. The Board queried the sharing the records involving child protection issues. The Associate Director explained the issues in achieving this are not insurmountable; however the biggest issue is around complying with information governance requirements. The Associate Director commented that Better Care funding would be used to put a data sharing agreement into place. Furthermore, there will be a need to do a privacy impact analysis, which is being prepared, plus other initiatives to comply with governance requirements about the sharing of health care records.

A member of the Board commented about an event organised by Kings Fund which discussed the how a similar data sharing scheme had been delivered in Canterbury, New Zealand. The Board were advised of the benefits reported of medical staff having access to real time when caring for patients.

The Board commented on concern that there will be parts of the population will never be adopt to using digital technology and queried how the proposal would respond to this challenge. The Associate Director commented that the expectation that the need for paper systems will continue to be made available to the public as means of accessing services. The Board were advised that Government guidance is that access to services should be moved online – digital by default. The Associate Director reassured the Board that the new LDR will not remove existing methods of people accessing health care services on the basis of digital by design.
The Board discussed that the Council is working on the principal of digital by design and not default as part of the Chanel Shift initiative to change how the public access Council services.

Ros Jervis, Service Director Public Health and Wellbeing, commented on the importance of using the work of the LDR to support the commissioning of services and also feeding into the work of the Joint Strategic Needs Analysis (JSNA).

The Board sought reassurance that the reference in the document to the safeguarding of adults, also applied to child care protection. The Associate Director confirmed. The Board commented that the aim of LDR programme is not just about information sharing and it was important that full use is made of the information.

The Board commented that the embedded documents listed in Appendix 2 of the report could not be opened and this problem should be corrected asap before it is shared with the public.

The Strategic Director, Community, queried the sign-off process for the LDR and if key people within the Council had been consulted about the plans. The Strategic Director commented that the report had not been shared with People Leadership Team and requested that it presented for more detailed consideration of the plan.

Cllr Samuels commented that the Cabinet Member with lead responsibility for Health and Wellbeing is Cllr Paul Sweet.

Resolved:

1. The Wolverhampton Local Digital Roadmap report to be presented to People Leadership Team.
2. The Board support the aims of Wolverhampton Local Digital Roadmap and approved the report.

12 **Sustainability and Transformation Plans (STP) 2016/17 update - 2020/2021**

Viv Griffin, Director Disabilities and Mental Health, gave an overview of the background and aims of the Black Country Sustainability and Transformation Plan (STP). The Director Disabilities explained that there has been a high level of engagement in the development of the plan, however there is more work to be done. The meetings with representatives of key partners have been positive and productive.

A final submission is timetabled to be completed in September 2016. The final version will provide details about specific areas of work, deliverables, outcomes and timings.

The Board agreed that the report should be added to the Forward Plan for consideration.

The Director of Disabilities outlined the main themes of the plan and explained that it was aimed at supporting people to be independent and move away from placements in institutional care settings. The amount spent on providing adult social care is too high.

The Board commented on the changes to the management and delivery of adult and social care as part of wider devolution plans affecting the Greater Manchester region The Greater Manchester Devolution and Locality Plans will give local control over how public money is spent in the area to deliver agreed improvements in health outcomes.

The Board commented the plans include looking at alternative models for delivering primary care and a recognition that acute care is the most expensive care to provide.

Tracey Cotterill, Deputy CEO, Black Country Partnership NHS Trust commented on the speed of progress and the need for the Board to review progress.

The Chair commented that the Board will watch the developments in Manchester with interest to see how it progresses.

The Board commented on the importance of public engagement about the plans for transforming services to provide reassurance, where the plans raise concerns. The Board commented that the Sustainability and Transformation Plan (STP) has to be the vehicle for any joint work planning in the future. The Board queried how the plan will fit with the bigger picture of other health improvement initiatives. The Board were advised that the SDP should be the 'golden' thread that links all part of the work aimed at improving health outcomes.

The Board discussed the reference in the report to reducing the number of acute mental health sites across the Black Country from five to four. Jo Cadman, Associate Director of Strategy, Black Country Partnership NHS Foundation Trust, responded that there is a discussion needed about what the appropriate level of provision required to deliver improved quality and economies of scale across the acute care sector.
The Board discussed the implications of the £124 million local authority balance of challenge and to work to reduce this gap in funding.

The Strategic Director, Community, outlined the process by which the local authority and finance leads have been engaged in the process to assess the scale of the financial challenge

Jan Sensier, Chief Executive, Engaging Communities, Healthwatch, Wolverhampton expressed concerns the speed of the timescale detailed in the report will militate against full public engagement. The Chief Executive commented on the challenges in getting the public involved and the work done by Healthwatch Sandwell and Walsall to explain the implications of the plans. Mike Hastings, Associate Director of Operations, commented that in discussions with Stephen Marshall there was acknowledgement that the pace has been quick. The Board were advised that any planned changes to services would be subject to full public consultation. The issue of public consultation has also been embedded into the project plan.

Jan Sensier commented on the value of pre-consultation work done with the public to help inform the development of standards in Sandwell. Jan Sensier commented on the statutory processes that need to be completed before the plans can be implemented. The Board discussed the issue of ownership of the plan and how the views of different partner organisations will be considered. The Board accepted that further work was needed to consider the implications of the proposals and also the concerns that it may be seen as top-down re-organisation, which may lead to resistance from the public and staff.

The Board discussed the timetable for the STP and agreed that it would be useful for this information to be shared.

Linda Sanders commented that the issue about pre-consultation with the public will be discussed at the next regional STP meeting.

Jeremy Vanes, Chair, The Royal Wolverhampton NHS Hospital Trust, commented that the service supported the transformation plans and the need for change, but shared the concern about the speed of the plans and the implications for governance. For example, the issue of pooled budgets and the different financial position of the partners involved. The Chair added that there was also a need to consult with staff about the plans

Resolved:

1. That the report be noted and received.
2. That a progress report on STP is added to the Forward Plan for further consideration.

13 **Revised Mission Statement**

Ros Jervis, Service Director for Public Health and Wellbeing, explained the Board requested an updated mission statement to that presented on 27 April 2017. The mission statement has been amended in response to comments received.

Resolved:

That the report be received and noted.

14 **Director of Public Health Annual Report 2015 16 - Presentation**

Ros Jervis, Service Director Public Health and Wellbeing, gave an overview of the content of the public health annual report. 2015/16 The report will detail the history of public health and the changes in Wolverhampton population and place over the last 150 years. The report will give a historical overview of changes in the population and the opportunity to celebrate the progress made, for example the reduction infant death rates.

The Service Director commented Wolverhampton appointed its first medical officer for health 150 years who led work to tabulate the causes of death for the first time. The main cause of death at the time was TB and smallpox. The Service Director commented on changes in the causes of death overtime and the analysis of six biggest killers. The list the list has remained unchanged and are linked to poor lifestyle choices.

The Service Director commented on changes in life expectancy between men and women and the challenge of how to support people, who typically will need a high level of care and provision. The annual report is timetabled to be completed in October 2016 and presented to a future meeting of the Board for consideration.

Resolved:

1. That the presentation be received and noted.
2. That the Director of Health Public Annual Report 2015/16 be added to the Health and Wellbeing Forward Plan 2016/17 for future consideration.

15 **Minutes from sub Group (Children's Trust Board)**

Resolved:

That the report be received and noted.

16 **Information and update item**

The Chair wanted formally record his thanks on behalf of the Board to Viv Griffin for all work and support, who will be leaving the Council.

The meeting closed at 14:04

Agenda Item No: 6

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

19 October 2016

Report title	Summary of outstanding matters	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Wards affected	All	
Accountable director	Ros Jervis, Service Director Public Health and Wellbeing	
Originating service	Governance	
Accountable employee(s)	Earl Piggott-Smith Tel Email	Scrutiny Officer 01902 551251 earl.piggott-smith@wolverhampton.gov.uk
Report to be/has been considered by		

Recommendations for noting:

The Health and Wellbeing Board is asked to note:

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	NHS Capital Programme – NHS England – GP practices in Wolverhampton	Dr Kiran Patel (NHS England)	Quarterly reports
10 February 2016	Quality and safety framework - outcome of discussions with partner organisations on framework and quarterly reports thereafter	Manjeet Garcha (WCCCG)	Report to a future meeting
20 July 2016	Sustainability and Transformation Plans (STP) 2016/17 update - 2020/2021	Steven Marshall – Director of Strategy & Transformation (WCCCG)	Report to this meeting

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.
[GS/11102016/O]

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.
[Legal Code: TS/11102016/G]

5.0 Equalities implications

5.1 None arising directly from this report. The environmental implications of each matter will be detailed in the report 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.

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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.

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Agenda Item No: 7

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

19 October 2016

Report title	Forward Plan	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Wards affected	All	
Accountable director	Ros Jervis, Service Director Public Health and Wellbeing	
Originating service	Governance	
Accountable employee(s)	Earl Piggott-Smith Tel Email	Scrutiny Officer 01902 551251 earl.piggott-smith@wolverhampton.gov.uk
Report to be/has been considered by		

Recommendations for noting:

The Health and Wellbeing Board is asked to:

1. Consider and comment on the draft forward plan which proposes a new format for presenting future agenda items.

2. Consider and approve the merging of ‘summary of outstanding matters’ into a new forward plan for future meetings of the Board

1.0 Purpose

1.1 The purpose of this report is to present a draft forward plan to the Board for comment and discussion. There is a new format to the proposed forward plan with the idea that this would be easier to plan and prioritise agenda items. The forward plan would in future also combine the summary of outstanding matters; which is currently subject to a separate agenda item.

1.2 This proposed change is intended to support a key aim of the Board – to promote integration and partnership working between the NHS, social care, public health and other commissioning organisations.

2.0 Background

2.1 At previous meetings of the Board the forward plan has been presented in the form of a list of items. The attached draft plan seeks to enable a fluid, rolling programme of items for partners to manage (see attached).

3.0 Financial implications

3.1 None arising directly from this report. [GS/11102016/R]

4.0 Legal implications

4.1 None arising directly from this report. [RB/11102016/V]

5.0 Equalities implications

5.1 None arising directly from this report.

6.0 Environmental implications

6.1 None arising directly from this report.

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7.0 Human resources implications

7.1 No HR implications arising directly from this report.
[HR/JF/RJ/030]

8.0 Corporate landlord implications

8.1 None arising directly from this report.

9.0 Schedule of background papers

9.1 Minutes of previous meetings of the Health and Well Being Board regarding the forward planning agenda items.

Health and Wellbeing Board: Forward Plan

Updated 03 October 2016

Items in red are new or amended from the previous version.

Items ~~crossed out~~ have been rescheduled for a later date.

Items are highlighted where no report was received and there is currently no arrangement to reschedule.

Items are in **bold** that are regular or standing items.

Date	Title	Partner Org/Author	JHWBS Priority	Paper Or Pres	Notes/comments
19 Oct 2016	Healthy Lifestyle Survey: Key findings	CWC/Ros Jervis		Paper	Paper, deferred from last meeting agenda
	City of Wolverhampton End of Life Strategy	CCG/Karen Evans		Paper	Deferred from last meeting agenda
	Workshop: "Living Well, Feeling Safe"	CWC/Linda Sanders		Paper	Planned for a focus on 'prevention' in the City.
	CAMHS Local Transformation Plan	CCG/Fred Gravestock		paper	Timelines directed by funding bid
	Primary Care Strategy – implementation update	CCG/Steven Marshall		paper	
	Better Care Fund (BCF): Quarterly Report	**CCG/Steven Marshall/CWC Paul Smith**		**paper**	**Last considered 10 February 2016**
	CCG Commissioning intentions	CCG/Steven Marshall		paper	In accordance with NHS planning guidance
	Sustainability and Transformation Plans (STP)	CCG/Steven Marshall and		**verbal**	Currently embargoed this needs to be in exempt section (below the line)

Key: JHWBS priorities

	2016/17 to 2020/21	CWC/Linda Sanders			
30 Nov 2016	Joint Strategic Needs Assessment	CWC/Ros Jervis			Last considered April 2016
	Dementia and Care Closer to Home	**CWC/David Watts and CCG/Steven Marshall**			**Deferred from last meeting**
	Better Care Fund (BCF): update report and 2017/18 programme	**CCG/Steven Marshall and CWC/David Watts**			
	Sustainability and Transformation Plans (STP) 2016/17 to 2020/21	CCG/Steven Marshall and CWC/Linda Sanders			Detailed plan previously embargoed
	Mental Health Services: revised Provider Trust Arrangements	BCPFT			
	JHWBS Priority update				
15 Feb 2017	**Better Care Fund (BCF): Quarterly Report**	**CCG/Steven Marshall/CWC David Watts**			**Last considered 30 November 2016**
	Public Health & Wellbeing Commissioning Intentions	CWC/Ros Jervis			
	JHWBS Priority update				
29 Mar 2016	**Better Care Fund (BCF): Update Report**	**CCG/Steven Marshall/CWC David Watts**			**Last considered 29 March 2017**
	JHWBS Priority update				
May to July 2017 TBC	**Director of Public Health Annual Report 2016/17**	**CWC/Ros Jervis**			

Key: JHWBS priorities

Key: JHWBS priorities

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Agenda Item No: 8

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

19 October 2016

Report title	Wolverhampton Children & Young People's Mental Health and Wellbeing Local Transformation Plan
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing
Wards affected	All
Accountable director	Linda Sanders, People Directorate
Originating service	People Directorate (on behalf of Children's Commissioning, Wolverhampton Clinical Commissioning Group)
Accountable employee(s)	Fred Gravestock Whole System Transformation Director Tel 01902 444537 Email f.gravestock@nhs.net
Report to be/has been considered by	

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Review and sign off the refresh of the Wolverhampton Children & Young People's Mental Health and Wellbeing Local Transformation Plan.

1.0 Purpose

1.1 The Health and Wellbeing Board is asked to review and sign off the refreshed Children and Young People's Mental Health and Wellbeing Local Transformation Plan (LTP) – see **Appendix 1**.

2.0 Background

2.1 NHS England requires that each Clinical Commissioning Group refresh the Children and Young People's Mental Health and Wellbeing Local Transformation Plan (LTP) that were submitted in October 2015 as part of the application for Future in Mind funding. The original LTP was signed off by the Health and Wellbeing Board at the meeting on 2 December 2015, and then published on the CCG website (https://wolverhamptonccg.nhs.uk/your-health-services/mental-health-services). The document has been prepared with a tight timeframe in order to be scrutinised by NHS England (West Midlands) prior to final submission and publication by 30 October 2016.

3.0 Executive Summary

3.1 The Wolverhampton Children & Young People's Mental Health and Wellbeing Local Transformation Plan 2015-20 (LTP) outlines the vision to implement a tier-less whole system across health, education and social care. This plan includes significant system re-design involving all providers of emotional health and wellbeing services. The document provides background information on why transformation is essential, and then outlines the place based care model aligning with Strengthening Family hubs and HeadStart hubs. Details are provided on how the Future in Mind funding (£532,047) has been allocated.

4.0 Progress

4.1 The most significant change to the LTP is the aligning of services with the Strengthening Family hubs and HeadStart hubs, using a place based care model. Also it links the LTP with the developments that are occurring through the Sustainability and Transformation Plan where commissioning will occur on a Black Country footprint.

4.2 There has been no change to the funding amount nor in the areas that were signed off at the Health and Wellbeing Board on 2 December 2015.

5.0 Financial implications

5.1 The elements of the LTP are fully funded through Future in Mind, and have been included as recurrent items in the CCG's funding of the Black Country Partnership NHS Foundation Trust delivery of CAMH services.

6.0 Legal implications

6.1 There are currently no outstanding legal issues that need to be highlighted to the Board.

7.0 Equalities implications

7.1 The LTP describe a range of on-going services that have been scrutinised by the CCG, and the NHS provider to ensure that they continue to comply with relevant legislation.

8.0 Environmental implications

8.1 There are currently no outstanding environmental issues that need to be highlighted to the Board.

9.0 Human resources implications

9.1 There are currently no outstanding human resources issues that need to be highlighted to the Board.

10.0 Corporate landlord implications

10.1 There are currently no outstanding corporate landlord issues that need to be highlighted to the Board.

11.0 Schedule of background papers

11.1 The ‘Wolverhampton Children & Young People's Mental Health and Wellbeing Local Transformation Plan’ October 2016 is attached.

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CITY OF WOLVERHAMPTON COUNCIL

NHS Wolverhampton Clinical Commissioning Group

Wolverhampton

Children & Young People's Mental Health and Wellbeing

Local Transformation Plan

October 2016

Contents

'Early Intervention to promote social and emotional development can significantly improve mental and physical health, educational attainment and employment opportunities. Early Intervention can also help to prevent criminal behaviour (especially violent behaviour), drug and alcohol misuse and teenage pregnancy'. Early Intervention: The Next Steps: An Independent Report to Her Majesty's Government, Graham Allen MP, 2016.

Introduction

In Wolverhampton emotional health and wellbeing health needs to be everyone's business and that all agencies (public, community, and private) need to work together to ensure that all children and young people enjoy good mental health and emotional wellbeing, including those that are most vulnerable in society such as children looked after by the local authority. This emphasis on children and young people is essential as the evidence shows that over three quarters of all mental health problems have emerged by the age of twenty, making childhood determinants primary in future mental wellbeing[1]. Good mental health and emotional wellbeing will be achieved by emphasising prevention, early identification and intervention using evidence-based approaches that represent value for money. Where a mental health problem or disorder is identified children and young people will have access to timely, integrated, high quality and multidisciplinary mental health services that are accessible and responsive to individual need.

The Wolverhampton Children & Young People's Mental Health and Wellbeing Local Transformation Plan 2015-20 (LTP) outlines the vision to implement a *tier-less whole system* across health, education and social care. This will include significant system re-design which involves all providers of emotional health and wellbeing services. This is not a criticism of the current Child and Adolescent Mental Health Service (CAMHS) provision, but recognition that resources and services need to be aligned and joined-up in order to meet growing need and increased demands upon the whole service system. Collaborative commissioning opportunities exist across the Black Country, for example regarding CAMHS Tier 3 Plus Services (CAMHS Crisis, Home Treatment and Assertive Outreach Services) and tri-partite funded care packages for children placed out of city. Aligning all contracts with the proposed model will be essential if transformation efforts are to be successful. Consequently, co-commissioning and partnering arrangement are essential for Wolverhampton Clinical Commissioning Group (WCCG) and City of Wolverhampton Council (CWC), as is the alignment of new developments with Strengthening Families initiative, HeadStart, the local offer for children and young people, initiatives delivered within schools such as counselling services, pastoral care and universal services, and the return of budgets for Tier 4 placements to local commissioners. It also includes the service re-design that is occurring in the Black Country Partnership Foundation Trust (BCPFT) – CAMHS provider – as part of their sustainability and partnering developments with two other West Midland NHS providers. The fundamental principle that underpins all of this transformation activity is the shifting of financial and service resources from acute settings to local community and early intervention services.

The CAMHS LTP for 2017-2020 is primarily a refresh of the previously submitted LTP for 15/16 and 16/17. The work outlined in this document builds upon the analysis that was conducted for the initial plans, and extends the scope of the original plan to ensure that services are sustainable, effective, integrated, and fit to meet future challenges.

For the sake of clarity, it is important to note that while the BCPFT provides a specific CAMH service, the proposed model focuses on improving the whole system of delivering emotional health and well-being services. It is suggested therefore that we review the language used in discussing services, to differentiate between the whole service system and the organisation that delivers 'Tier 3' and specialist services. When referring to the organisation and the specific service they deliver it is appropriate to reference CAMHS.

1 Better Mental Health For All: A public health approach to mental health improvement. Faculty of Public Health; London, 2016.

However, when referring to the whole system – early help to inpatient support – this is not CAMHS, but a range of emotional health and wellbeing services delivered by various providers.

Purpose of service system transformation and LTP

The Wolverhampton Transformation Partnership Board (WTPB) is the joint forum with responsibility to implement the strategic and service level changes required of the emotional health and wellbeing services for children and young adults. Membership of the Board includes senior managers from WCCG, CWC (social care and education), BCPFT, Royal Wolverhampton Trust (RWT), NHS England, and the voluntary sector. It is a key partnership Board that reports to Wolverhampton Health and Wellbeing Board, as well as the Wolverhampton Children's Trust. This Board has responsibility for overseeing the refresh and implementation of the Children & Young People's Mental Health and Wellbeing Local Transformation Plan (LTP). The CAMHS LTP has been submitted for review and sign off by the Health and Wellbeing Board at their next meeting on Wednesday 19th October 2016. Following successful progress through this Board, the CAMHS LTP will be published on the WCCG website.

Given the current financial circumstances, and the need to obtain greater efficiencies with current services, the WTPB must oversee and direct a range of activities, including**2**:

- re-design of the whole service system delivering emotional health, well-being and mental health services to children, young people and their families across Wolverhampton
- re-design of the whole system ensuring services are meeting the needs of all vulnerable children and young people, including children in need, looked after children, and those subject to child protection orders
- align the new service system with prevention and early help initiatives (i.e. HeadStart), and universal services (i.e. Health Visitors, and Public Health Nurses)
- identify opportunities for new and integrated models of working across the whole system and with a range of partners, including re-allocating resources across community and local services
- reduce need for high cost, out of area interventions; keep young people local; bring young people back to Wolverhampton early as possible, and improve patient and carer experience
- maintain Quality as pivotal in all developments, as well as safety and management of risk
- report to the Area Team and National Programme on performance against the Future in Mind CAMHS Transformational Plan.

To achieve the transformation outlined in the LTP**3**, the WTPB established 5 Task and Finish Groups**4** to progress its work. The Early Intervention and Pathways Task and Finish Group were responsible for the production of this proposed model.

The WTPB has a very clear vision for what the CAMHS transformation**5**. There will be an integrated range of services

> *….where a mental health problem or disorder is identified children and young people will have access to timely, integrated, high quality and multidisciplinary mental health services that are accessible and responsive to individual need.*

The service system will be continuous, from self-help, to early help, through early intervention, to specialist help. The service system will move children and young people smoothly to more intensive interventions and then down to less intensive interventions as the child and young person's need dictates. Professionals will work in a flexible manner, with as many services delivered locally. Multi-organisation and multi-disciplinary working will be the standard way of operating, with agreed governance arrangements in place. The service

2 Vision and model: CAMHS Transformation in Wolverhampton. March 2016.
3 Wolverhampton CAMHS Local Transformation Plan 2015/16.
4 Wolverhampton Transformation Partnership Board: Task and Finish Groups. April 2016.
5 Vision and model: CAMHS Transformation in Wolverhampton. CAMHS Transformation Partnership Board, 2016.

system will be without tiers, with intervention based upon a child need rather than the services that an organisation has been commissioned to deliver. The local authority, CCG, and providers will work closely at all levels within the respective organisations, with transition to adult services part of the seamless local offer.

Working across the whole of Wolverhampton, there are a number of critical fora that are key strategic drivers in the delivery of the LTP plan. The participation and cooperation of each of these bodies is essential to whole system transformation, and include:

- Wolverhampton CCG Commissioning Committee
- HeadStart Programme Board
- Integrated Commissioning Board
- Children and Young Peoples Trust Board
- Safeguarding Board
- Mental Health Stakeholder Forum
- Mental Health Partnership Forum
- Black Country Mental Health Leads
- Specialised Commissioning Oversight Group
- Health and Well-Being Board
- Families In Focus Programme Board
- WCCG and BCPFT Contract Monitoring
- WCCG and BCPFT Clinical Quality Review
- WCCG and BCPFT Joint Efficiency Review
- Black Country Clinical Senate
- Specialised Commissioning Oversight and Scrutiny Group.

Factors relevant to local transformation plan

Before considering the LTP, it is important to have an understanding of the Wolverhampton context, and the factors contributing to the model's design. These include the identifying the numbers of children and young people with emotional health and wellbeing challenges, the economic circumstances, policy drivers, as well as findings from mental health research. These are discussed briefly below.

1. Wolverhampton population

According to the latest Office for National Statistics (ONS)**6** population estimates, there are 252,987 residents in Wolverhampton. Of these, 32% (n=81,428) are children and young people under 25 years of age. This is a higher percentage compared to England's average, where 30.4% of the population are children and young people under-25 years – see Figure 1. While the Joint Strategic Needs Assessment (JSNA) for

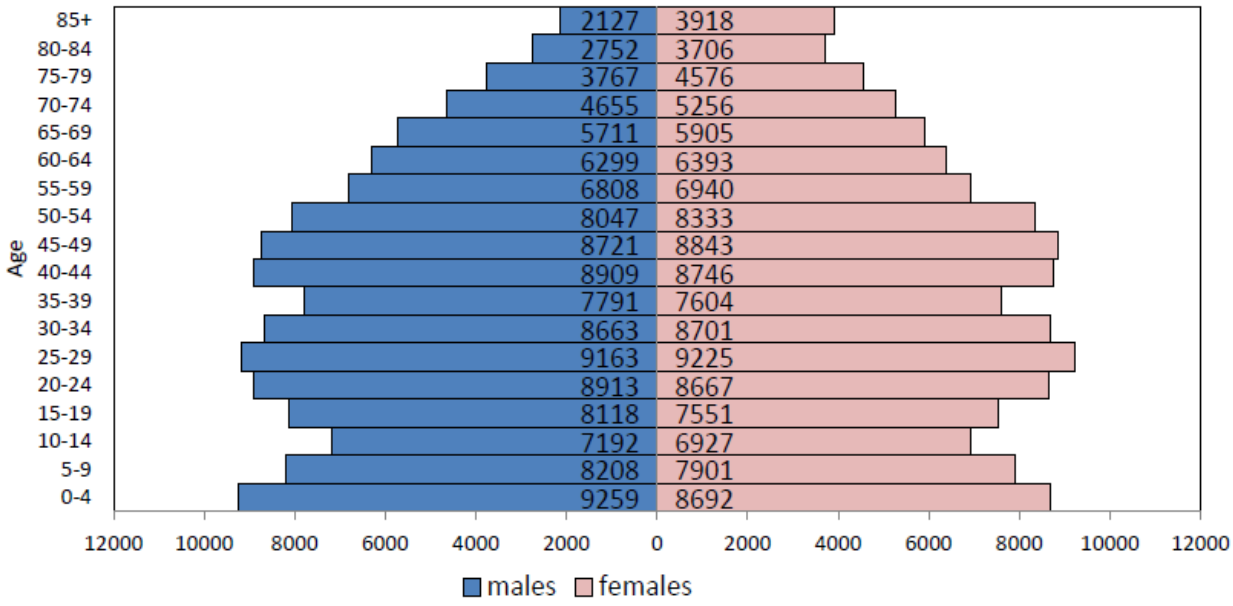

Figure 1: Mid 2014 Population estimates for Wolverhampton

6 Wolverhampton in Profile, City of Wolverhampton Council, *www.wolverhamptoninprofile.org.uk/*

Wolverhampton**7** is in the process of being refreshed, preliminary findings from this as well as the Children's Outcomes Framework spine chart (Appendix A) are used to inform the development of this strategy.
In Wolverhampton, the highest proportion of children and young people are in the age bands 0-4 years (22%) and 20-24 years (22%). This is similar to the national picture where 21% and 22% of children and young people are in the age bands 0-4 and 20-24 respectively – see Figure 2..

