CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel
20 September 2018

Time 1.30 pm **Public Meeting?** YES **Type of meeting** Scrutiny

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

Membership

Chair Cllr Jasbir Jaspal (Lab)
Vice-chair Cllr Paul Singh (Con)

Labour

Cllr Obaida Ahmed
Cllr Milkinderpal Jaspal
Cllr Asha Mattu
Cllr Phil Page
Cllr Martin Waite

Shelia Gill	Healthwatch Wolverhampton
Dana Tooby	Healthwatch Wolverhampton
Tracy Cresswell	Healthwatch Wolverhampton

Quorum for this meeting is three voting members.

Information for the Public

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

1 **Apologies**

2 **Declarations of Interest**

3 **Minutes of previous meeting** (Pages 5 - 10)
[To approve the minutes of the previous meeting as a correct record.]

4 **Matters Arising**
[To consider any matters arising from the minutes.]

DISCUSSION ITEMS

5 **Urgent and Emergency Care - 7 Day Services - Update** (Pages 11 - 16)
[Dr Jonathan Odum, Medical Director, Royal Wolverhampton Health Trust to present report]

6 **Black Country Sustainability and Transformation Plan - Update** (Pages 17 - 32)
[Dr Helen Hibbs, Senior Responsible Officer for the Black Country and West Birmingham Sustainability and Transformation Partnership (STP) to present report]

7 **Transforming Care Plans (TCP) for adults, children and young people with Learning Disabilities and/or Autism across the Black Country** (Pages 33 - 56)
[To receive a report and presentation on Transforming Care Plans (TCP) for adults, children and young people with Learning Disabilities and/or Autism across the Black Country].

8 **Joint Public Mental Health & Wellbeing Strategy** (Pages 57 - 208)
[Lina Martino, City of Wolverhampton Council and Sarah Fellows, Wolverhampton Clinical Commissioning Group, to present briefing]

9 **Mental Health Commissioning Review Update on Recommendations** (Pages 209 - 218)
[To receive an update on the recommendations from the Mental Health Commissioning Review].

10 **Joint Health and Wellbeing Strategy 2018-2023** (Pages 219 - 242)
[To receive the draft, Joint Health and Wellbeing Strategy 2018-2023]

11 **Work Programme** (Pages 243 - 246)
[To discuss the Work Programme of the Health Scrutiny Panel].

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 19 July 2018 Agenda Item No: 3

Attendance

Members of the Health Scrutiny Panel

Cllr Obaida Ahmed
Tracey Cresswell
Cllr Jasbir Jaspal (Chair)
Cllr Milkinderpal Jaspal
Cllr Paul Singh (Vice-Chair)
Cllr Martin Waite

In Attendance

Stephen Marshall	Wolverhampton CCG
Jo Cadman	Black Country Partnership NHS FT
Debra Hickman	Royal Wolverhampton Hospital NHS Trust

Employees

Dr Majel McGranahan	Public Health Registrar
Earl Piggott-Smith	Scrutiny Officer (Minutes)
Martin Stevens	Scrutiny Officer
Sarah Smith	Head of Strategic Commissioning
David Watts	Director of Adults Services

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**

Apologies were received from the following:

Cllr Linda Leach
Cllr Phil Page
Cllr Asha Mattu
Lesley Writtle - Black Country Partnership NHS FT
Elizabeth Learoyd - Wolverhampton Healthwatch
Shelia Gill - Wolverhampton Healthwatch
Dana Tooby - Wolverhampton Healthwatch
Ann-Marie Cannaby - The Royal Wolverhampton Hospital NHS Trust
Jeremy Vanes - The Royal Wolverhampton Hospital NHS Trust

2 **Declarations of Interest**

There were no declarations of interest recorded.

3 **Minutes of previous meeting (24 May 2018)**

The minutes of the previous meeting were approved as a correct record and were signed by the Chair.

4 **Matters Arising**

The Panel queried progress of the issue highlighted by David Loughton, RWHT, at a previous meeting about delays in getting planning permission from the City of Wolverhampton Council to provide extra car parking provision at the hospital. The Scrutiny Officer agreed to contact John Denley, Director of Public Health, who had agreed previously to follow up this mater on behalf of the Panel and report back to a future meeting.

The Chair suggested a special meeting be arranged to review the delays in issuing death certificates that was suggested as a topic for the panel work programme. The Chair suggested two possible dates 23 October and 25 October for the meeting. The Scrutiny Officer agreed to send details of the dates and would confirm asap.

The Panel agreed to add the Patient Advice and Liaison Service (PALS) as a future item for the work programme.

5 **Black Country Partnership NHS Foundation Trust - 2018/19 Quality Account Priorities**

Jo Cadman, Strategy and Transformation Director, Black Country Partnership NHS Foundation Trust, thanked Panel members for the comments on the Quality Accounts Report.

The Strategy and Transformation Director briefly outlined the response to issues that the Panel suggested it would welcome further information. The Panel were advised that there was now a dedicated CAMHS Crisis Intervention Home Treatment Team - the service worked with acute hospitals, street triage and to the local authority to respond to crisis referrals in a timely manner.

The Panel welcomed the report. The Panel queried progress on an issue raised at a previous meeting about the need for agencies to working more closely with schools to provide more appropriate support to young people.

The Strategy and Transformation Director advised the Panel of the range of broad support available and specialist mental health services and the increase in the number of cases.

The Panel discussed the merits of online counselling mental health support services. The Strategy and Transformation Director commented that young people can access support and there had been positive feedback from members of Wolverhampton Youth Council about the current provision of mental health services.

The Panel discussed the statistic that an estimated 30 per cent of young people needed mental health intervention. The Panel commented that this was likely to be an underestimate and that some young people were not able to get the support needed. The Panel discussed the profile of people who currently accessed the service. Stephen Marshall, Wolverhampton CCG, commented that an estimated 2300 people annually are referred to a Tier 3 service – approximately 1400 of these cases met the threshold to receive support. The Panel were advised that there was a

national target that 90 per cent of referrals for support receive their first intervention within two weeks. The Panel commented on the need to improve access to mental health services.

The Panel discussed the key role of the voluntary sector organisations in providing lower level support to young people who did not meet the threshold for more specialist interventions.

The Strategy and Transformation Director commented that the initial feedback following a CQC inspection of the service was very positive. The Panel agreed to receive a report at their meeting in September 2018.

Resolved: That the report be noted. The panel agreed to receive a report on the findings of CQC inspection of Black Country Partnership NHS Foundation Trust at the panel meeting in September 2018.

6 **Disbandment of Transforming Care Together - What next?**

Jo Cadman, Strategy and Transformation Director, explained that a report had been prepared in response to a Panel request to explain what had occurred in the disbandment of Transforming Care Together (TCT). The Strategy and Transformation Director explained the reasons for the decision not to proceed with the original plan.

The Strategy and Transformation Director advised that the future would be focused on developing a clinically driven Black Country strategy aligned to the Black Country Sustainability and Transformational Partnership (STP). The aim was to deliver effective support services. The Strategy and Transformation Director outlined the learning from the review and stressed there was a commitment to continue to work collaboratively to develop solutions which were clinically led.

The Strategy and Transformation Director commented on the need to develop local solutions and enhance services.

The Panel queried the costs of the work involved in preparing for the merger and the overall vision for the future of mental health services. The Strategy and Transformation Director advised the Panel that there were no additional costs involved and the learning from the process has been useful. The benefits of working with representatives from Dudley and Walsall was highlighted and there was a commitment across the service to more collaborative working.

The Strategy and Transformation Director briefed the Panel on progress of the Sustainability Transformation Plan (STP) and the benefits for supporting improvements in mental health provision. Steve Marshall commented on the investment in mental health provision and the need to improve the estate that could deliver improved services.

The Panel commented on the lack of public information about the decision not to proceed with the planned merger and suggested that there was a need to have a public engagement strategy to explain what had happened. The Strategy and Transformation Director accepted the need to improve services. In addition, he accepted that the estate was not considered fit for purpose and changes were needed.

The Panel thanked the Strategy and Transformation Director for her report.

Resolved: That the report be noted.

7 **Red Bag Project Evaluation Briefing**

Sarah Smith, Head of Strategic Commissioning, outlined the background to the Red Bag Project. The Head of Strategic Commissioning advised the Panel that the project involved a partnership approach from different agencies who agreed to be involved in the trial.

The Head of Strategic Commissioning outlined the training offered and plans to roll out the scheme. The Panel were advised that 16 care homes were involved in the project and it was planned to extend the scheme to other care homes. The project had received positive response from WMAS and they had highlighted the benefits of having timely access to patient information.

A key reported success of the scheme was the reduction in the time that people had to stay in hospital. A formal evaluation of the project was planned. The Panel members were shown a short video which included comments from patients, care staff and WMAS about their experiences of the project. The Head of Strategic Commissioning advised the Panel that the success of the scheme has been acknowledged nationally and other areas had been encouraged by NHS England to introduce the scheme in January 2019.

The Panel queried the cost of delivering the project and were advised that the project cost £60,000 with additional funding provided by WCCG. The Head of Strategic Commissioning commented on the training provided to care staff to support the delivery of the project. The Panel agreed that a copy of the evaluation report should be presented to a future meeting of the Panel.

Resolved:

a) The Panel welcomes the Red Bag presentation and wishes to formally thank those involved for delivering such a successful project.

b) That the Panel receive a copy of the Red Bag evaluation report at a future meeting.

8 **Healthwatch Wolverhampton Annual Report 2017/18**

Tracy Cresswell, Community Engagement/Volunteer Co-Ordinator, Healthwatch Wolverhampton, presented the annual report. The Community Engagement/Volunteer Co-Ordinator advised the Panel that the report covered the range of work done by Healthwatch staff and volunteers during the year. She wanted to put on record her appreciation and thanks to the work of volunteers.

The Community Engagement/ Volunteer Co-Ordinator outlined several successes which included the setting up of Café Neuro at Compton Hospice and the work done with Black Country Neurological Alliance, to provide a venue for people to talk, receive advice and help. She commented on survey results involving members of the deaf community.

The survey aimed to capture positive and negative experiences of the services offered to members of the deaf community. A survey of GP services was due to be completed in April 2019.

The Panel queried how members of Healthwatch engaged with members of the public. The Community Engagement/ Volunteer Co-Ordinator commented on the work done to build trust with individuals and offer support, but also the challenge in raising awareness amongst the public about the key role of Healthwatch.

The Community Engagement/ Volunteer Co-Ordinator commented on the advantage of offering the public an independent voice that could help them resolve issues or complaints about the service they had received.

Resolved: That the progress made by Wolverhampton Healthwatch be noted.

9 **Oral Health Needs of Older Adults - update**

Majel McGranahan, Public Health Registrar, presented an update on the previous report on the findings of oral health needs of older adults.

The Public Health Registrar briefed the Panel on progress made since the previous report was presented in March 2018.

The Public Health Registrar advised the Panel of plans to improve oral health in older adults in Wolverhampton and plans to extend the oral health improvement pilot, so that staff at care homes across Wolverhampton could be trained to provide oral care.

Resolved: That the report be commended, and the progress made on the oral health needs of older adults be noted.

10 **The Royal Wolverhampton NHS Trust reviews 'never events'**

Debra Hickman, Deputy Chief Nurse, RWHT, gave a presentation about the number and type of ‘never events’ and the learning from a review that would be used to inform future action.

The Deputy Chief Nurse advised the Panel that the NHS definition of a ‘never event’ has changed since 2011 following revised guidance. The Deputy Chief Nurse added, that as result of the changes it was more difficult to make a judgement about changes in the quality of patient care over time. This was because some previous errors were no longer classified as a ‘never event,’ which needed to be reported. The Deputy Chief Nurse explained that some incidents were not recorded in the year that they occurred, which could affect the annual reported figures.

The Deputy Chief Nurse advised that work was being done to standardise the data to improve the situation. The Deputy Chief Nurse reassured the Panel that there was no evidence to suggest that current systems and checks were at fault – work was being done to encourage greater openness among medical staff involved in invasive surgical procedures. The Deputy Chief Nurse gave an analysis of the data presented and the common themes identified as contributing to the number of reported incidents.

The Deputy Chief Nurse advised the Panel that policies and procedures had been revised and that findings from the causes of 'never events' were used to inform future practice – the work would include reviewing the patient pathway and supporting an environment which encouraged personal reflection and revalidation of staff to improve practice. The Deputy Chief Nurse commented on the difficulties in achieving compliance in terms of practice and greater understanding of hospital procedures, by using permanent staff rather than agency staff. An update on action to deliver safer care would be included in the hospital's next Quality Accounts report. The Panel thanked Debra Hickman for her presentation.

The Panel queried the reasons for the increase in the number of recorded wrong site incidents as 'never events'. The Deputy Chief Nurse explained that nationally there was an issue about the underreporting of wrong site incidents – where a procedure would have been necessary at a future date it was not always recorded as a 'never event'. The issue of consent was key – as the patient has agreed to a specific surgical procedure and if an operation had been done on the wrong site, then this should be counted as a 'never event'.

The Panel discussed the common themes contributing to 'never events' and the extent to which poorly trained staff were a factor.

David Loughton, Chief Executive, RWHT commented on the investment in surgical simulation suites to allow surgeons to practice procedures. The Chief Executive added surgical procedures were complex and people could make errors which had consequences for patients. The Chief Executive supported the reasons made by the Deputy Chief Nurse for not using agency doctors and nurses during surgery.

The Panel commented on the issue of human error which appeared as a common link in a list of themes in the presentation. They queried whether it was an issue of lower graded staff not feeling able to report senior staff, where they had concerns about their competence. The Chief Executive commented that the hospital was a good place for medical students to learn and the hospital was rated as offering a good learning experience. The Chief Executive commented on the work done to learn from the aircraft industry to reduce the number of accidents and the management of risks and variations in practice.

The Panel queried at what stage a person would be likely to be dismissed because of a 'never event'. The Chief Executive responded that each case would be judged on its own merits and that there was a set process before a surgeon was referred to the General Medical Council and this was rarely due to an individual error but a combination of varied factors.

The Chief Executive commented that following a recent inspection by CQC the hospital has been rated as being good and a similar rating was expected for Cannock Hospital. The good CQC assessment rating had made a positive impact on the recruitment at the hospital.

Resolved: That the report from the Royal Wolverhampton Health Trust on 'never events' be noted.

Health Scrutiny Panel
20th September 2018

Report title	Urgent and Emergency Care 7 day Services
Report of:	Medical Director Royal Wolverhampton NHS Trust
Portfolio	Adult Social Care, Health and Wellbeing

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

1. Be assured of current service delivery status
2. Support plans for future development which require cross organisation collaboration

1.0 Introduction

1.1 This report summarises the status of 7 day care for patients admitted to Royal Wolverhampton Hospitals hospital as an emergency or urgent admission. Achievement of the standards set by NHS England relies on cross organisation and agency cooperation and it is therefore relevant that the Health Scrutiny panel are aware of the success and barriers to achievement.

1.2 The report also describes a change to the monitoring, reporting and assurance approaches from autumn 2018.

2.0 Background

<u>The National Directive:</u>

2.1 NHS E committed in 2015 to providing a 7 day service across the NHS by 2020. The expectation is that all patients admitted through emergency and urgent care routes (also known as non-

elective), have access to consistent and equal clinical services on each of the 7 days of the week, at the time of admission and throughout the stay in an acute hospital bed.

2.2 The rationale for this is to improve safety, quality and efficiency of care, ensuring that senior decision makers are available to provide the same level of assessment, diagnosis, treatment and intervention on each day of the week. The expectation is that these senior staff will also be readily available to provide information to patients and relatives and to supervise junior staff.

2.3 In addition supporting services should be available so that the decisions of the senior team can be enacted in a timely manner and not be delayed because of lack of staffing or facility resource.

2.4 It is important to distinguish this intention from an expansion in elective care. Whilst RWT does provide some elective services at the weekend there is no national or local imperative to expand this at the present time.

2.5 The national 7 day service emergency directive also runs alongside the General Practice Five Year Forward View, an intention of this to expand GP access to weekends and evenings.

The National Standards

2.6 As a measure of 7 day provision, ten standards were developed by the NHS Services, Seven days a week forum and endorsed by the Academy of Royal Colleges. Four of these standards were selected on the basis of their potential to positively affect patient outcomes.

2.7 The four priority standards are:

- All patients admitted as an emergency to be reviewed by an appropriate consultant within 14 hours of admission
- All patients to be reviewed daily via a consultant delivered ward round
- Seven day access to consultant directed and reported diagnostics
- Twenty-four hour access to consultant directed interventions e.g. endoscopy, emergency surgery.

2.8 The six other standards, known as the Standards for Continuous Improvement, involve:

- Evidence of feedback from patients
- Consistent and timely multidisciplinary review
- Effective clinical handover between team members, led by a senior decision maker
- Timely and consistent access to mental health services
- Consistent access to support services to enable transfer out of hospital
- Assurance that trust board level reviews of patient outcomes cover elements of care and quality relating to the delivery of high quality care seven days a week

2.9 To date biannual national audits have been held each year to measure compliance against the 4 priority standards.

Outputs: 4 Priority Standards

2.10 The results of the RWT audits are as follows

Standard	October 2016	April 2017	Oct 2017	April 2018
14hour Consultant review	63%	92%	90%	91%
Daily Consultant review	73%	95%	Not audited	86%
Access to Emergency and Urgent Diagnostics	Pass	Pass	Not audited	Pass
Access to Emergency and Urgent Interventions	Pass with exception of provision of weekend interventional radiology	Pass	Not audited	Pass

2.11 National minimum compliance is set at 90% or Pass. RWT met these standards in 3 of 4 standards at the most recent audit.

2.12 There has been deterioration in compliance against the daily consultant review standard. In some areas this is due to lack of documentation of consultant presence, however there are still difficulties in recruitment (e.g. care of elderly), meaning that consultant teams are not to full strength and not all patients are seen each day by the most senior member of the team.

2.13 The Trust is actively seeking to increase the number of consultants in key areas, including care of the elderly, head and neck and urology.

Changes to reporting mechanisms

2.14 From autumn 2018, changes will be made to the 7 day service reporting and assurance approaches.

2.15 Measurement will broaden in its requirement. For instance inclusion of 7 day working in job plans, local audit, and service provision in process and policy documents will be used as evidence of compliance.

2.16 Reporting mechanisms will be via Trust Boards and CCG Improvement and Assessment Framework. The CQC will report on compliance as part of their inspection process.

2.17 Sustainability and Transformation Partnerships (STPs), offer the mechanism to create system wide transformation, particularly where greater cooperation between local providers is required to meet the 7DS Clinical Standards.

2.18 By way of example, progress of current 7 day service provision and areas requiring improvement at RWT is tabulated below

RWT Progress against 6 other standards

Clinical Standard	Evidence to support assurance of progress: Still to Provide:
1 – Patient Experience	*Evidence required:* *Local patient experience surveys on quality of care/consultant presence on weekdays vs weekends.* *Feedback e.g. Levels of complaints/l Healthwatch directly related to quality of care on weekdays and weekends.* RWT evidence to support assurance of progress: Family and Friends feedback has shown consistent good results, independent of day of admission
3 – Multi-disciplinary team review	*Evidence required:* *Assurance of written policies for MDT processes in all specialties, with appropriate members (medical, nursing, therapy, pharmacy etc) to enable assessment for ongoing/complex needs and integrated management of discharge planning and medicines reconciliation within 24 hours.* RWT evidence to support assurance of progress: Therapy: provision of service at weekends Social worker: provision 6 days /week Still to provide: MDT meetings (huddles) at weekend Consistent presence of senior nursing staff at weekend
4 – Shift handovers	*Evidence required:* *Assurance of handovers led by a competent SDM taking place at a designated time/place, with mdt participation from in-coming and out-going shifts. Assurance that handover processes, including communication/ documentation, are reflected in hospital policy and standardised across seven days of the week*. RWT evidence to support assurance of progress: Medical directorate handover is consistent and well embedded Surgical handover less well established. Still to provide*:* Policy in process of being written
7 – Mental Health	*Evidence required:* *Assurance that liaison mental health services are available to provide urgent and emergency mental health care in acute hospitals with 24/7 EDs, 24 hrs/day, 7days/week.* RWT evidence to support assurance of progress: Adult Mental Health teams available 24/7 to provide emergency support for adults. Still to provide: CAHMS services not as comprehensive. Awaiting CCG discussion
9 - Transfer to community, primary and social care	*Evidence required:* *Assurance that hospital services required to enable the next steps in the patient's care pathway are available every day of the week. These*

	services should include: • *Discharge coordinators.* • *Pharmacy services to facilitate discharge (e.g. provision of TTAs within same timescales on weekdays and weekends).* • *Physiotherapy and other therapies.* • *Access to social and community care providers to start packages of care.* *Access to transport services.* RWT evidence to support assurance of progress: Hospital services available 7/7, including patient flow co-coordinators, therapies, transport, transfer to rehabilitation hospital care. Additional support provided from Sept 2018 by clinical fellows at weekend. Limited access to community providers. Still to provide: weekend support from; pharmacy, improved local authority support e.g. start-up of care packages, placement of patients into nursing and residential homes
10 – Quality Improvement	*Evidence required:* *Assurance that trust board level reviews of patient outcomes cover elements of care and quality relating to the delivery of high quality care seven days a week e.g. weekday and weekend mortality, LOS and readmission ratios, and that the duties, working hours and supervision of trainees in all healthcare professions are consistent with the delivery of high-quality, safe patient care, seven days a week.* RWT evidence to support assurance of progress: Quarterly reports to Trust Board Still to provide: Reporting mechanisms for performance metrics will be reviewed with a view to ensuring that appropriate quality and performance is monitored across 7 days in all reports. Survey of junior doctor experience is being conducted

Summary

2.19 The data describes the changes to service delivery which have positively benefited the care of patients attending for Emergency care at RWT.

2.20 Work is required to further expand provision. This may require an investment in resources in some areas as well as a change in culture.

2.21 RWT has had support from Local Authority although there is more to do.

3.0 Impact on Health and Wellbeing Strategy Board Priorities

Which of the following top five priorities identified by the Health and Wellbeing Board will this report contribute towards achieving?

Wider Determinants of Health ☐

Alcohol and Drugs	☐
Dementia (early diagnosis)	☐
Mental Health (Diagnosis and Early Intervention)	X
Urgent Care (Improving and Simplifying)	X

4.0 Decision/Supporting Information (including options)

None

5.0 Implications

5.1 Change in working patterns for some organisations and working teams

5.2 Potential investment in staffing resource required

6.0 Schedule of background papers

6.1 Further information on RWT 7ds performance and strategy can be found by contacting the report writer:

Dr J Odum
Medical Director
Royal Wolverhampton NHS Trust
01902 695958
jonathan.odum@nhs.net

Agenda Item No: 6

Health Scrutiny Panel

20 September 2018

Report title Black Country Sustainability and Transformation Plan

Report of: Dr Helen Hibbs
Chief Officer Wolverhampton CCG/Black Country STP Senior Responsible Officer

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Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

1. Receive the report from the Black Country STP regarding the current status of the Sustainability and Transformation Plan and work to move forward towards becoming an Integrated Care System (ICS) by 2020.

1.0 Introduction

1.1 The purpose of the report is to update the Health Scrutiny Panel about the Black Country Sustainability and Transformation Plan.

2.0 Background

2.1 The report outlines the STP progress to date.

It also details the initial work around the Black Country Clinical Strategy, key areas of integrated working between health and social care, and the ongoing development of primary care.

It reports on some of the key challenges, risks and the drivers for delivering integrated care in the future.

3.0 Impact on Health and Wellbeing Strategy Board Priorities

Which of the following top five priorities identified by the Health and Wellbeing Board will this report contribute towards achieving?

Wider Determinants of Health	X
Dementia (early diagnosis)	X
Mental Health (Diagnosis and Early Intervention)	X
Urgent Care (Improving and Simplifying)	X

4.0 Decision/Supporting Information

Not applicable.

5.0 Implications

- New ways of working across health and social care.

6.0 Schedule of background papers

6.1 The background papers relating to this report can be inspected by contacting the report writer:

Dr Helen Hibbs
Chief Officer Wolverhampton CCG/Black Country STP SRO

Wolverhampton CCG
01902 444878

The Black Country and West Birmingham

Sustainability & Transformation Partnership

Our vision


Working together to improve the health,
wellbeing and prosperity of our local population

Leadership and governance

Over the last two years, the STP has provided us with a framework to transform our local health and care system in the Black Country and West Birmingham. It has enabled us to act systematically and together - to agree and address common challenges in a way that we could not as individual organisations.