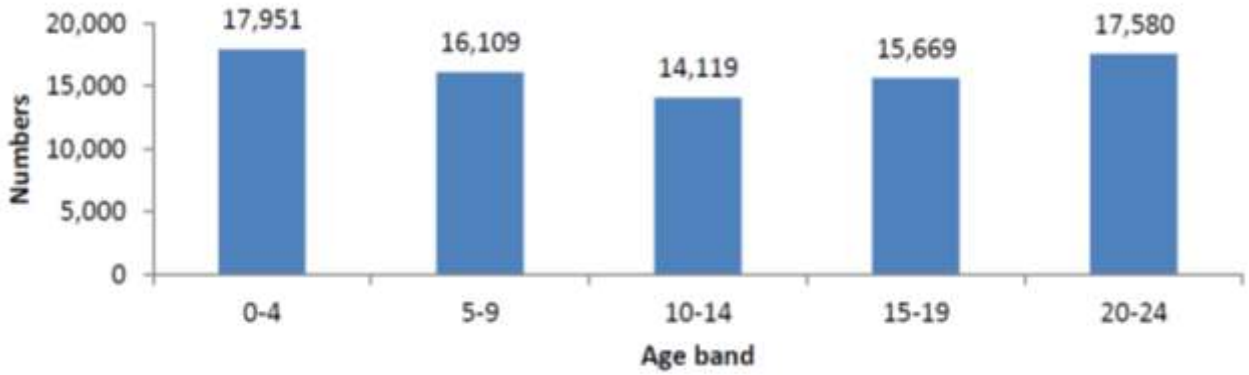

Figure 2: Population of children and young people by age bands

Wolverhampton residents are from a white ethnic background with the remaining 32% of residents belonging to black minority ethnic backgrounds (BME). Wolverhampton has high numbers of new arrivals arriving into the City each year including traveller families (estimated 2700 families in 2012). In terms of levels of deprivation in our City Wolverhampton is the 21st most deprived Local Authority in the country, with 51.1% of its population falling amongst the most deprived 20% nationally. Deprivation is disproportionate across the city, with the more affluent wards in the west of the city. A number of sources of evidence suggest that a number of equalities and demographic factors can have a significant effect on the local need and uptake of mental health for children and young people including:

- high numbers of Black and Minority Ethnic communities
- parents in prison or in contact with the criminal justice system
- social deprivation and high levels of unemployment
- high rates of housing and homelessness
- refugees and asylum seekers (new arrivals)
- children and young people with long term conditions/physical and/or learning disabilities
- lesbian, gay, bisexual and transgender people (LGBT)
- children and young people who are questioning their sexual orientation and/or gender (LGBTQ)
- substance misuse
- children and young people who are victims of violence, abuse and crime including domestic violence and bullying.

2. Emotional health and wellbeing challenges

Prevalence[8],[9] estimates are available for a range of common mental health disorders, and show that in Wolverhampton:

- nearly 4,000 children and young people (5 to 16 years) have a diagnosable mental health disorder
- conduct disorders are the most common diagnosis equating to nearly 2,400 young people

7 Draft Joint Health and Wellbeing Strategy 2013-2018, Published by City of Wolverhampton Council in 2013. *www.wolverhampton.gov.uk/CHttpHandler.ashx?id=2944&p=0*

8 Data in this section was obtained from Wolverhampton children and young people mental wellbeing needs assessment 2015 – A needs assessment to support Wolverhampton's Big Lottery HeadStart Phase 3 bid. Summary of Key points from analysis to date (28 Nov 2015).

9 Black Country CAMHS Tier 3 / 4 Co-Commissioning Project Report, April 2016, WCCG.

- more boys than girls are affected by conduct disorders
- over 1,500 young people have an emotional disorder - more girls than boys
- 570 boys, and 85 girls are estimated to have a hyperkinetic disorder
- 4,000 young people are expected to have an eating disorder
- 4,000 children and young people are expected to have ADHD
- 40% of young people who have a learning disability may also have a mental health disorder
- 70 children (aged 9 – 10 years) are estimated to have some form of autism spectrum condition
- 351 of looked after children have a mental health disorder
- 196 young people were admitted to an acute setting with diagnosis of self-harm or mental health disorder.

Since January 2014[10], the Child and Adolescent Mental Health (CAMH) service has been running at a capacity with 1,000 contacts per month, equating to 400 children. During the period January 2014, - September 2015, data indicates that 2,383 individual children and young people were seen by the CAMH service, with 49% (1,165) female, and 51% (1,201) male. Most children were between the ages of 10 and 17 years, however a significant proportion (26%) were under 9 years of age. Service users came from a wide range of ethnic backgrounds. 95% of referrals waited less than18 weeks, with 61% waiting for eight weeks or less. Fallings Park, Bushbury South and Low Hill, and East Park were the Wards with the highest numbers of children and young people referred to CAMHS. When compared with national data[11], children and young people in Wolverhampton receive a responsive service which is apparent from the positive patient reports obtained by BCPFT.

3. Consultation with children, young people, and stakeholders

The transformation plans have been developed and shaped through extensive consultation with children and young people, as well as stakeholders. This has been an on-going process that had commenced in early 2015. Emotional health and wellbeing issues were clearly identified through the consultation process conducted by HeadStart as they commenced designing the phase 3 of The Big Lottery bid. The initial consultation with HeadStarters (groups of young people actively engaged in design of HeadStart programme) and continued with stakeholders and service users. The most recent consultations are outlined in Figure 3.

Consultation	*Stakeholder group*
Emotional health and wellbeing	Children, young people, and families
Emotional health and wellbeing	General public and providers
CAMH services	Children, young people, and families
CAMHS transformation	Youth Council
CAMHS transformation plan 2017-19	Paediatric staff Royal Wolverhampton Trust
CAMHS transformation plan 2017-19	Voluntary sector agencies
CAMHS transformation plan 2017-19	Clinicians at Black Country Partnership NHS FT
CAMHS transformation plan 2017-19	CWC – Children & Young People's Team
CAMHS transformation plan 2017-19	CWC – People's Leadership Team
CAMHS transformation plan 2017-19	YOT Board
CAMHS transformation plan 2017-19	Wolverhampton Children's Trust Board
CAMHS transformation plan 2017-19	Better Care Fund Partnership Board
CAMHS transformation plan 2017-19	Strengthening Family Hub managers
CAMHS transformation plan 2017-19	HeadStart Executive Board
CAMHS transformation plan 2017-19	HeadStart Board
CAMHS transformation plan 2017-19	Head teachers and senior education staff
Commissioning intentions 2017-2019	BCPFT Commissioning and Contract leads

Figure 3: Consultations on CAMHS LTP, June – September 2016

10 Black Country CAMHS Tier 3 / 4 Co-Commissioning Project Report, April 2016, WCCG.
11 See Page 12 of this paper for national data.

These particular meetings were critical in obtaining confirmation from a broad range of stakeholders on the current model for transformation. The general consensus from these meetings was that the transformation plan:

- designed to meet needs of children and young people in Wolverhampton
- used the contribution of all stakeholder in its development
- effective governance process in place with the WTPB
- effective contract management processes for ensuring continuity of services
- taken into account the developments in the local service system
- linked effectively with the STP
- incorporated plans for eventual return of specialist commissioning's Tier 4 funds
- provide better outcomes for children and young people.
- improved and enhanced crisis and home treatment services.
- improved and enhanced Early Intervention in Psychosis Services.
- improved response times across all services
- introduced a single point of access.

Areas that had been identified through consultation that need further work, but are included in the LTP include:

- care as close to home as possible with fewer out of area education, health and social care placements outside Wolverhampton
- greater connectivity across education, health and social care system with fewer barriers and gaps and far greater integration in terms of delivering help and support
- support and advice in school, including peer support, targeted support in school/s from CAMHS staff and resilience and mental health awareness building training for staff, children and parents
- support and advice at 'our finger tips', i.e. digital resources including web based and social media solutions that provide help support and guidance
- '*a place to go'* which provides social interaction, support and positive role models and parental advice.

4. Locally available data

Comprehensive data is collected locally and presented in the Service Quality Performance Report (SQPR). The data for 15/16 and 16/17, used in the monthly contract monitoring meetings with provider, are included as embedded documents in Appendix B. The contract meeting analyses the activity and performance of the provider on a number of important measures, with actions agreed for the provider to implement.

5. Economic environment, and Sustainability and Transformation Plans

The current economic environment requires that all local authorities and NHS commissioners have reducing funds available, but must drive quality improvement and economic efficiencies within established financial parameters. Indeed, the NHS has to close a £30 billion gap and has outlined in *Five Year Forward View* how this can be achieved through transformational systemic changes[12].

In December 2015, the NHS shared planning guidance 16/17 – 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England was required to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next

12 Tackling the growing crisis in the NHS. The King's Fund 2016. http://www.kingsfund.org.uk/publications/articles/nhs-agenda-for-action.

five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency[13].

i) Black Country STP

Wolverhampton's CAMHS LTP is aligned to the Black Country STP. The ambition of the BC STP is to operate as 'one NHS commissioner' across the Black Country, leading to: substantial reductions in care and service variations; standardised services; maximisation of resources and workforce through better use of skill mix; alignment with West Midlands Combined Authority regeneration and MH Commission strategy. To deliver plans that are based on the needs of local populations, local health and care systems came together in January 2016 to form a Black Country 'footprint', with health and care organisations working together to develop a Black Country STP to drive genuine and sustainable transformation in patient experience and health outcomes of the longer-term.

By agreeing common service specifications/models across CAMHS, Black Country CCGs will be able to develop standardised and potentially more cost effective solutions, minimising 'differentiated' services and 'service flavours'. By comparing service delivery approaches across the Black Country and performance, opportunities to reduce variation will be identified. With the aim of reducing role duplication, streamline service management and allow investment in front line staff development and up-skilling, there will also be further opportunities to develop this across the wider West Midlands' health economy through the work in the MERIT vanguard. Standardisation across local areas will:

- simplify access to services improving health and wellbeing for users, families, staff and communities
- common responsive and standardised all age, Early Intervention services
- reduce variation in care and service delivery across the Black Country
- ensure clear, simplified pathways for users, ensuring most effective use of resources
- achieve economies of scale for providers and reduction of duplication
- improve utilisation in front line services through better skill mix usage and reduction in temporary and locum costs.

ii) Action plan for Black Country STP – workforce planning

Following the announcement of the £8.8M funding awarded by The Big Lottery for the HeadStart programme (early intervention services for emotional health and wellbeing), WCCG commenced a review of the whole service system workforce. Workforce issues had previously been identified with the provider of specialist CAMHS (BCPFT) by an external quality audit[14], as well as apparent in challenges faced in recruiting staff following the Future in Mind funding. With workforce development being one of the important areas of strategic planning for the Black Country STP, the local work in reviewing current workforce, and planning workforce requirements have been taken over by footprint wide efforts. It is anticipated that a complete five year forward workforce review and plan will be available by March 2017.

6. Influential policies and reports

Over the past three years there have been a number of influential policies and reports published. The direction established by these has helped to shape local thinking and the creation of a Wolverhampton model for mental health and wellbeing services. From a range of authors / organisations, these documents indicate that the CAMHS is not able to meet the current demand, that many children and young people are not able to access services, that the service will not be sustainable without significant

13 NHS: Sustainability and Transformation Plan https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/

14 WM QRS (2016). Towards Children and Young People's Emotional Health and Well-being: Sandwell & Wolverhampton Health & Social Care Economy. January 2016.

change - '*more of the same is simply not an option*[15]', and that whole service system transformation is required. They emphasise the benefits of early intervention, locally based multi-disciplinary teams, the impact of resilient families in reducing demands on services, and the emphasis on self-help using a strength based approach. They also identify the importance of schools in developing resilience in children and in providing a supportive environment.

The intention of this local transformation activity is best summarised by the 'triple aim' of NHS England outlined in the Five Year Forward View, which directs CCGs to (i) improve the health and wellbeing of the whole population; (ii) provide better quality for all patients, through care redesign; and (iii) have better value for taxpayers in a financially sustainable system**16**. There are also a significant number of key documents that have influenced the direction taken in the LTP and are listed in Appendix C:

7. Developments in mental health research

Psychological research over the past ten years has focused on the roles of nature and/or nurture in the determinants of mental ill health, and how this impacts on services development. Research has shown that the best predictors by far of all of mental health conditions, whether it is depression, suicidality, psychosis, are all life events, with the strongest predictor all by itself being poverty (Read, 2005). This is not because poverty by itself causes depression, but because it is a predictor of all the other things that are causal. So poverty has been described as the cause of the causes (Read, 2005).

In studying the determinants of psychosis for example, a condition thought to have a strong genetic predisposition, researchers have explored psychosocial factors as a causal agent, rather than as a mere triggers or contributing factor (Joseph, 2003: Kinderman, 2014). Indeed, poverty (Read, 2004), urban living (van Os et al., 2001), racism (Karlsen & Nazroo, 2002), other forms of discrimination (Janssen et al., 2003), child abuse (Read et al., 2003; Read et al., 2005), and having a rather battered mother (Whitfield et al., 2005) have all been shown to be highly predictive of psychosis. Some researchers have even suggested that schizophrenia is preventable via universal programmes enhancing children's safety and quality of life (Davies & Burdett, 2004). *'The simple truths appears to be that human misery is largely inflicted by other people and that the solutions are best based on human – rather than chemical or electrical – interventions'* (Read, 2005). As mental health is greatly influenced by complex psycho-social-biological factors, an integrated, multi-disciplinary approach focused on meeting the needs of children, young people, and families is essential.

The proposed vision for transformation of emotional health and wellbeing service system, and the associated LTP outlined in this paper have been informed from a number of sources. These have included the outcomes from the range of consultations with service providers, children and young people, and commissioners; as well as a review of the research literature on current trends in provision of health and social care services. Following is a brief review of each of these important and influential sources.

Research and best practice informing LTP

There is a large body of research and best practice documents that have influenced the development of the Wolverhampton transformation plan. Rather than going into to much detail, a number of key findings are highlighted below.

[15] Local Transformation Plans for Children and Young People's Mental Health and Wellbeing: Guidance and support for local areas, NHS England, August 2015; p. 9.

16 CCG improvement and assessment framework 2016/17, NHS England 2016.

1. Early intervention and prevention as a priority

Psychological and social research have demonstrated clearly that early intervention in a problem cycle results in better outcomes for children and families, including improvements in academic results, behaviour, educational progression and attainment; reduction in delinquency and crime, and labour market success[17][18]. These interventions also reduce stress and trauma experienced by the family, as well as the curbing the extent of associated issues that problem escalation produces.

The economic case for building sustainable prevention and early intervention programmes is argued in a published in 2011 by London School of Economics and Political Science[19]. It reported that:

- high value for money achievable by prevention and early intervention programmes
- ability to recover costs within a relatively short period of time for programmes addressing childhood mental health problems, which in the absence of intervention have a strong tendency to persist into adult life
- ability of such programmes to become self-financing in the longer term.

The report continues by calculating the return on investment across the NHS, public sector and non-public sector for every £1 spent on prevention and early intervention[20]:

- social and emotional learning programmes to prevent conduct disorder in children and young people showed a return on investment of £48.30 in 5 years, and
- school based interventions to reduce bullying showed a return on investment of £14.35 in 5 years.

2. Service integration

Apart from the research findings indicating that an integrated and multi-disciplinary approach is essential in delivering mental health services, governments view service integration as a key initiative in delivering efficiencies as well as improving patient outcomes (KPMG, 2013). While integration is a complex process it denotes efforts to increase the coordination of operations within the health and social care services systems, aiming to improve efficiency and client outcomes. There is no universal approach, and services integration may be viewed as a continuum of organisational relationships ranging from restricted integration (loose, informal cooperation) to full integration (joined infrastructure, resources and case management). Integration removes duplication and overlap, with services sharing common vision and values, and organisations working in close partnership, sharing infrastructure and resources.

3. Primary Care as important partners

A literature review[21] conducted by Public Health (CWC) found that universal delivery of interventions in schools has the best evidence for prevention of child mental health problems. GPs and other primary care professionals have been identified as a potential avenue for early intervention but the review shows that this may not be so straightforward. The research demonstrates that self-care has the potential to improve children and young people's mental health literacy, to help them recognise problems and help themselves. However, as demonstrated from the key messages extracted from the national and international literature on good practice in the delivery of CAMHS to build capacity in primary care. The following factors must be taken into account:

- financial and human resources are critical enablers in primary care

17 Early Intervention: The Next Steps, 2011, HM Government.
18 Proven Benefits of Early Childhood Interventions, Rand , 2005.
19 Mental health promotion and mental illness prevention: The economic case, London School of Economics and Political Science, April 2011.
www.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf
20 Similar savings were found in research conducted in USA – see Proven Benefits of Early Childhood Interventions, Rand, 2005
21 Public Health Wolverhampton Evidence Review: CAMHS. April 2016

- capacity needs to be built to collaboratively embed mental health services in primary care
- primary care providers must be supported with direct and easy access to specialist CAMHS consultation
- capacity of primary care workers to deliver child and adolescent mental health services must be developed through training, supervision and support (Leahy, et al., 2015).

4. Involvement of parents

While research has found that the involvement of parents is indicated in effective programmes for pro-social, mental health promotion, social and educational learning and stress and coping (Weare and Nind, 2011), it does not happen as often and consistently as needed. A major consultation**22** undertaken in England with parents found that parents and carers want:

- to be more involved in their children's treatment in CAMHS
- their opinions and experiences to be listened to and their skills and expertise valued
- to participate in service development, both locally and nationally.

Despite finding that parents and carers wanted greater involvement, how this is best achieved is still to be determined (Weare and Nind, 2011). CAMHS partnerships are at a less advanced stage of parent and carer involvement than with children and young people's participation, with a limited number of dedicated participation staff available to offer the engagement support needed[20].

5. Schools based interventions

In a recent publication, schools were reminded that they must ensure that arrangements are made to safeguard and promote the welfare of pupils.**23** Another Department for Education document stated that all pupils will benefit from learning and developing in a well ordered school environment that fosters and rewards good behaviour and sanctions poor and disruptive behaviour.**24** Governing bodies of maintained schools have a duty under section 175 of the Education Act 2002 requiring them to make arrangements to ensure that their functions are carried out with a view to safeguarding and promoting the welfare of children. The proprietors of Academies have a similar duty under paragraph 7 of Schedule 1 to the Education (Independent School Standards) (England) Regulations 2010.

School based programme had significant positive effects on students' emotional and behavioural wellbeing, including reduced depression and anxiety and improved coping skills. (Barry et al, 2013). In addition school-based life skills and resilience programmes received a moderate quality rating, with findings indicating positive effects on students' self-esteem, motivation and self-efficacy (Barry et al, 2013).

With regard to the school-based interventions, the quality of evidence from the 14 studies is moderate to strong. Findings from these studies indicate that there is reasonably robust evidence that school-based programmes implemented across diverse LMICs can have significant positive effects on students' emotional and behavioural wellbeing, including reduced depression and anxiety and improved coping skills.

> *'In order to help their pupils succeed, schools have a role to play in supporting them to be resilient and mentally health.***25**

6. Children and young people

Research has repeatedly found hurdles that make it difficult for children and young people to access mental health services. These barriers are no different to those identified by children and young people

22 The involvement of parents and carers in Child and Adolescent Mental Health Services. Report to CYP IAPT of the consultation conducted with parents and carers. Greater Involvement Future Thinking, November 2013 – March 2014.
23 Behaviour and discipline in schools: Advice for head teachers and school staff. DfE January 2016.
24 Mental health and behaviour in schools Departmental advice for school staff, DfE, March 2016.
25 Mental health and behaviour in schools Departmental advice for school staff, DfE, March 2016.

in Wolverhampton and include: stigma and embarrassment; difficulty in identifying symptoms of mental ill health; lack of knowledge of mental health services; lack of accessibility of services about mental illness and mental ill health; concerns about confidentiality, and lack of trust for those they might seek help from; fear and stress in seeking help; and a preference for self-reliance, rather than seeking help externally. (Gulliver et al, 2013). Strategies for improving the help-seeking behaviours of children and young people ought to focus on improving mental health literacy, reducing stigma and taking account of young people's desire for self-help.

One researcher identified the key feature, principles and targets for redesign of services to better meet the needs of young children and young people as:

- participation at all levels by children and young people, essential to create youth friendly, stigma-free cultures of care;
- holistic, preventive and optimistic stance with sequential/ stepwise care governed by risk/benefit and shared decision making principles;
- early intervention, social inclusion and vocational outcomes as core targets;
- care reflecting both the epidemiology of mental ill health in young people and the new developmental culture of emerging adulthood in the early 21st century;
- elimination of discontinuities at peak periods of need for care and developmental transition;
- positive and seamless linkages with services for younger children and older adults (McCorry et al, 2013).

Many of the issues identified by children and young people across Wolverhampton about CAMH services were consistent with those outlined in a recent report from the Children's Commissioner for England. Following extensive consultation the report found that young people wanted a number of important changes in CAMHS**26**:

- shorter waiting times
- someone to be available to talk to between the referral to CAMHS and the first appointment, 'they could be like a bridge and help you at the first CAMHS meeting'
- not relying on letters to get you to the first appointment, especially when your family is not reliable. Contacts and reminders should be sent by phone and text
- reducing the stigma around being in care or having a mental health need
- provide a drop-in service for young people where they could chat about things that worried them and get to know the people running the service.

7. Self help

Recent reviews have identified that self-help services for young people with mental health needs are not as effective, responsive, accessible or child-centred as they could be, research demonstrates that these interventions were effective at 6-month and 12-month follow-ups (Pryjmachuk, Elvey, Kirk, Kendal, Bower, & Catchpole, 2014). Using systematic literature reviews, it was found that the key elements of self-care support identified in the perceptions review were the acquisition of knowledge and skills, peer support and the relationship with the self-care support agent. While there were a mixture of theoretical approaches underpinning the services provided, no single model dominating. There was a wide variety of professional and lay people facilitating the services – even within the services themselves; the self-care support agents included social workers, counsellors, nurses, psychologists, youth workers, coaches, school staff, volunteers and CYP themselves.

While mental health self-care support interventions for Children and young people are modestly effective in the short to medium term, self-care support can be conceptualised as a process which has overlap with 'recovery'. Children, young people and their families want choice and flexibility in the provision of self-help interventions as well as a continued relationship with services after the nominal

26 Lightening Review: Access to child and adolescent mental health services, Children's Commissioner, London, 2016.

therapy period. Those delivering self-care support need to have specific child-centred attributes (Pryjmachuk, Elvey, Kirk, et al, 2014).

8. CCG Improvement & Assessment Framework

The LTP assurance process has been integrated within the WCCG's mainstream planning framework This plan outlines the priorities and key actions for 2017/18 and should be regarded as an iterative document, subject to assurance and evaluation and monitoring processes and therefore subject to continued development and change. The LTP has also been influenced by developments in the key initiatives:

- learning from the pilot schemes and initiatives that have provided additional funding into CAMHS Crisis Services, the Single Point of Access and Early Intervention in Psychosis Services through use of Targeted Resilience Funds in 14/15 and Future in Mind funds 15/16
- development and implementation of the Wolverhampton Mental Health Strategy including the Urgent and Planned Better Care Fund Care Pathways to support urgent and planned mental health care across the lifespan.
- promoting equality and addressing health inequalities are at the heart of NHS Wolverhampton's values. Throughout the development of this transformation plan due regard has been given to eliminate discrimination, harassment, victimisation and stigma and to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it and to reduce inequalities in terms of access to and outcomes from healthcare services and to commission children and young people's mental health services in an integrated way to support the reduction of health inequalities.

Transformation plan: Moving to a whole system approach

Promoting resilience, prevention and early intervention to support children and young people's wellbeing are best achieved through a whole system's approach from universal service provision through to highly specialist and bespoke intervention (Future in Mind, 2015). No one service can do this important work and improve mental health and emotional wellbeing. Starting with Health visitors, Sure Start Children's Centres, schools, school health services, school nurses, colleges, primary care and youth centres, all playing a key role in preventing mental health problems, through to specialist mental health consultants working with those experiencing significant emotional and mental health conditions. The 'As Is' picture of services in Wolverhampton is presented in Appendix D.

1. Workforce training and empowerment

The success of universal services requires staff to be trained and competent to deliver preventative services. Many staff working in primary health, social care, or educational contexts lack confidence and experience of helping children who have mental health issues, and thus training is required (Walker, 2008). Front line staff, including teachers, early years staff, and primary care practitioners often lack the necessary skills to assess and intervene, and need the skills to be identify and refer appropriately (Barry et al, 2013, Weare & Nind, 2011). A culture of protecting professional and organisational identities is one of the most prominent barriers to new ways of working, especially where established skills and roles are reconfigured (Gilburt, 2016). GPs identify low satisfaction about their postgraduate training in relation to child and adolescent mental health. Similarly in relation to early intervention, this requires being able to refer or direct children and young people into available services. Accessing services that meet the needs of children and young people with mental health difficulties was identified as problematic by GPs (Leahy et al, 2015).

Several studies reviewed highlighted the importance of teacher training and the provision of on-going support during programme implementation. Harnessing the skills of teachers and providing support in the school setting offers a sustainable and low cost method of improving children's emotional and behavioural wellbeing, developing positive coping strategies and promoting school performance.

However, single focussed and brief interventions are not always effective. Reviews found that interventions of at least 9 months to a year are more effective and show small to moderate effects. However, high quality implementation characterised by fidelity of implementation gives the best results, with interventions based on loose guidelines and broad principles were found to be ineffective. To be successful an intervention needs high levels of intensity, consistency, clarity, multi-resources, and programme fidelity.

2. Development of self – help resources

Self-help and self-care can be effective in helping children and young people to address their mental health and wellbeing concerns. A meta-analysis of self- help interventions and initiatives for children and young people with mental health problems shows that it is moderately effective at 6 and 12 months follow up, (Pryjmackhuk, 2014). However, effective self-care support services are predicated on flexibility; straightforward access; non-judgmental, welcoming organisations and staff; the provision of time and attention; opportunities to learn and practice skills relevant to self-care; and systems of peer support. In addition self-care needs to be child centred (Pyjamackuk, 2014). Establishment of effective self-help materials requires a great deal of time and research in order to identify, collate and produce the resources that are effective as well as child and parent friendly.

3. Primary and secondary schools supports and interventions

Primary and secondary schools play a central and pivotal role in the lives of children and young people. They are often the first place for a child's emotional or behavioural challenges to become apparent. In order to help their pupils succeed, schools have a role to play in supporting them to be resilient, as well as emotionally and mentally healthy. There are a variety of things that schools can do, for all their pupils and for those with particular problems, to offer that support in an effective way. Schools therefore need to be involved as a key agency in the transformation of the service system for children and young people. The importance of their position is reinforced by many of the policy and reports identified earlier in this document – see Appendix C for a summary of key findings.

School seek to be a safe and affirming place for children and young people, where they are able to develop a sense of belonging, feel able to trust, and talk openly with adults about their problems. For children and young people with an unsettled home environment, school may provide an important haven.

4. Centrality of the GP in interventions

The identification of mental health problems will often be through a child's GP. While GPs are not specifically trained in the complex needs of children and young people, they nonetheless play a pivotal role in the management of any intervention (Leahy, Schaffalitzky, Armstrong, et al., 2013; Leahy, Schaffalitzky, Saunders, et al 2015; Schaffalitzky, Leahy, Cullen, et al, 2015). Although medical practitioners cannot always share information, where possible service providers should try to be aware of any support programmes GPs are offering that may affect the child's behaviour. Due to the pivotal role played by GPs, it is vital to keep them apprised of interventions and outcomes.

5. Factors for success

Operating as a whole service system is not easily achieved, and requires a number of significant elements to be successful[27][28], including:

- strong leadership across the system, from chief executive to front line staff
- clear understanding of what success will look like
- agreement on what the issues are
- clear governance model with shared leadership across

27 Breaking the Lock: A new preventative model to improve the lives of vulnerable children and make families stronger. iMPOWER, 2015 Amanda Kelly

28 CAMHS: A time to transform, iMPOWER, London, 2015.

- clear roles and responsibilities
- sufficient capacity and capability to support and deliver change
- robust, open and honest relationships with local area
- aligned implementation of local partner's agreed vision for an 'integrated approach'
- real performance management focus and developing a culture of tackling poor performance
- focus on getting permanent staff in place and building a culture of support and trust.

The LTP acknowledges the importance of these elements and through the WTPB and five Task and Finish Groups has worked to implement these in all of its activities.

Wolverhampton context influencing LTP

To change any service system, and implement any plan, it is useful to understand the service system as it currently exists. A high level service mapping was undertaken, plotting the financial spend and activity (where possible) for emotional health and wellbeing related provision during 15/16 – see Appendix D. For the sake of simplicity, the 4 tier model of intervention has been used to classify the financial and activity data. As with any service system, the challenge is to improve early intervention to reduce the number of children accessing higher levels of intervention. An initiative of the WTPB is to explore how funds available to specialist commissioning in NHS England could be returned to the Black Country, and how with better management of intensive support, monies could be released and more effectively utilized for funding activities earlier in the intervention cycle. Both CWC and WCCG are committed to moving funds from acute provision to community based services that are more local to service users and patients.

1. Strengthening Family hubs

CWC is implementing a new early intervention and prevention strategy which sees the establishment of Strengthening Family Hubs. These provide creative and seamless support to families; ensuring children are safe and have a wide range of opportunities open to them. This movement to place based services is a trend that is occurring across a number of service sectors[29][30]

Eight Strengthening Families hubs are designed to facilitate an approach based on outreach work into the community – see Appendix E for a graphical representation of this model. Networks of universal services professionals will work within the locality to support and signpost families. Early Intervention and Prevention (EIP) staff will have a role in supporting, developing and training non-council community-level networks to fulfil their role in supporting families earlier. The aim is to build on the existing assets within the community, establishing better links with the voluntary sector, schools, health and adult education.

The principles that underpin this programme development include:

- supporting families to safely prevent family breakdown
- common and easily understood approach for early intervention and prevention
- approach that is flexible with the variation in need within localities and families
- interventions that respond as family needs change
- alignment with the MASH to be a powerful influence in good decision making across the partnership
- clear pathways allowing the service to offer the right level of support at the right time to families
- resources to be allocated based on meeting EIP objectives whilst providing value for money.

29 Place-based systems of care: A way forward for the NHS in England. Kings Fund, London, November 2015.
30 CAMHS: A time to transform, iMPOWER, London, 2015.

Practice principles that guide the operation of these hubs are:

- maintain a focus on impact, bringing more creativity and flexibility to respond to needs in order to achieve the best outcomes
- strong relationships with families, based on a clear set of values that encourage motivation, support empowerment of families and lead to the development of resilience
- staff skills and knowledge that draw upon evidence based practice but reflects local need
- great relationships across the partnerships which build confidence in EIP whilst balancing each other's' priorities, supported by clear information and experience sharing to break down siloes.

2. HeadStart hubs

Managed by CWC as lead partner, Wolverhampton has been successful in obtaining £8.8m in funding from The Big Lottery to extend the HeadStart programme following two years of pilot work. The funding is provided for the period 2016 to 2021. As well as a city-wide, mostly digital offer, a specific concentration of efforts will focus on four geographical areas within the city. The service will be to promote, protect and preserve the mental wellbeing of 10-16 year olds across our City, by inspiring them to dream big, supporting them to maintain motivation and control, and equipping them with resilience and the skills to cope with setbacks and adversity. The programme will empower the young people of Wolverhampton to improve and spread awareness of their own mental wellbeing and that of their peers[31]. Based in the local area, a range of interventions will be made available through community groups, schools and public services, including:

- city-wide mental wellbeing information and awareness raising
- an area-based, Universal Offer for 4 geographical areas, including school and community based activities
- a Universal Plus Offer for those in specified age-range, including specialised group work and peer support
- targeted Intervention for those most at risk.

3. Other key initiatives in Wolverhampton influencing system transformation

Several other important developments have influenced the development of the LTP. These include:

A. Project grant by the Children and Young People's Task Force to scope potential to re-design / improve current CAMHS commissioning models. The project focused 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 was delivered 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).

B. 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 placed in and out of city including those in high cost packages and placements. This will be addressed by delivering preventative, supportive and pro-active services locally and improving the outreach provision to and repatriation of children and young people placed out of City by ensuring far greater connectivity with CAMHS care pathways and services. Critically this will involve a special emphasis on children and young people with a Learning Disability, physical disabilities and / or autism to ensure full alignment with Transforming Care and SEND guidance and reforms.

31 HeadStart bid for The Big Lottery Funding 2016. http://www.headstartbid.com/

C. The Wolverhampton Crisis Concordat. The urgent care pathway development that has delivered a refreshed approach to the compassionate, pro-active and safe sound and supportive across the lifespan holds opportunities for further evaluation to develop greater connectivity across CAMHS and AMHS urgent care pathways, again across a Black Country wide footprint where possible and support and improve outcomes for the most vulnerable. In CAMHS this includes closing gaps concerning Section 136 MHA and Place of Safety facilities and developing new and dynamic 24/7 services, including Street Triage, Paediatric Liaison and Crisis Resolution and Home Treatment services for example.

D. Wolverhampton CCG is developing a Primary Care Strategy which will inform the Commissioning, modernisation and transformation of services and care pathways across primary, secondary care and tertiary care. Opportunities exist to increase connectivity across these tiers, to align this with the troubled families' agenda and to increase the capacity, capability and responsiveness of CAMHS at a primary care level.

4. Current pathway for accessing emotional health and wellbeing services

The current pathway for the majority of children and young people moving through the emotional health and wellbeing services is displayed in Figure 4. This includes referrals from a range of sources using inconsistent criteria. It has been known that a child could be referred to several agencies in the hope that one agency may have a shorter waiting list. It also involves children meeting a threshold of severity before a service is provided. Such an approach restricts the possibility of early intervention, and encourages silo working across a system with organisations struggling to manage demand.

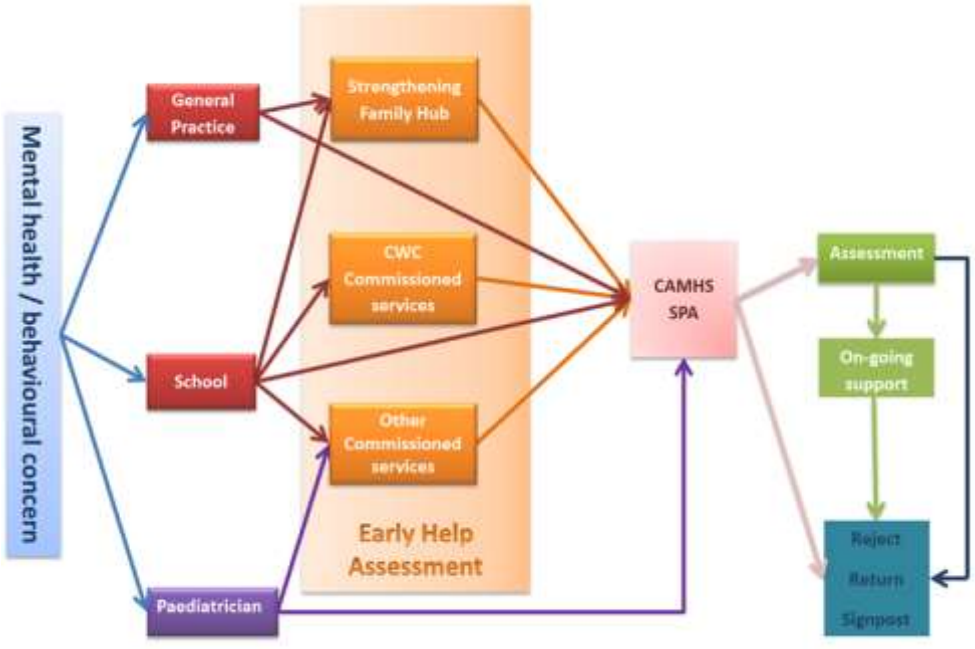

Figure 4: Current CAMHS pathway

To assist with local transformation planning it is important to understand the current flow of children and young people accessing the specialist provision of CAMHS – see Figure 5 below with 15/16 data[32]. This information relates to the flow of children and young people through the current CAMH service. While 66 per cent of children and young people assessed by a mental health practitioner were provided specific intervention by CAMHS professionals, a large minority (711 or 34%) were not. While a number

32 Figures obtained from BCPFT in email correspondence 2016.

of these children and young people were signposted to information, or other possible agencies to receive a service, many were returned to referral point (50%), or simply told that they did not meet threshold for service (36%). It is unfortunate that as providers and organisations have different information and data systems, it is currently impossible to track children and young people as they navigate through the pathway, and whether some return later with problems that have escalated such that they meet service thresholds.

The LTP links the emotional health and wellbeing services, including specialist CAMHS with the local authority's children and young people's services (Strengthening Family Hubs) and the early help available in four specific regions through HeadStart. By providing assessment and early help supports linked to both HeadStart and Strengthening Family Hubs, a number of assumptions have been made about future service demand. Based upon research, best practice and experience, it is likely that with an integrated system with a focus on early intervention, over time, there will be:

- reduction in referrals to Specialist CAMH for intervention will reduce
- reduction in wait times for Specialist CAMHS and all other services
- reduction in inappropriate referrals to agencies
- reduction in children and young people falling between agency/service gaps
- increase in services available locally
- increase in cooperation across agency and school boundaries
- reduction in children and young people admitted to external placements
- reduction in time spent by children and young people in external placements
- reduction in young people admitted to acute settings with primary mental health diagnosis
- reduction in time children with a primary mental health diagnosis spend in an acute setting
- improved understanding of how children and young people travel through services.

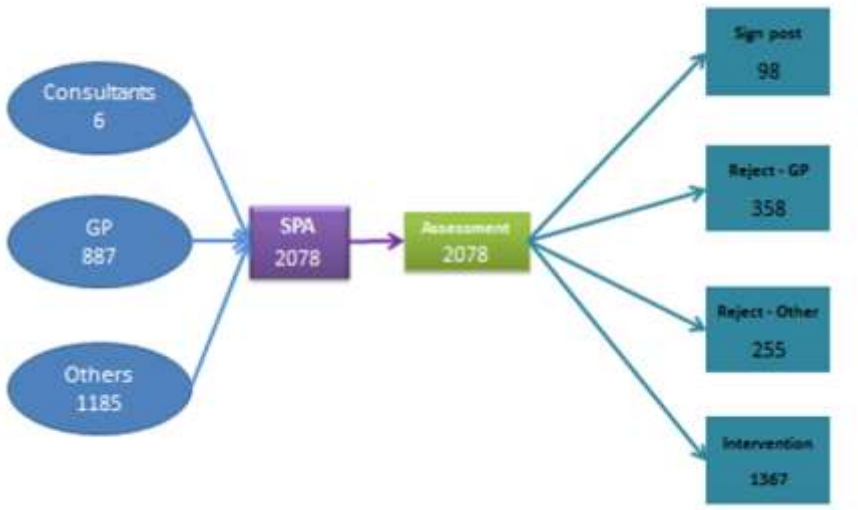

Figure 5: Flow of children and young people through CAMHS (15/16)

5. Issues with current service system

The current mental health service system is a referral based pathway. This means that agents pass the patient along to another agent whom they believe to be better placed to provide a solution to the patient. There are numerous issues with this system, including[33][34]:

33 Towards Children and Young People's Emotional Health and Well-being: Sandwell & Wolverhampton Health & Social Care Economy. WM QRS, January 2016.

34 Issues obtained through variety of consultations held with children, young people and stakeholders in 2014, 15, & 16

- referral handoff, where responsibility is transferred with a referral
- repeated patient storytelling, as each agent undertakes their own assessment
- little opportunity to refer patient to a lower level of intervention
- expert help is assumed to be able to 'fix' patient's problems
- system reliant upon interpersonal communication between professionals and agencies, without this built into the infrastructure
- no consistent form of case management or case activity recording
- inability to transfer knowledge to earlier levels of intervention
- lack of a robust programme of prevention and early intervention has an impact on service system
- limited range of targeted 'Tier 2' services has a significant detrimental impact on specialist CAMHS and on community paediatric services
- system being organisation and service focussed rather than patient centred and outcome focussed
- lack of integration across health, education, or social care, as they each have independent pathways
- children and young people not seen by CAMHS, filling appointments with other services (e.g. acute and community paediatricians), reducing capacity to see new patients
- lack of agreement on how and where neurodevelopmental conditions are best managed
- delayed discharge and lack of support on acute wards for young people with primary diagnosis of mental health
- complexity of referral processes of paediatricians to psychiatrists, as well as obtaining advice and guidance, not straight forward
- lack of easily accessed and readily available support for looked after children
- CAMHS workforce which was heavily weighted to psychology and more senior staff such as band 7 mental health practitioners
- transition of young people to adult mental health services not clearly defined
- arrangements for discharge from CAMH service not well developed.

The recent Children's Commissioner review[35] of the issues across England of the CAMH service presents a stark picture. While some of these findings may not be relevant to Wolverhampton, it is worth reviewing the local service with this data in mind. The investigators found that:

- 28% children and young people referred to CAMHS(on average) were not allocated a service
- 79% of CAMHS stated that they imposed restrictions and thresholds on children and young people accessing their services
- waiting times were extremely long – one West Midlands CAMHS the average waiting time was 200 days
- 3,000 children and young people were referred to CAMHS with a life-threatening condition (such as suicide, self-harm, psychosis and anorexia nervosa), of whom:
  - 14% were not allocated any provision
  - 51% went on a waiting list
  - Some waited over 112 days to receive services.
- 35% of all CAMHS stated that children and young people who missed appointments would face restrictions in accessing their services:
  - 28% of all CAMHS said that children and young people were stopped from accessing CAMHS if they missed appointments
  - 8% of CAMHS stated that this would happen following 2-3 missed appointments.

35 Lightening Review: Access to child and adolescent mental health services, Children's Commissioner, London, 2016.

The wide ranging mental health difficulties addressed by CAMHS LTP include conduct disorder; anxiety and depression, ADD, psychosis, Learning Difficulties, Co-morbid substance misuse, Eating Disorders, self-harm, suicidal behaviour, bullying, and challenging behaviour.

LTP for emotional health and wellbeing in Wolverhampton

The LTP summarises a number of important developments with the emotional health and wellbeing services in Wolverhampton. While some of the activities outlined in the plan serve to increase the number of children and young people accessing specialist services, the most important element is the cultural change that underpins all of the LTP. The changes that are necessary will impact on information governance, workforce, information technology, as well as governance and supervision of professional practice. A schedule for the implementation of the underpinning change is contained in Appendix F. The Gantt chart outlines the actions and timeframe during which the transformation activity of aligning services will be undertaken. This is an ambitious undertaking, but with the funding made available through The Big Lottery, and Future in Mind, coinciding with the restructuring of early intervention services in Wolverhampton, a unique opportunity was presented. Following are important elements in the cultural change required for service transformation.

1. Place based care system

The direction taken by HeadStart, and Strengthening Family Hubs is consistent with the approach suggested by a number of leading health and social care think tanks and policy makers[36]. To introduce efficiencies and to produce the best outcomes for service users, providers need to be developing integrated early help services with multi-agency, multi-disciplinary teams around localities – known as place based system of care. Fundamental changes to the role of commissioners are needed to support the emergence of placed based systems of care, with organisations needing to collaborate to manage the common resources available to them. Commissioning in future will need to be both strategic and integrated, based on long-term contracts tied to the delivery of defined outcomes. Commissioning arrangements will also need to be flexible to facilitate the development and operation of multi-agency and multi-disciplinary working.

Place based systems of care aims to provide a range of integrated services, including:

- dedicated multidisciplinary teams to provide and commission a broad range of support based upon the needs of the child, young person and family in each locality
- supports that build resilience, empowers others, and aids in developing self-help skills, and look to being solution focussed
- commissioned support and services to meet local needs with the aim of reducing demand
- focus on meeting child, young person, or family need, with less requirement to hand off or refer
- support for the individual (i.e. family member, community service provider, coach, minister, teacher, etc.) with whom the child, young person or family has the strongest relationship
- facilitate and encourage creative local commissioning arrangements to better meet local needs
- shifts focus from organisational allegiances to needs of child, young person, or family
    - holistic assessment and system for monitoring and managing the child, young person, or family's journey
    - support provided that is focussed on need, as well as reducing demand and improving outcomes.[37]

Place based care and integration also prioritises the key themes identified Future in Mind, including:

- emphasises the building resilience, promoting good mental health, prevention and early intervention

36 The Kings Trust, and iMPOWER

37 Place-based systems of care – A way forward for the NHS in England'. The Kings Fund: London, November 2015.

- simplifies structures and improve access
- deliver a clear joined up approach
- harness the power of information
- sustains a culture of continuous evidence-based service improvement delivered by a workforce with the right mix of skills, competencies and experience
- makes the right investments, with clarity about how resources are being used in each area.

Figure 6: Place based care model resulting from system transformation

For place based care to be successful, a number of important activities need to be undertaken, including:

- CCGs and local authorities working together to review and develop services
- service providers within a locality, together with GPs and schools must work together
- service system must have a multi-agency design, of which there is little current evidence
- detailed needs analysis to create understanding of where change will make the most impact
- service mapping across all service areas to identify any gaps in services and duplication.[38]

The figure above (Figure 6) is a graphical representation of the proposed new model. As services are for the most part local to the child or young person, professionals are the ones that move to a location that is easily accessible for the family. Interventions are built around the child, even when escalation of support is required.

The place based model of care has a dramatic impact on the pathway that children and young people will need to travel to access increasing support. Figure 3 represents the current pathway, while Figure 7 depicts the pathway emerging from the proposed transformation plan. When a child, young person or family need help for emotional health and well-being challenges, they are able to assess the local Strengthening Family or HeadStart hubs. The assessment conducted by the multidisciplinary team, in consultation with Link

38 CAMHS: A time to transform, iMPOWER, London, 2015.

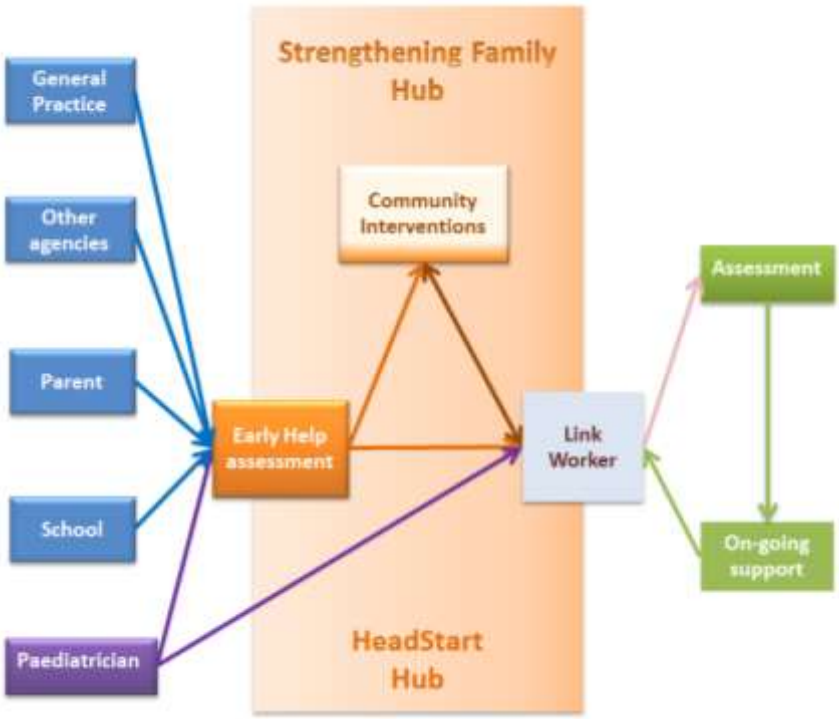

Figure 7: Proposed new CAMHS pathway

Workers will ensure that appropriate specialist support is obtained in a timely manner. The Link Worker is able to maintain the link between specialist services and local supports, so the transition to less intense interventions and support in the local community is managed effectively with minimal delay.

2. Key focus areas of LTP

The LTP has a focus on the following seven areas in order to transform emotional health and wellbeing services:

IAPT collaborative	Wolverhampton CCG has been accepted to join an IAPT collaborative. This will include interventions for very early years and linkage with the Adult IAPT programme in terms of parental IAPT programmes. This will all be aligned with the deliverables outlined in the HeadStart Wolverhampton Pilots in terms of resilience building and awareness raising in schools, use of digital technology and social media and other local anti-stigma and resilience funded initiatives including the pilots funded under HeadStart providing 'a place to go'.
Crisis and home treatment	Increased capacity and capability in crisis 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 and providing child suitable Section 136 MHA and Place of Safety facilities. This will include substantive funding for the Single Point of Access (SPA).
Early Intervention in Psychosis Services	Additional investment in Early Intervention in Psychosis Services for children and young people to achieve greater compliance / fidelity with the NICE guidance model, increasing numbers of patients achieving recovery and reducing the numbers of patients requiring high cost out of area placements and care packages. This includes a particular focus on improved joint working with substance misuse services for those with dual diagnosis needs and requirements. This model will be co-commissioned with Sandwell and West Birmingham CCG.

Eating Disorder Service	Investment in a local community Eating Disorder Service co-commissioned with Sandwell and West Birmingham CCG building on existing service provision which will deliver an assertive outreach community approach with better liaison with Acute, Paediatric, Primary Care and Tertiary Care services for children and young people as part of an all age model. This will also bridge the gap between hospital and community services, reducing the need for high cost Tier 4 Services and reduce the prevalence and impact of SEED (Severe and Enduring Eating Disorders).
CAMHS Link workers	Investment in CAMHS Link workers for schools, special schools and alternative provision providing targeted and specialist interventions within establishments and facilitating and supporting the HeadStart: Wolverhampton school peer support and mental health resilience training programmes and also facilitating speedy and responsive access to care pathways and services within generic and specialist CAMHS and primary care and universal services including GPs.
CAMHS Learning Disability	The re-specification of CAMHS Learning Disability services and Specialist and Generic CAMHS to support the needs of children with learning disabilities and / or physical disabilities who have the most complex requirements including children and young people with neurological conditions such as Attention Deficit Disorder and Autism. This will include a focus upon the local service developments required to deliver transforming care bed reductions at national regional level and local level and development of community based alternatives to In-patient provision, prevent and repatriate from tri-partite funded out of city placements wherever possible and ensure transition to adult services that is focussed upon and meets the needs of the individual young person. Co-commissioning options for repatriation, reviews and development of local services will be explored with neighbouring CCGs and Local Authorities. The re-specified services will include focus on compliance with most recent guidance regarding care and treatment reviews and step up and step down from TIER 4 services.
Perinatal Mental Health Service	Develop a Perinatal Mental Health Service working across CAMHS AMHS and Child and Maternity, Primary Care and Specialised Services develop a local Perinatal mental health service which will deliver local care pathways across agencies and support improved maternal mental health as outlined in Future in Mind.

Progress on the implementation of these specific areas of service transformation are reported on quarterly to NHS England visa a self-assessment process. This is used by WCCG to measure implementation against plan and introduce remedial action if necessary. The financial data is included as Appendix G.

3. Emotional health and wellbeing service system transformation

i) Local mental health practitioners

While specialist mental health staff are organised as a centralized resource, these can be accessed in a timely manner through CAMHS Link Workers. Through the Link Workers, this specialist mental health expertise is more readily available and accessible to all in the local area. Direct mental health service can be carried out alongside other family interventions in a more coordinated and effective manners. Communications will be enhanced with co-location or frequent visits to local hubs. CAMHS Link Workers will be available at each HeadStart hub to navigate children and young people

to more specialist services, while also being available to re-establish them into locally available services at the appropriate time. While specialist mental health professionals would be directly available at each locality, access to interventions from non-local resources would be expedited through the CAMHS Link Workers who will have well established communication systems and professional relationships.