- **Senior Responsible Officer, Dr Helen Hibbs** (April 2018)
- **Independent Chair, Jonathan Fellows** (July 2018)
- **Portfolio Director, Alastair McIntyre** (in post from December 2018)
- **Recruiting x3 STP Programme Management Office (PMO) roles** (September 2018)

STP Clinical Leadership Group – monthly

- Establishing clear, robust and manageable processes to provide clinical leadership and assurance across work programmes

STP Partnership Board - quarterly

- Sets the vision, strategy and pace of STP development
- Overseas the delivery of the Partnership
- Ensures effective collaborative working

STP Health Partnership Board - monthly

- Identifies and advances collaborative priorities across the health system
- Overseas delivery of national NHS targets
- Aligns integrated, place-based delivery in each locality

Our progress to date

Meeting targets for extended **GP access**

Black Country and West Birmingham named **GP retention intensive** support site

Individual Placement Support (IPS) service in all localities

Black Country and West Birmingham pilot site for **personalised care**

New Black Country Pathology Service due Autumn 2018

Action plan to **transform maternity** services in place

New Perinatal Mental Health Community Service launching Autumn 2018

Providers working in collaboration

Delivery and commissioning of some mental health services **'as one'** by April 2019

STP Independent Chair and Portfolio Director **appointed**

Walsall and Wolverhampton **Stroke Service Reconfiguration**

Clinical Strategy

Building on our strong place-based integration and financial performance, we are developing an STP clinical strategy which is clinically led. This strategy will inform service delivery across the Black Country and West Birmingham

It will make a difference to local patients by:

- Reducing unwarranted variation and duplication across health and care services
- Helping to address the triple aim: improve people's health, improve the quality of services and deliver financial stability.

The strategy has 12 priority areas: Cancer; Mental Health; Learning Disability Services; Maternity and Neonates; Children and Young People; Urgent and Emergency Care, Cardiovascular Disease, Clinical Support Services, Pathology, Musculoskeletal conditions; Respiratory Disorders and Frailty.

Clinical Strategy

Our current areas of focus are:

- **Cancer –** developing joint commissioning intensions across the Black Country and West Birmingham
- **Mental Health –** some services delivered and commissioned as one by April 2019
- **Learning Disability services –** new models of care implemented from September 2018
- **Maternity and neonates –** Action plan to develop maternity services by September 2018
- **Primary Care –** local place-based plans in development

We recognise that effective clinical engagement is fundamental to the delivery of our clinical strategy. Over the next few months we will be engaging with local clinicians and communicating with patients and the public, before launching the strategy in November 2018.

As part of this work, no current decisions have been made about redesigning local health and care services.

Interface with Adult Social Care

Adult Social Care is a component of the STP plan- the key points of integrated work are:

- Working alongside the Better Care Fund and Wolverhampton Integrated Care Alliance.
- Links to the Thrive initiative and Combined Authority plan for better mental health.
- An increased focus on the link between better physical health and mental health.
- The Transforming Care agenda and need to ensure people with disabilities are given every chance to live in the community and minimise the need for time in hospital.
- Commissioning for quality in care homes; to reduce unnecessary admissions to hospital and ensure good quality care.
- The need to ensure long term financial sustainability of health and social care (£512m financial gap for the NHS in the Black Country by 2020/21 and £188m gap for social care in the Black Country by 2020/21.
- Workforce planning- to ensure a workforce fit to meet the needs of an ageing and growing population.

Primary Care

Primary care is at the heart of our place-based plans and is integral to delivering improved health and wellbeing.

- Clinical champions in our four place-based areas
- GPs shaping and forming primary care networks
- GPs working together with secondary care to improve clinical pathways
- Local Medical Committee (LMC) engagement taking place in each area and at STP level
- Primary care involved and helping to shape workforce development
- The STP has received placements for up to 10 GP clinical fellowships
- New fund to aid GP retention - up to £400,000 will be made available to the STP to promote new ways of working and offer additional support to local GPs
- STP Primary Care Strategy launched - sets out how primary care services will be delivered across multidisciplinary integrated teams, seven days per week
- Meeting targets for extended GP access across the STP

Challenges/risks

- Collaboration across our 18 partner organisations
- Unwarranted clinical variation
- Recruitment and retention of clinical workforce
- Financial sustainability
- Development of population health management
- Digital innovation
- Primary and community care estates
- Wider determinants of health

Drivers for integrated care

Delivering integrated care by 2020

Building on our strong track record of delivery and innovation in the Black Country and West Birmingham, the STP will work collaboratively with its health and care partners to move towards an Integrated Care System (ICS).

We believe by bringing health, social care and voluntary sector organisations together, we can achieve improved health, wellbeing and prosperity for our local population.

The local picture

Integrated Care Alliance

- Bringing together health and social care partners (City of Wolverhampton Council, Black Country Partnership Foundation Trust, Royal Wolverhampton NHS Trust, Local GP Practice Groups, Healthwatch, Local Medical Committee and Wolverhampton Clinical Commissioning Group).
- Clinically led.
- Initial pathways – end of life, frailty, mental health, paediatrics and urgent and emergency care.
- Focusing on shifting resources out of hospital to support more patients in their homes and in their community.
- Health promotion and disease prevention.
- Appropriate financial incentives.

Thank you.

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Agenda item

Transforming Care Plans (TCP) for adults, children and young people with Learning Disabilities and/or Autism across the Black Country

1. Purpose:

The purpose of this presentation is to provide Wolverhampton Health Overview and Scrutiny Committee (HOSC) with:

- an overview of the Black Country Transforming Care Programme
- an update on progress to date and plans for the future.
- an outline of the new clinical 'national service model' of care details of the localised model to be delivered in Wolverhampton and across the Black Country.
- an opportunity to comment on progress and plans for the future.

2. Recommendation:

The committee is recommended to

- Note the programme of work taking place across the Black Country and in Wolverhampton
- through the Transforming Care Partnership
- Note the progress to date in supporting local citizens with learning disabilities and/ or autism out of hospital and to live as independently as possible in the community
- Note the new clinical service model being implemented across Wolverhampton and its implications for Wolverhampton
- Comment on and provide feedback to the BCTCP Board on any matters arising.

3. Background:

Following the exposure by the BBC of the abuse of people with learning disabilities that took place at Winterbourne View Hospital, the Government set out in a Concordat its pledge to work with others, including NHS and local government commissioners, to transform care and support for all children, young people and adults with learning disabilities and/or autism who display behaviour that challenges.

Although many were transferred out of inpatient care, the numbers admitted remained higher than the numbers transferred out. To make more and urgent progress on this issue, the LGA and five delivery partners (including NHS England, the Department of Health, the Association of Directors of Adult Social Services (ADASS), the Care Quality Commission and Health Education England) have developed the Transforming Care Programme. This renewed approach brings key local delivery partners together with shared governance structures to improve community services for this group and reduce the numbers in inpatient care, with a view to making significant progress by 2019.

To support TCPs a service model was also published in October 2015 to describe 'what good looks like' in services and support. The model is structured around nine principles seen from the point of view of a person with a learning disability and/or autism:

• I have a good and meaningful everyday life.
• My care and support is person-centred, planned, proactive and coordinated.
• I have choice and control over how my health and care needs are met.
• My family and paid support and care staff get the help they need to support me to live in the community.
• I have a choice about where I live and who I live with.
• I get good care and support from mainstream health services.
• I can access specialist health and social care support in the community.
• If I need it, I get support to stay out of trouble.
• If I am admitted for assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high-quality and I don't stay there longer than I need to.

In April 2016 the Black Country CCG's and Local Authorities formed a partnership to Transform Care for people with learning disabilities and/or autism. A board was established to ensure the success of the programme. The key aim of the programme is to reduce the number of Adults, Children and Young People with learning disabilities in hospital by March 2019 and put in place a new service model that will focus on keeping people well in the community and preventing their admission to hospital.

4. Presentation

Please find in the presentation attached an overview of the programme, details of the new community service model and update on the progress to date to deliver improved outcomes.

Black Country Transforming Care Partnership

Strengthening community services for people with learning disabilities and/or autism

Transforming Care – homes not hospitals

The Black Country Transforming Care Partnership (TCP) was established in April 2016 to transform health and care services for people with learning disabilities and/or autism. The programme aims to reduce the number of people with learning disabilities and/or autism residing in hospital so that more people can live in the community, with the right support, close to their home.

Transforming Care Partnership

For people with learning disabilities and/or autism in the Black Country

The partnership is made up of:

- Dudley Clinical Commissioning Group (CCG)
- Dudley Metropolitan Borough Council
- Sandwell and West Birmingham CCG
- Sandwell Metropolitan Borough Council
- Walsall CCG
- Walsall Council
- Wolverhampton CCG
- City of Wolverhampton Council
- Black Country Partnership NHS Foundation Trust

Case for change – Winterbourne View Hospital

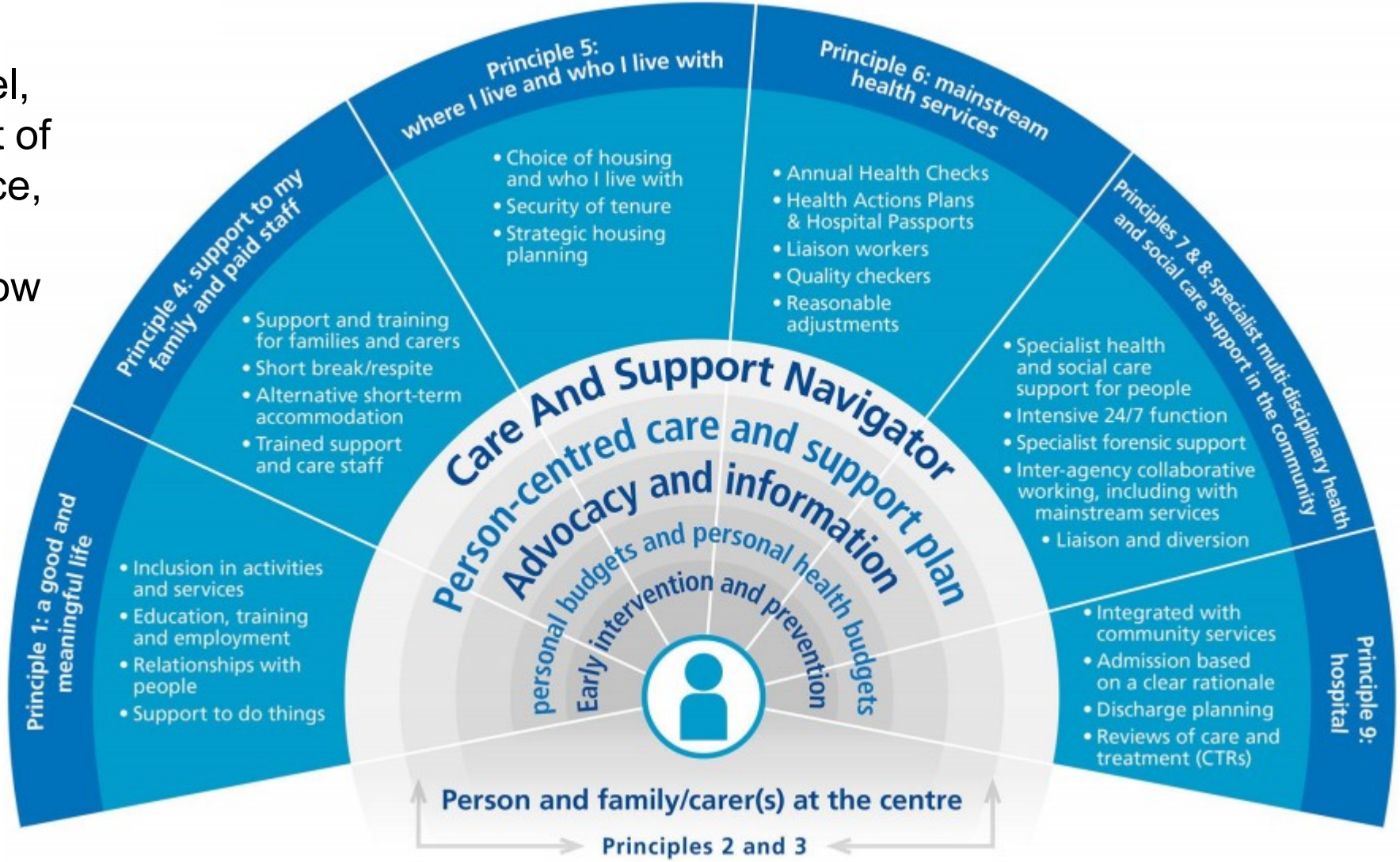
- 2011 BBC Panorama investigation exposes the **physical and psychological abuse** suffered by people with learning disabilities at Winterbourne View Hospital, South Gloucestershire.
- A clinical psychologist who reviewed the footage **described the abuse as "torture"**
- Hospital closed - **11 staff members sentenced** for criminal acts - **six imprisoned**.
- Damning verdict of the serious case review, calls for hospital placements for people with learning disabilities and autism to be radically reduced and subject to greater levels of scrutiny.
- Programme of action published, highlighting that people who are kept inappropriately in hospital should be transferred to community-based care.
- NHS England publishes a national plan in 2015 - 'Building The Right Support' to drive system-wide change and put in place new models of care by March 2019.

The Black Country TCP is now working with people with learning disabilities and autism, their families and carers to agree and deliver local plans for the programme.

‘Building the Right Support’
National Service Model

The National Service Model, developed with the support of people with lived experience, clinicians, providers and commissioners, sets out how services should support people with a learning disability and/or autism.

With the right set of services in place in the community, the need for inpatient care will significantly reduce.



Developing a Black Country clinical model

Using the nine principles from the National Service Model and guidance from NHS England, the TCP has developed a new clinical model for learning disabilities services in the Black Country. Before undertaking the development of the new model, a series of internal processes were strengthened in order to support the transformation required.

The following areas were identified as key building blocks for developing the model:

- Support the main provider and commissioners to produce an adult community and inpatient model for services. This model should cover the next five operational years and should include staffing structures and service capacity (with consideration of other resource implications).
- Consider the children and young people pathway and provide recommendations for future inclusion, with particular reference to transition
- Engage and involve social care and the Third Sector as part of the community based model of provision
- Ensure that community based providers can be supported to meet the needs of people moving out of hospital.

Developing a Black Country clinical model

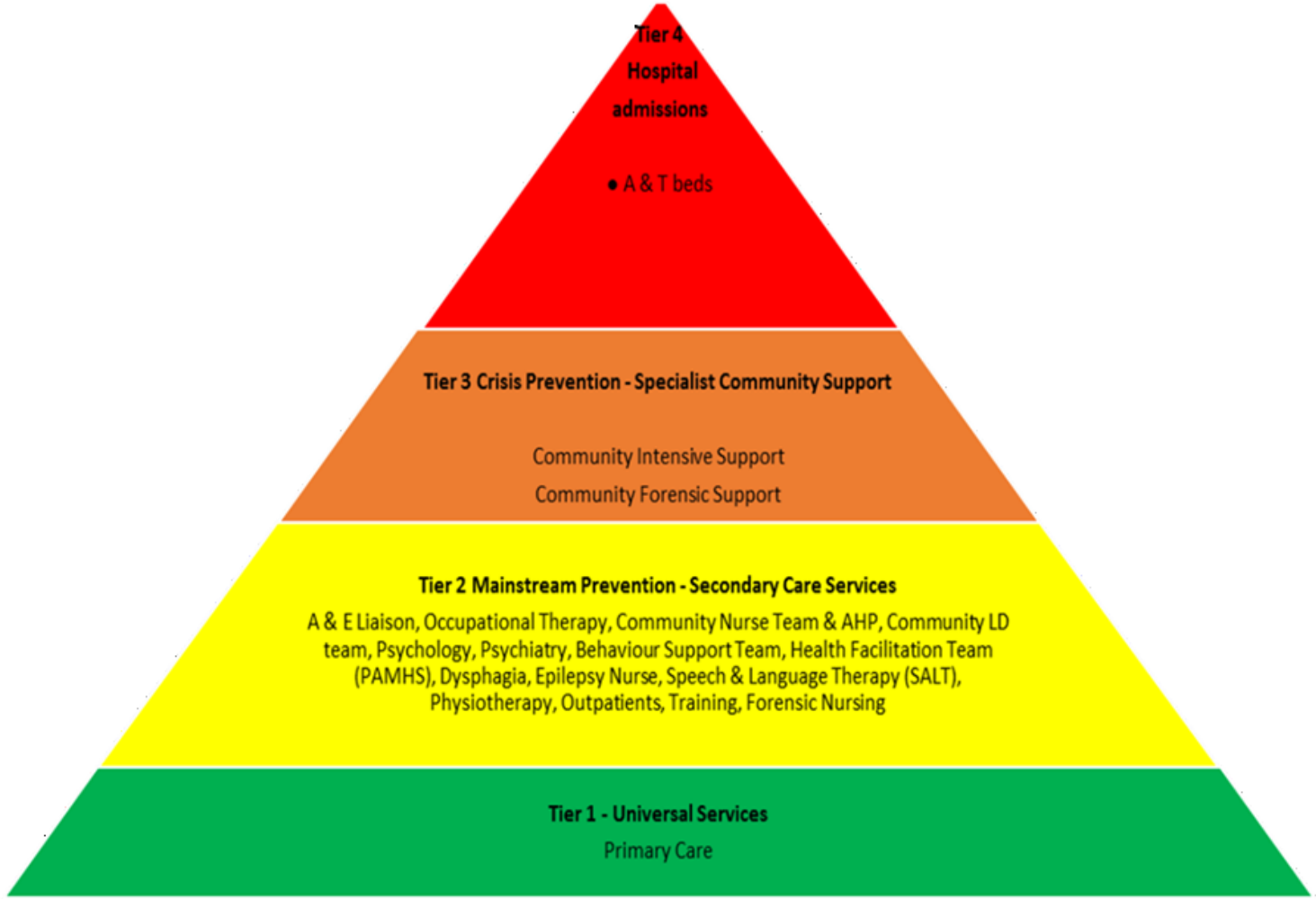
The National Transforming Care Programme mandates that each TCP meets the nationally prescribed trajectory for bed reduction by March 2019. For the Black Country this is reducing CCG commissioned beds from 41 to 16.

- **Dudley** - Beds at Ridge Hill have temporally closed to new admissions due to staffing provision concerns. The provider undertook an estates assessment and concluded that the most efficient and effective resource to deliver assessment and treatment would be located from Sandwell Heath Lane Hospital.
- **Sandwell** - A provision of 10 assessment and treatment beds will remain open at Sandwell Heath Lane Hospital, as a single facility to serve Black Country patients. This is in alignment with the national recommended bed provision in proportion with the population size.
- **Walsall** – Patients have been using a range of independent assessment and treatment facilities as all current beds are spot purchased. Following the temporary closure to new admissions at Orchard Hills, patients use other facilities in the Black Country.
- **Wolverhampton** - Assessment and treatment beds at Pond Lane closed following a consultation process in July-August 2016. Patients use other facilities in the Black Country.

Proposed Black Country Transforming Care Model

The new clinical model for the Black Country, focuses on having the right support, at the right time, in the right pla to maintain people's rights, respect and dignity.

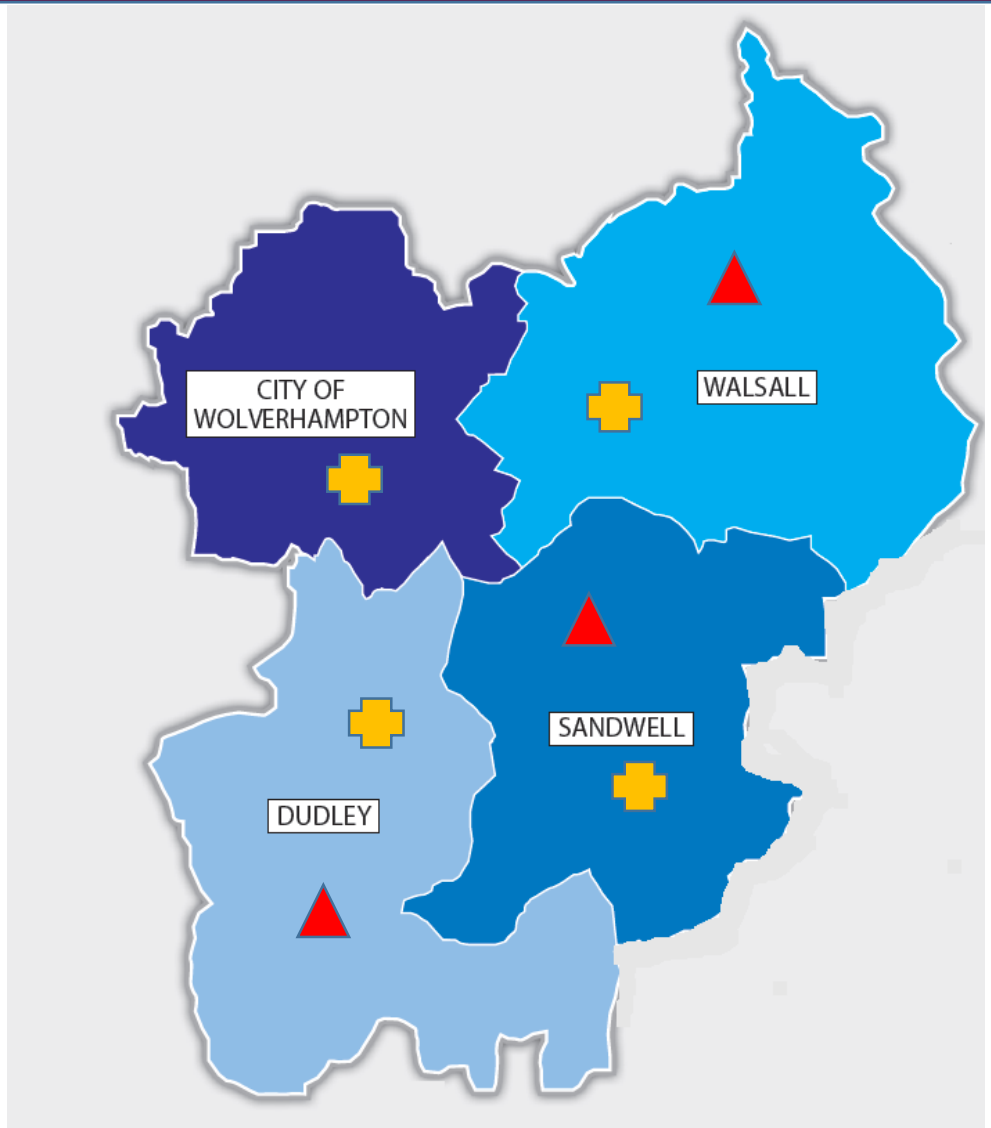
- It is based on the nine principles outlined in 'Building the Right Suppo
- Focused specialist care and treatme will be available for the people who require it
- Admissions to hospital will be for the least amount of time required.



Black Country Transforming Care
Current service provision

Current service provision

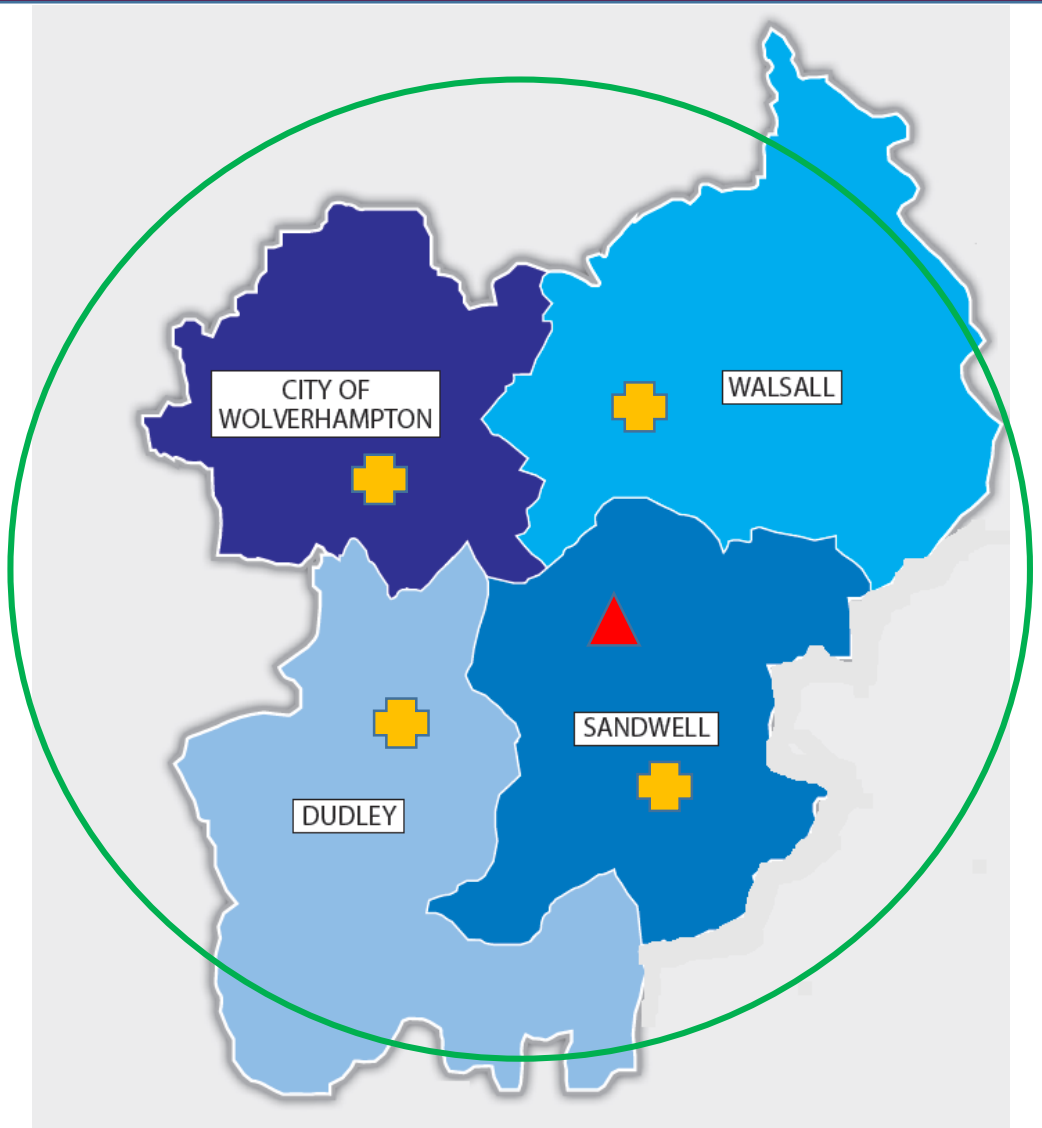
- **Community Learning Disability Service** - delivered locally across the four Black Country boroughs
- **Assessment and treatment beds** - available for the few people who need it and those who do not have access to intensive support services or specialist care.
  Walsall - Orchard Hills temporally closed to new admissions
  Dudley - Ridge Hill temporally closed to new admissions.



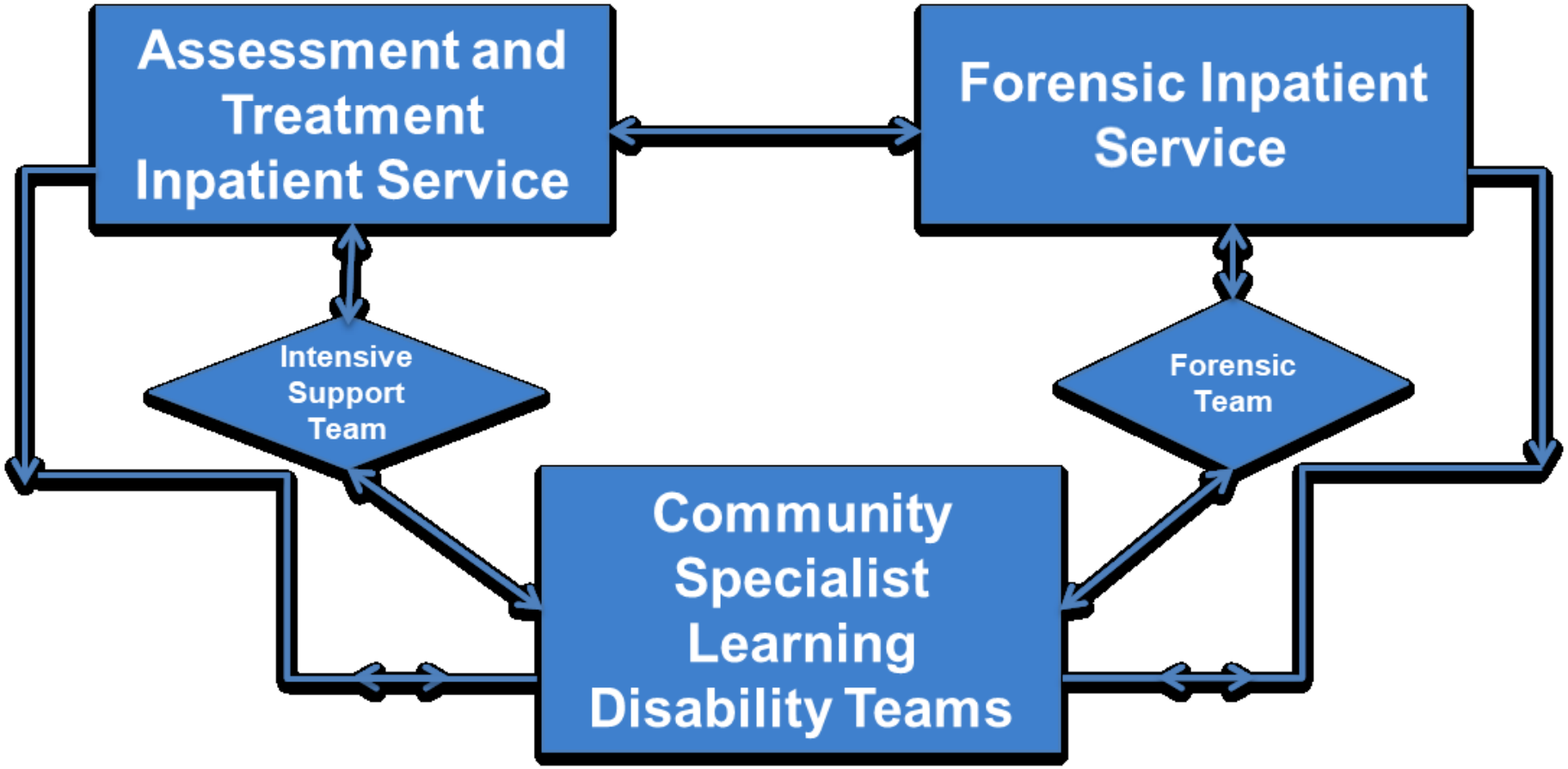
Black Country Transforming Care
Proposed community model

Community model

- **Community Learning Disability Service** - delivered locally across the four Black Country boroughs
- **Assessment and treatment beds** - available for the few people who need it
- **Intensive support service** **New Service** delivered at-scale across the Black Country
- **Forensic Support Service** **New Service** delivered at-scale across the Black Country Implementation of new services – September 2018.



Black Country Transforming Care
Assessment, treatment and forensic pathway



Black Country Transforming Care
Children and young people workstream

As part of this programme, children's commissioners and service providers are working together to ensure that children and young people with diagnosed learning disabilities and/or autistic spectrum disorder (ASD) are supported within local communities, within capable environments to avoid unnecessary inpatient mental health admissions.

The children and young people (CYP) workstream is currently focused on:

- Early intervention: Strengthening integrated working across the system to support children and young people with learning disabilities and/ or autism to stay well and out of hospital, particulary through transition
- Supporting timely discharge of children and young people currently in hospital – including strengthening of governance arrangements around long stays and delayed discharges
- Working with provider organisations to ensure there is the right support to prevent admission and support discharge
- Better understanding of the Black Country TCP CYP population through joint/aligned dynamic and at risk of admission registers
- Development of CYP and parent/ carer involvement

Black Country Transforming Care
Equality impact assessment analysis

An equality impact assessment has been carried out for implementing the new model of care. Across all protected characteristics there are no negative impacts identified. There is a positive impact in relation to disability, as the proposed changes will provide service improvements for community care, and rights based principles developed by people with learning disabilities and/or autism.

Increased investment in community services: Assessment and treatment inpatient bed closures and reductions are in line with the national recommendations, so that reinvestment can be made into community provision. This shift means that care will be personalised to meet the individual needs of each citizen. This is a positive impact where investment in more appropriate, high quality services can prevent inappropriate hospital admissions and reduce reliance on unnecessary inpatient stays. The shift in the clinical model to community assessment and treatment will provide the right care, at the right time in the right place.

Black Country Transforming Care
Finance introduction

- **Activity overview**

- **Financial overview**
  - Modelling
  - Transformation monies

- **Financial implications** - service model

- **Issues and Risks**

Black Country Transforming Care
Activity overview

- Patient trajectory
  - Started with 102 Black Country inpatients in March 2017
- Current position

	ACTUAL 31/3/2017	ACTUAL 5/9/2018	TARGET 31/3/2019
CCG	41	35	16
SPECIALISED COMMISSIONING	61	45	27
TOTAL	102	80	43

- Performance against the trajectory
- Issues to consider
  - Local trajectory
  - Risks

Black Country Transforming Care
Financial overview

- Financial model
  - Each CCG and LA has modelled the impact
  - Total impact across the four Black Country CCGs and LAs circa £4m
  - Impact of new funding arrangements
  - Level of certainty
  - Varying impact for stakeholders
  - Affordability

- Transformation bid monies (matched funding)
  - 2017/18 - £559k
  - 2018/19 - £750k & £350k

- Investment in inpatient and community services

- Other local issues

Black Country Transforming Care
Service Model

Overview

- Total investment by CCGs with Black Country Partnership NHS Foundation Trust (BCPFT) in respect of LD services (£14m)

Inpatient Service Model

- Reduction in beds
- New model – Unit of 10 assessment and treatment beds commissioned across the Black Country
- Cost reduction £3.5m

Community Service Model

- Increase in community service provision (e.g. intensive support and forensic community services)
- The funding released from inpatient beds (£3.5m) is to be reinvested in community services

Black Country Transforming Care
Service User engagement

Consultation with carers - conducted by Chris Sholl in April 2016, commissioned by Sandwell and West Birmingham CCG

- Sent out to 26 families who had recent experiences of Care and Treatment Reviews (CTRs). 11 respondents and four families were met face to face and others engaged via telephone. One of the recommendations made by families was for an *"increased focus on early intervention to avoid hospital admissions".*

'So what, what next' project - conducted by Community Catalysts, commissioned by the Local Government Association

- The project was initiated by the National Empowerment Steering Group, a group of people with a lived experience who say "getting out of hospital is important but the work doesn't stop there." The aim of the project was to talk to people with learning disabilities and/or autism and capture their experiences post discharge. Community Catalysts care are also helping to identify people across the Black Country who are happy to share their story. The findings of this report has been shared with the Board and is informing the roll out of the programme.

Black Country Transforming Care
Service User engagement

Patient experience questionnaires developed in easy read by Dudley Voices for Choice

Piloted in Dudley and Wolverhampton during September 2017 (now being rolled out across the wider Black Country). The questionnaire identified current perceptions of services, impact of the care and treatment review process for Black Country patients, what was important to patients when looking at service improvement.

- 82 responses from people who are in assessment and treatment units or are at risk of admission. Respondents aged between 17-69.

Initial feedback has echoed the sentiments of the programme and has highlighted the importance of good quality care coordination, effective timely information and interventions. The results also highlighted that people were experiencing things very differently, with a wide variation in their responses that the services offered were very different.

Some stated that their experiences were positive, where others felt unsafe in their service. Two quotes which were received from patients were "*there was no choice in where I live*" and *"nothing to learn when I was in hospital".*

Black Country Transforming Care
Service User experience and feedback

The priorities highlighted by patients were about activities and the lack of opportunities available to people with learning disabilities. Parent and carers comments were more focused on the lack of services available for people with learning disabilities.

Other key messages were:

- Questions around whether they would still see the same team and the same doctor
- A high number of respondents said they did not know who their key workers/contacts were
- The terminology used was unfamiliar and should not be used e.g. blue light review
- There was some doubt that the people who were asked to support others had the right skills and training
- Respondents were not sure about independent advocates and what support they provide
- Respondents who had not used the assessment and treatment service had little or no knowledge of what services were available if they were to go into crisis or need intensive support

Black Country Transforming Care
Engagement approach

Dudley Voices for Choice have been commissioned to develop communication materials in easy read formats and to carry out engagement activities for the Black Country TCP.

This will be a targeted approach with patients, relatives, carers and their representatives, whom the programme will have an impact on. There will also be a number of opportunities for the wider public and potential future users of the service to engage.

This will be a provider led, eight week exercise carried out in two phases:

- Phase one will consist of face to face meetings on an individual basis with patients and their relatives, with a focus on gathering patient experience/insight via face to face interviews
- Phase two will consist of patient and public engagement events with a focus on gathering feedback on the proposed community model, via questionnaire. Including the proposed future inpatient consolidation.

Outcomes for vulnerable people balanced with community safety

Once the new community model is in place, all citizens in inpatient care will a have a regular Care and Treatment Review (CTR). These reviews will assess whether someone's care is safe, effective, whether they need to be in hospital, and whether there is a plan in place for their future care.

Clinicians, commissioners and social workers will participate in these reviews. Treatment is personalised to address issues and if felt appropriate, planning for discharge will commence. Staff will use a 12 point discharge pathway with each individual to carefully plan a discharge and ensure all the right support is available in the community.

A small number of people in inpatient care will have Ministry of Justice (MOJ) restrictions. The risk assessment for these individuals will be particularly robust.

Thank You

Questions?

Agenda Item No: 8

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel
20 September 2018

Report title	Joint Public Mental Health & Wellbeing Strategy for Wolverhampton	
Cabinet member with lead responsibility	Councillor Hazel Malcolm Health and Wellbeing	
Accountable director	All John Denley, Director of Public Health David Watt, Director for Adult Services Steven Marshall, Director of Strategy and Transformation and Deputy Chief Operating Officer, NHS Wolverhampton Clinical Commissioning Group (CCG)	
Originating service	Public Health; Commissioning	
Accountable employee(s)	Lina Martino Tel Email	Consultant in Public Health 07973 715 555 Lina.Martino@wolverhampton.gov.uk
	Sarah Fellows	Mental Health Commissioning Manager NHS Wolverhampton CCG
Report to be/has been considered by	People Leadership Team Strategic Executive Board Health & Wellbeing Board NHS Wolverhampton CCG Governing Body Children's Trust Board Health Scrutiny Panel	25 June 2018 3 July 2018 11 July 2018 July 2018 20 Sept 2018 20 Sept 2018

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

1. Review the Joint Public Mental Health & Wellbeing Strategy for Wolverhampton.

Recommendations for noting:

The Health Scrutiny Panel is asked to note:

1. The Joint Public Mental Health & Wellbeing Strategy is an overarching document that incorporates City of Wolverhampton Council (CWC) and NHS Wolverhampton CCG's Joint Mental Health Commissioning Strategy for 2018-2019–2020-2021. It includes not just commissioned services to support people with mental health problems, but wider public services and workstreams to prevent mental ill health and promote population wellbeing.

2. The Joint Public Mental Health & Wellbeing Strategy and Joint Mental Health Commissioning Strategy were informed by an extensive consultation that was carried out as part of a Mental Wellbeing Needs Assessment completed in June 2017. This included:

    a. The Wolverhampton Healthy Lifestyle Survey conducted in March 2016, which included specific questions related to mental wellbeing and elicited responses from 9,048 individuals across the city;
    b. 24 focus groups with the community such as younger adults, older working age adults, and older people; and
    c. 34 interviews with professional stakeholders including voluntary sector representatives, health professionals such as GPs and Pharmacists, and Council officers from a variety of teams.

    Initial feedback was sought on the draft Strategy document from Council and NHS professionals, and members of the Wolverhampton Mental Health Stakeholder Forum and Suicide Prevention Forum. A process of further engagement is currently underway to capture feedback from a broader range of stakeholders.

1.0 Purpose

1.1 This report describes the aims and scope of the Joint Public Mental Health and Wellbeing Strategy for Wolverhampton, produced by City of Wolverhampton Council and NHS Wolverhampton CCG.

2.0 Background

2.1 Mental health is integral to overall health, and recognised as being fundamental to growth, development, learning and resilience. Accordingly, the social, physical and economic environments in which people are born, grow, live, work and age have important implications for mental health.

2.2 The cross-Government strategy *No Health Without Mental Health* (2011) set out ambitions for mental health to be given equal importance to physical health ('parity of esteem'), and to become 'everyone's business' – that is, for health services, local authorities, education, employers, third sector organisations and communities to work in partnership to address the causes and consequences of poor mental health and promote mental wellbeing in populations.

2.3 The Mental Health Five Year Forward View (2016) emphasises the need for a shift towards prevention and better integration of care in order to improve outcomes and experiences for people with mental health problems and their carers, and reduce health inequalities. This aligns with priorities outlined in the Wolverhampton Health & Wellbeing Board Strategy and NHS Wolverhampton Clinical Commissioning Group (CCG) Operational Plan.

3.0 National and local context

3.1 Half of all mental health problems emerge by age 14, rising to 75% by age 24. People with severe and prolonged mental illness die 15-20 years earlier on average than others – two thirds of these deaths are due to avoidable physical illness, including heart disease and cancer linked to smoking. At all ages traumatic experiences, poor housing or homelessness, being part of a marginalised group, or having multiple needs such as a learning disability or autism are all associated with increased risk of mental health problems, and may also limit access to support.[1]

3.2 In Wolverhampton:[2]

- 66 people died by suicide between 2014 and 2016
- There were 19,815 adults with depression known to their GP (20162017), and 2,683 adults with severe mental illness (2015-2016)
- An estimated 3,906 children aged 5-16 had a diagnosable mental health disorder (2015)
- Just 50.9% of adult social care users and 25.2% of adult carers report having as much social contact as they would like (2016-2017)
- Among people in contact with secondary mental health services, only 27% live in stable and appropriate accommodation (2016-2017)

3.3 A recent report by the Mental Health Foundation (2017) found that that only 13% of people in England consider themselves to have good mental health. This highlights the importance of improving mental health and wellbeing at population level, beyond the prevention of diagnosable or definable conditions.

4.0 Joint Public Mental Health & Wellbeing Strategy

4.1 While it is essential to provide high quality services for people experiencing mental health problems, and to ensure timely and equitable access to these services, it is equally important to prevent the onset of mental health problems and to support vulnerable people before referral to specialist services becomes necessary.

[1] Source: Five Year Forward View For Mental Health - https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[2] Source: Public Health Profiles: Mental Health

4.2 However, it is also important that available support and pathways are clear to individuals and professionals, and that work is joined up across the wider system. This helps to avoid unnecessary duplication and allows the identification of any gaps or unmet need.

4.2 The Joint Public Mental Health & Wellbeing Strategy provides a high-level summary of current and planned workstreams across the CWC and CCG to promote population wellbeing and improve mental health. It follows a life course approach, covering all levels of support from universal prevention through to tier 5+ specialist services. This includes but is not limited to:

- Joint Mental Health Commissioning Strategy and Stakeholder Forum
- Child & Adolescent Mental Health Services (CAMHS)
- Social, emotional and mental health needs in schools
- Suicide Prevention Stakeholder Forum and action plan
- Workplace wellbeing and mental health & work
- Dementia Strategy and Autism Strategy
- Reducing social isolation among carers
- Improving the built environment and access to green spaces

4.3 The aim is to not only meet the specific needs of different age groups, but also to reduce cumulative disadvantage associated with poor mental health and wellbeing and related risk factors.

5.0 Financial implications

5.1 The Strategy brings together existing workstreams and strategies across the CWC and CCG to show links across the life course, and what provision and support there is at all levels. It includes commissioned services (by CWC and CCG) but also wider workstreams across Public Heath and other departments. The new Joint Public Mental Health and Wellbeing Strategy will therefore be delivered within the existing budgets of the CWC and the CCG.
[MI/29062018/Z]

6.0 Legal implications

6.1 The CCG has statutory obligations to commission safe, effective services that deliver value for money in partnership with key stakeholders and in response to levels of need and service user and carer views. This is in keeping with the seven key principles of the NHS Constitution (2015) and also with operational and planning guidance as laid out in the mandate to NHS England by the Department of Health.

6.2 The Health and Wellbeing Board is a statutory board established under the Health and Social Care Act 2012. It has a statutory duty to promote the integration of commissioning.

6.3 The Health and Social Care Act 2012 led to the transfer of public health services to local authorities in order to strengthen links to the wider determinants of mental and physical health which encompass the approach taken in this strategy.

6.4 The Mental Health Acts 1983 and 2007 and the Care Act 2014 are the main laws relating to assessment and meeting need of individuals with mental health needs.
[Legal Code: TS/28062018/Q]

7.0 Equalities implications

7.1 A reduction in health inequalities is an overarching aim of the Strategy. Equalities impact assessments will be carried out as appropriate within the work programmes that make up the overarching Strategy.

7.2 Commissioning mental health services that are mental health blue print compliant and are also compliant with NICE Clinical Guidance and Quality Standards will reduce health inequalities. Equality Impact Assessments (EIAs) and Quality Impact Assessments (QIAs) have been conducted as part of the Joint Mental Health Commissioning Strategy. These focus upon the requirements of the needs of protected groups and groups who require targeted engagement and interventions. CCGs are working with NHS England and colleagues in Public Health to utilise refreshed Right Care benchmarking to support the needs analysis and service specification development process and the further production of EIAs and QIAs.

8.0 Environmental implications

8.1 There are no environmental implications directly associated with this report.

9.0 Human resources implications

9.1 There are no human resources implications directly associated with this report.

10.0 Corporate landlord implications

10.1 There are no Corporate Landlord implications associated with this report.

11.0 Schedule of background papers

11.1 Joint Public Mental Health & Wellbeing Strategy for Wolverhampton 2018 – 2021 (draft)

11.2` Joint Mental Health Commissioning Strategy 2018-2019 – 2020-2021 (draft)

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Joint Public Mental Health and Wellbeing Strategy 2018 – 2021

City of Wolverhampton Council
NHS Wolverhampton CCG

DRAFT

wolverhampton.gov.uk

CITY OF WOLVERHAMPTON COUNCIL

Contents

Foreword

Mental health is integral to overall health, and recognised as being fundamental to growth, development, learning and resilience. Accordingly the social, physical and economic environments in which people are born, grow, live, work and age have important implications for mental health. The support needs of people experiencing mental health difficulties therefore extend beyond health service provision and into wider public services.

This Joint Public Mental Health & Wellbeing Strategy for Wolverhampton follows a life course approach, covering all tiers of service provision and support for all ages. In addition, it sets out key programmes and strategies acting on the wider social, environmental and economic determinants of health to create mentally healthy places and keep people well.

The aim is to not only meet the specific needs of different age groups, but also to reduce cumulative disadvantage associated with poor mental health and wellbeing and related risk factors.

The Strategy brings out key strategic and delivery themes across Council and CCG workstreams to articulate a cohesive, population-based approach to promote wellbeing and improve mental health in the city.

Councillor Hazel Malcolm
Cabinet Member for Health & Wellbeing
City of Wolverhampton Council

John Denley
Director of Public Health
City of Wolverhampton Council

Helen Hibbs
Chief Officer
NHS Wolverhampton CCG

Vision and values

Our vision is for every resident in the City of Wolverhampton to have the best mental health that they can at every stage of their life.

We will promote an approach that prevents and treats mental health problems with the same drive, passion and commitment as for physical health problems, embedding mental health and wellbeing across the health, care and wider system. This approach recognises the importance of enabling everyone to feel good and function well throughout their everyday lives.

This will be achieved through the following key objectives, drawing upon the wealth of skills and expertise across the Council, NHS and partner organisations:

- Focus on mental health promotion, mental illness prevention and recovery throughout the life course
- Promote resilience in individuals, families and communities through asset-based working and the wider social determinants of health
- Deliver timely, person-centred, effective services that align health and social care outcomes to provide integrated, responsive services and care
- Improve people's experiences of mental health and social care services
- Reduce inequalities in mental health and wellbeing and in access to care and support
- Challenge stigma and discrimination related to mental health problems

Key strategic and policy drivers

- **Five Year Forward View for Mental Health (2016)** emphasises the need for a shift towards prevention and better integration of care in order to improve outcomes and experiences for people with mental health problems and their carers, and reduce health inequalities.
- **Prevention Concordat for Better Mental Health (2016)** advocates a prevention-focused approach to mental health improvement in populations through evidence-based planning and commissioning. It also acknowledges the active role played by people with lived experience of mental health problems.
- **Care Act 2014** places statutory duties on Local Authorities to promote wellbeing, ensuring personal dignity; physical and mental health and emotional wellbeing; protection from abuse and neglect; control by the individual over their day-to-day life; participation in work, education, training or recreation; social and economic wellbeing; domestic, family and personal domains; suitability of the individual's living accommodation; and the individual's contribution to society.
- **No Health Without Mental Health:** a cross-government outcomes strategy (2011) set out ambitions for mental health to be given equal priority to physical health ('parity of esteem'), and to become 'everyone's business' – that is, for health services, local authorities, education, employers, third sector organisations and communities to work in partnership to address the causes and consequences of poor mental health and promote mental wellbeing in populations.
- **Better Care Fund (BCF)** is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.
- **Transforming children and young people's mental health provision: a green paper (2017)** sets out the ambition that children and young people who need help for their mental health are able to get it when they need it.
- **Suicide Prevention Strategy for England (2012)** sets out plans for reducing suicide rates and supporting people affected by suicide.
- **Being mindful of mental health – the role of local government in mental health and being (2017)** of the Local Government Association aspires to the creation of "mentally healthy" places for people of all ages across their whole life-course.
- **Distinctive, Valued, Personal (ADASS, 2015): Why Social Care matters – the next five years** describes the distinctive role and value of social care in taking a whole-person approach to supporting people with complex needs.
- **Thrive Mental Health Commission (WMCA, 2017): An Action Plan to drive better mental health and wellbeing in the West Midlands** sets out key actions for working in partnership to reduce the impact of mental ill health across the region.

Local and national context

Mental health problems have very high rates of prevalence, estimated to affect around **1 in 4 people every year**. They are often of long duration, even lifelong in some cases and have adverse effects on many aspects of people's lives.

Nationally, poor mental health is estimated to cost the economy approximately **£105 billion per year**, including **£34 billion on dedicated mental health support and services**.