Secondary consultation is available to support professionals known to the child, young person and family, continue to provide support. This will reduce the referrals for specialist CAMHS, and enables the child and family to be supported by local services, which could flex as needed. The availability of this consultation service will enable local professions to learn more about a young person's condition and treatments that are effective. The learning can be generalised to other children and young people as well as shared with colleagues. A stronger and more knowledgeable workforce would be the outcome.

ii) Specialist emotional health and wellbeing service

The current Crisis Team, Home Treatment services, Youth Offending Team worker, and Looked After team, will remain centralised resources, with specialist workers engaging with localised services. It may be that these two services are combined into a joint specialist service that works closely with family support workers from the Strengthening Family Hubs, and other Link Workers in HeadStart Hubs. This would ensure that a whole service response could be mobilised to support all members of the family affected by the crisis. The benefit of close locality working means that the child, or young person remains known to local workers who are able to continue working with the family through the crisis, and continue well after crisis has past, This will ensure that children and young people do not fall through the gaps. Young people requiring Tier 4 specialist care would be monitored by local professionals, as well as the Crisis Team. This oversight will enable a coordinated treatment plan to be delivered to the young person and their family, and enable localised planning to reduce length of stay.

iii) Special Education needs and/or a disability (SEND) service

A requirement of the Children and Families Act 2014 is that each Local Authority is to produce and publish a Local Offer. This sets out in one place information about provision available across education, health and social care for children and young people in the area who have special educational needs or are disabled[39]. Part of the local offer is the Inspire Team, which supports children and young people (from birth up to the age of 18years) who have a learning disability, as well as their families. Inspire is part of the Specialist CAMH services provided by BCPFT and provides a broad range of community and school based, emotional health and wellbeing interventions, including individual therapy, group support, family working, consultation to professionals and services, teaching and training, skills training. Educational Psychology staff have developed specific to guidance about what schools should be offering for students with social, emotional and mental health needs, and is to be used to inform decisions about whether a child needs an education health and care plan, and what level of support they need[40].

iv) Implementation of Improving Access to Psychological Therapies

An important aspect of the LTP is the establishment of Improving Access to Psychological Therapies (IAPT) for children and young people. A major NHS initiative, the aim of IAPT is to increase the provision of evidence-based treatments for common mental health conditions (i.e. anxiety and depression) by primary care organisations. While unsuccessful in an early application to join an IAPT collaborative, Wolverhampton has just been accepted into the Midlands Collaborative.

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39 City of Wolverhampton Council have published the local offer for children and young people at: http://win.wolverhampton.gov.uk/kb5/wolverhampton/directory/localoffer.page?localofferchannel=0

40 Social, emotional and mental health. Produced by Educational Psychology service, CWC.

The IAPT development means that front line staff will receive specialist training to provide evidence based interventions, and then not need to refer to more specialist services. This will have a positive impact on the workforce, by providing front line workers with new skills in managing emotional health and wellbeing issues. If these interventions are unsuccessful, more intense interventions would be available from specialist CAMHS practitioners.

4. Barriers to service transformation

A review of all the published LTP was conducted by the Education Policy Institute and identified six barriers to transformation (Frith, 2016). The Wolverhampton LTP has taken account of these and worked with BCPFT on developing strategies to minimise their impact – see Figure 8.

Barrier [41]	*Strategy adopted in Wolverhampton*
Workforce	• Employment of temporary staff with associated skills • Training and supervision given a priority
Funding	• Future in Mind funding was dedicated to specialist CAMH service • Alignment of services so early intervention services bolstered
Commissioning	• LTP involves systems transformation with a focus on aligning all services involved with emotional health and wellbeing
Data	• LTP involves systems transformation with a focus on aligning all services involved with emotional health and wellbeing • While IT systems will not be integrated, the move is to develop more flexible information sharing arrangements. • Data will be captured through the Strengthening Family and HeadStart hubs, and providers will contribute data to the system used in these hubs
Fragmentation	• LTP involves systems transformation with a focus on aligning all services involved with emotional health and wellbeing, so gaps between services disappear
Intervening too late	• LTP focuses on whole system transformation with an emphasis on early intervention. • Pathways will be made more straightforward, to ensure children are seen by right practitioner in a timely manner

Figure 8: Barriers to transformation across England with action taken

5. Transformation implications

Working together in a multi professional and multi-agency environment requires a new set of relationships and rules to be established. These include:

- traditional organisational authority structures will need to become more flexible, as multi-agency team members learn how to work together and overcome professional and organisational differences
- professionals may need to work beyond what has been seen as outside their traditional ways of working

41 Barriers identified in the Education Policy Institute – see report by Frith (2016).

- commissioning of local activities will need to be changed so that multi-agency (and multi-commissioning arrangements) can be used to support children and their families more flexibly
- workforce will need further training on managing mental health issues and when to involve other team members, or when to refer to crisis services
- rules for sharing information will need to be examined otherwise records or notes that would be useful for one practitioner may be unavailable to others
- governance arrangements will need to be put into place to ensure that multi-agency and multi professional working is not hindered by bureaucratic processes, and that staff are appropriately supported

6. Funding and sustainability

The model proposed for CAMHS transformation is built upon the following assumptions about budgets:

- current levels of expenditure will remain constant, with possibility of adjustments due to inflation only
- no further investment will be made by either CWC or WCCG in early intervention services
- any structural or organisational changes will have to be met within current financial resources
- savings derived from reduced spending in acute and specialist services may be redistributed into early intervention and prevention services.

The sustainability of emotional health and wellbeing services in Wolverhampton services is based upon the three elements outlined below.

1. *Whole system transformation*: There is currently an over reliance on NHS acute care for children with mental health and emotional wellbeing issues. Lack of preventative measures and early interventions means that there is a continual slide into the more intense and costly secondary care services. The delivery of HeadStart activities, as early intervention and resilience building 'downstream' is likely to reduce the demand on CAMH services 'upstream'. It is expected that some of the budget savings due to reduced demand will be used to fund further early intervention and prevention services.

2. *Tier 4 commissioning returning to local area*: With NHS England committed to returning the commissioning of specialist Tier 4 provision to local commissioners, there may be an opportunity for reinvestment of savings. If per capita funding is returned to Wolverhampton, then as a low user of Tier 4 beds, funding may be able to be released for early intervention and prevention services. However, how the budget to be returned to local commissioners is calculated is yet to be announced.

3. *Schools in joint funding or traded services model*: The positive impact of emotional health and well-being services on student attainment and attendance may provide the foundation joint funding of locality based initiatives. Some schools have already started to invest in pastoral care workers who will be supported through the HeadStart and Strengthening Family hubs. As other schools recognise the benefits it is anticipated that they will move towards a joint funding or even purchase of a traded services model on a phased and incremental basis. With the Director of Education (CWC), commissioners from WCCG have established a working party to develop a plan for working closely with head teachers to explore alternative sources of funding.

Risks and mitigations associated with the transformation plan

An undertaking of this magnitude is not without its risks. A number have been identified below, with some strategies that can be used to mitigate these risks. Prior planning and anticipation are crucial in increasing the chance of successful transformation.

Risk	*Mitigation*
Failure of NHS E to return commissioning and funds for Tier 4 placements back to CCG commissioners.	NHS England are committed to returning specialised commissioning to the local area. It will be very difficult to provide the service without the associated funding (@£1.5M).
Failure of BCPFT to implement agreed changes	Will need to use contracting levers, with the possibility of considering an open tender process if they fail to deliver the necessary changes.
CAMHS staff unwilling to work in or with Strengthening Family hubs and in a collaborative manner	Will need to use contracting levers, with the possibility of considering an open tender process if they fail to deliver the necessary changes.
Skill mix of CAMHs staff not appropriate to meet intervention requirements of new model	Will need to use contracting levers, with the possibility of considering an open tender process if they fail to deliver the necessary changes.
Insufficient resources (human and financial) to meet the demands of place based care – assumption is that over time, referrals to Specialist CAMHS will reduce.	Using population and service utilisation data, a robust model needs to be developed. Using parity of esteem and other levers, the CCG and partners may need to review the level of services that can be delivered.
Failure of organisations to work together due to structural or contracting impediments	Due to the imperative of STP, senior executives will need to be informed of any failure of organisations to cooperate with agreed plans. Also, could use contracting levers, with the possibility of considering an open tender process if they fail to deliver the necessary changes.
Increase in identification of children and young people with emotional health and wellbeing challenges	As this is likely to be a temporary increase, the numbers will be managed by front line staff having IAPT training, and secondary consultation support from Link Workers, and availability of advice and guidance from specialist CAMHS consultants.
Management of current referred cases while transition to new processes occurs	The new arrangements will be rolled out over a period of time, and Hub by Hub, so change will occur gradually, and the transition from current workload to new processes will not happen all at once.
Confusion resulting from poor planning and lack of clarity concerning roles and responsibilities	The LTP and cultural transformation is occurring with the full participation of all organisation involved in commissioning and delivering services. A comprehensive communication plan will be developed and implemented to minimise confusion due to change in processes and pathways.

Next steps

Next steps that need to be taken in the implementation of the system transformation include: as follows:

- Development and implementation of service specifications as outlined in the 16/17 and 18/18 plan
- Report to Health and Well-Being Board and development of communication, consultation and publication plan with timelines
- Continue the transformation of the service system using actions outlined in Gantt Chart in Appendix F
- Continued development of commissioning intentions and service models across our Black Country STP Footprint, following NHS England assurance continued implementation, monitoring and review of pilot schemes.

Summary

Using current resources, the LTP address the problems that have been articulated about the current service system. Using a collaborative approach which encourages organisations to work in new ways, the aligning of emotional health and wellbeing services with locally based hubs has been devised. There is no one solution that will keep all stakeholders satisfied, as the resources available are limited and need to be deployed wisely for the good of children and young people of Wolverhampton. Change is an element of the service system landscape, as supports need to be flexed to meet emerging needs. The LTP needs to be judged by whether it meets the vision established by for Wolverhampton.

> *In Wolverhampton we believe that mental health is everyone's business and that all agencies (public, community, and private) need to work together to ensure that all children and young people enjoy good mental health and emotional wellbeing, including those that are most vulnerable in society such as children looked after by the local authority. We will achieve this through an emphasis on prevention, early identification and intervention using evidence-based approaches that present good value for money. Where a mental health problem or disorder is identified children and young people will have access to timely, integrated, high quality and multidisciplinary mental health services that are accessible and responsive to individual need[42].*

42 Vision and model: CAMHS Transformation in Wolverhampton. CAMHS Transformation Partnership Board, March 2016.

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Reports - NHS

NHS Shared Planning Guidance: Operational Planning and Contracting Guidance 2017 – 2019 (NHS, 2016)
Specialised tertiary Mental Health Commissioning to return to local CCGs (NHS 2016)
Five Year Forward View (NHS 2014)
Five Year Forward View for Mental Health (NHS 2015)
Future in Mind: Promoting, Protecting and Improving our Children and Young People's Mental Health and Wellbeing (NHS, 2015)
Transforming Care Partnerships (NHS, 2015)

Reports - Other

CAMHS: A time to transform (iMPOWER, 2015)
Young People in Mind (Youth Action, 2016)
Lightening Review: Access to CAMHS (Children's Commissioner, 2016)
Better Mental Health For All: A public health approach to mental health improvement (Faculty of Public Health, 2016)
Mental health and behaviour in schools: Departmental advice for school staff (DfE, 2016)
THRIVE: Model for CAMHS. (AFC, 2014)

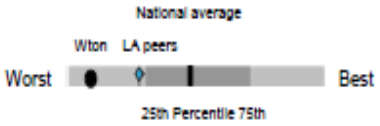
Appendix A: Children's Outcomes Framework spine chart - JSNA

Appendix 5: Children's Outcomes Framework spine chart

Key:

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

Spine chart explanation:



Completed by Wolverhampton Public Health Intelligence Team-September 2012

Area	Indicator	Local Value	Nat Avg	Nat Worst	National Range	Nat Best
Be healthy	Infant mortality 2008-10	7.7	4.6	19.2		2.2
	Under 18 conception rate 2010	55.5	38.1	64.9		10.8
	Teenage mothers (under 18) 2010-11	2.8	1.5	3.5		0.3
	Hospital admissions due to alcohol misuse (under 18) 2007-2010	37.2	61.8	154.9		18.6
	Children using alcohol 2009	12.0	15.0	23.0		3.0
	Substance misuse by young people 2009	8.3	9.8	16.5		2.6
	Children and young people smoking 2009	4.0	4.0	9.0		1.0
	Breast feeding initiation Q4 2011-12	65.2	74.5	39.0		94.7
	Proportion of Reception children classified as obese 2010/11	12.6	9.4	14.6		6.0
	Proportion of Year 6 children classified as obese 2010/11	23.8	19.0	26.5		10.7
	Rate of tooth decay in children aged 5 years 2007-08 (completed every four	0.7	1.1	2.5		0.5
	Hospital admission due to substance misuse (15-24) 2008-10	36.1	63.5	163.6		19.8
	Child mortality rate (aged 1-17) 2002-10	15.6	16.5	27.6		10.5
	% low birth weight babies, under 2500g 2010	7.7	7.0	11.5		4.3
	Breastfed at 6-8 weeks Q4 2011-12	41.6	46.1	19.0		83.2
	% of women smoking at delivery Q1 2012-13	18.3	12.7	28.0		1.0
	Hospital admissions for mental health 2010-11	37.9	109.4	722.1		36.8
	Hospital admissions for self harm 2010-11	176.4	158.8	359.5		34.3
Stay safe	Children in care 2011	94.0	59.0	142.0		20.0
	% of pupils who say they have been bullied 2009	10.9	9.6	14.4		5.6
	Homeless households 2010-11	3.3	2.0	10.4		0.1
	DTaP/IPV/Hib uptake at 2 years at Jan-Mar 2012 (by PCT)	95.7	96.3	85.5		99.5
	Men C coverage at 2 years at Jan-Mar 2012 (by PCT)	93.7	95.3	82.0		99.5
	PCV coverage at 2 years at Jan-Mar 2012 (by PCT)	89.0	92.5	72.7		100.0
	Hib/Men C booster at 5 years at Jan-Mar 2012 (by PCT)	90.9	91.4	70.1		99.0
	PCV booster at 5 years at Jan-Mar 2012 (by PCT)	87.7	91.4	68.4		96.8
	MMR uptake at 2 years at Jan-Mar 2012 (by PCT)	90.0	92.0	73.1		97.7
	MMR 1 dose coverage at 5 years at Jan-Mar 2012 (by PCT)	93.0	95.8	83.0		98.8
	MMR 2nd dose uptake at 5 years at Jan-Mar 2012 (by PCT)	80.9	91.2	68.7		95.2
	TD/IPV booster at 13-18 years 2010-11 (by PCT, of those where data was a	17.4	18.6	0.3		100.0
	HPV vaccine uptake complete course at June 2012 (Provisional-by PCT)	61.8	82.6	45.2		97.6
	Children in care immunisations 2011	93.4	79.0	20.0		142.0
	Accident admissions rate per 10,000 population for 0-17 year olds due to inj	106.0	124.3	235.1		73.2
	KSI rate for children 2008-10	24.9	23.6	64.2		2.1
	Chlamydia diagnosis rate per 100,000 15-24 year olds 2011	2733.5	1979.2	5995.0		464.0
Enjoy and achieve	% participation in at least 3 hours of sport/PE 2009-10	60.6	55.1	40.9		79.5
	Good development at age 5 2011	52.0	59.0	48.0		74.0
	% GCSE pass rate (5 A*-C, inc English and Maths) 2010-11	57.6	58.4	40.1		79.9
	% GCSE pass rate (5 A*-G) 2010-11	93.6	93.8	85.1		100.0
	% GCSE pass rate for children in care (5 A*-C) 2010-11	<5	12.8	0.0		40.0
Positive contribution	Children who have someone to talk to 2009	67.0	64.0	56.0		74.0
	% of children working securely at foundation level 2010-11	46.0	54.0	40.0		85.0
	Pupils who voted in school elections % 2007					
Economic wellbeing	School absentees, % half days lost to unauthorised absence 2010-11	1.5	1.1	2.4		0.2
	First time entrants to the justice system, young people 2011	830.8	748.8	953.6		450.5
	Children in Poverty 2009	30.8	20.9	57.0		3.9
	NEET's at 16-19 years as at 2010-11	7.6	6.7	8.9		4.9

Source: http://www.wolverhampton.gov.uk/article/3647/Joint-Strategic-Needs-Assessment-JSNA

Appendix B: Data available in planning

Service Quality Performance Report 15/16 and 16/17

Wolverhampton_SQPR_2015-16_M12_v2 (

Wolverhampton_BCPFT_1617_SQPR_V05_

Using data from the SQPR, the following Key trends for 2015/16 were noted:

Percentage of children referred who have had initial assessment and treatment appointments within 18 weeks	• remained on target throughout the year • has not breached.
Percentage of caseload aged 17 years or younger - have carers care plan. (CAMHS and EIS)	• 100% for 11 months
Percentage of DNAs for follow-up contact	• on target for the full year.
SAFEGUARDING CHILDREN% compliance with staff safeguarding training strategy at level 2	• under target from April to November • substantial improvement in Qtr 4 • remained on target for the rest of the year.
SAFEGUARDING CHILDREN% compliance with staff safeguarding training strategy at level 3	• under target from April to November • substantial improvement in Qtr 4 • remained on target for the rest of the year.

Using data from the SQPR, the following Key trends for 2016/17 were noted:

Percentage of all referrals from paediatric ward/s for self-harm assessed within 12 working hours of referral	• 100% every month YTD
Every young person presenting with self-harm or crisis seen within 4 hours regardless of setting.-	• 100% every month YTD
Percentage of caseload aged 17 years or younger – have care plan (CAMHs and EIS	• 100% for Q1 • Q2 data not available yet.

Appendix C: Influential policy and reports

	Major implications or findings
NHS Shared Planning Guidance: Operational Planning and Contracting Guidance 2017 – 2019 *(NHS, 2016)*	NHS England and NHS Improvement have published this year's operational and contracting planning guidance three months earlier than normal to help local organisations plan more strategically. For the first time, the planning guidance covers two financial years, to provide greater stability and support transformation. This is underpinned by a two-year tariff and two-year NHS Standard Contract. It provides local NHS organisations with an update on the national priorities for 2017/18 and 2018/19, as well as updating on longer term financial challenges for local systems. Key features include: • planning process has been built around STP so that the commitments and changes coming out of these plans translate fully into operational plans and contracts • timetable has been brought forward to enable earlier agreement locally about contracts • adjustments have been made to national levers such as tariff and CQUIN to support local systems in implementing service transformation • in line with NHS England's expectation of greater collaboration between organisations locally, there will be a single NHS England and NHS Improvement oversight process providing a unified interface with local organisations to ensure effective alignment of CCG and provider plans.
Five Year Forward View *(NHS 2014)*	This policy sets out a new shared vision for the future of the NHS based around the new models of care: • radical upgrade in prevention and public health activities • patients gaining far greater control of their own care • breaking down the barriers in how care is provided • new models of care, i.e. multi-specialty community providers • care provided closer to patient's home • seven day services • CCGs to develop Sustainability and Transformation Plans
Five Year Forward View for Mental Health *(NHS 2015)*	The independent Mental Health Taskforce published this report, setting out the beginning of a ten-year journey for the transformation of NHS mental health services in England. Commissioning Managers will need to work in new ways, including: • work in partnership with local stakeholders and voluntary organizations • co-produce with clinicians, experts-by-experience and carers • consider mental and physical health needs • plan for effective transitions between services • enable integration • draw on the best evidence, quality standards and NICE guidelines • make use of financial incentives to improve quality • emphasise early intervention, choice and personalisation and recovery • ensure services are provided with humanity, dignity and respect.
Future in Mind: Promoting, Protecting and Improving our Children and Young People's Mental Health and Wellbeing *(NHS, 2015)*	This policy recommends '*Promoting resilience, prevention and early intervention*' and '*Improving access to effective support – a system without tiers'*. It considers 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. It brings together core principles and requirements considered to be fundamental to creating a system that properly supports the emotional wellbeing and mental health of children and young people developed around key themes: promoting resilience, prevention and early intervention improving access to effective support – a system without tiers accountability and transparency developing the workforce. '*One-stop-shop services based in the community should be a key part of any universal offer*.' Future in Mind.

Transforming Care Partnerships *(NHS, 2015)*	The Transforming Care programme is now changing how we deliver and commission services, so that more people with learning disabilities and/ or autism, with behaviour that challenges – including those with a mental health condition – can live in the community, closer to home. This will reduce the reliance on in-patient beds and close some facilities.
CAMHS: A time to transform *(iMPOWER, 2015)*	iMPOWER produced the A Time to Transform in 2015, detailing a model based on a shared understanding that mental ill health problems are far more commonplace issues than we think for our children and young people. It is essential that the system cut through the complexity. Demand management, new service models, and multiagency work and support offer unique opportunities to change the way CAMH services are commissioned and delivered. Delivery of this change will require: • earlier intervention when a child's difficulties first arise • focus on the lower tiers in the system, in the hope that escalation to the higher ones will not be needed • breaking down the barriers between services as a deliberate, focused, planned action for all concerned • good information sharing and a mind-set that expects to share, not to withhold • triage as a way of assessing children's needs at each stage, not creating barriers but means of ensuring the child "lands" with the next stage of help and support • multi-agency working as a foregone conclusion, including during the transition to adults' services, or out of intensive help and support and back into communities and lower level interventions after a period of specialist treatment • developing the workforce to have at least a basis of knowledge, understanding and expertise in mental and emotional health, wellbeing and development.
Young People in Mind (*Youth Action, 2016*)	This report forms part of the Young People in Mind project, funded by the Department of Education. The project was delivered via a consortium of nine Youth Information, Advice and Counselling Services (YIACS) working across England led by Youth Access, with two key strands of activity: 1. increase young people's access to counselling and other psychological therapies 2. build the local YIACS' capacity to engage with local statutory bodies. The report focuses on the first area of Young People in Mind's areas of activity by providing an insight into the young people who accessed the counselling and other psychological therapies offered during the year in which the project ran. It provides policymakers, commissioners and providers with a practical insight into the range of young people's needs. The reports also show how investment in YIACS can bring an improved and integrated response to the delivery of local mental health and wellbeing support to young people; showing their particular value to young people as they move through late adolescence and into young adulthood.
Specialised tertiary Mental Health Commissioning to return to local CCGs *(NHS 2016)*	NHS England is committed to returning a range of specialised commissioning responsibilities back to the local CCG commissioners. In particular, commissioning of specialist placements for children and young people with serious mental health conditions (known as Tier 4 placements) will be returned to the local areas. This will provide local commissioning partnerships to seek more creative solutions for local children and young people rather than the current situation where the regional managers from NHS England take over commissioning responsibilities. NHS E has recently called for applications for the funding of new care model for tertiary mental health services. Partners across the Black Country have requested funding of £10.5M.
Lightening Review: Access to CAMHS *(Children's Commissioner, 2016)*	This Review, published by the Children's Commissioner in May 2016, was designed to cast light on potential issues that existed in the mental health services vulnerable young people need. The Commission found that: • large numbers of children and young people are turned away from CAMHS upon referral and/or are having to wait long periods of time for treatment • many children are waiting a long time to be seen by mental health services • many children are falling out of the system because they miss appointments and then have to be re-referred.

Better Mental Health For All: A public health approach to mental health improvement *(Faculty of Public Health, 2016)*	Public mental health is fundamental to public health in general because mental health is a determinant and consequence of physical health as well as a resource for living. A public mental health approach is concerned with promoting mental wellbeing, preventing future mental health problems and with recovery from mental health problems. It advocates that public health practitioners become advocates for public mental health providing strong leadership and prioritising mental health within current public health practices. Here is a list of key actions that all professionals working in public health and beyond can take to promote mental wellbeing and prevent mental health problems. • consider what you can do within your sphere of influence to advance the public's mental health as a leader, partner and advocate • move from deficit to strengths-based approaches and ensure you promote good mental wellbeing, • adopt a proportionate universalism approach, including universal interventions to promote mental wellbeing across whole populations, with more progressively targeted interventions to address specific needs among more vulnerable and at risk groups • ensure that you are working towards your own mental wellbeing and your colleagues • move towards ensuring mental health receives the same priority as physical health • adopt a life course approach. Place-based intervention in settings such as schools, workplaces and communities complements the life course approach and makes the most of existing opportunities. • reduce stigma and discrimination by increasing mental health and wellbeing literacy across the whole population, and • contribute to the expansion of the public mental health evidence base and focus on the interventions and activities that make the biggest impact.
Mental health and behaviour in schools: Departmental advice for school staff *(DfE, 2016)*	This non-statutory advice clarifies the responsibility of the school, outlines what they can do and how to support a child or young person whose behaviour - whether it is disruptive, withdrawn, anxious, depressed or otherwise - may be related to an unmet mental health need. The role that schools play in promoting the resilience of their pupils is important, particularly so for some children where their home life is less supportive. School should be a safe and affirming place for children where they can develop a sense of belonging and feel able to trust and talk openly with adults about their problems. The culture and structures within a school can promote their pupils' mental health through: • committed senior management team that sets a culture within the school that values all pupils • ethos of setting high expectations of attainment for all pupils with consistently applied support • effective strategic role for the qualified teacher who acts as the special educational needs co-ordinator (SENCO) • working with parents and carers as well as with the pupils themselves, ensuring their opinions and wishes are taken into account • continuous professional development for staff that makes it clear that promoting good mental health is the responsibility of all members of school staff and community • clear systems and processes to help staff who identify children with possible mental health problems; providing routes to escalate issues with clear referral and accountability systems • working with others to provide interventions for pupils with mental health problems • healthy school approach to promoting the health and wellbeing of all pupils in the school, with priorities identified and a clear process of 'planning, doing and reviewing'. Schools with these characteristics mitigate the risk of mental health problems in their pupils by supporting them to become more resilient and preventing problems before they arise. In addition, schools should also have in place arrangements which reflect the importance of safeguarding and protecting the welfare of their pupils as set out in the latest safeguarding guidance. Schools should work closely with other professionals to have a range of support services that can be put in place depending on the identified needs (both within and beyond the school). These should be set out clearly in the school's published SEND policy.