Prevalence of diagnosable mental health problems across the life course

In Wolverhampton in 2015/16, up to 510 women had mild to moderate perinatal anxiety and/or depression

An estimated 105 women had severe perinatal depression

Perinatal and early years

Anxiety and depression affect 10-15% of women having a baby

50% of diagnosed mental health problems emerge by age 14, and 75% by age 24

In 2015 an estimated 3,906 children in Wolverhampton aged 5-16 had a diagnosable mental health disorder

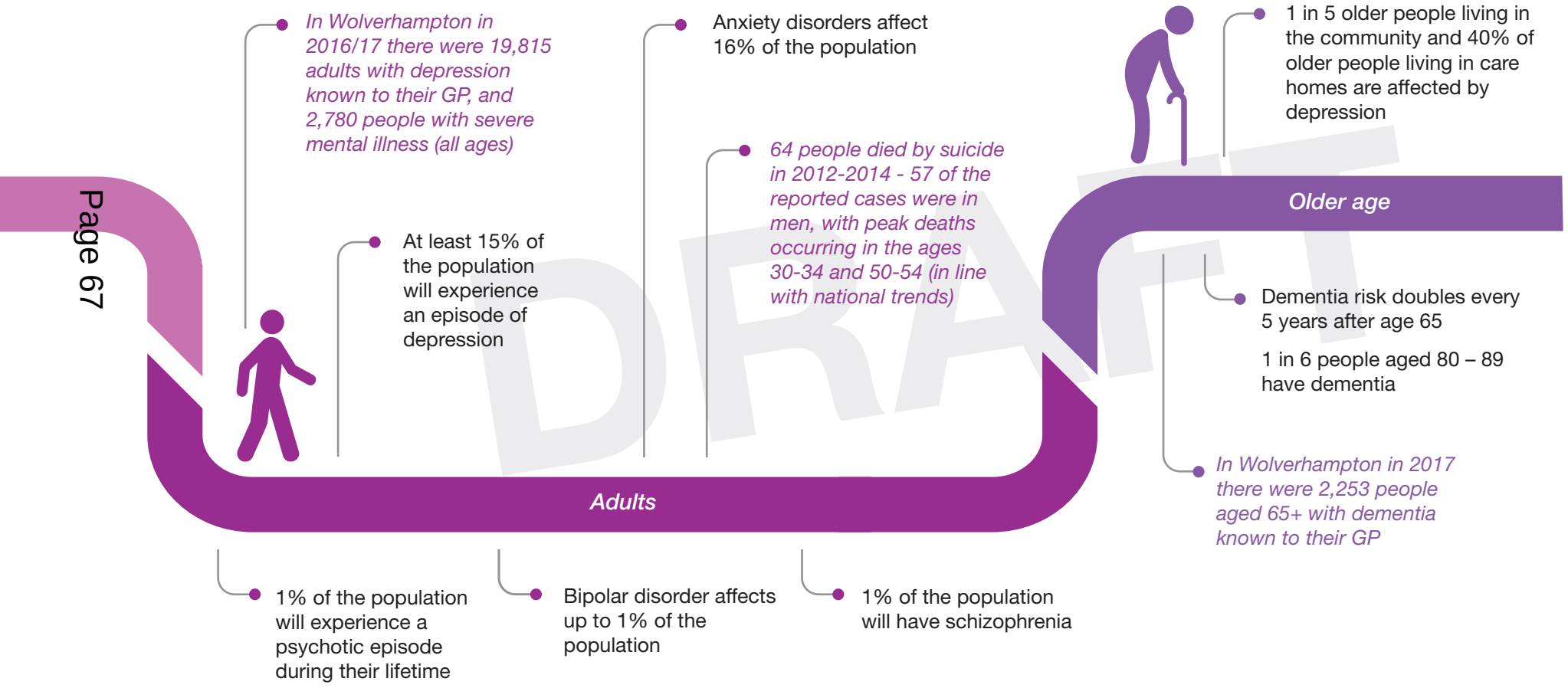
Childhood and adolescence

1 in 150 females and 1 in 2000 males will develop an eating disorder such as anorexia nervosa

1 in 10 children will be affected by depression, anxiety or a conduct disorder (aggression, destructive behaviour, consistent breaking of rules, deceitful behaviour)

[1] NHS England internal analysis – Five Year Forward View for Mental Health (2016).
[2] Sources: Public Health Profiles: Mental Health, Dementia & Neurology; Mental Health Foundation.

*Approximately **1 in 4 people** in the UK will experience a mental health problem each year*



[3] 5 Year Forward View for Mental Health (2016)

Wellbeing

Wellbeing encompasses social, emotional and mental wellbeing. It can be best summarised as **feeling good and functioning well**.

A recent report by the Mental Health Foundation (2017) found that that only 13% of people in England consider themselves to have good mental health. This highlights the importance of improving mental health and wellbeing at population level, beyond the prevention of diagnosable or definable conditions.

Creating the conditions for mental health and wellbeing

Poor mental health is both a cause and consequence of overall health inequalities due to its associations with physical health, employment, housing and lifestyle factors. People with severe and prolonged mental illness die 15-20 years earlier on average than others – two thirds of these deaths are due to avoidable physical illness, including heart disease and cancer linked to smoking.

At all ages **traumatic experiences, poor housing or homelessness**, being **part of a marginalised group**, or having **multiple needs** such as a learning disability or autism are all associated with increased risk of mental health problems, and may also limit access to support.[4]

[4] Prevention Concordat for Better Mental Health (2016)

Best start in life

- Adverse Childhood Experiences (ACEs) describe childhood trauma through abuse, neglect and difficulties in the home environment. ACEs are linked to poorer health and social outcomes, including smoking, substance use and incarceration.
- Children in care are 4 times more likely than their peers to have a mental health difficulty, which may be exacerbated with placement breakdown.
- Resilience factors such as feeling loved and having good social support network can help protect against the effects of childhood trauma.
    - We are developing ways to systematically capture information on ACEs, and intervene early to reduce the occurrence and impact of ACEs and prevent intergenerational problems as part of the **Early Years Strategy** and Healthy Child Programme.

Education

- School ethos, bullying and teacher wellbeing all have an influence on children's mental health. In an average classroom of 30 15-year-old pupils, 3 could have a mental health problem, 7 are likely to have been bullied, and 6 may be self-harming.[5]
- The **Social, Emotional & Mental Health (SEMH) Plan** for schools sets out actions for identifying and responding to SEMH needs. This includes workforce development and training, and off-site and on-site enhanced or alternative provision for pupils with identified SEMH needs.

Employment

- As of November 2017, there were 12,010 Employment Support Allowance (ESA) claimants living in Wolverhampton.
- It is estimated that approximately 5,525 of these are due to mental health problems.[6]
- We are strengthening pathways across health and employment services to improve access to employment for people with mental health problems.

Housing

- Among people in contact with secondary mental health services, only 27% in Wolverhampton live in stable and appropriate accommodation (2016/17).
- This is lower than both the regional average (45%) and national average (54%).
- We are actively working to improve the quality of rented accommodation, and to reduce homelessness - working in partnership with mental health services – as part of the **Housing Strategy**.

[5] Lavis P (2015). Promoting children and young people's emotional health and wellbeing: A whole school and college approach. London: Public Health England.

Community

- Just 50.9% of adult social care users and 25.2% of adult carers in Wolverhampton report having as much social contact as they would like (2016/17).
- We are developing a system to measure social isolation locally, and mobilise the community to meet these needs (e.g. through social prescribing).
- Young offenders are known to be a key group at increased risk of mental health issues. Our Reducing Gangs & Youth Violence Strategy will be incorporated into a wider **Exploitation Strategy** in 2019.

Environment

- Access to green spaces has a lasting positive effect on mental wellbeing for all ages and socioeconomic groups. However, these spaces are not equally distributed and are not always safe or accessible within deprived areas.[7]
- We are working to improve access to green spaces for wellbeing and physical activity through the **Open Spaces Strategy and Action Plan**.

[6] Data from 2016 identified 46% of ESA claimants cited mental illness as the reason for being unable to work.
[7] Better Mental Health For All: A Public Health Approach to Mental Health Improvement (2016). London: Faculty of Public Health and Mental Health Foundation.

Physical health problems

Physical and mental health are inextricably linked. Mental wellbeing and resilience are protective factors for physical health as they reduce the prevalence of risky behaviours such as smoking, substance misuse and unhealthy eating, which are often used as coping mechanisms in the absence of other support. Conversely, people with cancer, diabetes, asthma and high blood pressure are at greater risk of a range of mental health problems such as depression, anxiety and PTSD.

People with long term physical health conditions are more likely to have poor mental health compared with the general population, indicating a need to ensure approaches to improve mental wellbeing are integrated into physical care pathways.

- 30% of the UK population live with one or more long-term health conditions. Of these, approximately 27% will also have a mental health problem.[8]
    - This means that approximately 20,664 people in Wolverhampton with a long-term health condition also have a mental health problem.[9]
- In Wolverhampton smoking prevalence in people with severe mental illness is 46.5%, compared with 16.5% in the general population. This is similar to the national average.

[8] Naylor C et al (2012). Long-term conditions and mental health – The cost of co-morbidities. London: The King's Fund & Centre for Mental Health.
[9] Based on mid-year population estimate of 255,106 (ONS)

Access to and experience of services

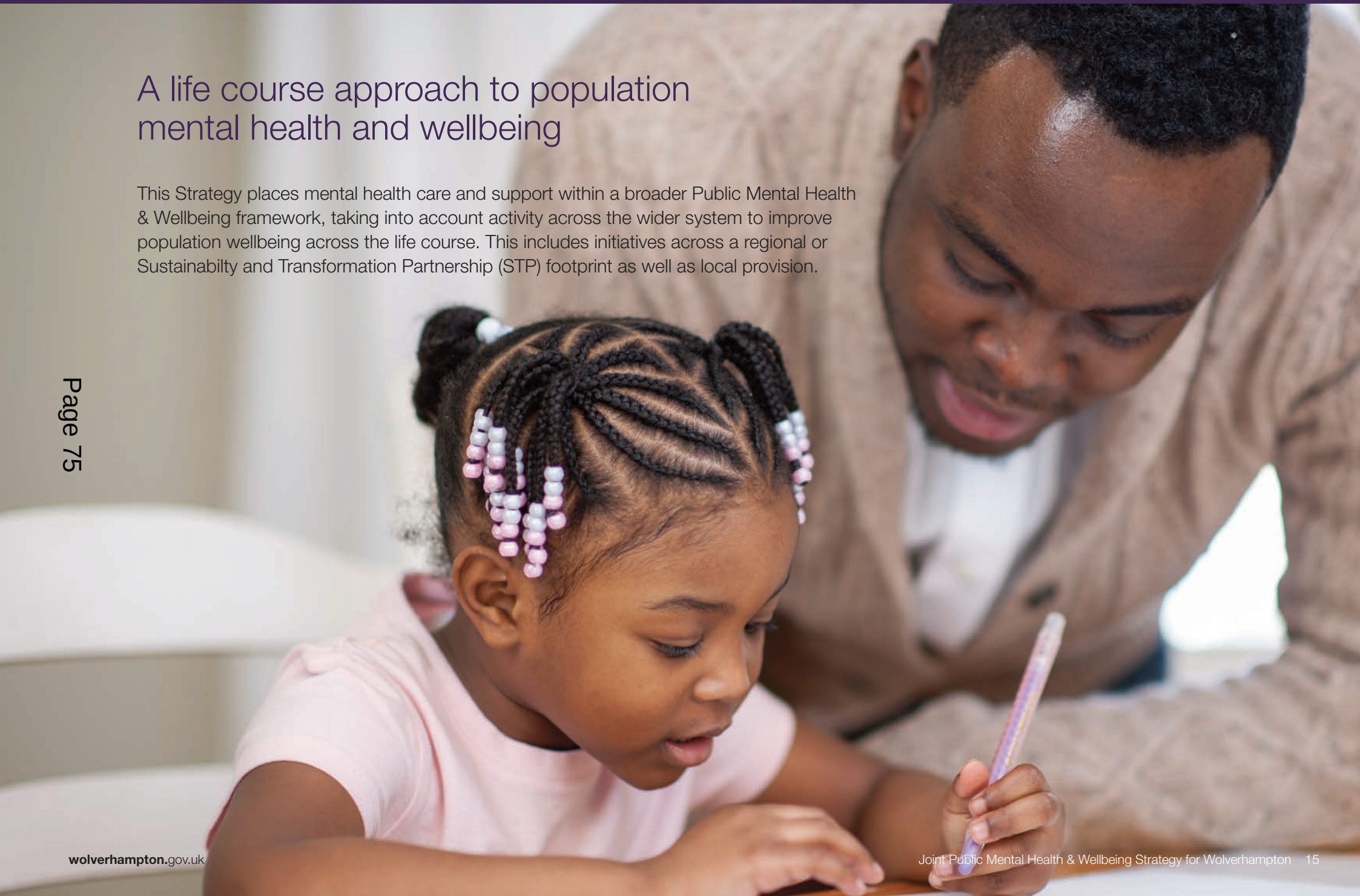
Mental Wellbeing in Wolverhampton – an assessment of needs (2017) reported evidence from responses to a survey of users about their experiences of mental health service highlighted the following:

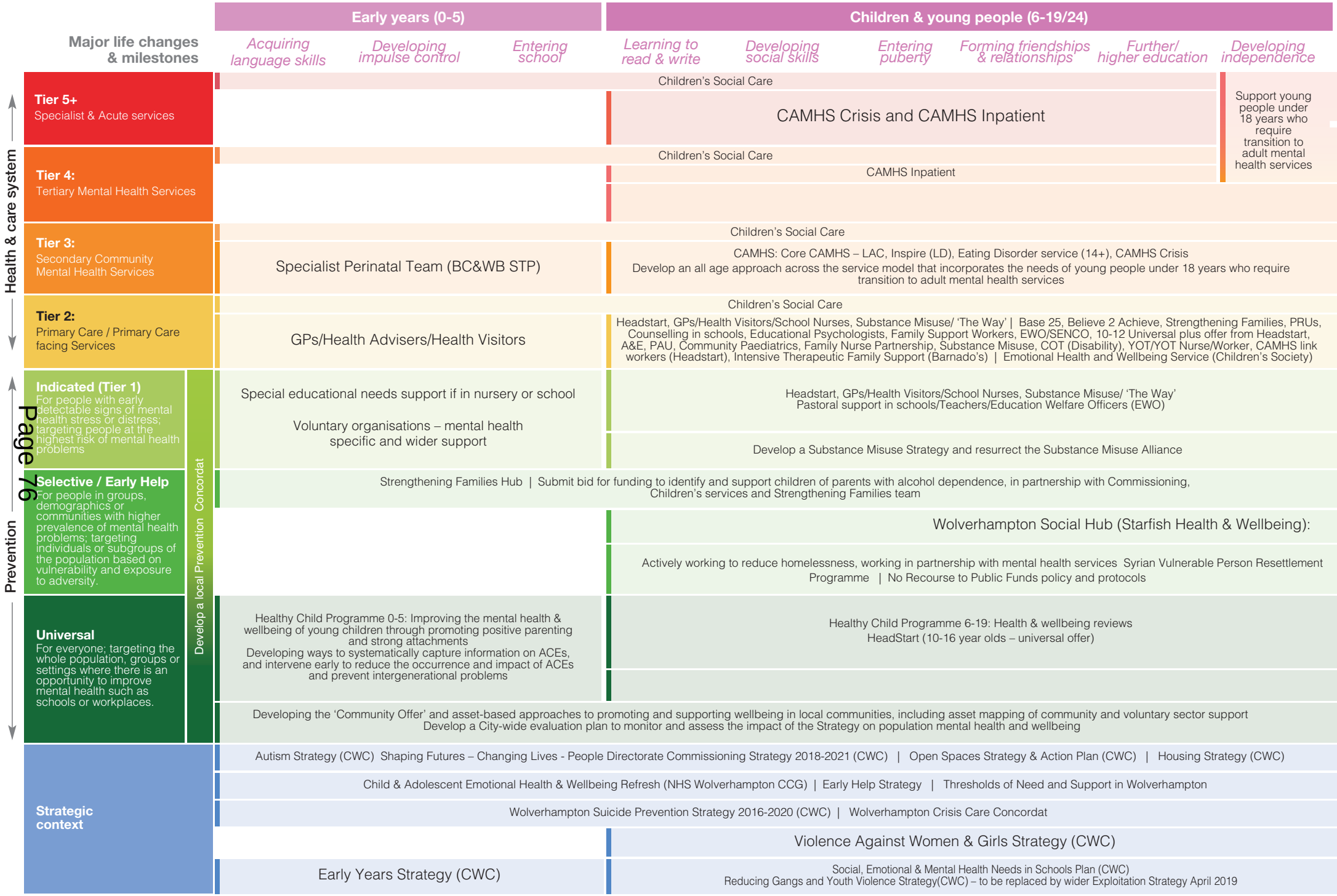
- **Groups at higher risk of poor mental wellbeing** - unemployed, lesbian, gay, bisexual and transgender (LGBT+), homeless, Black and Minority Ethnic (BAME) groups, refugee and migrants, students, ex-offenders, carers
- **Key issues highlighted**: isolation, access to support groups, housing employment, financial stability, physical health
- **Stigma:** lack of understanding from front line services, lack of support for coming back into work.

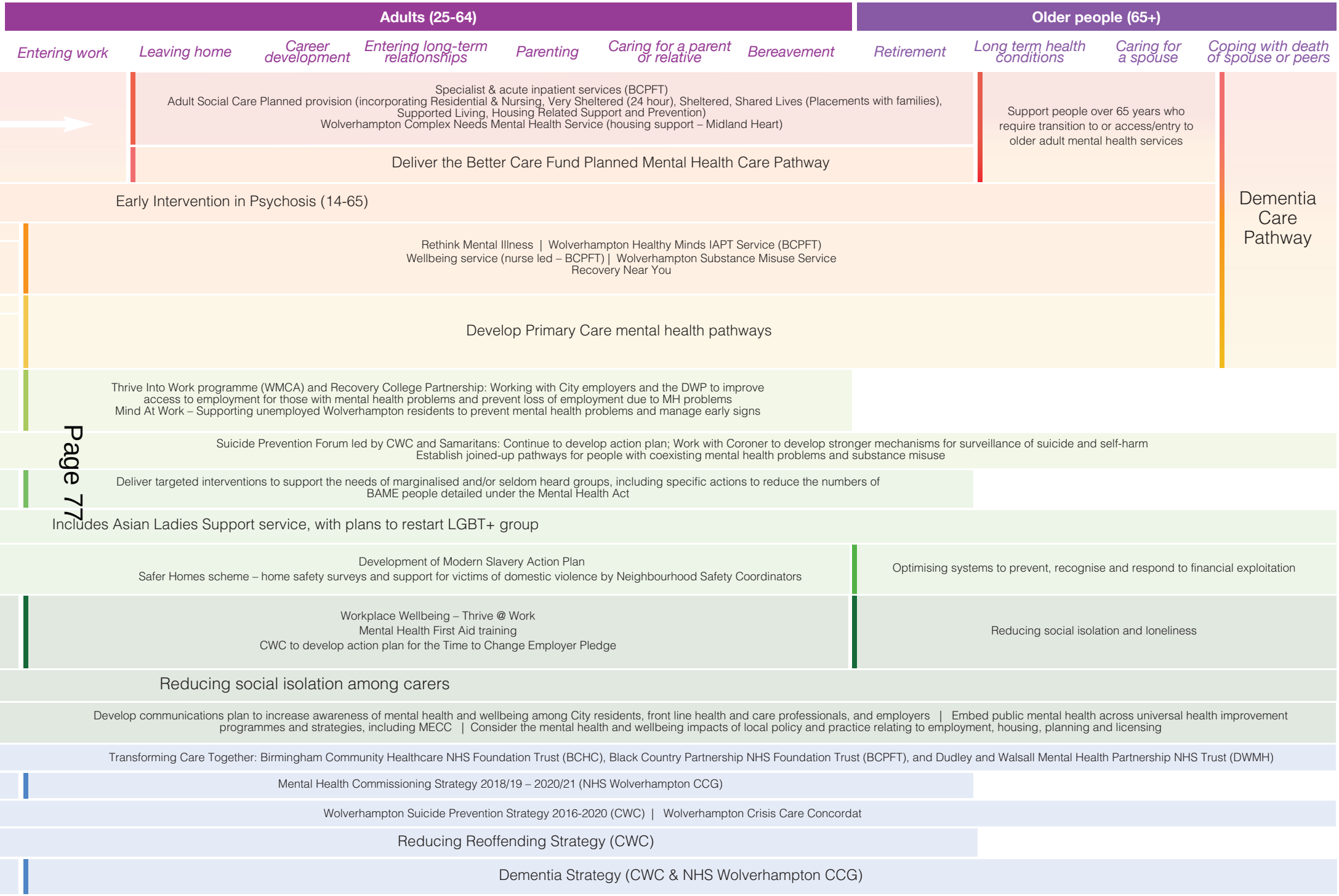
There was concern around people wanting support but not meeting the threshold for accessing services, and accessing difficulty in getting timely access to appropriate services. The report also indicated a need to raise awareness of where the public can get help, whether signposts or more information on mental health issues.

A life course approach to population mental health and wellbeing

This Strategy places mental health care and support within a broader Public Mental Health & Wellbeing framework, taking into account activity across the wider system to improve population wellbeing across the life course. This includes initiatives across a regional or Sustainabilty and Transformation Partnership (STP) footprint as well as local provision.




Early years (0-5)
Children & young people (6-19/24)
Major life changes & milestones
Acquiring language skills
Developing impulse control
Entering school
Learning to read & write
Developing social skills
Entering puberty
Forming friendships & relationships
Further/ higher education
Developing independence
Health & care system
Prevention
Tier 5+
Specialist & Acute services
Tier 4:
Tertiary Mental Health Services
Tier 3:
Secondary Community Mental Health Services
Tier 2:
Primary Care / Primary Care facing Services
Indicated (Tier 1)
For people with early detectable signs of mental health stress or distress; targeting people at the highest risk of mental health problems
Selective / Early Help
For people in groups, demographics or communities with higher prevalence of mental health problems; targeting individuals or subgroups of the population based on vulnerability and exposure to adversity.
Universal
For everyone; targeting the whole population, groups or settings where there is an opportunity to improve mental health such as schools or workplaces.
Develop a local Prevention Concordat
Strategic context
Children's Social Care
CAMHS Crisis and CAMHS Inpatient
Support young people under 18 years who require transition to adult mental health services
Children's Social Care
CAMHS Inpatient
Children's Social Care
Specialist Perinatal Team (BC&WB STP)
CAMHS: Core CAMHS – LAC, Inspire (LD), Eating Disorder service (14+), CAMHS Crisis
Develop an all age approach across the service model that incorporates the needs of young people under 18 years who require transition to adult mental health services
Children's Social Care
GPs/Health Advisers/Health Visitors
Headstart, GPs/Health Visitors/School Nurses, Substance Misuse/ 'The Way' | Base 25, Believe 2 Achieve, Strengthening Families, PRUs, Counselling in schools, Educational Psychologists, Family Support Workers, EWO/SENCO, 10-12 Universal plus offer from Headstart, A&E, PAU, Community Paediatrics, Family Nurse Partnership, Substance Misuse, COT (Disability), YOT/YOT Nurse/Worker, CAMHS link workers (Headstart), Intensive Therapeutic Family Support (Barnado's) | Emotional Health and Wellbeing Service (Children's Society)
Special educational needs support if in nursery or school
Voluntary organisations – mental health specific and wider support
Headstart, GPs/Health Visitors/School Nurses, Substance Misuse/ 'The Way'
Pastoral support in schools/Teachers/Education Welfare Officers (EWO)
Develop a Substance Misuse Strategy and resurrect the Substance Misuse Alliance
Strengthening Families Hub | Submit bid for funding to identify and support children of parents with alcohol dependence, in partnership with Commissioning, Children's services and Strengthening Families team
Wolverhampton Social Hub (Starfish Health & Wellbeing):
Actively working to reduce homelessness, working in partnership with mental health services Syrian Vulnerable Person Resettlement Programme | No Recourse to Public Funds policy and protocols
Healthy Child Programme 0-5: Improving the mental health & wellbeing of young children through promoting positive parenting and strong attachments
Developing ways to systematically capture information on ACEs, and intervene early to reduce the occurrence and impact of ACEs and prevent intergenerational problems
Healthy Child Programme 6-19: Health & wellbeing reviews
HeadStart (10-16 year olds – universal offer)
Developing the 'Community Offer' and asset-based approaches to promoting and supporting wellbeing in local communities, including asset mapping of community and voluntary sector support
Develop a City-wide evaluation plan to monitor and assess the impact of the Strategy on population mental health and wellbeing
Autism Strategy (CWC) Shaping Futures – Changing Lives - People Directorate Commissioning Strategy 2018-2021 (CWC) | Open Spaces Strategy & Action Plan (CWC) | Housing Strategy (CWC)
Child & Adolescent Emotional Health & Wellbeing Refresh (NHS Wolverhampton CCG) | Early Help Strategy | Thresholds of Need and Support in Wolverhampton
Wolverhampton Suicide Prevention Strategy 2016-2020 (CWC) | Wolverhampton Crisis Care Concordat
Violence Against Women & Girls Strategy (CWC)
Early Years Strategy (CWC)
Social, Emotional & Mental Health Needs in Schools Plan (CWC)
Reducing Gangs and Youth Violence Strategy(CWC) – to be replaced by wider Exploitation Strategy April 2019


Adults (25-64)
Older people (65+)
Entering work
Leaving home
Career development
Entering long-term relationships
Parenting
Caring for a parent or relative
Bereavement
Retirement
Long term health conditions
Caring for a spouse
Coping with death of spouse or peers
Specialist & acute inpatient services (BCPFT)
Adult Social Care Planned provision (incorporating Residential & Nursing, Very Sheltered (24 hour), Sheltered, Shared Lives (Placements with families), Supported Living, Housing Related Support and Prevention)
Wolverhampton Complex Needs Mental Health Service (housing support – Midland Heart)
Support people over 65 years who require transition to or access/entry to older adult mental health services
Deliver the Better Care Fund Planned Mental Health Care Pathway
Dementia Care Pathway
Early Intervention in Psychosis (14-65)
Rethink Mental Illness | Wolverhampton Healthy Minds IAPT Service (BCPFT)
Wellbeing service (nurse led – BCPFT) | Wolverhampton Substance Misuse Service
Recovery Near You
Develop Primary Care mental health pathways
Thrive Into Work programme (WMCA) and Recovery College Partnership: Working with City employers and the DWP to improve access to employment for those with mental health problems and prevent loss of employment due to MH problems
Mind At Work – Supporting unemployed Wolverhampton residents to prevent mental health problems and manage early signs
Suicide Prevention Forum led by CWC and Samaritans: Continue to develop action plan; Work with Coroner to develop stronger mechanisms for surveillance of suicide and self-harm
Establish joined-up pathways for people with coexisting mental health problems and substance misuse
Deliver targeted interventions to support the needs of marginalised and/or seldom heard groups, including specific actions to reduce the numbers of BAME people detailed under the Mental Health Act
Includes Asian Ladies Support service, with plans to restart LGBT+ group
Development of Modern Slavery Action Plan
Safer Homes scheme – home safety surveys and support for victims of domestic violence by Neighbourhood Safety Coordinators
Optimising systems to prevent, recognise and respond to financial exploitation
Workplace Wellbeing – Thrive @ Work
Mental Health First Aid training
CWC to develop action plan for the Time to Change Employer Pledge
Reducing social isolation and loneliness
Reducing social isolation among carers
Develop communications plan to increase awareness of mental health and wellbeing among City residents, front line health and care professionals, and employers | Embed public mental health across universal health improvement programmes and strategies, including MECC | Consider the mental health and wellbeing impacts of local policy and practice relating to employment, housing, planning and licensing
Transforming Care Together: Birmingham Community Healthcare NHS Foundation Trust (BCHC), Black Country Partnership NHS Foundation Trust (BCPFT), and Dudley and Walsall Mental Health Partnership NHS Trust (DWMH)
Mental Health Commissioning Strategy 2018/19 – 2020/21 (NHS Wolverhampton CCG)
Wolverhampton Suicide Prevention Strategy 2016-2020 (CWC) | Wolverhampton Crisis Care Concordat
Reducing Reoffending Strategy (CWC)
Dementia Strategy (CWC & NHS Wolverhampton CCG)

Outcome measures

An overarching evaluation and monitoring framework will be developed as part of this Strategy.
This will include indicators relating to wider determinants, vulnerable groups, service activity and outcomes.

Wider determinants

Reduce the number of 16-18 year olds not in employment, education or training

Increase use of green spaces for physical activity

Increase self-rated population wellbeing scores

Vulnerable groups

Increase identification of social, emotional and mental health needs in schools

Reduce number of permanent exclusions from schools

Increase access to employment for people with mental health problems

Increase numbers of people with mental illness and/or disability in settled accommodation

Reduce episodes of violent crime

Reduce the number of first time entrants to the youth justice system

Increase the wellbeing of carers

Service activity

Improve access to and satisfaction with mental health and support services

Increase rates of completed treatment and recovery, including drug and alcohol treatment

Reduce inequalities in access to treatment and support

Reduce emergency admissions due to mental health problems, including substance misuse

Reduce in-year bed days for mental health

Health and care outcomes

Reduce the incidence and prevalence of mental health problems, and inequalities in the population

Reduce inequalities in physical health outcomes between people with mental health problems and the general population

Reduce the number of suicides

Recommendations

1. Work in partnership across agencies, service users and their carers via the Wolverhampton Mental Health Stakeholder Forum to implement integrated approaches to mental health promotion, support, care and recovery.
2. Continue to co-ordinate activity to improve mental health and wellbeing outcomes through multi-agency partnerships, including the Suicide Prevention Forum.
3. Develop a Prevention Concordat for Wolverhampton to facilitate local and action around preventing mental health problems and promoting good mental health.

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wolverhampton.gov.uk 01902 551155

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NHS
Wolverhampton
Clinical Commissioning Group

WCC 1708 06/18

MENTAL HEALTH COMMISSIONING STRATEGY

2018/19-2020/21

CONTENTS

1. INTRODUCTION AND OVER VIEW

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

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

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

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

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

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

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

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

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

A link to the WOLVERHAMPTON CAMHS PLAN is provided below:

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

Some Key Important Points are highlighted in the table below

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

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

groups including disabled people, people with learning difficulties and older people both in terms of social isolation and self-efficacy and barriers to accessing appropriate levels of support (including barriers to communication in the case of people with sensory impairments and c/ or physical disabilities and / or LTCs for example). This will include focussed support to carers both in terms of access to and responsiveness of services but also by ensuring there are adequate and supportive 'carers care plans' especially for carers of people with high levels of need including people subject to Section 117 Mental Health Act 1983 and the **Care Programme Approach (CPA).**
7. Our **Mental Health Integrated Care System** will work to **reduce the impact of known risk issues and inequalities upon mental health, delivering a focus upon the wider determinants of mental health**, **providing dedicated and targeted support that responds to the particular needs of** people who are economically inactive, un-employed people, people with housing needs and / or who are homeless, people with physical disabilities and / or a long term condition, people with a neurological condition such as Autism and / or ADHD (Attention Deficit Hyperactivity Disorder), people with enduring mental health difficulties such as depression and anxiety, psychosis and personality disorder, people who have a history of mental or physical trauma including sexual abuse and exploitation, bullying including work and school based bullying, domestic violence and veterans, people from Black and Minority Ethnic Groups (BAME), and / or LGBT+ (Lesbian Gay Bisexual Transgender Questioning Intersexual Asexual Groups), refugees, migrants and new arrivals, looked after children (LAC), women and their partners, children and families who have a mental health difficulty related to pregnancy and / or child birth, people who have a history of offending behaviour, Veterans and Serving Members of her Majesty's Armed Forces and their families and carers, and people with a dual diagnosis (alcohol and/ or substance misuse) supporting us all to **achieve self-efficacy, fulfil personal hopes, dreams, goals and aspirations and thrive**.
8. Our **Mental Health Integrated Care System** will deliver a **'Think Family'** approach **responding pro-actively to the needs of poor parental and spousal mental health upon the mental health and developmental milestones of children**

and adolescents, partners and the whole family and within this context will deliver a focus upon perinatal mental health working with partners in Childrens and Maternity Services Universal and Primary Care Services Public Health Teams and Mental Health Secondary and Tertiary Services across our Sustainability and Transformation Partnership (STP) to deliver a perinatal mental health 'whole system' of care pathways and services that achieves the key outputs of the **Black Country and West Birmingham Local Maternity System (LMS)** including the aspirations of **Better Births Improving outcomes of maternity services in England A Five Year Forward View for maternity care (2016)** for our local system. This will include a focus upon **reducing maternal mental health related deaths including deaths related to alcohol and / or substance misuse and suicide**. This will also include a focus upon improved health and developmental outcomes for the child, sibling, partner and the whole family.
9. Our **Mental Health Integrated Care System** will deliver a set of **interoperational processes systems care pathways and services across primary secondary and tertiary care to ensure more pro-active and responsive approaches within primary care for people with mental health difficulties** – delivered by staff within NICE Guidance compliant services with mental health expertise in line with the **General Practice Forward View – blurring some boundaries across primary and secondary care for people with mental health difficulties and improving systems and processes for better shared care**. This will involve inclusion of mental health staff working in and embedded in primary care services and primary care and mental health multi-disciplinary team meetings in each GP practice and in every Primary Care Group including the Vertical Integration with the Royal Wolverhampton NHS Trust. There will be a particular focus upon improving access and responsiveness to evidence based care including physical health checks for people with SMI (Severe Mental Illness), improved care pathways for people with co-occurring mental health problems .and physical ill health including Long Term Conditions (LTCs) - such as Diabetes, Cancer, Cardio-Vascular Disease including Stroke and Heart Disease, Chronic Obstructive Pulmonary Disease, Neurological Disorders, Dementia, Physical Disability, Musculoskeletal Disorders and or

Acquired Brain Injury - shared care and improved information sharing, improved referral processes for mental health secondary care generally but including a focus on improved referral processes for primary care and social care staff and staff working in statutory and non-statutory services and looking at ways to support and improve self-referral and access support and advice for carers.
10. Our **Mental Health Integrated Care System** will support the mental health needs of all staff patients and service users and carers including friends and family members and informal carers by ensuring appropriate levels and types of support across the system and particularly at times of escalation and crisis helping us all to work together and support each other with professionalism and with accountability and in enabling, kind and compassionate ways.

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


10 WAYS TO LOOK AFTER YOUR MENTAL HEALTH
Talk about your feelings
Keep active
Eat well
Take a break
Drink sensibly
Keep in touch
Do something you're good at
Accept who you are
Ask for help
Care for others
Mental Health Foundation
mentalhealth.org.uk

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

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

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

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

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

- **Integration of mental and physical health - closing the mortality gap** - having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50% and doubles the risk of coronary heart disease in adults. People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population (Future in Mind 2015). Five Year Forward View For Mental Health highlights that people with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care by an average of 45 % whereas providing dedicated mental health provision can improve outcomes, such as in the case of Type 2 diabetes, £1.8 billion of additional costs can be attributed to poor mental health. Pilot schemes show providing such support improves health and cuts costs by 25%.

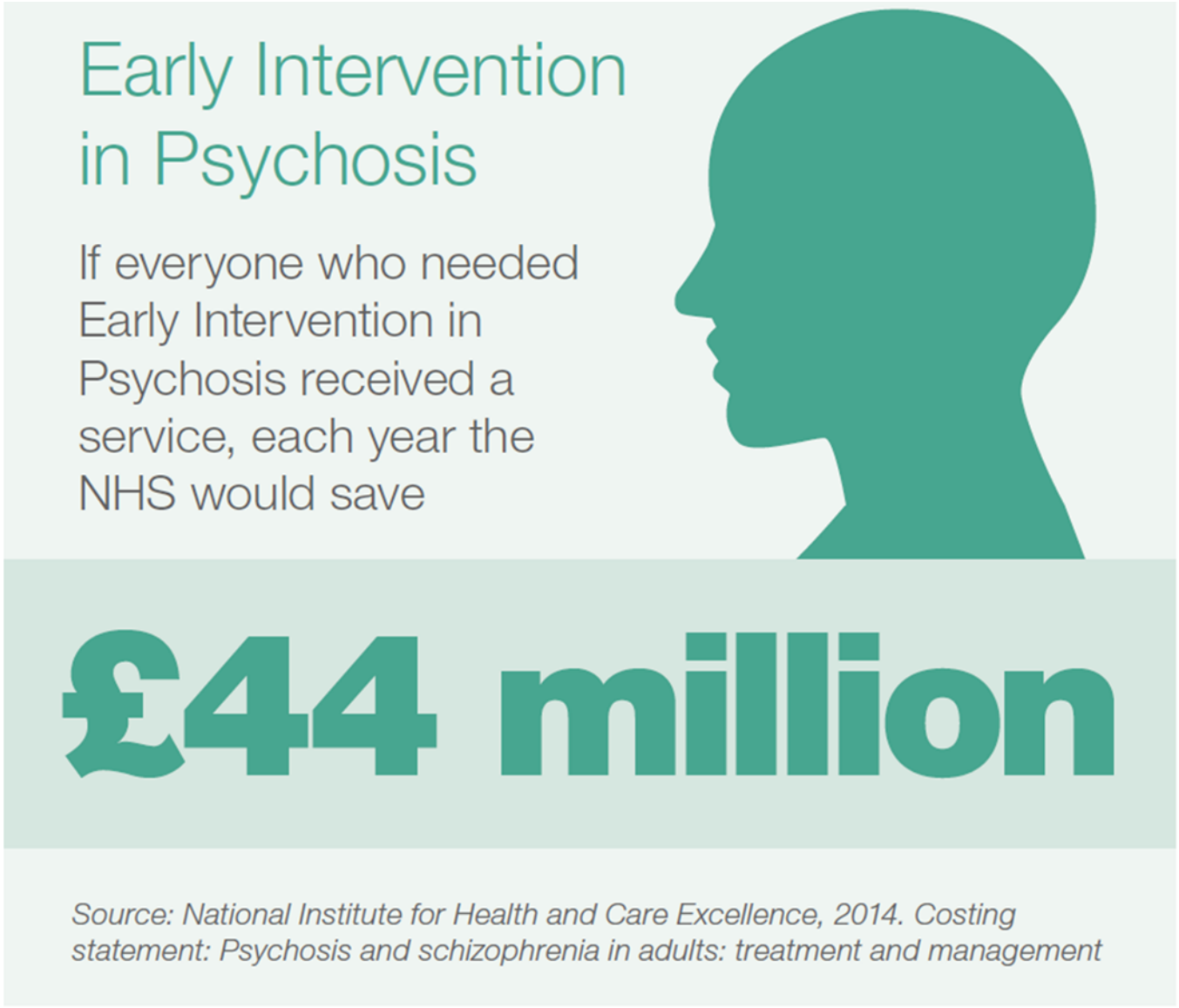
- **Improving access to the quality and evidence base and improving access to and responsiveness of services, referral to treatment and waiting times - closing the treatment gap** - a UK epidemiological study suggests that less than 25% – 35% of individuals with a diagnosable mental health condition accessed appropriate help (Future in Mind 2015). In addition there is a strong link between parental (especially maternal) mental health and children's mental health. Future in Mind highlights that according to a recent study, maternal perinatal depression, anxiety and psychosis together carry a long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK, equivalent to a long-term cost of just under £10,000 for every single birth in the country and that almost three-quarters of this cost (72%) relates to the impact on the child / infant. £1.2 billion of the long-term cost is borne by the NHS (Future in Mind, 2015). **There is a requirement for access to evidence based interventions across the lifespan and that access to services in a NICE concordant evidence based care pathway is measured and reported along with measurement of outcomes.** (See Fig. 2 below).

- **Improving Data Quality – closing the data quality gap** - our system recognises that there is a need for good, transparent, regular data and information that is collected in line with national requirements reporting recording new KPIs / measurements etc. including use of the APRIL 17 New MH SDS and the monitoring new access and waiting times and referral to treatment standards such as within IAPT, Early Intervention In Psychosis and Eating Disorders Services. We will build on our achievements in promoting better, more joined-up data.

- **CCGs commitment to Mental Health Investment Standard - closing the parity of esteem / funding gap** (in addition to the Mental Health Investment Standard our commitment to parity of esteem includes submitting applications for NHS E Transformation funding and funding for New Models of Care that meet our local needs and needs on a BC&WB footprint).

- **Improving the Wider Determinants of Mental Health – closing the early intervention and prevention gap** - the Five Year Forward View for Mental Health highlights that between 60–70 % of people with common mental health problems are in work, yet few employees have access to specialist occupational health services and that for people being supported by secondary mental health services, there is a 65 % employment gap compared with the general population. People with mental health problems are also often overrepresented in high-turnover, low-pay and often part-time or temporary work. Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high. Children living in poor housing have increased chances of experiencing stress, anxiety and depression. People in marginalised groups are at greater risk, including people from BAME and LGBT+

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


Early Intervention in Psychosis
If everyone who needed Early Intervention in Psychosis received a service, each year the NHS would save
£44 million
Source: National Institute for Health and Care Excellence, 2014. Costing statement: Psychosis and schizophrenia in adults: treatment and management

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

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

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

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

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

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

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

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

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

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

Overall Goals for 2017-2019
Implementing the Mental Health Forward View (2017) sets out clear deliverables for putting the recommendations of the Independent Mental Health Taskforce Report into action by 2020/21. The publication of Stepping Forward to 2020/2021 in July 2017 provides a roadmap to increase the mental health workforce needed to deliver this.
Deliverables for 2018/19 and 2019/2020 2020//2021
Each CCG must meet the Mental Health Investment Standard (MHIS) by which their 2018/19 investment in mental health rises at a faster rate than their overall programme funding. CCGs' auditors will be required to validate their 2018/19 year-end position on meeting the MHIS.
Ensure that an additional 49,000 children and young people receive treatment from NHS-commissioned community services (32% above the 2014/15 baseline) nationally, towards the 2020/21 objective of an additional 70,000 additional children and young people. Ensure evidence of local progress to transform children and young people's mental health services is published in refreshed joint agency Local Transformation Plans aligned to STPs.
Make further progress towards delivering the 2020/21 waiting time standards for children and young people's eating disorder services of 95% of patient receiving first definitive treatment within four weeks for routine cases and within one week for urgent cases (in WOLVERHAMPTON this standard is also being applied to our Adult Eating Disorder Service).
Deliver against regional implementation plans to ensure that by 2020/21, inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements, within a context of 150-180 additional beds.

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

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

home treatment teams and mental health liaison services in acute hospitals.
Increase baseline spend on mental health to deliver the Mental Health Investment Standard.
Eliminate out of area placements for non-specialist acute care by 2020/21.
Measurable improvement on all areas of Prime Minister's challenge on dementia 2020, including: • maintain a diagnosis rate of at least two thirds • increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral • improve quality of post-diagnosis treatment and support for people with dementia and their carers
To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce).
Access and waiting time standards for mental health services embedded, including: 50% of people experiencing first episode of psychosis to access treatment within two weeks; and 75% of people with relevant conditions to access talking therapies in six weeks; 95% in 18 weeks.
Deliver the contribution to the mental health workforce expansion as set out in the HEE workforce plan, supported by STP-level plans. At national level, this should also specifically include an increase of 1,500 mental health therapists in primary care in 2018/19 and an expansion in the capacity and capability of the children and young people's workforce building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence based interventions by 2020/21.
Deliver against multi-agency suicide prevention plans, working towards a national 10% reduction in suicide rate by 2020/21.
Deliver liaison and diversion services to 83% of the population.
Ensure all commissioned activity is recorded and reported through the Mental Health Services Dataset.

2. INFORMATION REGARDING PREVALENCE AND NEED

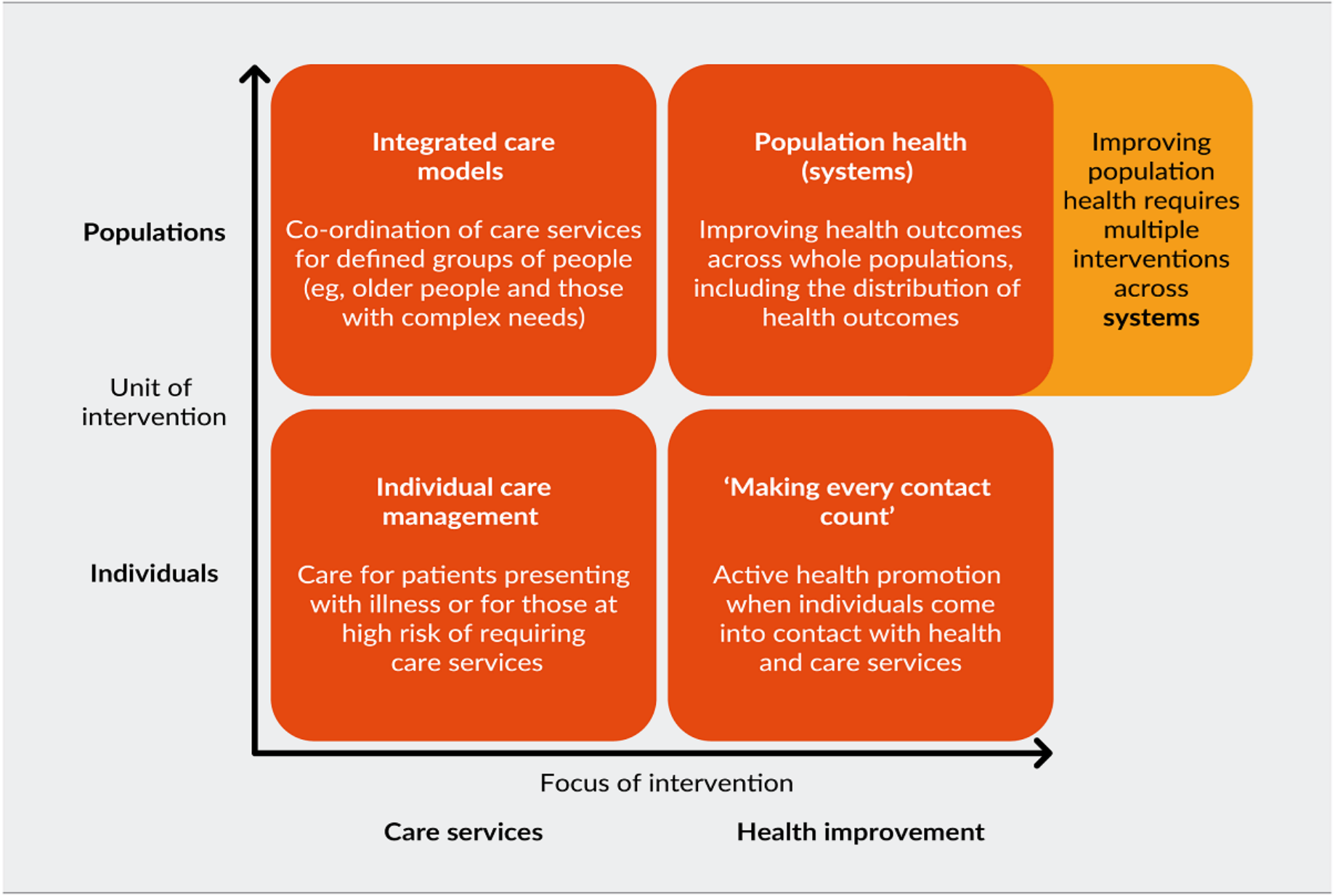
This section of our strategy outlines key information and associated priorities and deliverables in terms of our understanding of the local and national picture in terms of mental health need.

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

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

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

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


Integrated care models
Co-ordination of care services for defined groups of people (eg, older people and those with complex needs)
Population health (systems)
Improving health outcomes across whole populations, including the distribution of health outcomes
Improving population health requires multiple interventions across systems
Individual care management
Care for patients presenting with illness or for those at high risk of requiring care services
'Making every contact count'
Active health promotion when individuals come into contact with health and care services
Populations
Unit of intervention
Individuals
Focus of intervention
Care services
Health improvement

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

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

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

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

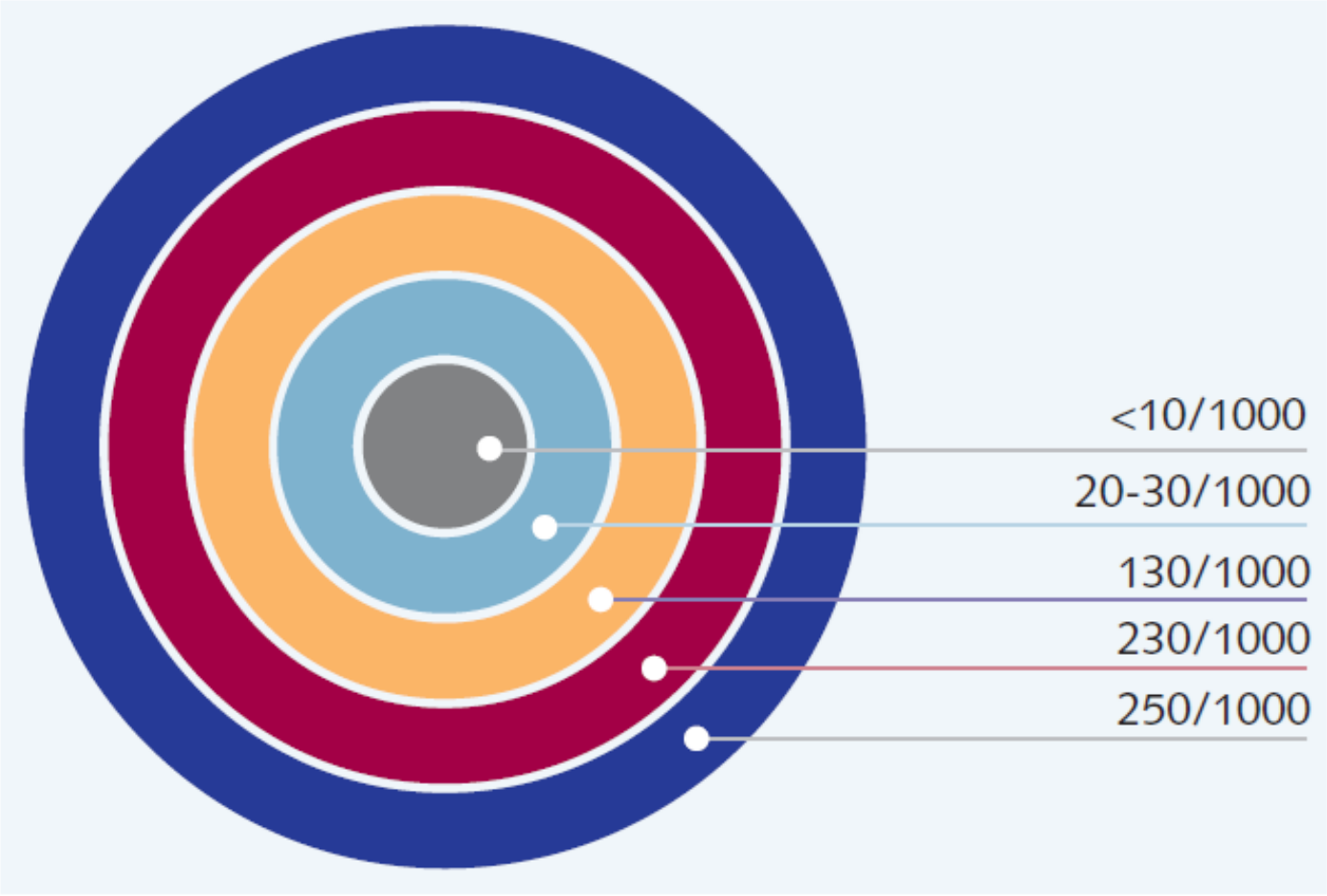
Our commissioning priorities outlined in this strategy re-fresh will respond to the critical issues and factors that exist in Wolverhampton in terms of levels of inequality in health and social outcomes and also address our knowledge and understanding of local levels and type of mental health need and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

A local assessment of need is attached as Appendix 1.