- National service framework: children, young people and maternity services (2004).
- Joint Commissioning Panel for Mental Health Guidance for commissioners of child and adolescent mental health services (2013).
- Mental Health Policy Implementation Guide -Dual Diagnosis Good Practice Guide (HM Government 2002).
- The National Service Framework for Mental Health (HM Government, 1999, 2004).
- Preventing suicide in England: One year on (HM Government 2014).
- 'Closing the Gap' (HM Government 2014).
- Achieving Better Access to Mental Health Services by 2020 (HM Government 2014).
- Wolverhampton crisis concordat action plan (2016).
- Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16
- Access and Waiting Time Standard for Children and Young People with an Eating Disorder
- Commissioning Guide (2015)
- House of Commons Education Committee
- Mental health and well-being of looked-after children Fourth Report of Session 2015–16
- Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report (2014)
- Promoting the health and well-being of looked-after children. Statutory guidance for local authorities, clinical commissioning groups and NHS England (HM Government March 2015)
- Looked-after children and young people NICE guidance PH28 (NICE and SCIE MAY 2015).
- The Children Act 1989 Guidance and Regulations Volume 2: Care Planning, Placement and Case Review.
- National Framework for Children and Young People's Continuing Care (HM Government 2010).
- Winterbourne view – Time for change Transforming the commissioning vof services for people with learning disabilities and/or autism (HM GOVERNMENT 2014)
- Transforming Care for People with Learning Disabilities Next Steps (2015)

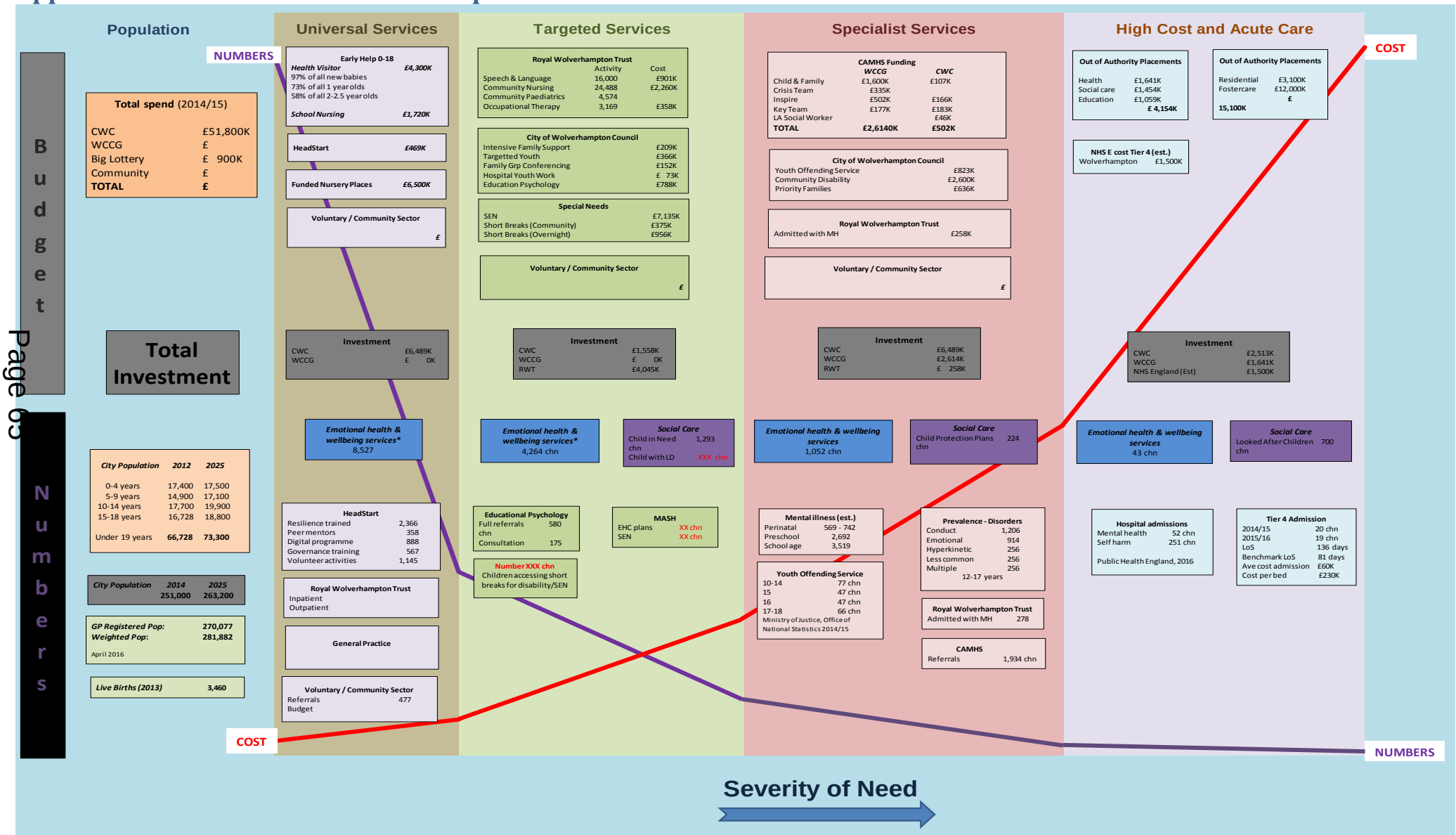
Nice Guidance Including but not exclusively includes:

- Depression in children and young people: Identification and management in primary, community and secondary care
- Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care
- Self-harm: longer-term management
- Autism diagnosis in children and young people: Recognition, referral and diagnosis of children and young people on the autism spectrum.
- Autism NICE quality standard [QS51]
- Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults.
- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges

CITY OF WOLVERHAMPTON COUNCIL

NHS Wolverhampton Clinical Commissioning Group

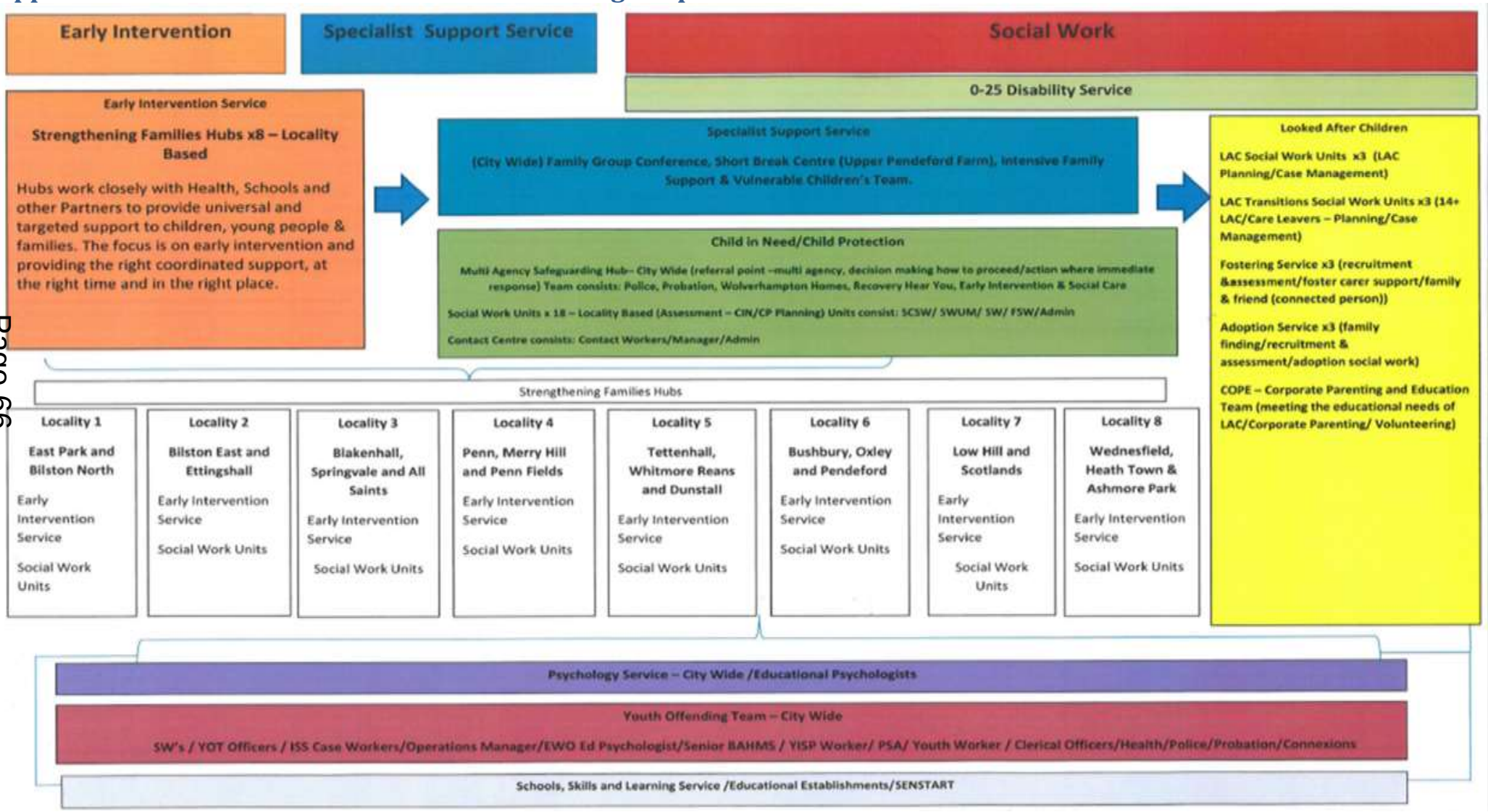
Appendix D: The 'As Is' in Wolverhampton



CITY OF WOLVERHAMPTON COUNCIL

NHS Wolverhampton Clinical Commissioning Group

Appendix E: Service model for Children and Young People's Services



CITY OF WOLVERHAMPTON COUNCIL

NHS Wolverhampton Clinical Commissioning Group

Appendix F: Gantt Chart outlining transformation plan to align services

Activity	*Action*	*RAG*	*Jan 16*	*Feb 16*	*Mar 16*	*Apr 16*	*May 16*	*Jun 16*	*Jul 16*	*Aug 16*	*Sep 16*	*Oct 16*	*Nov 16*	*Dec 16*	*Jan 16*	*Feb 16*	*Mar 16*	*Apr 17*
Establishing transformation process	Establish CAMHS Transformation Partnership Board (CTPB)																	
	Agree Terms of Reference of CTPB																	
	Develop mode of working of CTPB - aims, objectives, and outcomes																	
	Participate I Head Start funding application																	
	Establish Task & Finish Groups - leads, members, and meetings																	
	Establish reporting mechanism on activity and finances associated with each Transformation activity																	
	Establish links with community & voluntary agencies																	
	Develop robust reporting process for NHS E																	
Diagnostic and design	Obtain research & examples of best practice resources for early intervention																	
	Develop and agree work plans for each Task & Finish Group																	
	Undertake mapping of current service provision for emotional health and well being in Wolverhampton																	
	Complete Black Country CAMHS Tier 3 / 4 Co-Commissioning Project																	
	Co produce pathways for Early Intervention & Prevention																	
	Approval of co-produced pathways by CTPB																	

	Agree plans and service specification for increased operational capacity of Eating Disorder service																	
	Agree plans and service specification for increased operational capacity of Early Intervention for Psychosis service																	
	Meet NHS E Director and establish agreement about progressing Tier 4 commissioning locally in Black Country																	

Building	Develop plan with options for implementation for commissioning Tier 4 locally																	
	Review governance and operational structure to ensure suitable for implementing co designed pathway																	
	Identify and develop strategic plans that build on enabling factors and minimise project risks																	
	Operational Processes, Human Competencies; Information Technologies																	
	Develop performance and outcome measures																	
	Engagement with staff affected by transformation plans																	
	Consider draft Service Specification																	
	Produce Project Initiation Document for Better Care Fund Partnership Board																	

Implementation	Interim service arrangements																	
	Develop transition plan																	
	Roll out of implementation plan																	
	Implement quality measures and outcomes																	

Appendix G: Transformation funding

1. COMMISSIONING CAPACITY COSTS					
COMMISSIONING CAPACITY COSTS			15/16	16/17	Additional 16/17 (£148,000)
Role Description	Band	Total WTE	Total 15/16 COST	Funds required for 16/17	
TRANSFORMATION DIRECTOR	8D	0.50	13,697	30,819	
CAMHS TIER 3 PLUS / TIER 4 BLACK COUNTYRY WIDE PROJECT SUPPORT	8B	1.00	23,614		
DEDICATED PROJECT COSTS, COMMS, BUSINESS INTELLIGENCE SUPPORT, STAKEHOLDER ENGAGEMENT			20,000		
TOTAL PAY COSTS			57,311	30,819	
NON PAY COSTS (5%)			2,866	2,866	
PLUS OVERHEADS (5%)			2,866	2,866	
TOTAL COSTS			£63,042	£36,550	£0

2. CAMHS IAPT COSTS					
CAMHS IAPT COSTS					
Role Description	Band	Total WTE	Total 15/16 COST	Funds required for 16/17	Additional 16/17 (£148,000
CAMHS IAPT SCOPING CLINICAL LEAD	7	1.00	16,782	0	
TOTAL PAY COSTS			16,782	0	
NON PAY COSTS (5%)			839		
PLUS OVERHEADS (5%)			839		
TOTAL COSTS			£18,460	£0	£0

3. CAMHS CRISIS RESOLUTION HOME TREATMENT COSTS					
CHRT COSTS TO INCLUDE SPA					
Role Description	Band	Total WTE	Total 4 Month Cost	Funds required for 16/17	Additional 16/17 (£148,000
CLINICAL NURSE SPECIALIST	7	1.00	16,737	37,845	
BAND 6 NURSE PRACTITIONERS	6	2.00	21,047	63,142	
ENHANCEMENTS EXISTING STAFF		3.00	8,491	25,473	
TOTAL PAY COSTS			46,275	126,460	
NON PAY COSTS (5%)			2,314		
PLUS OVERHEADS (5%)			2,314		
TOTAL COSTS			£50,903	£126,460	

4. EARLY INTERVENTION IN PSYCHOSIS COSTS					
EARLY INTERVENTION IN PSYCHOSIS SERVICE COSTS					
Role Description	Band	Total WTE	Total 4 Month Cost	Funds required for 16/17	Additional 16/17 (£148,000
PHARMACIST	7	0.50	8,391	21,397	
NURSE	6	1.00	14,116	35,996	
TOTAL PAY COSTS			22,507	57,393	
NON PAY COSTS (5%)			375	1,125	
PLUS OVERHEADS (5%)			375	1,125	
TOTAL COSTS			£23,257	£59,644	£0

5. EATING DISORDER SERVICE COSTS					
EATING DISORDER SERVICE COSTS					
Role Description	Band	Total WTE	Total 4 Month Cost	Funds required for 16/17	Additional 16/17 (£148,000
MEDICAL COVER	CONSULTANT	1.00	70,496	44,941	
PSYCHOLOGY	8A	1.00	19,553	0	
CLINICAL SPECIALIST	8A	0.40	5,869	14,966	
DIETICIAN	6	0.20	2,016	5,141	
BAND 6 NURSE PRACTITIONERS	6	3.00	31,571	80,506	
TOTAL PAY COSTS			129,505	145,554	
NON PAY COSTS (5%)			6,475		
PLUS OVERHEADS (5%)			6,475		
TOTAL COSTS			£142,456	£145,554	£0

6. CAMHS LINK WORKERS FOR SCHOOLS					
CAMHS LINK WORKERS FOR SCHOOLS COSTS					
Role Description	Band	Total WTE	Total 4 Month Cost	Funds required for 16/17	Additional 16/17 (£148,000
CLINICAL NURSE SPECIALIST	7	1.00	16,782	37,845	
BAND 6 NURSE PRACTITIONERS	6	3.00	52,928	47,357	
ADMIN	2	1.00	7,323	9,223	
TOTAL PAY COSTS			77,033	94,424	
NON PAY COSTS (5%)			3,852		
PLUS OVERHEADS (5%)			3,852		
TOTAL COSTS			£84,736	£94,424	£0

7. SPECIALIST, COMPLEX AND LEARNING DISABILITY CAMHS COSTS					
SPECIALIST AND LEARNING DISABILITY CAMHS COSTS					
Role Description	Band	Total WTE	Total 15/16 COST	Funds required for 16/17	Additional 16/17 (£148,000
CLINICAL LEAD EPP	7	1.00	16,782	0	
CLINICAL LEAD YOUTH OFFENDING TEAM	8	1.00	22,486	0	
TOTAL PAY COSTS			39,268	0	
NON PAY COSTS (5%)			1,963		
PLUS OVERHEADS (5%)			1,963		
TOTAL COSTS			£43,195	£0	£0

8. PERI-NATAL MENTALHEALTH COSTS					
PERI-NATAL MENTAL HEALTH COSTS					
Role Description	Band	Total WTE	Total 4 Month Cost	Funds required for 16/17	Additional 16/17 (£148,000)
MEDICAL COVER	CONSULTANT	0.40	20,886	0	
CLINICAL NURSE SPECIALIST	7	1.00	16,782	37,845	
BAND 6 NURSE PRACTITIONERS	6	1.00	14,316	31,571	
ADMIN	2	0.50	3,662	0	
TOTAL PAY COSTS			55,646	69,416	
NON PAY COSTS (5%)			2,782		
PLUS OVERHEADS (5%)			2,782		
TOTAL COSTS			£61,211	£69,416	

9. COMMUNITY MENTALHEALTH COSTS					
COMMUNITY MENTAL HEALTH COSTS					
Role Description	Band	Total WTE	Total 4 Month Cost	Funds required for 16/17	Additional 16/17 (£148,000)
SUPPORT FOR CRISIS HELP LINE LGBT					£10,000
SEXUALLY HARMFUL BEHAVIOUR TRAINING					£10,000
TOTAL COSTS					£20,000

	Total 15/16	16/17 ALLOCATION	ACTUAL 16/17 ALLOCATION	Additional 16/17 (£148,000)	
	COSTS				
1. COMMISSIONING CAPACITY COSTS	63,042	36,550			
2. CAMHS IAPT	18,460	0			
3. CAMHS CRHT	50,903	126,460			
4. EARLY INTERVENTION IN PSYCHOSIS	23,257	59,644			
5. EATING DISORDERS	142,456	145,554			
6. CAMHS LINK WORKERS IN SCHOOLS	£84,736	£94,424			
7. SPECILAIST AND LEARNING DISABILITY CAMHS	43,195	0			
8. PERI-NATAL MENTAL HEALTH	61,211	69,416			
9. COMMUNITY MENTAL HEALTH					
TOTAL COSTS	487,261	532,047	587,000	£20,000	

Agenda Item No: 9

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

19 October 2016

Report title	Wolverhampton Integrated End of Life Care Strategy	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders, People Directorate	
Originating service	People Directorate (on behalf of Wolverhampton CCG)	
Accountable employee(s)	Karen Evans	Solutions & Development Manager, Wolverhampton CCG
	Tel	01902 4446034
	Email	karen.evans35@nhs.net
Report has been considered by	Wolverhampton CCG Governing Body	11 October 2016

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Receive this strategy for endorsement

1.0 Purpose

1.1 The purpose of this report is to inform the Board of the development of an integrated strategy for End of Life Care developed by commissioners and providers across the Wolverhampton health and care economy. This strategy seeks to provide the evidence base for the delivery of a whole pathway approach to End of Life care. The vision of the Strategy is an integrated, person-centred approach to the provision of care and support to people approaching the end of life and those important to them.

1.2 This report is being presented to the Board to seek their formal approval of the final version of the Strategy.

2.0 Background

2.1 To ensure delivery with the CCG priorities of care and the priorities of the Joint Health & Wellbeing Strategy, there is a need for a jointly developed, integrated health and care strategy for End of Life care in Wolverhampton. An early draft strategic approach was agreed through Commissioning Committee in 2014.

2.2 The CCG has worked with a wide range of partners to develop a comprehensive, co-produced strategy that will ensure provision of a whole pathway approach for people approaching the end of life. The strategy identifies how pathways need to be redesigned and how service providers need to coordinate their activities to ensure that the people of Wolverhampton receive the best possible responsive care and support as they reach the end of their lives.

2.3 The strategy also addresses the needs of carers and details the importance of ensuring those needs are assessed and addressed to enable them to effectively undertake their caring role and also maintain a good quality of life.

2.4 Children transitioning into adult services are also covered in the strategy. Providers need to ensure that children and their families are supported and enabled to undertake a smooth transition from children's to adult's services.

2.5 The development of the strategy and of the plan for its implementation is being managed through a Strategic steering group with representation from the key partners in commissioning and delivery of end of life and palliative care, and includes a clear focus on engagement with patients, service users, carers and families and the wider public to make sure their views are recognised, considered and represented throughout the strategy.

2.6 The co production of the Strategy with all partners ensures support for both the principles and practice of the strategy and the implementation plan set out.

2.7 A detailed implementation plan including any proposals for service redesign, commissioning and decommissioning has been developed and agreed in conjunction with the strategy document. Decisions can then be taken on how services will be contracted/commissioned and an appropriate timetable developed.

2.8 The Strategy has adopted the definition of term "approaching the end of life" that is used in "One Chance to Get it Right" :

" Patients are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions;
- general frailty and co-existing conditions that mean they are expected to die within 12 months;
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition;
- life-threatening acute conditions caused by sudden catastrophic events."

2.9 The Strategy also recommends the earliest possible implementation of Advance Care Planning for personalised end of life care for people and a newly developed document will be piloted this year with a view to fully roll this out by April next year (based on the evaluation of the pilot).

2.10 The model of care proposed for end of life care in Wolverhampton places the person and those closest to them, firmly in the centre.

2.11 There are a number of key issues that need to be addressed to improve delivery of End of Life care in Wolverhampton, not least, the earlier identification of those approaching end of life to ensure that they have the opportunity and are empowered to plan how their future needs will be met. The support and care they receive will be coordinated, and information about their choices, preferences and needs will be shared with all professionals through the development and implementation of an electronic shared record across all the agencies involved.

3. CLINICAL VIEW

3.1. Clinical input and guidance into the strategy is being provided through the Steering Group chaired by Dr Manny Samra, a local Macmillan GP Facilitator. The Steering Group also includes a range of clinicians and health and care professionals from partner agencies involved in the provision of End of Life care including Consultants in Palliative medicine.

3.2. Further clinical scrutiny will be provided by the CCG Clinical Reference Group as and when required.

4.0 Financial implications

4.1 No immediate financial and resource implications have been identified. The implementation planning process will identify any such implications and these will be reported through the relevant governance processes.

5.0 Legal implications

5.1 No immediate legal implications have been identified. The implementation planning process will identify any such implications and these will be reported through the relevant governance processes.

6.0 Equalities implications

6.1 A full equality impact assessment will be undertaken during the development of the the strategy. The recent CQC Report "A Different Ending" will inform part of this work. The City of Wolverhampton has a very diverse population with a wide range of cultural differences. These will be addressed within the Strategy and its implementation plan.

7.0 Environmental implications

7.1 There are no known environmental implications.

8.0 Human resources implications

8.1 No immediate human resources implications have been identified. The implementation planning process will identify any such implications and these will be reported through the relevant governance processes.

9.0 Corporate landlord implications

9.1 There are no known implications for the City Council's property portfolio.

10.0 Schedule of background papers

10.1 The following documents are referred to in the Strategy :

- NHS Five Year Forward View – NHS England, October 2014
- A Commitment to You for End of Life Care – Department of Health, July 2016
- Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020 - National Palliative and End of Life Care Partnership, September 2015
- End of Life Care Strategy – Department of Health, July 2008
- Every Moment Counts – National Council for Palliative Care, March 2015
- What's Important to Me – A review of Choice in End of Life Care - Choice in End of Life Care Programme Board, February 2015
- A Different Ending – Addressing Inequalities in End of Life Care – Care Quality Commission, May 2016

Agenda Item No: 10

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

19 October 2016

Report title	Living Well, Feeling Safe Event	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Key decision	No	
In forward plan	No	
Wards affected	All	
Accountable director	Linda Sanders, People Directorate	
Originating service	Public Health	
Accountable employee(s)	Ros Jervis	Service Director for Public Health and Wellbeing
	Tel	01902 550347
	Email	Ros.Jervis@wolverhampton.gov.uk
Report has been considered by:		
Updated report:		

Recommendation for action or decision:

The Health and Wellbeing Board is recommended to:

1. hold a “Living Well, Feeling Safe” engagement event in the City of Wolverhampton

1.0 It is recommended for an event to be hosted by the Health & Wellbeing Board (HWBB) with a "wellbeing" theme to celebrate the good work happening across the City, supporting people to have a good quality of life to live happy and healthy lives and to protect them from harm. It will provide an opportunity for the sharing of information across the HWBB and other key partnerships about the wealth of preventative resources in the City.

1.1 **Overview**

Through the "Living Well, Feeling Safe" event the aim would be to:

- Increase understanding and raise awareness of the depth and breadth of community and agency support available in the city;
- Engage the Voluntary and Community Sectors to showcase their contributions for Wolverhampton's residents;
- Provide an opportunity to register with the Wolverhampton Information Network (WIN)
- Through the provision of stands and space for presentations enable partners to showcase their contribution and share information and learn what others are doing to support our residents.

It is proposed that this event takes place on **14 February 2017**. The venue is being arranged.

2.0 Background

The Health and Well Being Board enables key leaders from the health and social care system to work together to improve the health and wellbeing of the local population and reduce health inequalities. Through the collaboration of members, we are able to gain a better understanding of local community needs and enable commissioners to work in a more joined up way providing our service users with a seamless experience from a more effective, responsive local health and social care system. It is proposed that the HWBB organise a city-wide event that brings together key agencies from the public, private, and voluntary sector to show case the rich contribution being made across the city to both support and protect our citizens.

Impact on Wolverhampton council and / or city

The event would enhance the awareness of the community based help and support available for Wolverhampton residents. Voluntary and Community Sector groups would be able to show case their services and demonstrate the value they provide for local people to live full and active lives and the good work happening within communities themselves. We would be able to encourage organisations and groups register their services or 'offer' on the Wolverhampton Information Network (WIN).

The event will link to the Council's corporate objectives:

- Promoting and enabling healthy lifestyles; promoting independence for all communities, and enabling them to support themselves so they can achieve their full potential;
- Improving personal resilience and wellbeing of residents (the City already has some of the most cohesive communities to be found anywhere in the country)
- Safeguarding people and ensuring the support and protection to improve their life chances and ensuring they feel safe in their own communities.
- Successful partnerships between health, policy, voluntary, community and private sectors are essential to successful delivery of the Corporate Plan and tackling social challenges across the City. These should be collaborative, involve co-production and shared services.
- Tackling lifestyle issues will improve the quality of life of our residents and have a positive effect on healthy life expectancy in the city.

Next Steps

We propose to establish a steering group across public, private and voluntary sector agencies to develop a detailed plan for the day including the communicating and publicising of this event.

5.0 Financial implications

5.1 Any costs arising from the detailed plan will be met by member organisations of the HWBB.
[GS/11102016/J]

6.0 Legal implications

6.1 There are no immediate legal implications arising from this report.
[RB/11102016/C]

7.0 Equalities implications

7.1 This event will raise awareness on the range of support and advice partners are providing to address and improve the inequalities of health amongst a diverse range of people from different cultural backgrounds and equality strands within our communities.