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

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

Numbers of people affected by mental health problems



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

Number of people affected by mental health problems

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

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

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

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

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

Mental Health Illness by ethnic group

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

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

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

Mental Health Illness by gender

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

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

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

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

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

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

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

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

Perinatal Mental Health

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

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

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

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

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

- Perinatal mental health difficulties

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

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

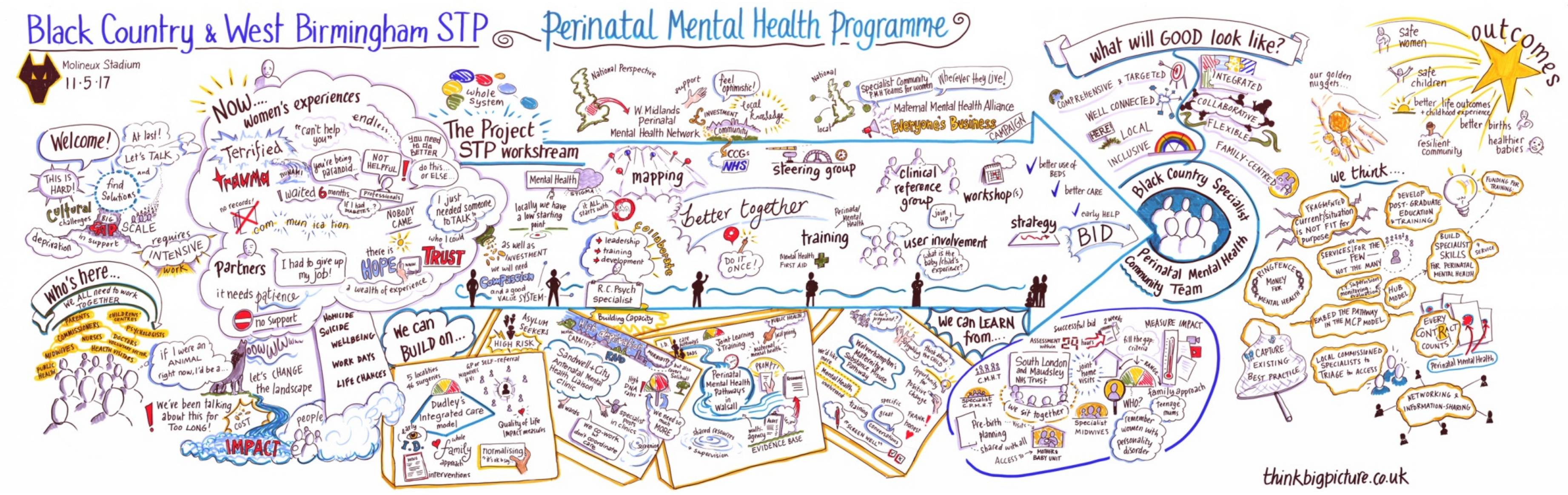
- promote the self-efficacy and resilience of the patient, child, family, friends and carers

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

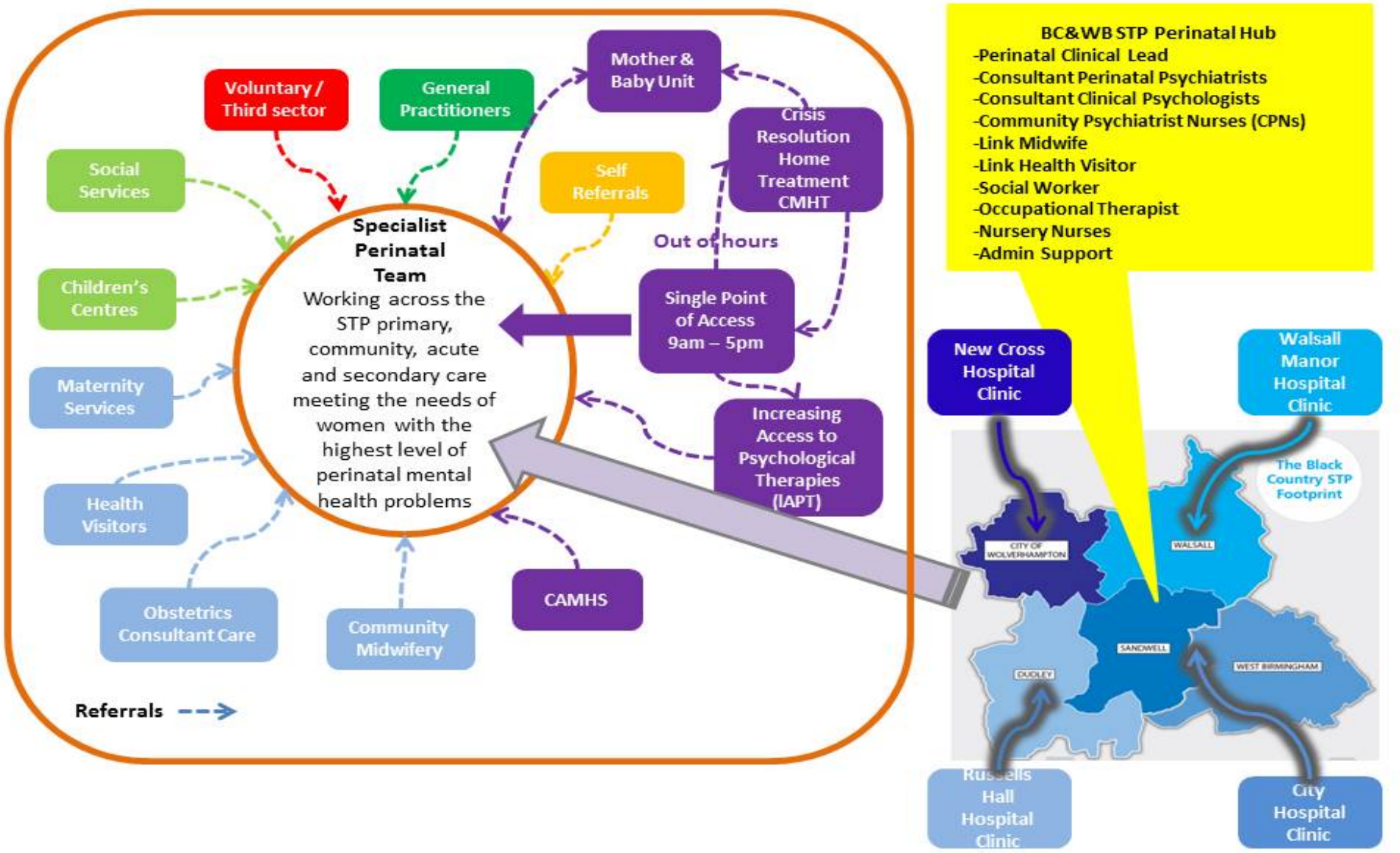
Our Black Country and West Birmingham Perinatal Mental Health Whole System is described in the diagram below:

Key outcome themes are:

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


Black Country & West Birmingham STP
Perinatal Mental Health Programme
Molineux Stadium
11·5·17
Welcome!
At last!
Let's TALK
and
find Solutions
THIS IS HARD!
Cultural challenges
BIG GAP in support
SCALE
deprivation
requires INTENSIVE work
who's here...
we ALL need to work TOGETHER
PARENTS
CHILDRENS' CENTRES
COMMISSIONERS
PSYCHOLOGISTS
NURSES
DOCTORS
VOLUNTARY SECTOR
MIDWIVES
HEALTH VISITORS
PUBLIC HEALTH
if I were an ANIMAL right now, I'd be a...
We've been talking about this for TOO LONG!
COST
IMPACT
people
let's CHANGE the landscape
NOW.... women's experiences
Terrified
Trauma
TSUNAMI
"can't help you"
endless....
you're being paranoid...
NOT HELPFUL
You need to do BETTER
do this... or ELSE...
I waited 6 months
Professionals
If I had DIABETES..?
no records!
com mun ica tion
NOBODY CAME
I just needed someone to TALK to
who I could TRUST
there is HOPE
Partners
I had to give up my job!
a wealth of experience
it needs patience
no support
HOMICIDE
SUICIDE
WELLBEING
WORK DAYS
LIFE CHANCES
whole system
The Project STP workstream
Mental Health
STIGMA
locally we have a low starting point
it ALL starts with
as well as INVESTMENT we will need COMPASSION and a good VALUE SYSTEM
leadership
training
development
collaborate
R.C. Psych specialist
National Perspective
W. Midlands Perinatal Mental Health Network
support
feel optimistic!
INVESTMENT
local knowledge
community
CCGs
NHS
mapping
better together
DO IT ONCE!
steering group
training
Perinatal Mental Health
Mental Health FIRST AID
National
local
Specialist Community P.M.H Teams for women
Wherever they live!
Maternal Mental Health Alliance
Everyone's Business
CAMPAIGN
clinical reference group
Join up!
workshop(s)
user involvement
what is the baby/child's experience?
strategy
better use of BEDS
better CARE
early HELP
BID
We can BUILD on...
ASYLUM SEEKERS
HIGH RISK
5 localities
46 surgeries
GP or SELF-referral
Dudley's Integrated Care model
early I.D.
whole family approach
interventions
Quality of Life IMPACT measures
normalising
Sandwell+City Antenatal Mental Health Liaison Clinic
High deprivation
CAPACITY?
RAID
MORBIDITY
but also covers Solihull
High DNA rates
Specialist posts in clinics
We need so much MORE
we co-work but don't coordinate care
Building Capacity
PUBLIC HEALTH
Joint Learning & Training
care pathways
DADS
maternal mental health
PROMPT
Perinatal Mental Health Pathways in Walsall
shared resources + supervision
multi-agency
AUDIT
EVIDENCE BASE
Wolverhampton's Maternity + Substance Misuse Pathway
who's pregnant?
think about the CHILD
Opportunity for Positive change
we'd like more Mental Health involvement
training
specific
great conversations
"SCREEN WELL"
FRANK! honest
We can LEARN from...
Successful bid
2 weeks
ASSESSMENT within 24 hours
C.M.H.T
South London and Maudsley NHS Trust
joint home visits
fill the gap: criteria
RANGE
MEASURE IMPACT
family approach
Specialist C.P.M.H.T
we sit together
Pre-birth planning
visits
shared with all
ACCESS to MOTHER & BABY UNIT
Specialist MIDWIVES
WHO?
teenage mums
remember women with personality disorder
what will GOOD look like?
COMPREHENSIVE & TARGETED
WELL CONNECTED
HERE!
LOCAL
INCLUSIVE
INTEGRATED
COLLABORATIVE
FLEXIBLE
FAMILY-CENTRED
Black Country Specialist Perinatal Mental Health Community Team
our golden nuggets...
outcomes
safe women
safe children
better life outcomes + childhood experience
better births
resilient community
healthier babies
we think....
FRAGMENTED current situation is NOT FIT for purpose
DEVELOP POST-GRADUATE EDUCATION & TRAINING
FUNDING FOR TRAINING
SERVICES FOR THE FEW NOT THE MANY
BUILD SPECIALIST SKILLS FOR PERINATAL MENTAL HEALTH
RINGFENCE MONEY FOR MENTAL HEALTH
HUB MODEL
EMBED THE PATHWAY IN THE MCP MODEL
CAPTURE EXISTING BEST PRACTICE
LOCAL COMMISSIONED SPECIALISTS to TRIAGE to ACCESS
EVERY CONTRACT COUNTS!
Perinatal Mental Health
NETWORKING & INFORMATION-SHARING
thinkbigpicture.co.uk

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



Black and Minority Ethnic Groups

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

Dual Diagnosis

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

The term Dual Diagnosis can apply to people who:

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

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

Substance Use and Psychiatric Syndromes (Rassool 2009):

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

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

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

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

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

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

(NICE Clinical Guideline, 2011)

Rassool (2009) – Problems associated with Dual Diagnosis

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

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

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

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

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

Alcohol and Mental Health (Rassool 2009)

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

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

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

Autism and Suicide

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

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

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

1. Understanding local needs by collecting accurate data about autism

2. Providing access to high quality information, advice and support

3. Developing a clear and consistent diagnostic pathway, including post-diagnostic support

4. Increasing awareness and understanding of autism

5. Supporting children and young people with autism in preparing for adulthood

6. Enabling access to lifelong learning, increasing skills and inclusive employment

7. To help people with autism to keep healthy

8. Living well and increasing independence for people with autism

9. Access to support for families, parents and carers of people with autism

Adult Attention Deficit Hyperactivity Disorder symptoms may include:

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

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

ADHD has been linked to:

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

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

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

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

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

SF DON'T FORGET REFERENCE

Sexual Abuse

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

Personality Disorder

Personality Disorder

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

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

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

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

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

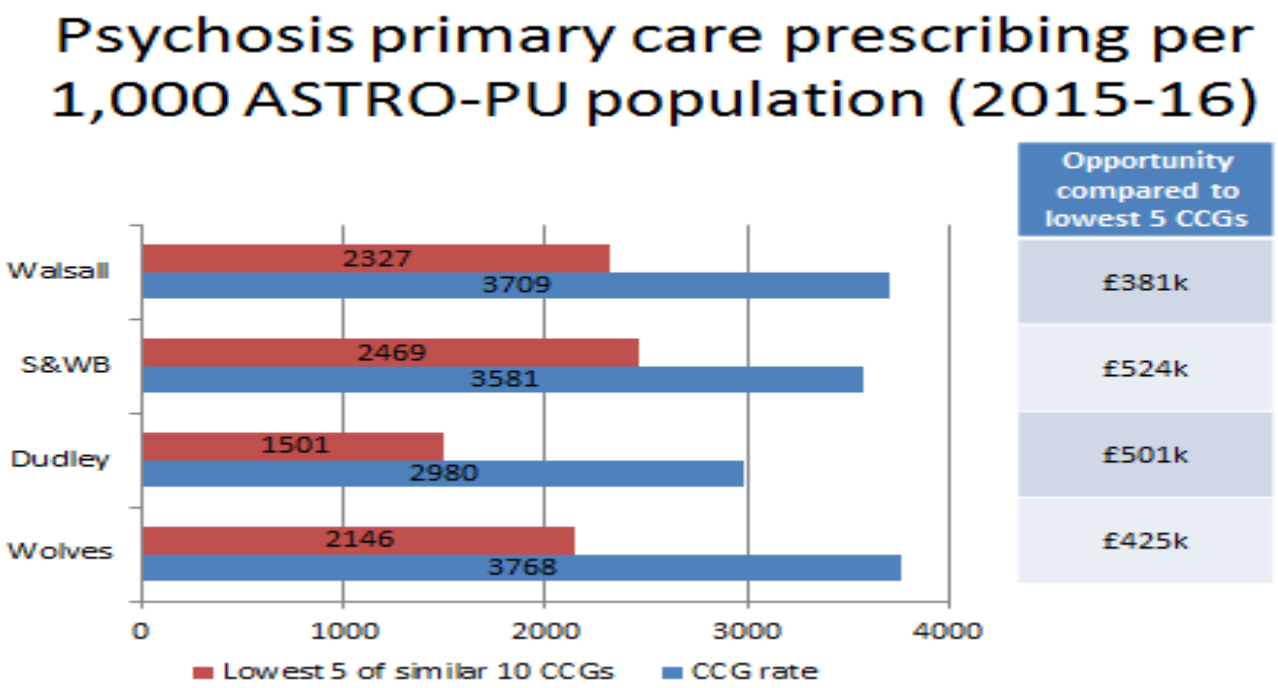
The Right Care Data identifies the following key issues / areas for improvement for WOLVERHAMPTON

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

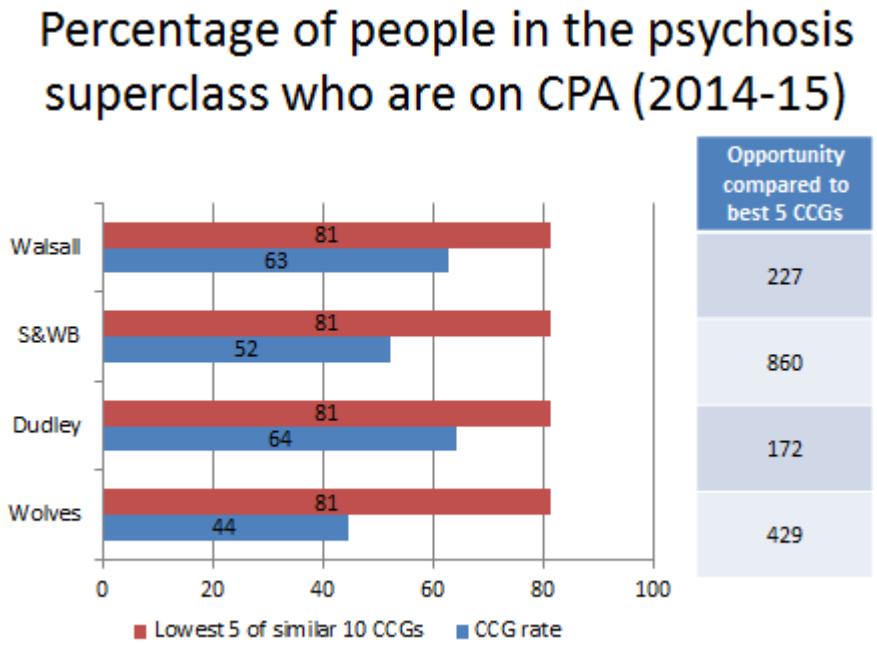
Severe mental illness pathway

NHS RightCare

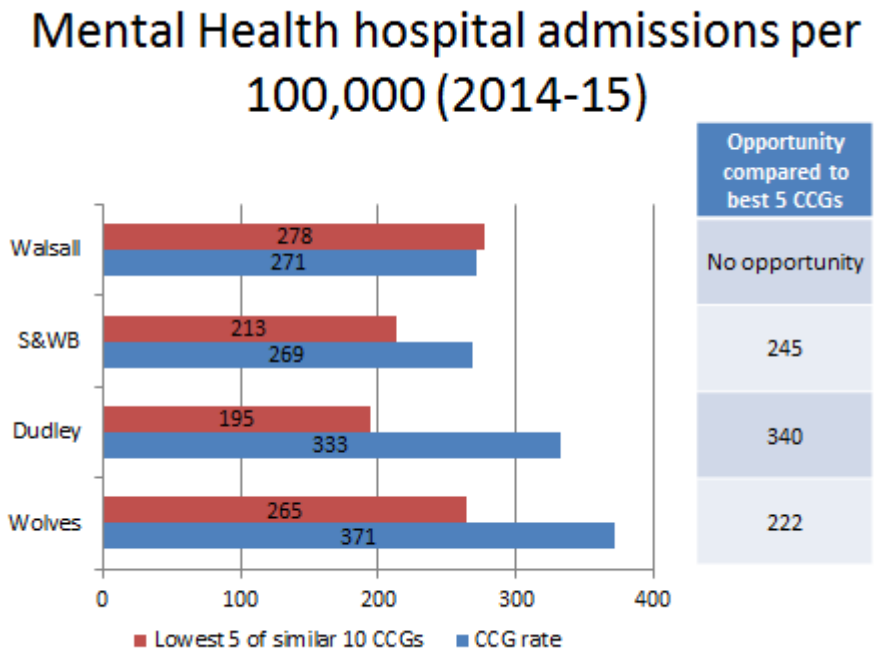
	2015	2012	2015/16	2015/16	2014/15	April 2016-August 2016	April 2016-August 2016	2015/16 Q4 (Year End)	2015/16 Q2	2015/16 Q4	2015/16 Q4	2014/15	2015/16 Q2	2015/16 Q2	2015/16 Q2
	Deprivation	Estimate of people with a psychotic disorder	People with SMI known to GPs: % on register	Primary care prescribing spend	Physical health checks	% of EIP referrals waiting <2 wks to start treatment (Complete)	% of EIP referrals waiting >2 wks to start treatment (Incomplete)	New cases of psychosis served by Early Intervention teams	People treated by Early Intervention Teams	People on Care Programme Approach	% Service users on CPA	Mental health hospital admissions	People subject to mental health act	People on CPA in employment	% adults on CPA in settled accommodation
STP opportunity (to Best 6)					**640 Pats.**	**17 Pats.**	**12 Pats.**				**1,216 Pats.**	**807 Adm.**	**112 Ppl.**	**102 Ppl.**	**80 Ppl.**
Wolverhampton	▲	△	▲	▲			▽	▽	▽	▽	▽			▽	
Walsall	▲	▽	▽	▲	△	△	△	▽	▽	▽	▲			▽	
Dudley	▲	▲	▲	▲	▽	△	▽	△	▲	▽	▲				
Sandwell and West Birmingham	▲	▲	▲	▲			△	▽	▲	▽	▽		△	▽	△



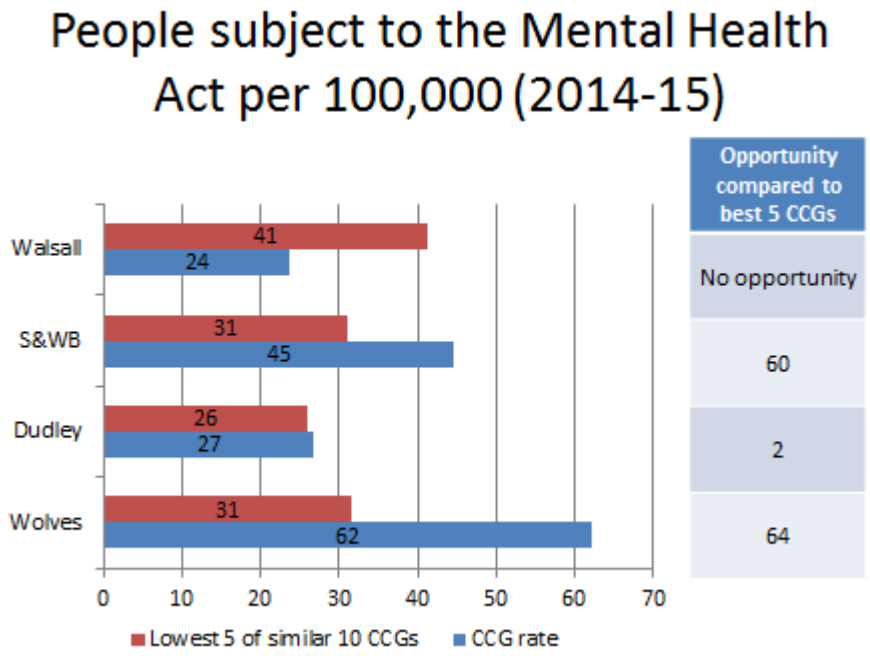
Opportunity compared to lowest 5 CCGs
£381k
£524k
£501k
£425k



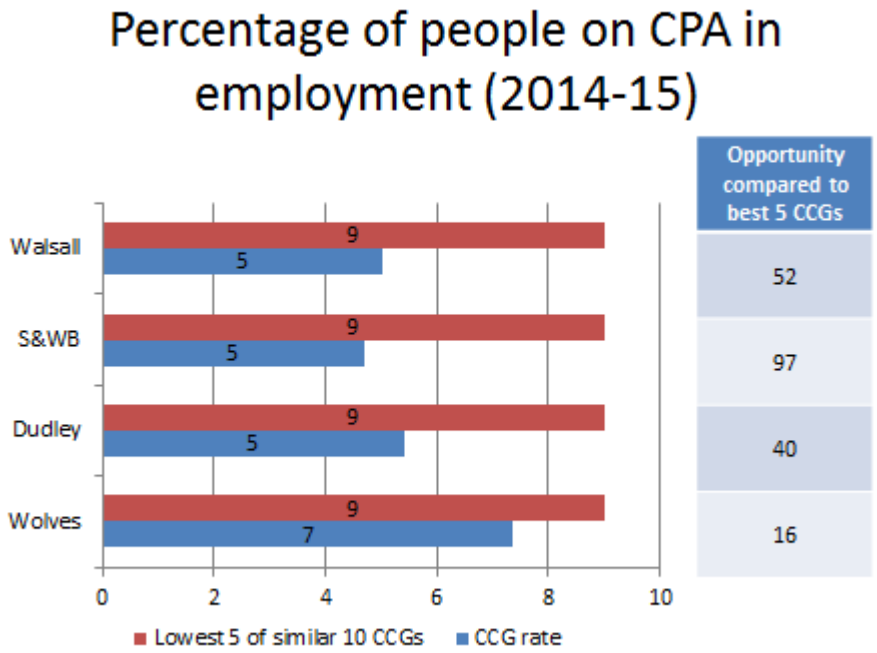
Opportunity compared to best 5 CCGs
227
860
172
429