8.0 Environmental implications

8.1 There are no environmental implications to this report.

9.0 Human resources implications

9.1 There are no HR implication following agreement to this report. [HR/JF/RJ/028]

10.0 Corporate landlord implications

There are no landlord implications to this report

11.0 Schedule of background papers

Agenda Item No: 11

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

19 October 2016

Report title	Wolverhampton CCG Commissioning Intentions 2017/18-2018/19	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders, People Directorate	
Originating service	People Directorate (on behalf of Wolverhampton CCG)	
Accountable employee(s)	Steven Marshall	Director of Strategy & Transformation Wolverhampton CCG
	Tel	01902 445797
	Email	ehull@nhs.net
Report to be/has been considered by		

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Endorse the CCG commissioning intentions

1.0 Purpose

1.1 To share the Commissioning intentions of the CCG for the FY 17/18 – 18/19 with the HBB and gain endorsement of the direction of commissioning travel and the associated action

2.0 Background

2.1 In FY 16/17 the CCG outlined it's direction of travel for the services it intends to commission, which are cascaded from the 5 year strategy and the (annually updated) two year operating plan, both of which have been endorsed by the HWB.

The Commissioning intentions issued to providers for FYs 17/18 & 18/19 are a refresh of the 4 year road map which is attached as Appendix 1.

The slight adjustment to previous years (as a consequence of recently published planning guidance) is the shift to a two year contract. This eliminates the need for a repeat of the intentions being issued and contract negotiations being entered into in FY 17/18. There nevertheless remains the option to amend any service as part of the normal contracting process.

3.0 Progress

3.1 The road map has been cascaded into a series of specific and detailed programmes and plans of work, aligned to which part of the health provider eco-system it will impact (Acute, Community Primary Care, Mental health). For the first time the CCG have equally shared the intentions with GP Primary Care in recognition of the CCG becoming fully delegated as of 1 April 2017 and also as part of the reflection of the increasing speed of implementation of the Primary Care Strategy.

4.0 Financial implications

4.1 Components of the planned activity will become part of the s.117 BCF.

5.0 Legal implications

5.1 It is the statutory duty of the CCG to plan and procure services for its resident population.

6.0 Equalities implications

6.1 Each new programme and/or service change delivered as part of the Commissioning Intentions is subject to both a quality and equality impact assessment.

7.0 Environmental implications

7.1 N/A

8.0 Human resources implications

8.1 N/A.

9.0 Corporate landlord implications

9.1 N/A.

10.0 Schedule of background papers

10.1 N/A.

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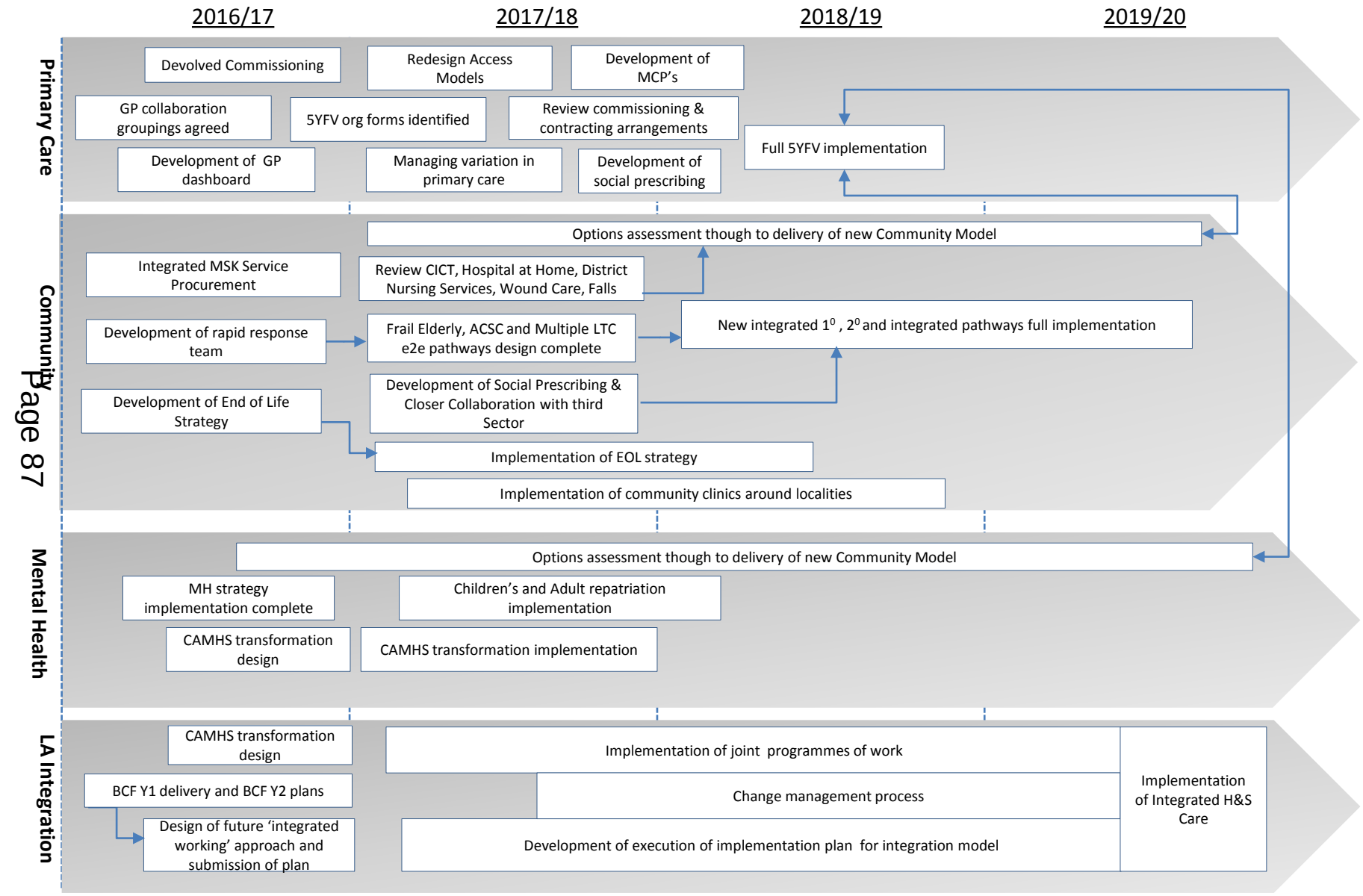
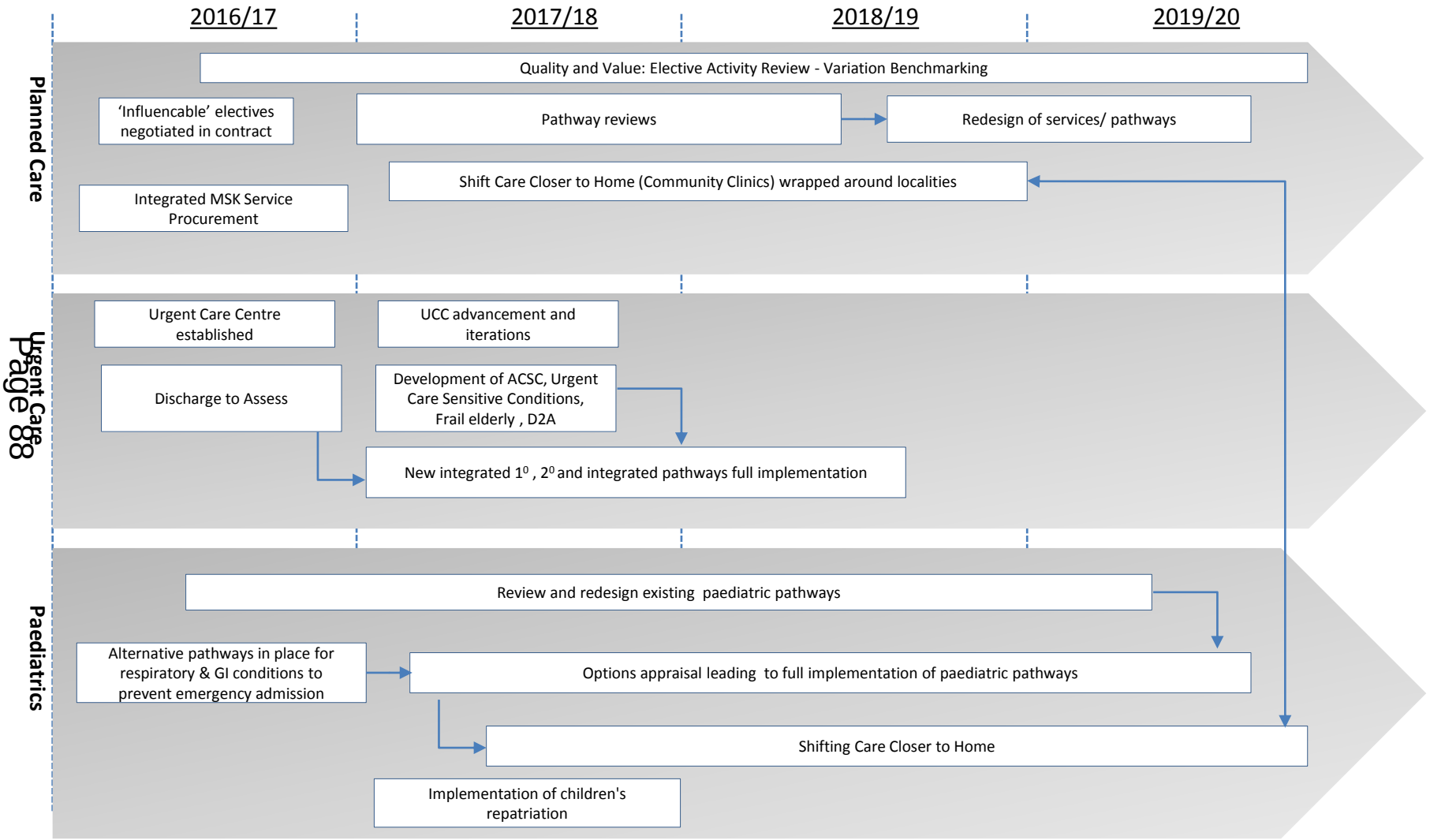
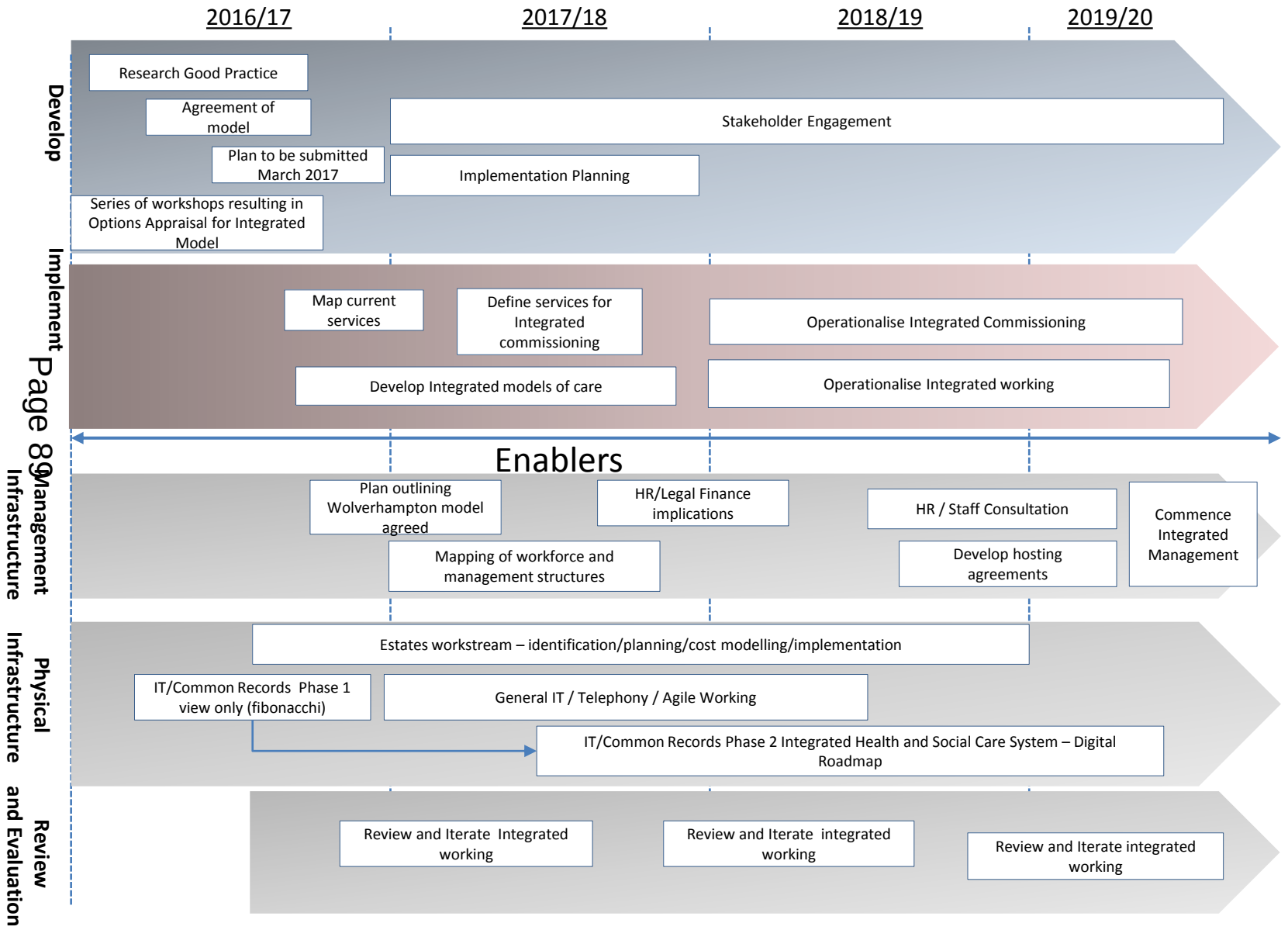
Strategic Roadmap 2016/17 – 2019/20



Strategic Roadmap 2016/17 – 2019/20



LA Integrated Roadmap 2016/17 – 2019/20



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Agenda Item No: 12

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

19 October 2016

Report title	Primary Care Strategy Update	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders, People Directorate	
Originating service	People Directorate (on behalf of Wolverhampton CCG)	
Accountable employee(s)	Steven Marshall	Director of Strategy & Transformation Wolverhampton CCG
	Tel	01902 445797
	Email	ehull@nhs.net
Report to be/has been considered by		

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Note the contents of the report provided.

1.0 Purpose

1.1 Provide assurance on progress made towards implementation of the Clinical Commissioning Group (CCGs) Primary Care Strategy:-

- Formation of a Primary Care Strategy Committee & associated governance structure
- Program of Work Delivery Update
- Emerging New Models of Care

2.0 Background

2.1 The CCGs Primary Care Strategy was ratified by the Governing Body in January 2016 in recognition of the changing demands in primary care. The CCGs vision seeks to achieve universally accessible high quality out of hospital services that promote the health and wellbeing of our local community, ensuring that the right treatment is available in the right place at the right time and to improve the quality of life of those living with long term conditions and also reduce health inequalities.

3.0 Discussion

3.1 PRIMARY CARE STRATEGY COMMITTEE

In July 2016 the Primary Care Strategy Committee was formed, in line with the plan for implementation. The committee has met in July, August and September with the intention for meetings to be held on a monthly basis thereafter in line with the agreed terms of reference. The function of the committee is to have oversight of an extensive transformation program focussing on care provided in primary care now and in the future.

A corresponding governance structure has been compiled which provides clarity regarding the inter-dependencies between other associated forums also providing direct reports into the Governing Body pertaining to the primary care agenda. The committee will provide reports on a monthly basis to the Governing Body hereafter.

An extensive program of work has been defined to underpin the successful delivery of the Primary Care Strategy and comprises of a series of task and finish groups as follows:-

- Practices as Providers
- Localities as Commissioners
- Primary Care Contracting
- Workforce Development
- Clinical Pharmacists in Primary Care
- Estates
- Information Technology

Each of the above has been formed in line with the CCGs program management office approach. All work streams have a series of objectives and timescales for delivery that are overseen by the committee.Highlight reports are prepared by the work stream lead(s) following each meeting for consideration at the Primary Care Committee, exceptions will be reported with corresponding remedial actions identified by the task and finish group for consideration by the committee.

Whilst this program of work is in its infancy there are a series of items that have been achieved at this early stage including:

- Formation of a Primary Care Joint Committee
- Formation of a Primary Care Operational Management Group
- Project Management Support assigned to Primary Care Home Model
- Review of enhanced primary care services
- Investment Plan for Primary Care Reserves Funding
- Introduction of a Clinical Reference Group
- Development of a Primary Care Service Costing Template
- Primary In Reach Service specified and implemented
- Gap Analysis of Primary Care workforce needs & responsive plan
- Collaborative approach to contract review visits using a standardised process & tool
- Proposals submitted for Estate Transformation Fund
- Baseline survey of estate completed
- Estate Strategy developed and implementation commenced
- Work with Primary Care Home test site(s) to investigate technological solutions

There are many other items from the work program that have commenced and will be measured in line with the critical path that has been assigned to each component.

In order to sustain primary medical services in Wolverhampton, and in line with the CCG members' decision to pursue the Multi-speciality Care Provider (MCP) Framework, groups of practices are aligning themselves in readiness to deliver against the framework from April 2017.

In August an application was made to the National Association of Primary Care from Wolverhampton Care Collaborative, with support from the CCG. This is the second group of practices who have come together with the intention to adopt the Primary Care Home Model. Other groups are intending to function as 'Medical Chambers' or an 'Alliance', where they intend to fulfil the requirements of an MCP contract whereby each practice will sign up to a Memorandum of Understanding (MoU) with the practices included in their group. Each group will be responsible for serving the commissioned needs of their registered population. More detail on the logistics of this contracting model will be provided following further guidance due to be published at the end of September.

In addition, a governance structure has been developed with the aim of enabling dialogue between the Royal Wolverhampton Trust and the CCG in relation to the second new model of care Primary and Acute Care (PACs) Model. There are currently three practices from across the city who integrated with the trust on 1 June 2016, discussions continue with other practices to determine their level of interest in the model.

The CCG are supporting the exploration of this model in addition to the MCP model detailed above. The mutually agreed objectives for the model are as follows:-

- Delivering better outcomes for patient from Primary Care Services (Right Care)
- Delivering more care for patients, closer to home (Right Place)
- Improvement access for patients (Right Time)

A number of work streams have been established within the trust to support these objectives, reporting on progress will be monitored at the Vertical Integration Joint Executive Group. NHS England have also formed a Joint Governance Group to support the management of the General Medical Services Contract that has been sub-contracted to Royal Wolverhampton Trust.

Also in August, a report was provided to the Primary Care Joint Commissioning Committee with a corresponding action plan detailing each of areas of action arising from the General Practice Five Year Forward View.

4.0 Financial implications

4.1 At this stage there are no financial and resource implications for the Governing Body to consider, representation and involvement from finance colleagues at committee and tasks and finish group level will enable appropriate discussions to take place in a timely manner.

5.0 Legal implications

5.1 The Primary Care Strategy demonstrates how the CCG seeks to satisfy its statutory duties and takes account of the key principles defined within the General Practice Five Year Forward View.

6.0 Equalities implications

6.1 The strategy has a full equality analysis in place. This will require periodic review during the implementation phase.

Agenda Item No: 14

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

19 October 2016

Report title	Public Health Lifestyle Survey 2016	
Decision designation	AMBER	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Key decision	No	
In forward plan	No	
Wards affected	All	
Accountable director	Linda Sanders, People Directorate	
Originating service	Public Health	
Accountable employee(s)	Ros Jervis	Service Director for Public Health and Wellbeing
	Tel	01902 550347
	Email	Ros.Jervis@wolverhampton.gov.uk
Report has been considered by:	Public Health Senior Management Team	30 June 2016
	People Leadership Team	4 July 2016
Updated report:	People Leadership Team	10 October 2016

Recommendation for action or decision:

The Health and Wellbeing Board is recommended to:

1. Accept the findings of the Wolverhampton Healthy Lifestyle Survey, support its use for the Joint Strategic Needs Assessment and determining future offers for healthy lifestyle services for the City.

1.0 Purpose

1.1 The purpose of this report is to present the summary report and some of the more detailed analysis undertaken with data taken from the Wolverhampton Healthy Lifestyle Survey conducted in early 2016.

2.0 Background

2.1 It has been estimated that around 80% of deaths from major diseases, for example, cancer and heart disease, are attributable to lifestyle risk factors such as smoking, excess alcohol consumption, lack of exercise and an unhealthy diet. These major causes of premature death are preventable conditions that are inextricably linked to lifestyle choices and deprivation.

2.2 In response to lower than national average life expectancy and healthy life expectancy figures the Director of Public Health Annual Report 2014/15 launched a prevention plan. One of the recommendations of the report was the development a lifestyle survey to provide information to shape the delivery of programmes to improve the health and wellbeing of the population.

3.0 The Wolverhampton Healthy Lifestyle Survey: key headlines

3.1 A population lifestyle survey was commissioned by the City of Wolverhampton Council Public Health & Wellbeing Service. This was conducted between January and April 2016 by M-E-L Research.

3.2 A total of 9,048 residents of Wolverhampton over the age of 16 years participated in the doorstep survey. This is the biggest health survey ever conducted in Wolverhampton, collecting data on healthy eating, smoking, alcohol intake, physical activity and mental wellbeing. The survey also included three questions regarding resident satisfaction with council services. The survey sample was monitored throughout the period of the survey to ensure that the sample would represent the demographic profile of the City.

3.3 The aim of the survey was to identify the level of lifestyle risk factors across the city and identify what would help residents choose healthier options. It will provide ward level data on lifestyle risk factors not previously available. A copy of the full report from M-E-L Research can be accessed on request.

Some of the key headlines include:

Healthy Eating

- Only 26% of respondents eat the recommended five portions of fruit and vegetables per day, of these, young people aged 16-19 years are least likely to eat their ‘Five-a-day’
- 62% of respondents would like to eat more healthily and 50% would like help to eat more healthily
- Cheaper healthy food (39% of respondents) and more time to prepare healthy food

- (39% of respondents) were the most popular types of help wanted
- 55% of respondents are considered overweight or obese calculated from self-reported height and weight figures
- However, 51% of respondents calculated to be overweight and 17% of respondents calculated to be obese, thought they were at about the 'right weight'

Smoking

- 22% of respondents currently smoke; socioeconomic status is linked to whether a person smokes or not. Only 13% of people living in the least deprived areas smoke, compared to 30% of people in the most deprived areas
- 58% of smokers would like to stop smoking; 33% do not want to stop and 9% did not know if they would like to stop
- 41% of smokers said that they did not need help to stop smoking

Alcohol intake

- 18% of the population, 26% for men and 12% for women, drink at levels that potentially put them at risk (score of five or more on Audit C).
- 16-19 year olds are less likely to drink alcohol than older people, however those that do report drinking are just as likely to drink at harmful levels
- 52% of respondents stated that they drink alcohol; men (59%) were more likely to drink alcohol than women (46%). This is lower than the England average, where 85% men and 79% of women are reported to drink.

Physical activity

- 77% of the population engage in moderate activity however only 10% are vigorously active
- 56% of respondents felt they did enough exercise for someone their age
- 58% would like to be more active and 32% would like help to become more active
- When asked 'what would help you to become more active?', 35 % stated having more time, followed by 28% requesting free access to a gym and 20% wanting lower prices for a gym

Mental Wellbeing

- The average wellbeing score was slightly higher in Wolverhampton at 53.6 than the England average of 51.6. Although average wellbeing is higher in Wolverhampton, life satisfaction, happiness and sense of worthwhileness are all lower in Wolverhampton than the national average.
- Having a health condition or disability that limits daily activities leads to a significantly lower wellbeing score (44.9) than the Wolverhampton average
- 32% of respondents said that more money would increase their wellbeing and 9% stated that more time for themselves would help

Satisfaction with Council Services

- Overall, how satisfied or dissatisfied are you with the following as a place to live:
  - Your neighbourhood: 84% were very or fairly satisfied
  - Wolverhampton as a whole: 62% were very or fairly satisfied
- How well informed do you feel about how council services are performing?
  - 55% of respondents felt very or fairly well informed

- Overall, how well do you think Wolverhampton City Council is performing?
  - 62% of respondents felt the City Council was performing very or fairly well

4.0 The Wolverhampton Healthy Lifestyle Survey: Cluster analysis

4.1 Public Health is currently conducting a detailed analysis of the data which will provide ward level information, highlighting variation across the city and any inequalities. This will help shape and target services in the future to meet the needs of the local population.

4.2 The detailed analysis includes a cluster analysis where all the survey responses, after screening for completeness, were categorised accordingly into the seven lifestyle behaviours as described in table 1.

Table 1: behaviours and levels used in the cluster analysis

Lifestyle behaviour	Levels
Healthy eater	Yes/no (yes: five fruit and veg on average per day, cooked meal from scratch most days or more, ate takeaway or ready meals less than once or twice a week)
Vigorously active	Yes/no (yes: five times per week or more activity that gets you out of breath and sweaty lasting longer than ten minutes)
Moderately active	Yes/no (yes: five times per week or more activity that gets you breathing harder lasting longer than ten minutes)
Ever smoked	No, used to, currently
Alcohol	Abstain, low risk (Audit C five and less), high risk (Audit C score of over five)
BMI category	Underweight, healthy, overweight, obese
Wellbeing	Very low, below average, average, above average

4.3 A total of ten different clusters have been identified; and although behaviours can appear in more than one cluster, individuals can only appear in one cluster. Public health has identified the key features and behaviours for each cluster and identified where clustered individuals live across the city so that any recommendations can be targeted.

4.4 The table below provides a simple description of each of the ten clusters and its size by survey population. Further detail, including the ward distribution maps, has been attached for your information at Appendix one.