Opportunity compared to best 5 CCGs
No opportunity
245
340
222

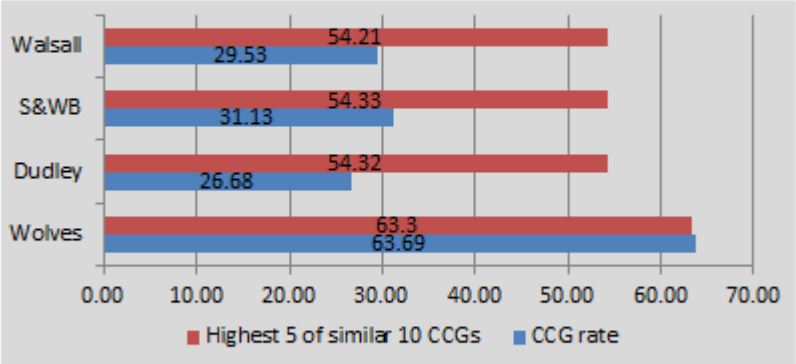


Opportunity compared to best 5 CCGs
No opportunity
60
2
64



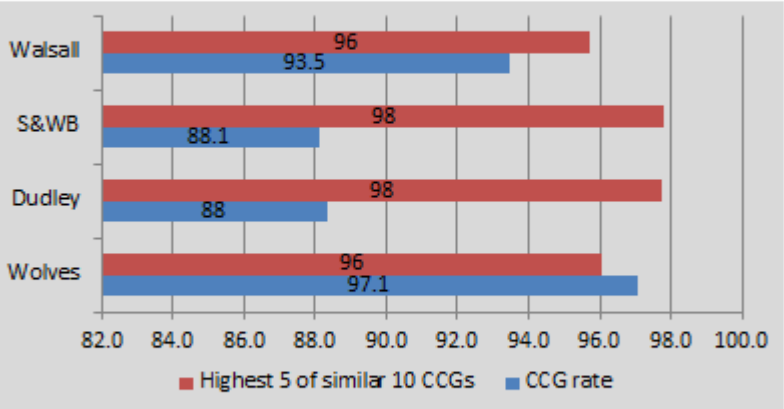
Opportunity compared to best 5 CCGs
52
97
40
16

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

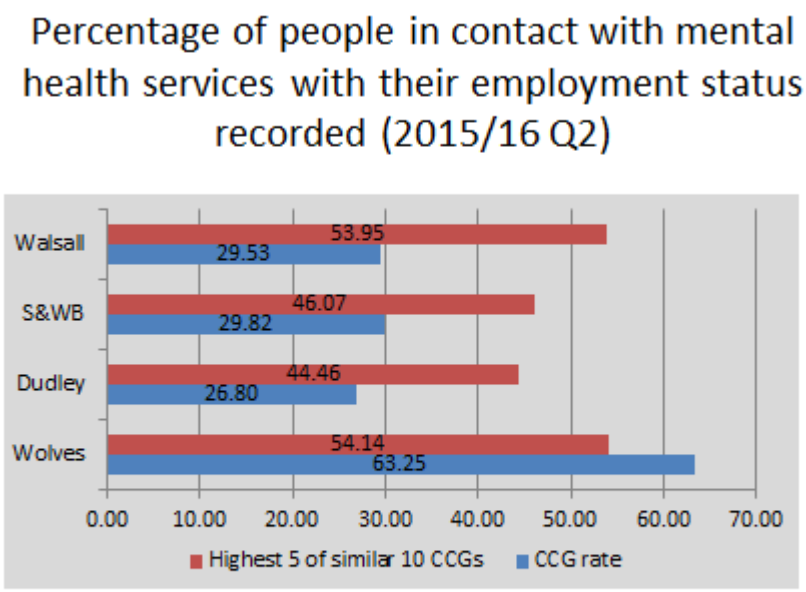


Opportunity – 4824 more people with accommodation status recorded. NB. Wovlerhampton higher than average of highest 5 and therefore not included.

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



Opportunity – 2705 more cases with ethnicity recorded.



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

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

The above information identifies key priorities however which are to:

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

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

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

Young People

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

Mothers

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

Physical Health

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

Stable employment and housing

'Stable employment and housing are both factors contributing to someone being able to maintain good mental health and are important outcomes for their recovery if they have developed a mental health problem. Between 60–70 per cent of people with common mental health problems are in work, yet few employees have access to specialist occupational health services. For people being supported by secondary mental health services, there is a 65 per cent employment gap compared with the general population. People with mental health problems are also often overrepresented in high-turnover, low-pay and often part-time or temporary work. Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high. Children living in poor housing have increased chances of experiencing stress, anxiety and depression.'

Veterans

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

Older People

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

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

Marginalised Groups

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

Suicide

'Suicide is rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4,882 deaths in 2014. The rise is most marked amongst middle aged men. Suicide is now the leading cause of death for men aged 15–49. Men are three times more likely than women to take their own lives - they accounted for four out of five suicides in 2013. A quarter of people who took their own life had been in contact with a health professional, usually their GP, in the last week before they died. Most were in contact within a month before their death. More than a quarter (28 per cent) of suicides were amongst people who had been in contact with mental health services within 12 months before their death, amounting to almost 14,000 people in the ten years from 2003-2013.'

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

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

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

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

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

3. VISION AND VALUES

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

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

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

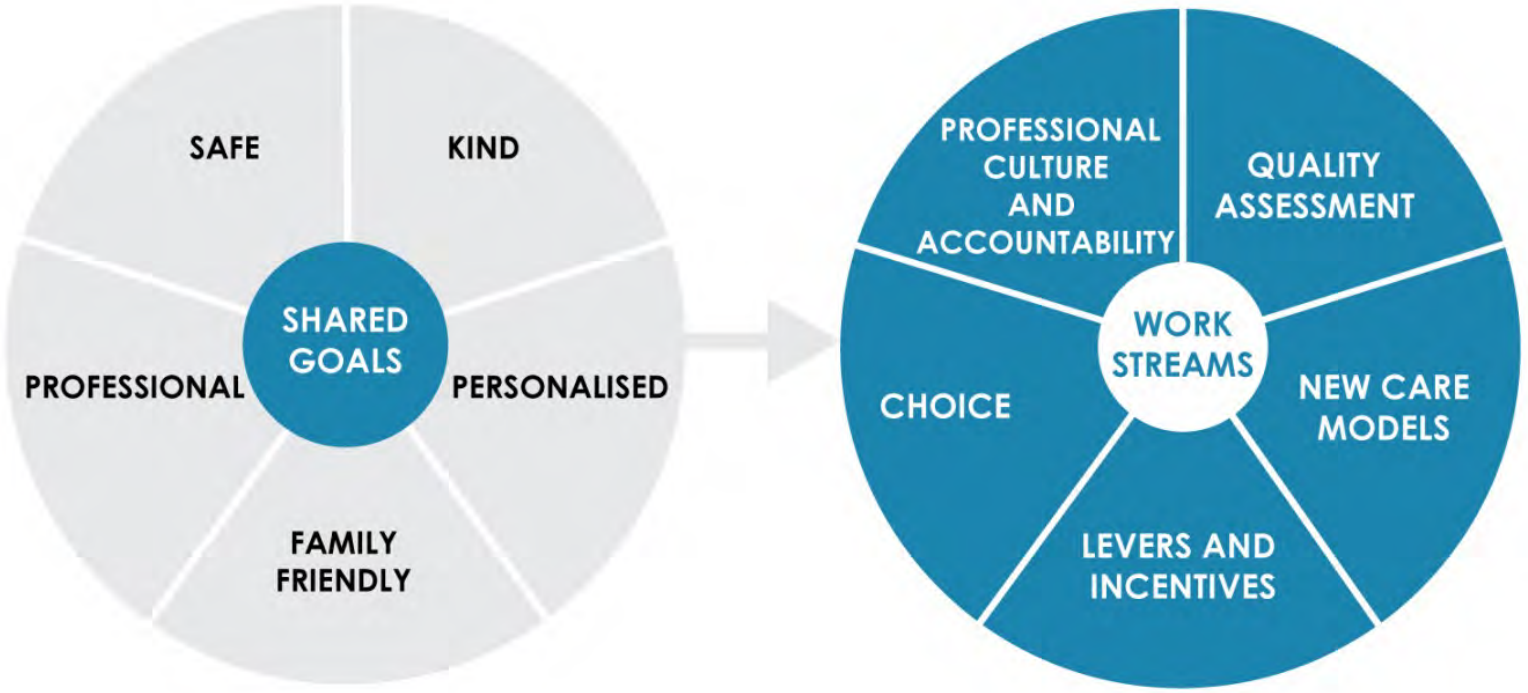
Coproduction with all service users and carers and staff across our Mental Health Integrated Care System is a key and important focus of our vision and values. We will all work together to establish the self-efficacy and recovery of our system, remove the stigma associated with mental health and support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

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

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

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

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



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

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


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

Key aspirations of our vision

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

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

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

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

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

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

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

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

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

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

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

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

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

4. OUR MODEL OF CARE

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

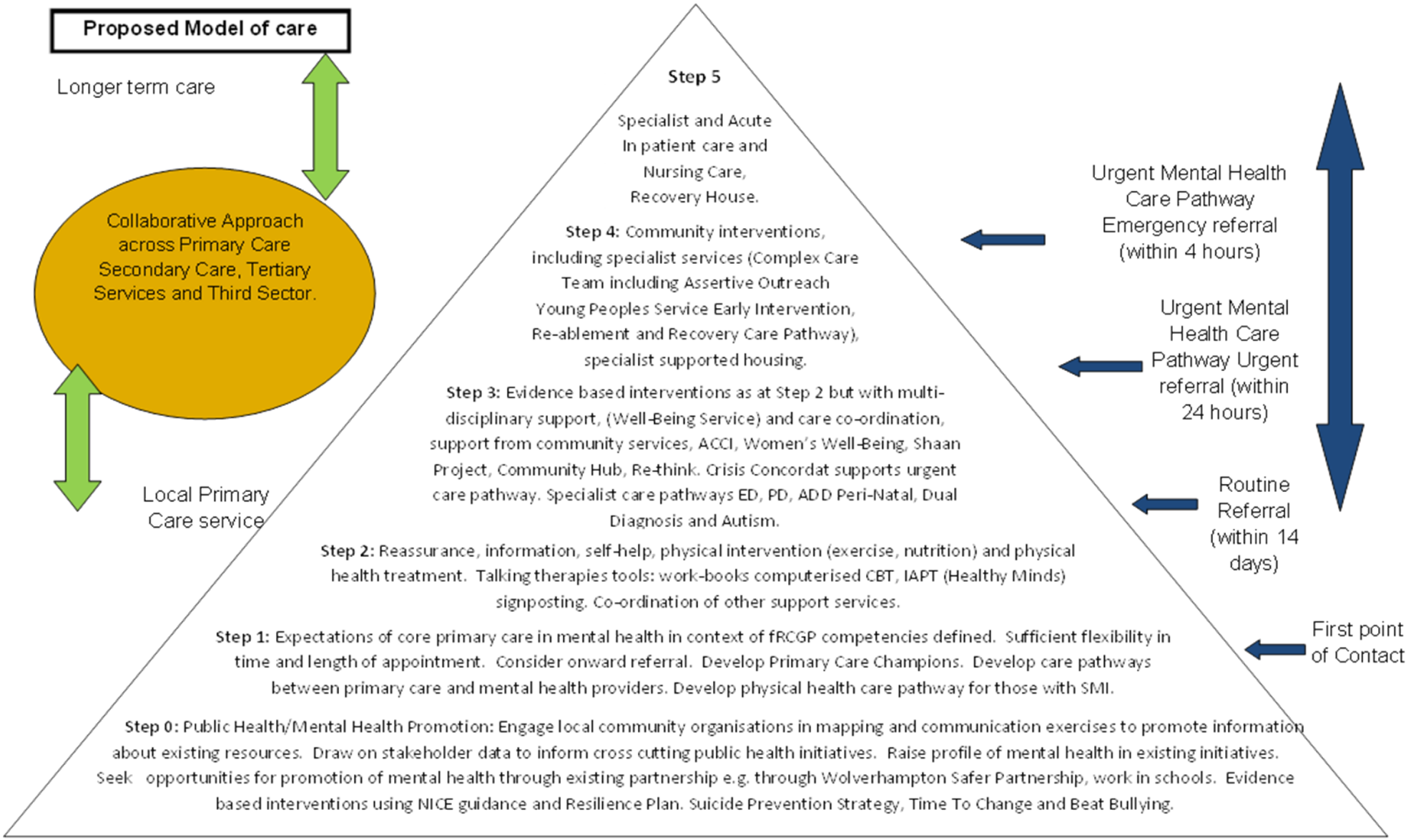
- A mental health 'whole system' of care pathways and services delivering recovery orientated interventions and support.
- The Mental Health Better Care Fund Urgent and Planned Mental Health and Dementia Care Pathways delivering integrated health and social care
- Improved connectivity and joined up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

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

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

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

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


Proposed Model of care
Longer term care
Collaborative Approach across Primary Care Secondary Care, Tertiary Services and Third Sector.
Local Primary Care service
Step 5
Specialist and Acute In patient care and Nursing Care, Recovery House.
Step 4: Community interventions, including specialist services (Complex Care Team including Assertive Outreach Young Peoples Service Early Intervention, Re-ablement and Recovery Care Pathway), specialist supported housing.
Step 3: Evidence based interventions as at Step 2 but with multi-disciplinary support, (Well-Being Service) and care co-ordination, support from community services, ACCI, Women's Well-Being, Shaan Project, Community Hub, Re-think. Crisis Concordat supports urgent care pathway. Specialist care pathways ED, PD, ADD Peri-Natal, Dual Diagnosis and Autism.
Step 2: Reassurance, information, self-help, physical intervention (exercise, nutrition) and physical health treatment. Talking therapies tools: work-books computerised CBT, IAPT (Healthy Minds) signposting. Co-ordination of other support services.
Step 1: Expectations of core primary care in mental health in context of fRCGP competencies defined. Sufficient flexibility in time and length of appointment. Consider onward referral. Develop Primary Care Champions. Develop care pathways between primary care and mental health providers. Develop physical health care pathway for those with SMI.
Step 0: Public Health/Mental Health Promotion: Engage local community organisations in mapping and communication exercises to promote information about existing resources. Draw on stakeholder data to inform cross cutting public health initiatives. Raise profile of mental health in existing initiatives. Seek opportunities for promotion of mental health through existing partnership e.g. through Wolverhampton Safer Partnership, work in schools. Evidence based interventions using NICE guidance and Resilience Plan. Suicide Prevention Strategy, Time To Change and Beat Bullying.
Urgent Mental Health Care Pathway Emergency referral (within 4 hours)
Urgent Mental Health Care Pathway Urgent referral (within 24 hours)
Routine Referral (within 14 days)
First point of Contact

Universal Services

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

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

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

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

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

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

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

V12 November 2017

New Models of Care (Wolverhampton)

NHS
Wolverhampton
Clinical Commissioning Group

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

Primary & Acute Care Systems (PACs/VI)
This model is based on:-

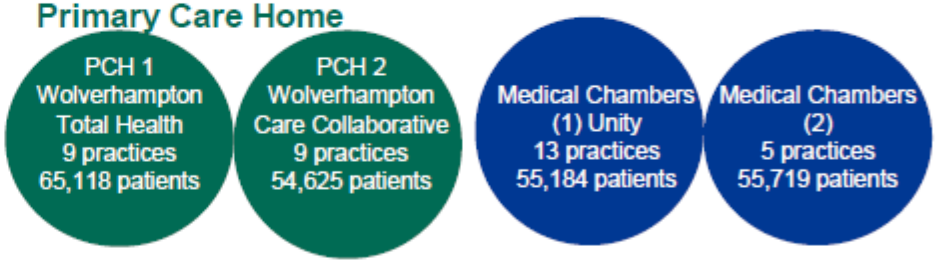
- Collaboration between NHS Trusts and GP Practices
- Practices have entered into a sub-contract agreement with the trust (GMS/PMS)
- Meet the needs of registered list(s) of patients
- Opportunity for trust's to kick-start primary care expansion but reinforce out of hospital care
- Potential to take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

Primary Care Home is a joint NAPC and NHS confederation programme.
The model is based on:-

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

Vertical Integration (VI)

Primary Care Home



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

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

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

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

Key services include:

- Primary Care Counselling Service (Relate and partners)

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

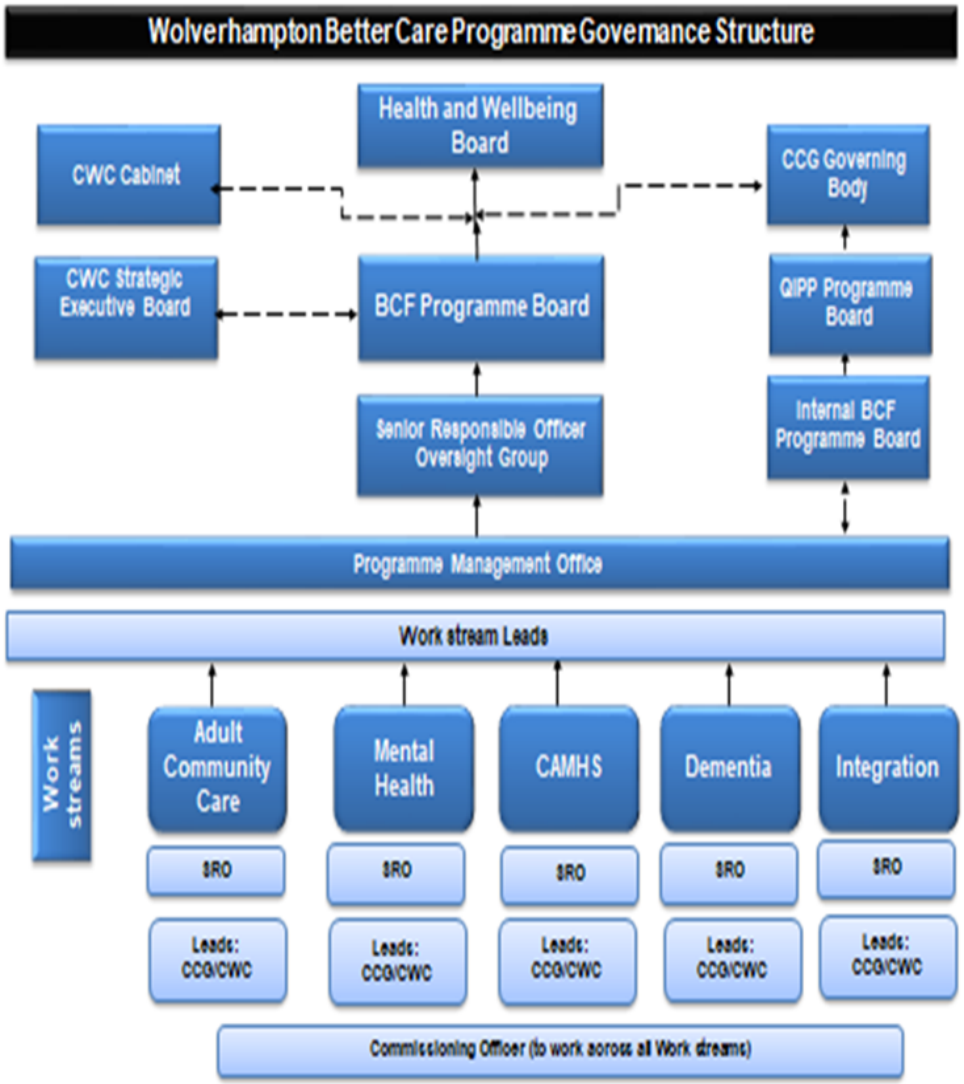
The Better Care Fund

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

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

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

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


Wolverhampton Better Care Programme Governance Structure
Health and Wellbeing Board
CWC Cabinet
CCG Governing Body
CWC Strategic Executive Board
BCF Programme Board
QIPP Programme Board
Senior Responsible Officer Oversight Group
Internal BCF Programme Board
Programme Management Office
Work stream Leads
Work streams
Adult Community Care
Mental Health
CAMHS
Dementia
Integration
SRO
Leads: CCG/CWC
Commissioning Officer (to work across all Work streams)


Mental Health Workstream
CWC Mental Health Adult Social Care
Wolverhampton Homes
CWC Commissioning
CWC Public Health
BCPFT – Mental Health Provider
West Midlands Police (Street Triage)
CCG Commissioning

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

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

Key services include:

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

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

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

Key services include:

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

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

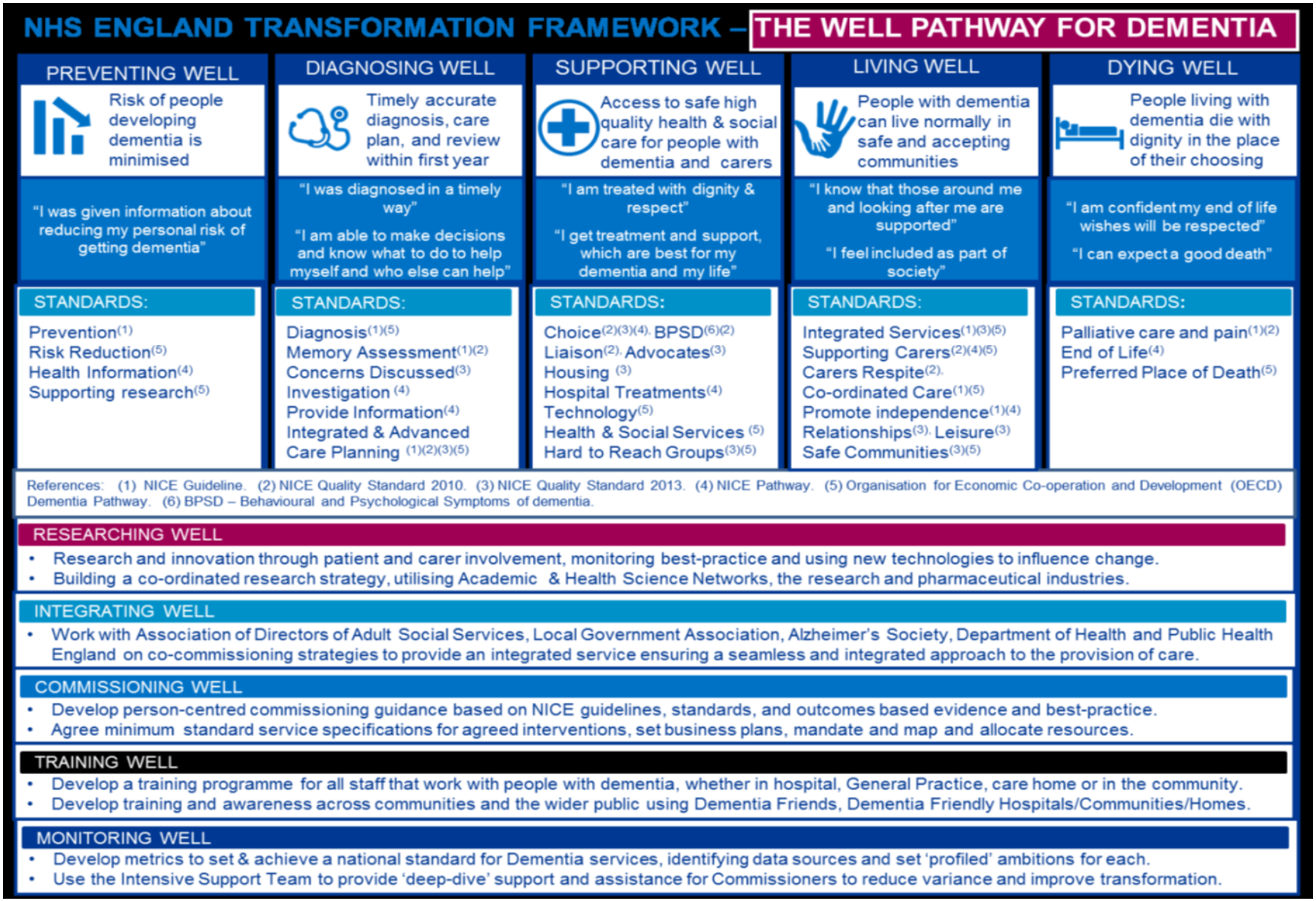
Better Care Fund Key Activity for 2018 -2019 and beyond Urgent and Planned Mental Health