Table 2: Cluster description

Cluster	Description	Population size
1	Vigorously Active	8.7%
2	Healthy eaters	12.5%
3	Used to smoke	10.2%
4	Healthy weight; poor lifestyle	20.6%
5	Overweight	15.3%
6	Drinkers and smokers	9.2%
7	Obese and Average Wellbeing	12.2%
8	Underweights	2.8%
9	Below Average Wellbeing	6.2%
10	Very Low Wellbeing	2.3%

4.5 **So what?**

It is important to understand and maximise the benefits from having access to data of this this quality, the list below highlights a few:

- The survey report does not assume anything but collates responses received directly from people who live in Wolverhampton;
- The survey size was large enough to draw robust findings from the analysis undertaken and be considered representative for the whole population;
- Use of this survey information particularly in combination with others such as the Wolverhampton Health Related Behaviour Survey (for children) will support robust Joint Strategic Needs Assessment (JSNA) development for use by all commissioners across the City;
- The survey does not simply report on lifestyle behaviours but makes links to a variety of demographics including employment and educational attainment;
- The findings will support how we redesign future healthy lifestyle services for the City. This is particularly useful for clusters that demonstrate strong links between certain lifestyle behaviours such as alcohol and smoking, and the benefits that can be derived through the ‘Making Every Contact Count’ principle with a workforce that can support behaviour change across several different lifestyle factors, for example GPs, health visitors, teachers, and school nurses;
- Qualitative information will support social marketing campaigns;
- The cluster analysis will enable targeted work to take place with a view to reducing health inequalities; and
- The data could be used to develop a model around how lifestyle behaviours affect mental wellbeing, through the identification of factors that can be targeted to improve mental wellbeing.

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 and the grant allocation for 2016/17 is £21.9 million There are no direct financial implications related to the findings of the Wolverhampton Healthy Lifestyle Survey summary report. [GS/06102016/C]

6.0 Legal implications

6.1 There are no legal implications related to this report.
[TS/06102016/H]

7.0 Equalities implications

7.1 This report does highlight historical and current health inequalities that can then be addressed through services commissioned by the City of Wolverhampton Council and other key partners across the Health and wellbeing Board.

8.0 Environmental implications

8.1 There are no environmental implications of the report.

9.0 Human resources implications

9.1 There are no human resource implications related to this report.

10.0 Corporate landlord implications

10.1 There are no corporate landlord implications for the Council's property portfolio in relation to this report.

11.0 Schedule of background papers

11.1 There are no background papers in relation to this report.

Wolverhampton Healthy lifestyles survey:

clustering summary

Methods

7,414 responses were used after removing incomplete and blank responses. These responses were categorised accordingly into the seven lifestyle behaviours as described below.

Area	Levels
Healthy eater	Yes/no (yes: 5 fruit and veg on average per day, cooked meal from scratch most days or more, ate takeaway or ready meals less than once or twice a week)
Vigorously active	Yes/no (yes: 5 times per week or more activity that gets you out of breath and sweaty lasting longer than 10 minutes)
Moderately active	Yes/no (yes: 5 times per week or more activity that gets you breathing harder lasting longer than 10 minutes)
Ever smoked	No, used to, currently
Alcohol	Abstain, low risk (Audit C 5 and less), high risk (Audit C score over 5)
BMI category	Underweight, healthy, overweight, obese
Wellbeing	Very low, below average, average, above average

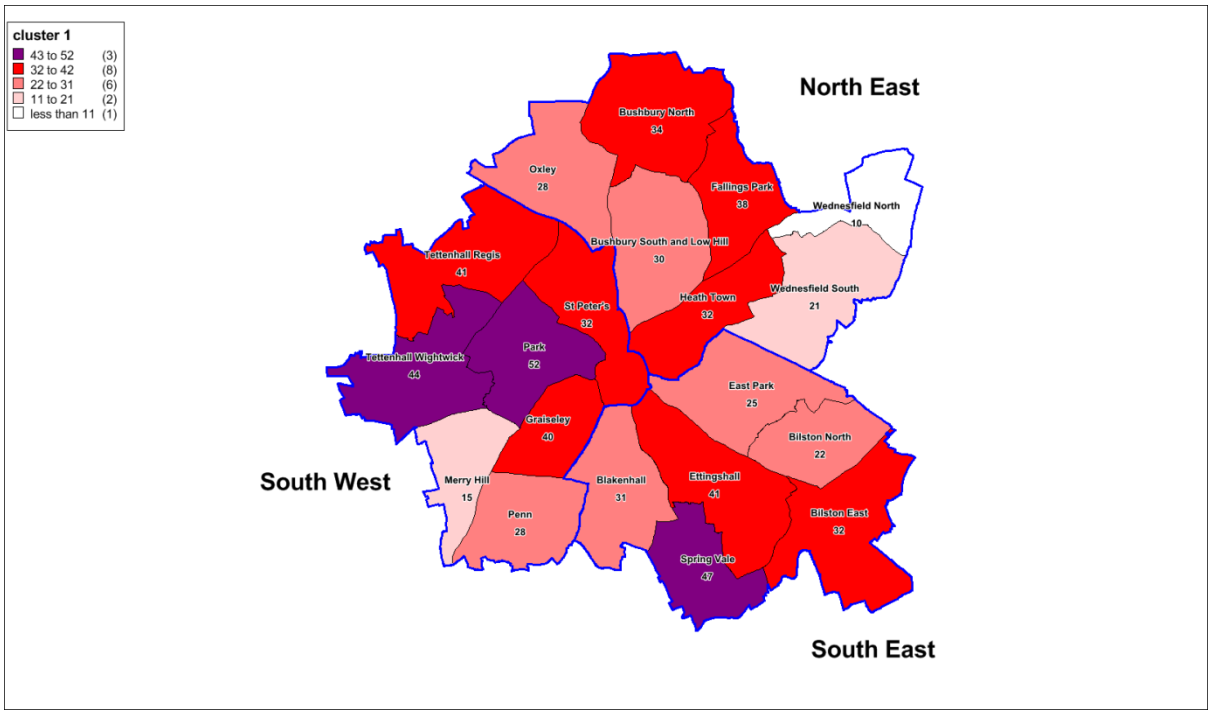
Cluster 1 "Vigorously Active": Contains people who are vigorously active and the majority from the overall vigorously active population (82%) appear in this cluster. Individuals in this cluster have higher wellbeing compared to the overall population. The majority of this cluster have never smoked, are more likely to be a healthy weight and less likely to be obese. Despite being more likely than the overall population to eat healthily a substantial number eat an unhealthy diet, this is a possible area of improvement in the lifestyles of this cluster. Finally people in this cluster are much less likely to be high risk drinkers.

643, 8.7% of survey population

This cluster are mostly male (nearly 65%) and young, with over half aged under 39 and the largest group being those aged 20-24. Although most of this group are white, this is under-represented compared to the overall population. In contrast, those from an Asian ethnic background are largely over-represented. In terms of deprivation, the distribution is similar to the population overall, however, there is an overrepresentation of individuals who reside in the Park and Spring Vale wards (see map below). In terms of economic activity and qualifications, this cluster has much more people who are working full time and are more likely to have qualifications (and at a higher level) compared to the general population. There are also a higher proportion of students and those who are self-employed.

As diet has been identified as an area of improvement for this group, it is encouraging that 63% would like to eat healthier, this is slightly higher than the population overall. Of those that want to eat more healthily, 37% stated that they can do this on their own without help, slightly more than the overall population and in fact the largest proportion out of all ten clusters. Other things that would help are cheaper healthy food and more time to prepare healthy food. Interestingly, this cluster has the lowest proportion who stated 'more healthy produce available in local shops'.

Number in cluster by ward of residence



Cluster 2 "Healthy Eaters": This cluster contains people who are healthy eaters and 49% of the overall healthy eater active population appear in this cluster. This cluster is more likely to have higher wellbeing compared to the overall population. People in this cluster are less likely to be smokers and high risk drinkers than the overall population. They are substantially less likely to be obese and more likely to be a healthy weight, however slightly more in this cluster are overweight than compared to the overall average. The majority of people in this cluster are not vigorously active, suggesting that this is the most important aspect that this cluster could target to improve their lifestyles.

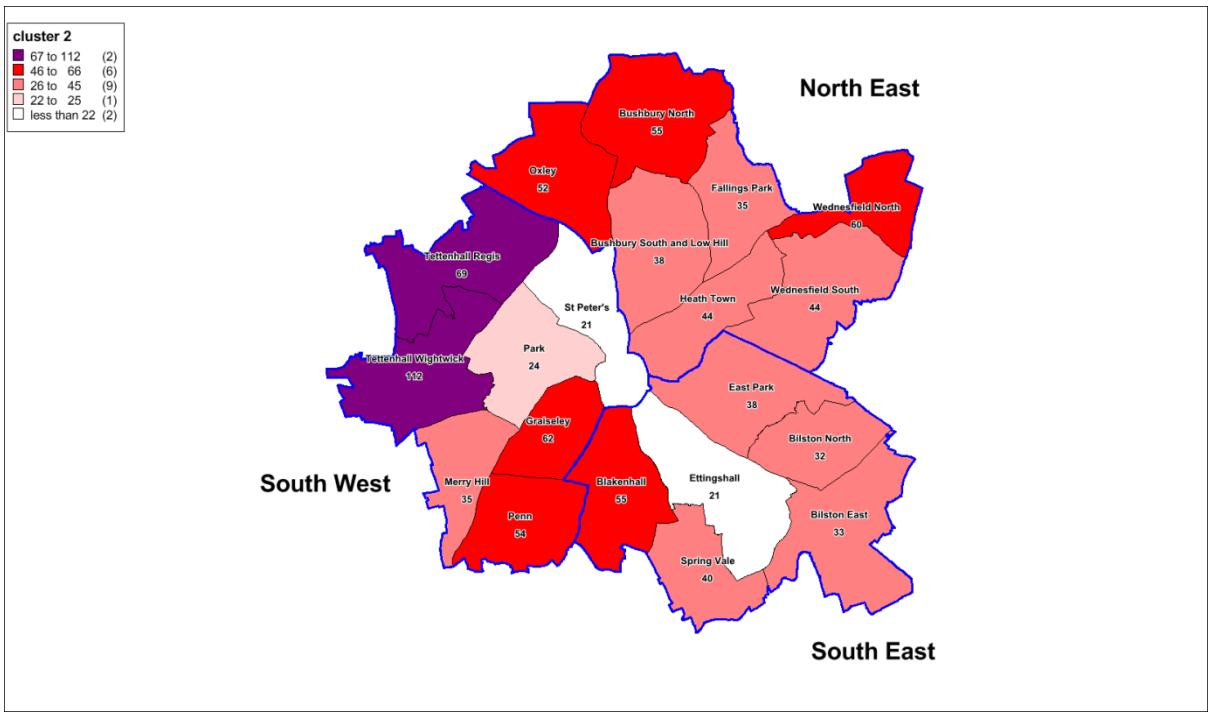
924, 12.5% of total population

The people in this cluster are much more likely to be female (nearly 61%). The age distribution is fairly similar to that of the overall population, with a slightly higher proportion of the older population (over 65). The ethnic background distribution is similar to the overall population.

In terms of deprivation, there is an under-representation of those from the most deprived deciles and more individuals from the more affluent areas compared to the overall population. This coincides with the distribution by ward as most from this cluster reside in the more affluent wards to the West of the City (see map below). In terms of economic activity and qualifications, this cluster has much more people who are working full time and are retired and this is over represented compared to the overall population. The level of qualifications are similar compared to the general population but with a slightly higher proportion that have a degree or higher.

Just under half of this cluster stated they wanted to be more active, a key area of improvement identified for this group and a lower proportion than in the population overall. Of those that want to be more active, 46% stated that they did not want help to be more active as they can do it on their own, much lower than the overall population. Having more time was the most popular response, however, key things to consider are; the reduction in prices or free membership to gym/leisure centres, availability of exercise/activities for people with medical conditions and supporting people to improve motivation.

Number in cluster by ward of residence



Cluster 3 "Used to Smoke": Contains people who used to smoke and the majority from the overall population who use to smoke appear (83%) in this cluster. This cluster is more likely to have average wellbeing. Although the majority of this cluster is not vigorously active they are more likely to be moderately active. Healthy eating is not significantly different from the overall population level. This cluster is less likely to abstain from drinking alcohol compared to the overall population however they have similar levels of high risk drinking.

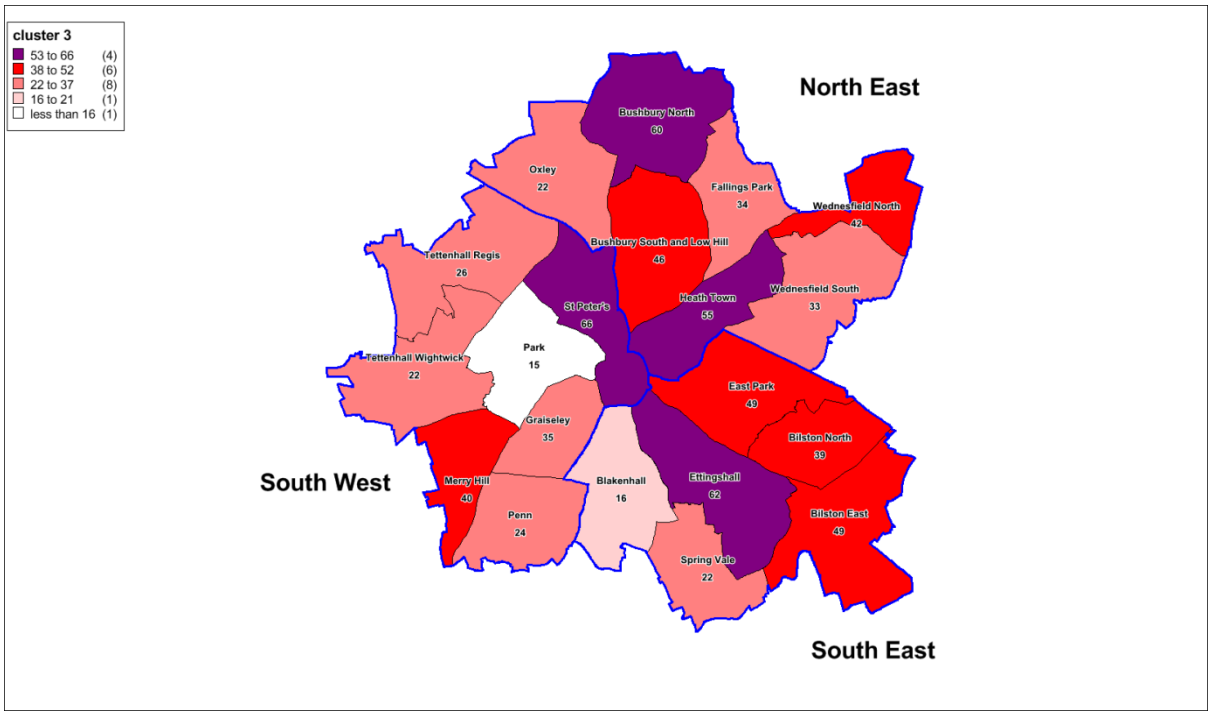
People from this cluster are more likely to be overweight and significantly more likely to be obese. Nothing on its own stands out as a single factor for this cluster to focus on they require improvement across all lifestyle areas.

757, 10.2% of total population

In this cluster there are a slightly higher proportion of males compared to the overall population, the age distribution is not too dissimilar from the overall population for those aged under 70, however, there is an over-representation of those aged over 70. In terms of ethnicity, there is a large over representation of those from a white ethnic background. Only 15% of this cluster is from a Black Minority Ethnic (BME) group. There is a slight over representation of those from the more deprived areas, in particular the St Peters ward, but in general, individuals in this cluster are spread across the city. There is an over-representation in this group of those who are retired, the rest of the group are mainly working full or part time. People in this cluster have similar qualifications to the overall population, however, they are less likely to have qualifications higher than GCSEs A-C or equivalent.

It was identified that this group need to improve in all areas, it is encouraging that 66% want to eat healthier and 60% want to be more active, both more than the overall population. Things that would help this group to eat more healthily are similar to the overall population; cheaper healthy food, more healthy produce available in local shops and more time to prepare healthy food. 60% of this cluster stated that they did not need any help to be more active. For those that do want help the most popular choices were; availability of local sports/leisure facilities close to home, having more time, reduced/free membership to gym or leisure facilities and someone to exercise with. It is worth noting that the response, ‘having someone to exercise with’ is over represented compared to the overall population. Furthermore, this cluster had the lowest response for ‘More healthy options in takeaway/convenience foods’.

Number in cluster by ward of residence



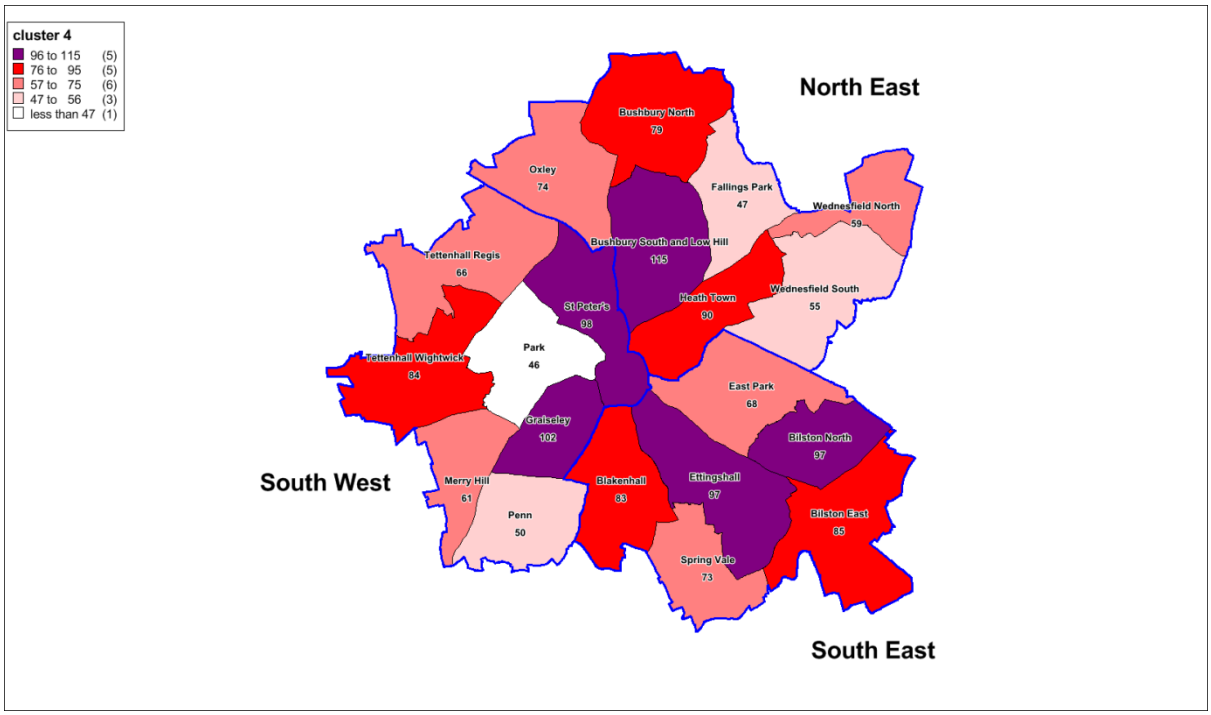
Cluster 4 "Healthy Weight Poor Lifestyle": Contains people who are a healthy weight, 50% of the healthy weight population appear in this cluster. People in this cluster are more likely to have average wellbeing. Despite being a healthy weight nearly all the people in this cluster eat unhealthily. Compared to the overall population people in this cluster are more likely to be smokers. People from this cluster mainly abstain from drinking and none are high risk drinkers. They are much less likely to engage in vigorous activity, although they have similar levels of moderate activity compared to the overall population. For this cluster despite being a healthy weight they are at risk of becoming overweight and obese given their lifestyle choices and the focus should be on improving diet and exercise levels as well as smoking cessation where appropriate.

1529, 20.6% of total population

This cluster has a higher proportion of females (58%). The age distribution is fairly similar to that of the overall population, with a slightly higher proportion of the younger population (those aged under 29). The breakdown of ethnicity is fairly similar to the overall population, however, it is worth noting there is a slightly higher proportion of those from an Asian background. Deprivation and ward breakdowns are similar to the population overall. This is supported by the map of individuals who are spread across the city. Despite the majority of this cluster working or being retired, there is also an over represented proportion of those who are students. In terms of qualifications, there are no clear differences between this cluster and the overall population.

62% want to eat more healthily and of these, 32% said they could do this by themselves (similar to the overall population). Things that would help are; cheaper healthy food, more healthy produce available in local shops and more time to prepare healthy food. It is also worth noting that this group are least likely to want 'advice from a GP / Nurse', with the lowest proportion out of all the clusters. 57% of this cluster wants to be more active, and half of these want help with this. Common responses were; having more time, availability of local sports/leisure facilities close to home, free/reduced price leisure and gym memberships and having someone to exercise with. Although not as popular, there is an indication that advice from a health care professional may be beneficial. Of those who smoke, only 36%, lower than the overall population, said they wanted to quit. Of those who want to quit, 41% said they could do this on their own. Other things that would help (in order of preference), are: e-cigarettes, NRT, support from a GP/nurse and using an NHS stop smoking service/Smoking Advisor.

Number in cluster by ward of residence



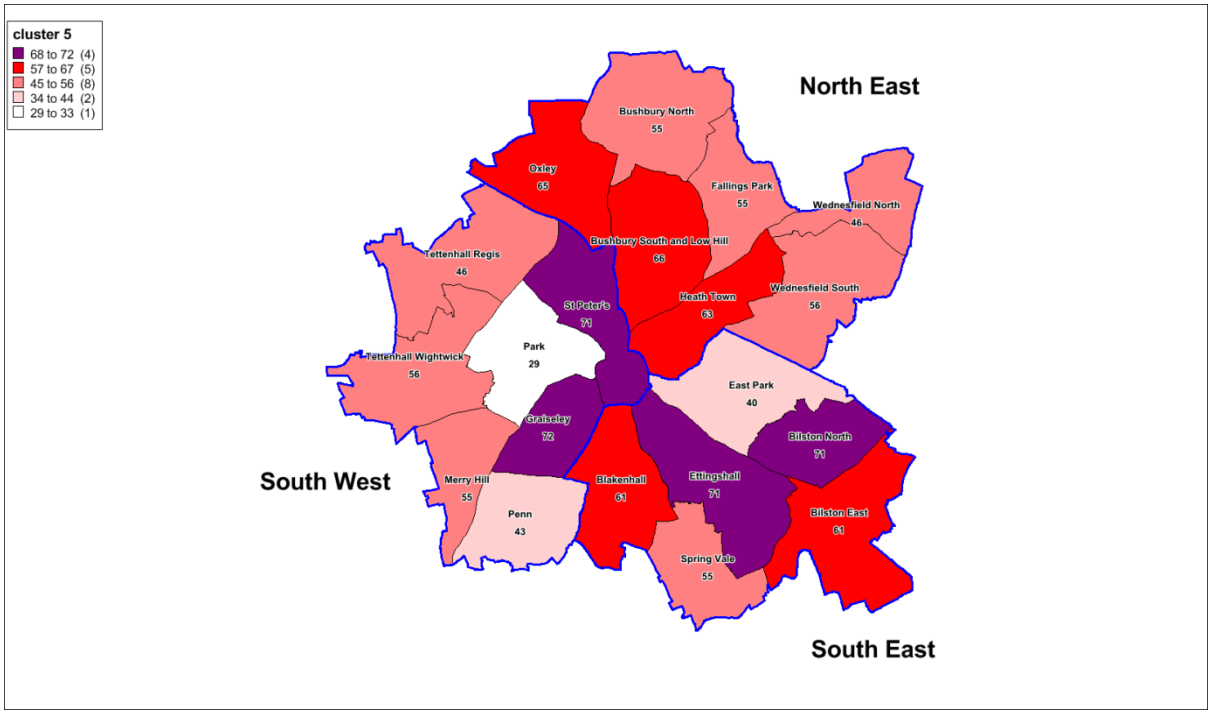
Cluster 5 "Overweight's": Contains people who are overweight, 45% of the overweight population appear in this cluster. People in this cluster are more likely to have average wellbeing. All of the people in this cluster eat unhealthily however they are less likely to smoke and none are high risk drinkers. This cluster is much less likely to engage in vigorous activity, although they have similar levels of moderate activity compared to the overall population. Individuals from this cluster should consider healthy eating and increasing their exercise levels to improve their lifestyles.

1137, 15.3% of total population

This cluster has a fairly equal gender split like the overall population, but with slightly more males. Although fairly similar to the overall population, this cluster has a slight under-representation of the younger population (aged under 24). This cluster is similar to cluster 4 (healthy weight; poor lifestyle) but slightly older and is potentially where individuals from cluster 4 could end up. The ethnic breakdown is similar to cluster 4 but with a larger over representation of those from an Asian ethnic background. Deprivation and ward breakdowns are similar to the population overall. This is supported by the map of individuals who are spread across the city. It is logical that the retired population is over represented and there are less students in this cluster, compared to cluster 4 and the majority of the others work full or part time. Qualifications are similar to the overall population but there is a higher proportion of those who have none.

63% want to eat more healthily and of these, 32% said they could do this by themselves (similar to the overall population and cluster 4). Things that would help are; cheaper healthy food, more healthy produce available in local shops and more time to prepare healthy food. 56% of this cluster wants to be more active, and it is encouraging that over half of these want help with this. Common responses were; having more time, availability of local sports/leisure facilities close to home, free/reduced price leisure and gym memberships, improved personal motivation and having someone to exercise with. Interestingly, the proportion who responded 'reduced price leisure and gym memberships' is lower than the overall population, however, for 'free leisure and gym memberships' this cluster has the highest response out of all ten (43%). Although not as popular, there is an indication that advice from a health care professional may be beneficial.

Number in cluster by ward of residence



Cluster 6 "Drinkers and Smokers": This cluster contains people who are all high risk drinkers making up 70% of the overall high risk drinking population. As well 45% of people in this cluster are current smokers. The majority of those in this cluster have average wellbeing. For this cluster people are more likely to be overweight and less likely to be obese compared with the overall population. For this cluster activity levels and healthy eating behaviour are also worse than the overall population. The focus for this cluster should be on reducing alcohol consumption as well as smoking cessation, although healthy eating and exercise levels could also do with improvement for this cluster.

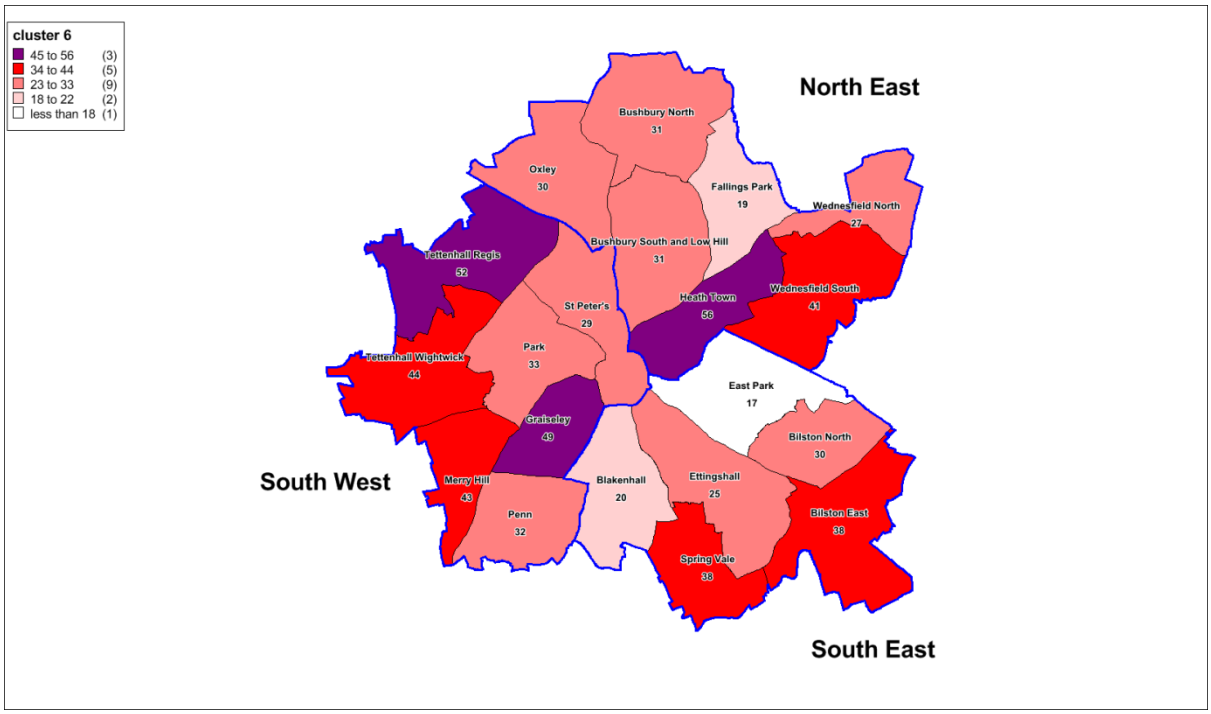
685, 9.2% of total population

This cluster contains mainly males (70%), much more than the overall population, the age distribution is fairly similar to the overall population, however, there are more in this cluster that are aged between 25 and 49 and less aged over 60. This cluster have an over represented proportion of people who are white (83%). Interestingly, although people are spread across the city for this cluster there is a higher concentration of people from the south western wards of the city, this is also reflected in terms of deprivation whereby there is a slightly higher proportion in the least deprived compared to the overall population. This cluster has a much higher proportion compared to the overall population of those who work full time, there is also a higher proportion of those who are self-employed or unemployed. In terms of qualifications, noticeable differences to the overall population include; a lower proportion of those with no qualifications and more individuals that have A levels or equivalent.

Alcohol is the main issue to address for this cluster, unfortunately, it is not possible to identify whether individuals want to reduce alcohol consumption, however, a proxy indicator for this is that 11% of this group who made a "New Year's" resolution, did so about alcohol. This is much higher than any other cluster. Only 39% of those who smoke want to stop. Of these, 38% said they could do this on their own, slightly less than the overall population. Of those that want to quit, 29% suggested that e-cigarettes would help, this is higher than the overall population and one of the highest responses for e-cigarettes overall. Other popular responses were; NRT, using a stop smoking service (slightly lower than the overall population) and support from a GP/nurse (much lower than the overall population and the lowest response out of all the clusters). 65% of this cluster wants to eat more healthily, one of the highest responses overall. Interestingly, only 26% said that they can do this on their own, this is much lower than the overall population and the second lowest response overall. Things that would help are; cheaper healthy food, more time to prepare healthy food and more healthy produce available in local shops. Interestingly, 33% stated more time to prepare healthy food, this is much higher than the overall population and any other cluster, coinciding with this, although not as popular as other options, this cluster have the highest proportion who stated 'more healthy options in takeaway/convenience foods'. It is encouraging that 62% of this cluster

stated that they wanted to be more active, the joint highest response and greater than the population overall. 49% stated that they could do this on their own. Of those that do want help, common responses were; reduced/free membership to gyms/leisure facilities, having more time, availability of local sports/leisure facilities close to home, improved motivation and someone to exercise with. It is worth noting that 24% responded 'improved motivation', the highest response out of all the clusters and much higher than the overall population.

Number in cluster by ward of residence



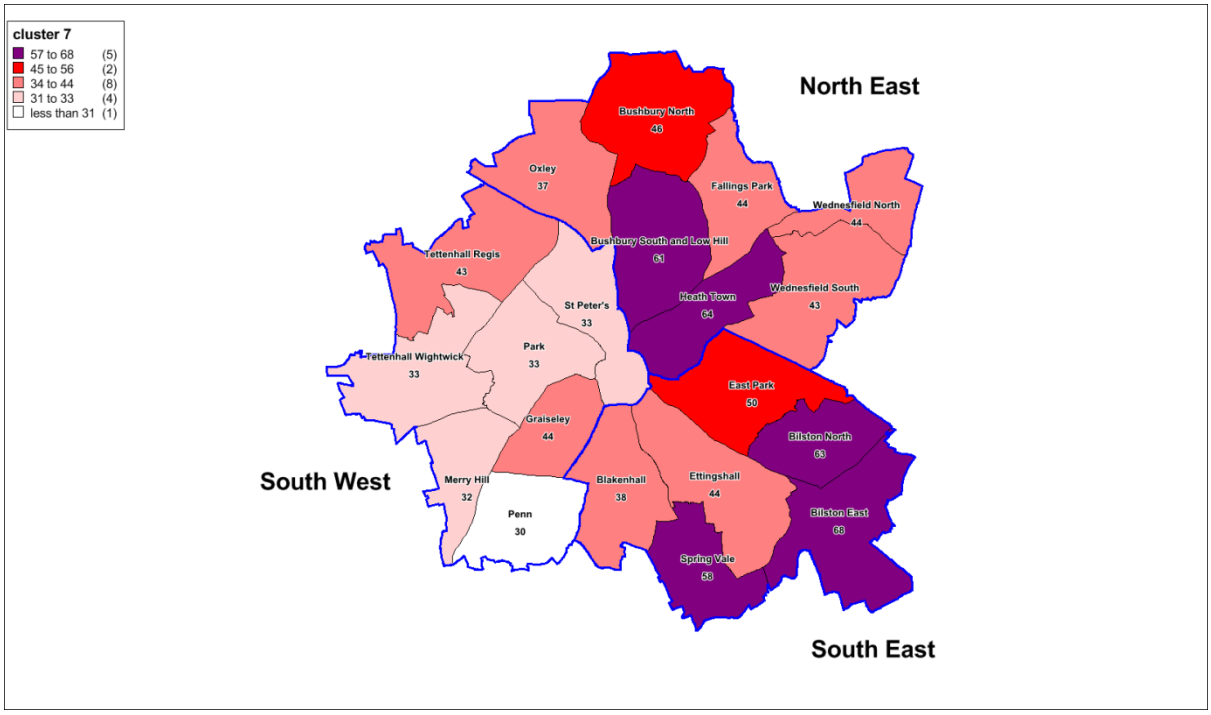
Cluster 7 "Obese and Average Wellbeing": Contains people who are obese, 58% of the obese population appear in this cluster. The overwhelming majority of those in this cluster have average wellbeing. People in this cluster have similar healthy eating behaviour to the overall population and are less likely to be vigorously/moderately active. However most of this cluster do not smoke and are most likely to abstain or drink at low risk. The focus for lifestyle improvement for this cluster should be on healthy eating as well as increasing exercise levels.

908, 12.2% of total population

This cluster contains more females than the population overall, the age distribution is an under representation of the younger population and contains more of those who are aged 50 and over. The ethnic distribution is similar to that over overall population, however, there is an over representation of those from a black ethnic group. The ward and deprivation distributions are fairly similar to that of the overall population but with a slightly higher distribution in the South East of the city, as can be seen in the map below. There is an over represented proportion of those who are retired and those who have no qualifications.

67% of this cluster wants to eat more healthily, this is much more than the overall population and the highest response out of all the clusters. Only 26% of this cluster stated that they could do this on their own. Things that would help are; cheaper healthy food, more time to prepare healthy food and more healthy produce available in local shops. Although not as popular as the other options it is worth noting that 12% responded 'advice from a dietician/nutritionist', much higher than the overall population and one of the highest responses out of all the clusters. 65% of this group want to be more active, the highest response overall, of these, 60% suggest that they can do this by themselves. Of those that do want help, common responses were; reduced/free membership to gyms/leisure facilities (although this was lower than the overall population), having more time, availability of local sports/leisure facilities close to home, improved motivation and someone to exercise with. It is also worth noting that 12% suggested advice from a health care professional may help and 9% responded 'improved personal safety', the highest response out of all the clusters and much higher than the overall population.

Number in cluster by ward of residence



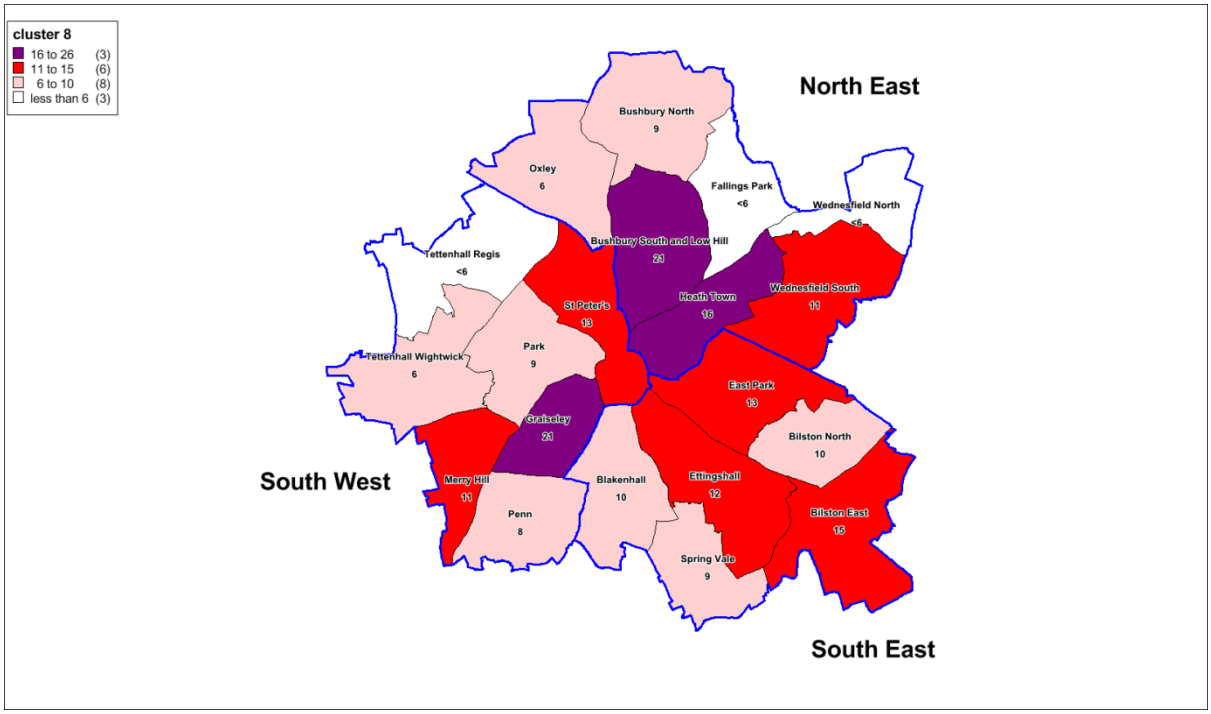
Cluster 8 "Underweight's": Contains people who are underweight, 97% of the underweight population appear in this cluster. The majority of this cluster eat unhealthily and are much more likely to be smokers. More of this cluster abstains from drinking however they are only slightly less likely to be high risk drinkers as well. This cluster has a similar profile for wellbeing as the overall population. Moderate activity levels for this cluster are just below the overall population average whilst vigorous activity appears to be just higher but neither are significantly different. The focus for this cluster should be improving healthy eating levels as well as smoking cessation.

208, 2.8% of total population

This group is mainly female (63%) and predominantly young with 50% of this cluster being under 29 and nearly a quarter are aged 16-19. Although this cluster are predominantly white, there is an over representation of the Asian population, accounting for just over 20%. Individuals in this cluster are more likely to live in the more deprived areas of the City, particularly towards the centre. Although over 20% are working full time, this is under represented compared to the overall population and a similar proportion of individuals are in full time education or a student, there is also an over representation of those who are unemployed. Although like the overall population, the majority have no qualifications, there is an over representation of those who have GCSE's.

Only 56% of this cluster want to eat more healthily, one of the lowest responses overall. 28% suggested that they can do this on their own. 27% suggested that more healthy produce available in local shops would help, the highest response out of all the clusters. Interestingly, despite being the most popular response, this cluster had the lowest response for 'cheaper healthy food' at 34%. 'More time' would also help and this cluster had the highest response for 'cooking classes/lessons to learn how to cook/prepare healthy foods', however, small numbers require interpreting with caution. Despite small numbers, it is encouraging that 44% of this population want to quit smoking, higher than the overall population. Just over half of these suggest they can do it alone. Although small numbers, the others suggest that help from a GP/nurse may be beneficial.

Number in cluster by ward of residence



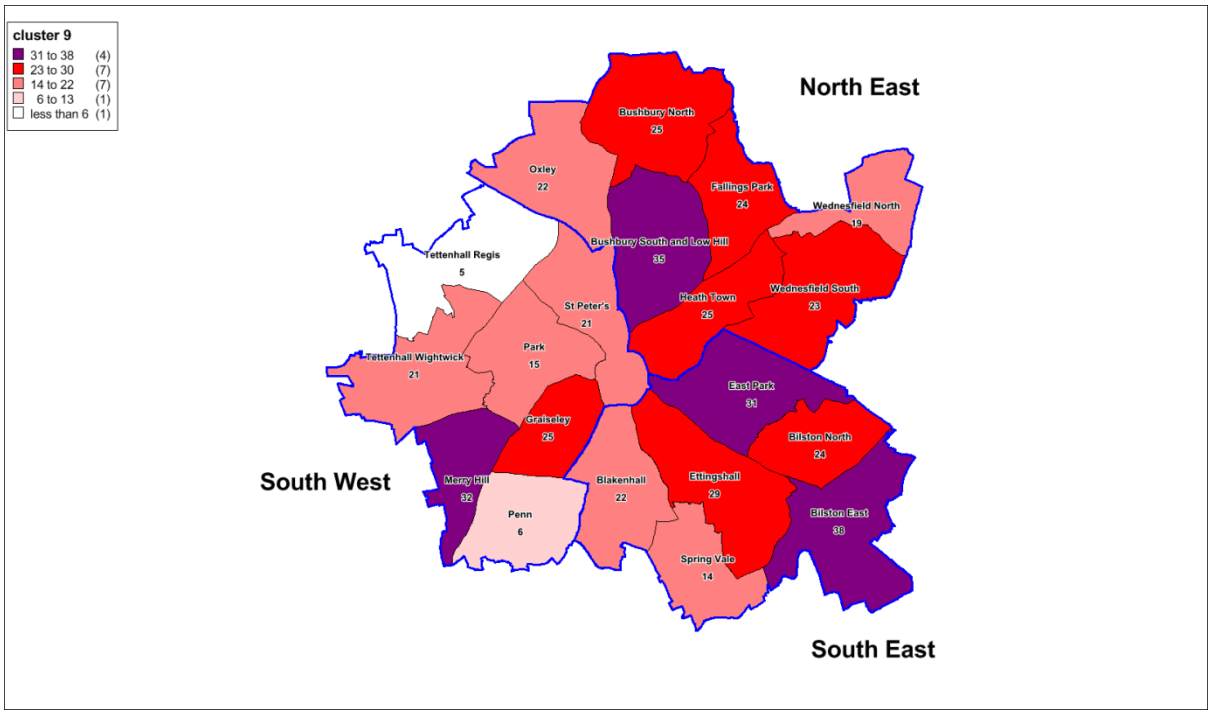
Cluster 9 "Below Average Wellbeing": Contains people who have below average wellbeing, 97% of the below average wellbeing population appear in this cluster. People in this cluster are much more likely to be obese, smoke and not take part in vigorous/moderate activity. In addition they are much more likely to eat unhealthily. Rates of high risk drinking for this cluster are a little lower than in the levels within the overall population and they are slightly more likely to abstain from alcohol. For this cluster a multitude of factors are an issue therefore they will need to focus on lifestyle improvement across all factors.

456, 6.2% of total population

This cluster has slightly more women compared to the overall population, and the age distribution contains more of those aged over 40. There is a large over representation of the white population (80%). Individuals in this cluster are more likely to live in the more deprived areas of the City (70% of individuals), particularly in the South East, Bilston East ward. The majority of this group are retired, followed by long term sick/disabled, working full time and then unemployed, all except working full time are over represented compared to the overall population. 46% of this cluster have no qualifications, 14% more than the overall population.

Only 56% of this cluster wants to eat more healthily and 25% said they can do this on their own. Things that would help are; cheaper healthy food, more healthy produce available in local shops and there are indications that advice from a GP/nurse or dietician/nutritionist may also be beneficial. 58% want to be more active and 66% want help to be more active. Of those that do want help suggested that reduced price/free gym/leisure facilities membership may help and availability of specialised exercise/activities for people with medical conditions. It is also worth noting that this cluster had the highest response (17%) for advice from a health care professional. It is encouraging that 46% of those who smoke want to stop and only 33% said they could do this on their own. Interestingly, 30%, (the highest overall) suggested that e-cigarettes would help, the next most popular were support from GP/nurse, stop smoking services and NRT. Areas that were suggested that would help improve well-being were; more money, being able to get out and do more, more time to themselves, help from a GP/nurse, counselling and someone to talk to.

Number in cluster by ward of residence



Cluster 10 "Very Low Wellbeing": This cluster contains all of those with the lowest level of wellbeing in the overall population. People in this cluster are much more likely to eat unhealthily, not take part in moderate/vigorous activity, smoke and be obese. However they are more likely to abstain from drinking alcohol but have higher risk drinking rates similar to the overall population level. For this cluster a multitude of factors are an issue therefore they will also need to focus on lifestyle improvement across all factors.

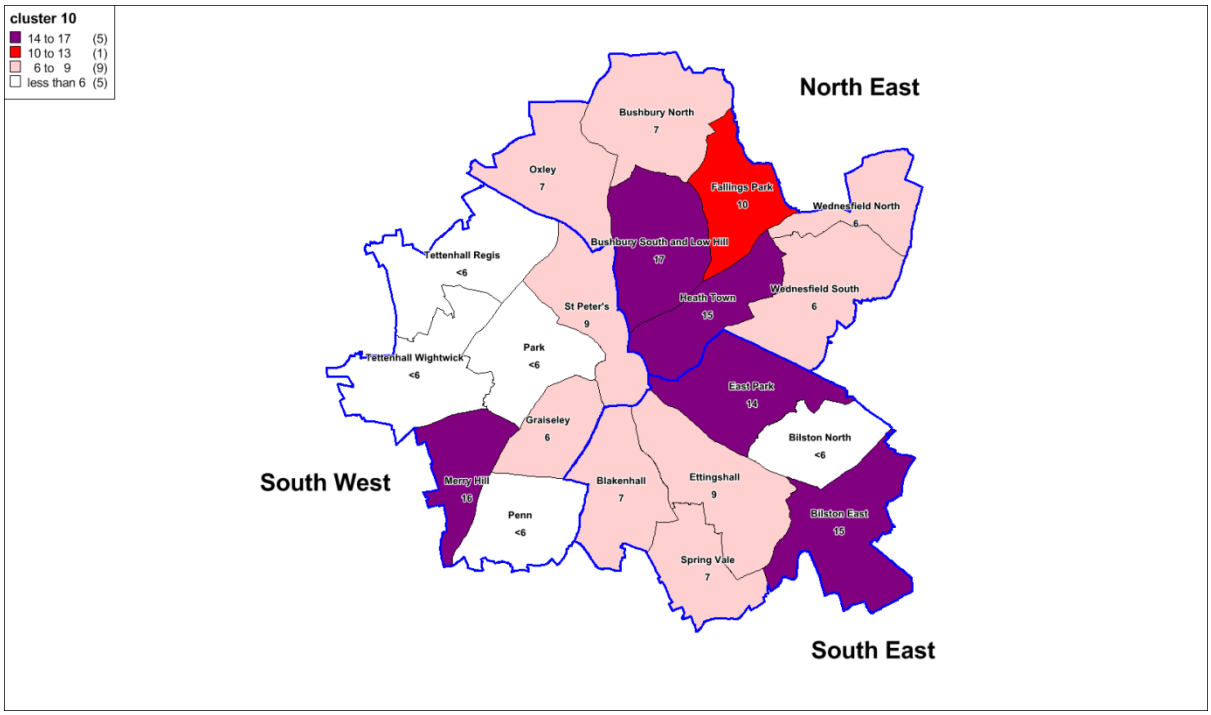
167, 2.3% of total population

This cluster is similar to cluster 9 (below average wellbeing) and has slightly more women compared to the overall population, and the age distribution contains more of those aged 45 to 64. There is a large over representation of the white population (84%). Also like cluster 9, individuals in this cluster are even more likely to live in the more deprived areas of the City (75% of individuals), particularly in the East. The majority of this group are retired, followed by unemployed and long term sick/disabled which is largely over represented compared to the overall population. 47% of this cluster have no qualifications and there is an over represented proportion of those who have lower level GCSE's or equivalent.

66% of this cluster want to eat more healthily and only 21% (the lowest response overall) said they can do this on their own. Other things that would help are; cheaper healthy food (54% said this, the highest overall), more healthy produce available in local shops and there are indications that advice from a GP/nurse or dietician/nutritionist may also be beneficial, with the highest responses overall. 62% want to be more active and 84% want help to be more active.

Of those that do want help suggested that free gym/leisure facilities membership may help, availability of specialised exercise/activities for people with medical conditions, availability of local sports/leisure facilities close to home, someone to exercise with and if they could exercise at home. It is also worth noting that this cluster had the highest response for exercise on referral and personalised exercise advice and sessions. It is encouraging that 42% of those who smoke want to stop and only 27%, the lowest of all responses, said they could do this on their own. Interestingly, 40%, the highest overall, suggested that support from their GP/nurse would help, the next popular was stop smoking services, NRT and e-cigarettes. Areas that were suggested that would help improve well-being were; more money and advice about money, being able to get out and do more, more time to themselves, help from a GP/nurse, counselling and someone to talk to.

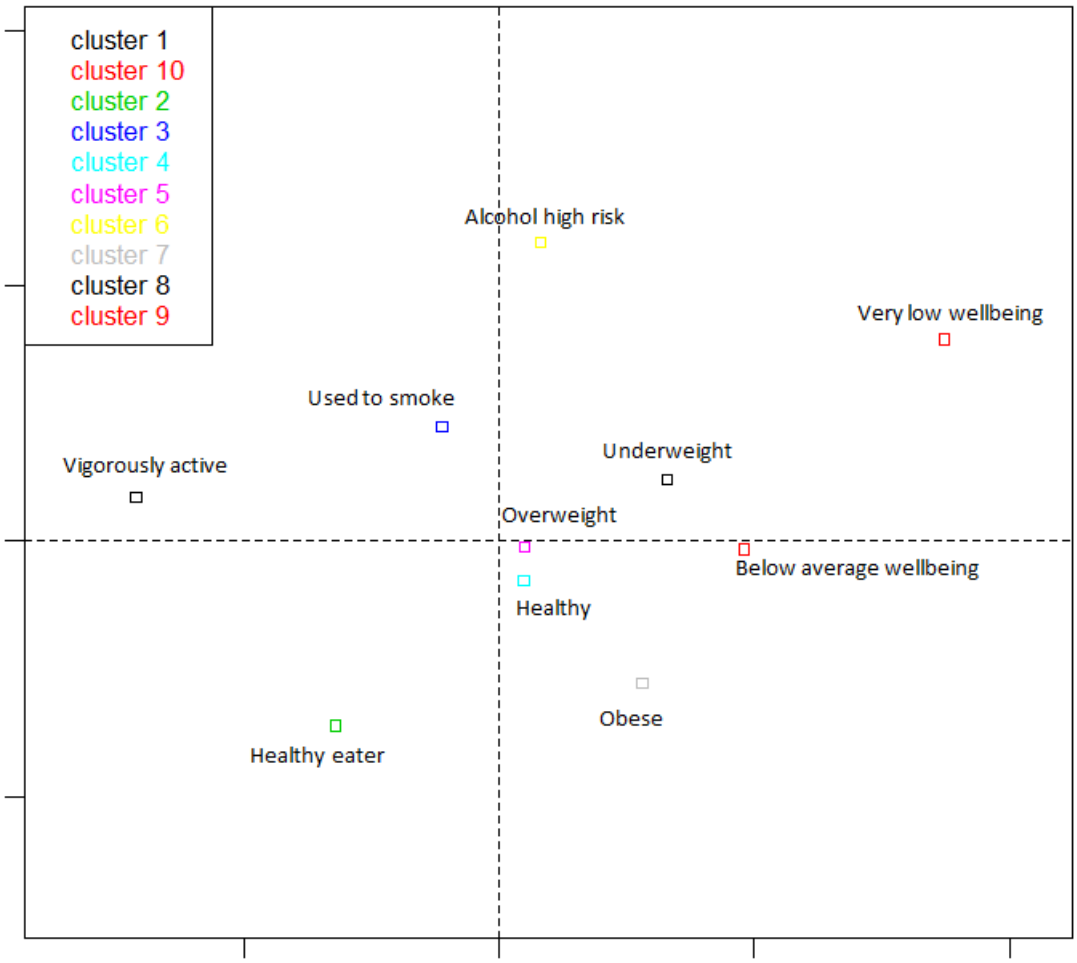
Number in cluster by ward of residence



Clusters by main behaviour type

Looking at cluster centres (figure below), it can be further established which clusters may be similar and dissimilar.

Each cluster is labelled by their most prominent feature. The most similar clusters are 4 and 5, the “Overweight’s” and “Healthy Weight Poor Lifestyle” clusters. This is unsurprising as these individuals have similar demographics, unhealthy behaviours; they do not eat healthy, and tend not to be physically active. In addition both groups tend to have average wellbeing scores and are less likely to be high risk drinkers. It appears the main difference between these clusters is caused by the higher smoking rates in the “Healthy Weight Poor Lifestyle” cluster. The clusters that are polar opposites in terms of similarity are the “Drinkers and Smokers” compared to the “Healthy Eaters”; and those who are “Vigorously Active” compared to those with “Very Low Wellbeing”.



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