Completed 2017/18 programme	Community Prevention Support	Integrated Discharge Planning
Activity: • On-going implementation of Mental Health Liaison & Crisis Resolution Home Treatment moving toward fidelity with CORE Model/s (as per FVYRFWMH) with focus on high volume service users as per national CQUIN. • Designated SW role in Mental Health Urgent Care Pathway (A&E Delivery Board funded) focusing on improved patient flow. • Service mapping and gap analysis –focus on prevention of crisis.	**Activity:** • Using mapping and scoping to improve information and guidance and pathway support for people with mental health difficulties to better prevent crisis and relapse and optimise early intervention support • Develop a shared vision for urgent and planned mental health which can be really joined up with primary care voluntary and community sector and tertiary care • Ensure a focus upon dual diagnosis care urgent and planned care which ensures that people do not 'fall through gaps'	**Activity:** • Develop shared vision regarding multi- agency discharge and care planning that is compliant with the Care Programme Approach (CPA) • Agree Section 117 Protocols and Processes as enablers to delivering improved patient flow and recovery focussed services • Consider dedicated resource to aid patient flow in the planned care process (replicating urgent care dedicated resource and further embedding joint / integrated practice)

The Dementia Care Pathway

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

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


NHS ENGLAND TRANSFORMATION FRAMEWORK – THE WELL PATHWAY FOR DEMENTIA
PREVENTING WELL
Risk of people developing dementia is minimised
"I was given information about reducing my personal risk of getting dementia"
STANDARDS:
Prevention(1)
Risk Reduction(5)
Health Information(4)
Supporting research(5)
DIAGNOSING WELL
Timely accurate diagnosis, care plan, and review within first year
"I was diagnosed in a timely way"
"I am able to make decisions and know what to do to help myself and who else can help"
STANDARDS:
Diagnosis(1)(5)
Memory Assessment(1)(2)
Concerns Discussed(3)
Investigation (4)
Provide Information(4)
Integrated & Advanced Care Planning (1)(2)(3)(5)
SUPPORTING WELL
Access to safe high quality health & social care for people with dementia and carers
"I am treated with dignity & respect"
"I get treatment and support, which are best for my dementia and my life"
STANDARDS:
Choice(2)(3)(4). BPSD(6)(2)
Liaison(2). Advocates(3)
Housing (3)
Hospital Treatments(4)
Technology(5)
Health & Social Services (5)
Hard to Reach Groups(3)(5)
LIVING WELL
People with dementia can live normally in safe and accepting communities
"I know that those around me and looking after me are supported"
"I feel included as part of society"
STANDARDS:
Integrated Services(1)(3)(5)
Supporting Carers(2)(4)(5)
Carers Respite(2).
Co-ordinated Care(1)(5)
Promote independence(1)(4)
Relationships(3). Leisure(3)
Safe Communities(3)(5)
DYING WELL
People living with dementia die with dignity in the place of their choosing
"I am confident my end of life wishes will be respected"
"I can expect a good death"
STANDARDS:
Palliative care and pain(1)(2)
End of Life(4)
Preferred Place of Death(5)
References: (1) NICE Guideline. (2) NICE Quality Standard 2010. (3) NICE Quality Standard 2013. (4) NICE Pathway. (5) Organisation for Economic Co-operation and Development (OECD) Dementia Pathway. (6) BPSD – Behavioural and Psychological Symptoms of dementia.
RESEARCHING WELL
• Research and innovation through patient and carer involvement, monitoring best-practice and using new technologies to influence change.
• Building a co-ordinated research strategy, utilising Academic & Health Science Networks, the research and pharmaceutical industries.
INTEGRATING WELL
• Work with Association of Directors of Adult Social Services, Local Government Association, Alzheimer's Society, Department of Health and Public Health England on co-commissioning strategies to provide an integrated service ensuring a seamless and integrated approach to the provision of care.
COMMISSIONING WELL
• Develop person-centred commissioning guidance based on NICE guidelines, standards, and outcomes based evidence and best-practice.
• Agree minimum standard service specifications for agreed interventions, set business plans, mandate and map and allocate resources.
TRAINING WELL
• Develop a training programme for all staff that work with people with dementia, whether in hospital, General Practice, care home or in the community.
• Develop training and awareness across communities and the wider public using Dementia Friends, Dementia Friendly Hospitals/Communities/Homes.
MONITORING WELL
• Develop metrics to set & achieve a national standard for Dementia services, identifying data sources and set 'profiled' ambitions for each.
• Use the Intensive Support Team to provide 'deep-dive' support and assistance for Commissioners to reduce variance and improve transformation.

Key aspirations / goals are as follows:

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

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

Post diagnostic care and support. This includes:

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

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

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

Key Deliverables are as follows:

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

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

Key services include:

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

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

Completed 2017/18 programme	Community Prevention Support	Integrated Discharge Planning

Activity: • On-going implementation of Mental Health Liaison & Crisis Resolution Home Treatment moving toward fidelity with CORE Model/s (as per FVYRFWMH) with focus on high volume service users as per national CQUIN. • Designated SW role in Mental Health Urgent Care Pathway (A&E Delivery Board funded) focusing on improved patient flow. • Service mapping and gap analysis –focus on prevention of crisis.	**Activity:** • Using mapping and scoping to improve information and guidance and pathway support for people with mental health difficulties to better prevent crisis and relapse and optimise early intervention support • Develop a shared vision for urgent and planned mental health which can be really joined up with primary care voluntary and community sector and tertiary care • Ensure a focus upon dual diagnosis care urgent and planned care which ensures that people do not 'fall through gaps'	**Activity:** • Develop shared vision regarding multi- agency discharge and care planning that is compliant with the Care Programme Approach (CPA) • Agree Section 117 Protocols and Processes as enablers to delivering improved patient flow and recovery focussed services • Consider dedicated resource to aid patient flow in the planned care process (replicating urgent care dedicated resource and further embedding joint / integrated practice)

Services that will be delivered locally but commissioned on a BC&WB STP foot print

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

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

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

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

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

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

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

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

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

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

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

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

Mental Health Integrated Care System to improve mental health and wellbeing and prevent mental health difficulties and reduce and eliminate the stigma attached to mental ill health. We will align this with our public health interventions regarding obesity, smoking, and alcohol and substance misuse are all strongly associated with poor mental health (Kings Fund, Getting Serious about Public Mental Health, 2017).		
Primary Care Mental Health Services Refreshing evidence based care pathways to deliver early intervention and prevention and the GP Five Year Forward View and the Five Year Forward View for Mental Health deliverables including IAPT PERINATAL IAPT and LTC IAPT IPS & SMI Physical Health Checks in Primary Care and also delivering Primary and Secondary Care MDT meetings in each Primary Care Group including the Vertical Integration. There will be a focus upon improving BAME and Older People IAPT access and outcomes **Services in Scope** • Primary Care Counselling Service (Relate and partners) • IAPT, PERINATAL IAPT and IAPT LTC Wolverhampton Healthy Minds (BCPFT) IAPT for BAME Groups Older People and Carers • Base 25 Counselling and Drop In Services	**2018/19**	**2019/20**

• Secondary IPS (DWMHPT) • Primary IPS RCT (with WMCA) (Remploy) • Social Prescribing Pilot (WOLVERHAMPTON VSC) • Depression Care Pathway (BCPFT) • Physical Health Checks and Care Pathway in keeping with the Lester Guidance for example and NICE Clinical Guidance and Quality Standards (Shared Care BCPFT and Primary Care)		
Better Care Fund Mental Health Urgent and Planned Care Pathways Refreshing evidence based care pathways which integrate health, social care and to improve acute and crisis based support and on-going planned person centred care to achieve the Five Year Forward View for Mental Health deliverables and compliance with NICE GUIDANCE and the CPA. **Services in scope** • **SINGLE POINT OF ACCESS (SPA) (BCPFT)**	**2018/19**	**2020/21**

• **STREET TRIAGE (commissioned on STP footprint across BC&WB)** • **MENTAL HEALTH LIAISON SERVICE (MHLS) ENHANCED / CORE 24 (24/7 365) (including Older Adult MHLS) (BCPFT)** • **SECTION 136 MHA SUITE (BCPFT)** • **CRISIS RESOLUTION HOME TREATMENT (CRHT) CORE (24/7 365) (including Older Adult CRHT which also forms part of the Better Care Fund Dementia Care Pathway) (BCPFT)** • **MENTAL HEALTH IN-PATIENT CARE (including Penn In-patient Wards including Older Adult Services, Acute Overspill Out of Area Treatments – OATs) (BCPFT, Cygnet Healthcare and NCA)** • **PSYCHIATRIC INTENSIVE CARE (PIC) (BCPFT and NCA)** • **DUAL DIAGNOSIS CARE PATHWAY (Mental Health and Alcohol and Substance Misuse) (BSMHFT and BCPFT)** • **COMMUNITY RECOVERY SERVICE and PERSONALITY DISORDER HUB (including ASSERTIVE OUTREACH TEAM, encompassing services currently known as the WELL-BEING SERVICE and COMPLEX**		

CARE) • **SECTION 117 MENTAL HEALTH ACT 1983 COMMUNITY CARE PACKAGES** • **SPECIALIST MENTAL HEALTH SUPPORTED ACCOMMODATION and STEP DOWN (including ACCI and VICTORIA COURT)** • **SPECIALIST NURSING and RESIDENTIAL and DOMICILIARY CARE (including ACCI and VICTORIA COURT)** • **MENTAL HEALTH IN-PATIENT CARE (including more specialist hospital placements for people stepping down from NHS England funded Secure Care and / or people requiring specialist In-patient support and treatment including Rehabilitation and / or Personality Disorder In-patient Care, such as Cygnet Healthcare)** • **DUAL DIAGNOSIS CARE PATHWAY (Mental Health and Alcohol and Substance Misuse) (BSMHFT and BCPFT)** • **Approved Mental Health Practitioners (AMHPs) including those from the Council who undertake assessments under the Mental Health Act**		

1983, the Mental Capacity Act 2005 and the Care Act 2014 (CWC.) • **Other Council contributions such as the deployment of council care services across a range of community hubs, housing support and public health initiative (CWC.)** **<u>Better Care Fund Dementia Care Pathway</u>** Refreshing evidence based care pathways which integrate health, social care and to improve diagnosis and post diagnosis intervention and support to deliver the NHS England Well Pathway for Dementia and the NHS I Dementia Standards ensuring a focus upon personalisation, living well and ensuring pro-active and responsive support for people with high levels of need and their carers to achieve the Five Year Forward View for Mental Health deliverables and compliance with NICE GUIDANCE and the CPA. **<u>Services in scope</u>** • **OLDER ADULTS COMMUNITY MENTAL HEALTH TEAM (BCPFT)** • **DAY SERVICES – BLAKENHALL DAY SERVICES and THE GROVES DAY HOSPITAL (BCPFT)** • **The MEMORY CLINIC (BCPFT)**		

• **EARLY ONSET DEMENTIA SERVICES (BCPFT)** • **MENTAL HEALTH LIAISON SERVICE (MHLS) ENHANCED / CORE 24 (24/7 365) (including Older Adult MHLS) (BCPFT)** • **The DEMENTIA OUTREACH TEAM (RWT)** • **CRISIS RESOLUTION HOME TREATMENT (CRHT) CORE (24/7 365) (including Older Adult CRHT which also forms part of the Better Care Fund URGENT MENTAL HEALTH Care Pathway) (BCPFT)** • **OLDER ADULT MENTAL HEALTH IN-PATIENT CARE (including Penn In-patient Wards including Older Adult Services, WARD C22 at RWT and Acute Overspill Out of Area Treatments – OATs) (BCPFT, RWT and others)** • **Community care packages including Nursing Residential and Domiciliary Care including Continuing Healthcare (CHC) (various)**		
BC &WB STP Commissioned Services **Refreshing evidence based care pathways to achieve the Five Year Forward View for Mental Health deliverables on an STP footprint to pool expertise and**	**2018/19**	**2020/21**

resources and improve the capacity and capability of the system. **<u>Services in scope</u>** • **Early Intervention in Psychosis - 14-65 years (BCPFT & DWMHPT)** • **Eating Disorders – all age (BCPFT)** • **Specialist Perinatal Mental Health Community Service all age (BSMHFT, BCPFT &DWMHPT)** • **Specialist Community Personality Disorder Service (BCPFT & DWMHPT)** • **Specialist Community Autism and ADHD Service (DWMHPT)** • **Street Triage (BCPFT & DWMHPT)** • **Mental Health Criminal Justice Care Pathways and Services including liaison and diversion services and the Forensic Liaison Scheme (BCPFT & DWMHPT)** • **Secondary IPS (DWMHPT)** • **Psychiatric Intensive Care (BCPFT – Male – Female currently NCA)**		

• **Veterans Care Pathway (alignment with NHS E commissioned services)** • **Alignment with the West Midlands Combined Authority THRIVE Action Plan**		

5. KEY PRIORITIES

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

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

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

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

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

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

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

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

Neeraj to insert SUICIDE PREVENTION SUMMARY here

Sarah to insert CRISIS CONCORDAT HERE

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

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

Severe mental disorder (including personality disorder) with high degree of clinical complexity
Current or potential risk(s), including:

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

Vulnerable adult /child safeguarding including for example:

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

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

Experiencing disadvantage or difficulty as a result of:

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

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

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

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

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

Service users needing (new) CPA	Other service users
An individual's characteristics: Complex needs; multi-agency input; higher risk.	**An individual's characteristics:** More straightforward needs; one agency or no problems with access to other agencies/support; lower risk.
What the service users should expect: • Support from CPA care co-ordinator (trained, part of job description, co-ordination support recognised as significant part of caseload). • A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks. • An assessment of social care needs against FACS eligibility criteria (plus Direct Payments). • Comprehensive formal written care plan: including risk and safety/contingency/crisis plan. • On-going review, formal multi-disciplinary, multi-agency review at least once a year but likely to be needed more regularly • At review, consideration of on-going need for (new) CPA support • Increased need for advocacy support. • Carers identified and informed of rights to own	**What the service users should expect:** • Support from professional(s) as part of clinical/ practitioner role. Lead professional identified. • Service user self-directed care, with support. • A full assessment of need for clinical care and treatment, including risk assessment. • An assessment of social care needs against FACS eligibility criteria (plus Direct Payments). • Clear understanding of how care and treatment will be carried out, by whom, and when (can be a clinician's letter). • On-going review as required. • On-going consideration of need for move to (new) CPA if risk or circumstances change. • Self-directed care, with some support if necessary. • Carers identified and informed of rights of own assessment.

assessment.	

6. IMPLEMENTATION , NEXT STEPS AND 14 KEY GOALS

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

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

1. DEVELOP AN ALL AGE APPROACH ACROSS OUR SERVICE MODEL THAT INCORPORATES THE NEEDS OF PEOPLE UNDER 18 YEARS WHO REQUIRE TRANSITION TO ADULT MENTAL HEALTH SERVICES.

We will develop a commissioning plan / care pathway/s that align all initiatives within the MENTAL HEALTH STRATEGY

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

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

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

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

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

3. DEVELOP A LOCAL PREVENTION CONCORDAT

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

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

- Ending stigma attached to mental health

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

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

4. MAINTAIN OUR WOLVERHAMPTON SUICIDE PREVENTION STRATEGY

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

Strategy areas for action:

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

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

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON SUICIDE PREVENTION STAKEHOLDER FORUM

5. DEVELOP PRIMARY CARE MENTAL HEALTH

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

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

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

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

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

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

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

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

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

8. MAINTAIN OUR WOLVERHAMPTON CRISIS CONCORDAT

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

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

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

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

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

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

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

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

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

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

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

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

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

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

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

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

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

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

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

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

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

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

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

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

Summary

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

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

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

6. LIST OF APPENDICES

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

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Agenda Item No: 9

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

20 September 2018

Report title	Mental Health Scrutiny Update	
Cabinet member with lead responsibility	Councillor Hazel Malcolm - Cabinet member for Health and Wellbeing Councillor Sandra Samuels OBE – Cabinet Member for Adult Social Care	
Wards affected	All	
Accountable director	John Denley	Director – Public Health and Wellbeing
	David Watts	Director – Adult Social Care
	Helen Hibbs	Accountable Officer – Wolverhampton CCG
Originating service	City Health	
Accountable employee(s)	Sarah Smith	Head of Commissioning
	Sarah Fellows	Mental Health Commissioning Manager NHS Wolverhampton CCG
	Neeraj Malhotra	Public Health Consultant
	June Pickersgill	Head of Service – Mental Health
Report to be/has been considered by	Cabinet Members	

Recommendations for noting:

For the Health Scrutiny Panel

- to note the contents of this update on responses to the recommendations of the 2017-2018 Mental Health Scrutiny Review and comment as needed

1.0 Purpose

1.1 To complete the process of the 2017-2018 Mental Health Scrutiny, by updating the Health Scrutiny Panel on overall progress on mental health issues and service development in the City of Wolverhampton as response to the recommendations of the Mental Health Scrutiny Review.

2.0 Background

2.1 A Scrutiny Review of the Adult Mental Health Commissioning of mental health led by Councillor Lynne Moran was undertaken in the 2017-2018 municipal year. A report of the findings and recommendations was presented to Cabinet on 20 February 2018. The scrutiny included a range of interviews and meetings with key staff. A copy of the report is available at: https://wolverhamptonintranet.moderngov.co.uk/documents/s64207/Scrutiny%20Review%20of%20Adult%20Mental%20Health%20Commissioning.pdf

2.2 In the period in which the Scrutiny was conducted, significant work has been undertaken on two significant strategies which were considered by the Health and Wellbeing Board in July 2018:

- an updated draft Mental Health Commissioning Strategy 2018-2021 which includes the next steps in the development of clinical services to respond to people in a range of circumstances. The process of developing the strategy included a meeting with Stakeholders in July 2018 as well as seeking feedback from the Council.
- an over-arching Joint Public Mental Health and Wellbeing Strategy 2018-21 which addresses the wider preventative context in which people might access support they need when they need it.
- The Reports are available at: https://wolverhamptonintranet.moderngov.co.uk/ieListDocuments.aspx?CId=178&MId=9230&Ver=4)

2.3 The content and implementation of these strategies takes up the recommendations of the Mental Health Scrutiny as detailed below (from para. 3.0 ff.) Some background features highlighted in the strategies are helpful to note at the outset and include:

- Many people are able to respond to any mental health challenges they face in response to normal difficult human experience such as bereavement through their own capacity and ordinary supportive networks of family, friends, neighbours, community or work colleagues who might help informally as needed.
- Nevertheless, about one-in-four people will experience a mental health need at some point in their lives.
- When people seek formal support, they generally do so in primary care settings, seeking advice and support from a GP.

- Access to "universal" services i.e. services which anyone can access such as the Wolverhampton Information Network, can help a person to find a solution to their own challenges when they are able to do so.
- The NHS commissions and provides the large part of professional mental health services through the Wolverhampton Clinical Commissioning Group (CCG) and the Black Country Partnership NHS Foundation Trust.
- The Council commissions and provides related mental health and well-being services including preventative services through both Adult and Childrens services. The Council also makes a significant wider contribution to promote mental health through education, housing and employment and skills.
- In terms of age group, the main focus of the Mental Health Commissioning Strategy is adults. A separate strategy for Child and Adolescent Mental Health has been developed and will be considered by the October Health and Well Being Board
- The West Midlands Combined Authorities (WMCA) "Thrive" initiative embraces a range of actions to support people with mental health needs. Their work coheres with that of the Council in its focus on employment for people including those with disabilities through the *Wolves@Work* programme.

3.0 Progress, options, discussion, etc.

3.1 The process of updating the Mental Health strategies referred to at para. 2.2 was enhanced by the questions raised and recommendations produced through the 2017-2018 mental health scrutiny. In large measure, the content of the Strategies provide the response to the recommendations made by the Scrutiny Review of Adult Mental Health Commissioning. Any outstanding query can be followed up as the strategies are currently open for consultation and will be finalised for approval by the Cabinet later in 2018.

3.2 Eighteen recommendations were made by the Scrutiny Review of the Adult Mental Health Commissioning. This update on the recommendations is made in the remainder of the report over the four main sub-headings used to group the recommendations:

- Mapping of service provision - current services and future intentions
- Commissioning activity and intentions
- "So what?" - How effective are the commissioned services for individuals?
- Raising awareness of mental health and promoting the importance of mental wellbeing

3.3 Senior officers from contributing organisations are in attendance to respond to any questions or comments on next steps in the light of the Mental Health Scrutiny and the new draft strategies.

3.4 ***Mapping of service provision - current services and future intentions***

3.4.1 The draft Joint Public Mental Health and Wellbeing Strategy 2018-21 and the draft Mental Health Commissioning Strategy 2018-21 (both available at: https://wolverhamptonintranet.moderngov.co.uk/ieListDocuments.aspx?CId=178&MId=9230&Ver=4) set out the desired direction of travel for people's experience of mental health in the City of Wolverhampton and the availability of an integrated mental health system. This involves Wolverhampton CCG's ambitious programme of mental health service re-design / delivery and modernisation to meet the requirements of the NHS England Five Year Forward View for Mental Health and the General Practice Forward View. It includes a number of new services and service models including some to be delivered / commissioned on an STP footing (Perinatal Mental Health for example). The CCG is also engaging in NHS Digital pilots / innovation with the Black Country Partnership NHS Trust as part of the modernisation agenda.

3.4.2 It is recognised that the primary care / primary care facing community settings require access to support which augments that available to individuals through informal networks. Therefore, services responding to "common" mental health experiences such as depression, anxiety or stress have been developed which include

- Access to GP consultation with National Institute for Health and Care Excellence (NICE) Guidance compliant care pathways for anxiety and depression
- better support at work e.g. through the "THRIVE at work" commitment which engages employers in improving support to people with mental health needs in the workplace who are receiving support in Primary Care (in Wolverhampton this service is provided by Remploy. A secondary care service also exists and this is provided by Dudley and Walsall Mental Health Partnership Trust.)
- availability of the Wolverhampton Information Network as part of the developing Community Offer so that people are free to find their own solutions when they are able to do so and refresh / relaunch of the Mental Health Services Brochure
- a council commissioned service, Starfish - this service is subject to contract monitoring by the Commissioning Unit (see para. 3.5.2 below;)
- a CCG commissioned service – Healthy Minds, provides psychological therapies for those experiencing "common" mental health problems and will include highly specialised support for people with a long term condition (LTC) as part of the Improving Access to Psychological Therapies (IAPT) expansion and targeted support / care pathways for Older People, Black, Asian and Minority Ethnic communities and Perinatal IAPT
- A Primary Care Counselling Service embedded in GP surgeries commissioned by the CCG from Relate and partners
- A Social Prescribing service commissioned by the CCG from the Voluntary Sector Council

- 23 self-help / peer support groups across the City – supported by the Voluntary Sector Council
- support for carers

3.4.3 The mental health component of the Better Care Fund is constantly under review at the monthly programme management meeting. Integrated care planning arrangements have improved through better crisis management arrangements through mental health social workers have been co-located with the Crisis Team at Penn Hospital. NHS mental health services in the City of Wolverhampton have developed their contact with others across the Black Country under the auspices of the Sustainability and Transformation Partnership (STP.) The explicit requirement in the Mental Health Five Year Forward View to promote parity of esteem between the treatment of physical health and mental health is included in the Mental Health Commissioning Strategy. The Better Care Fund meetings for Mental Health cover / include Urgent and Planned Mental Health Care Pathways and along with the Mental Health Primary Care Steering Group provide the task and finish group function for the CCG's programme of service re-design / transformation across Adult and Older Adults care (including some all age services such as Eating Disorders and Early Intervention in Psychosis). There is also a Dementia Better Care Fund work stream which addresses elements of the Five Year forward View transformation that pertain to dementia and are co-terminus with some urgent and planned older adult mental health service re-design.

3.4.4 In terms of intelligence, the mental wellbeing needs assessment was completed in 2016. It is available at: http://www.ecstaffs.co.uk/wp-content/uploads/2017/08/Wolverhampton-Mental-Wellbeing-Needs-Assessment-Final-Version.pdf This assessment shows the continuing challenge of factors such as apparently increased loneliness in the City. A new Joint Strategic Needs Assessment (JSNA) for dementia has been produced and is informing the updating of the Dementia Strategy. It has been noted that the prevalence of dementia amongst the over-65's in the City of Wolverhampton at 4.96% is higher than the West Midlands (4.13%) and England occurrence (4.29%.) This data may be the result of high performing diagnosis services with high diagnosis rates in Wolverhampton – as opposed to an actual higher prevalence – which is not evidenced.

3.4.5 Now that the Strategies have been approved for consultation by the Health and Well Being Board, arrangements are beginning to re-establish the Mental Health Partnership. It is envisaged that this partnership will influence strategy implementation. A further key aspect of partnership activity will be sharing the outcome of the needs analysis with people who use services as requested in the Mental Health Scrutiny Recommendations. Wolverhampton CCG have plans to develop their Stakeholder Forum which will support dialogue with the public and other agencies.

3.5 ***Commissioning activity and intentions***

3.5.1 Overall, across all organisations serving people with mental health needs in the City of Wolverhampton, the resources available have to be used wisely to ensure that the needs of all sectors of the community are served well and equally. Current analysis of gaps in

provision and desired outcomes are identified in the strategy e.g. increasing the wellbeing of carers.

3.5.2 The recommendation relating to the prevention of suicide relates to the update report made to Health Scrutiny Panel in March 2018. Since then, the forum has undertaken a review of work to date and has developed a revised action plan. This is to be considered by Health and Well Being Together in autumn, 2018.

3.5.3 Service re-design of crisis arrangements include mental health social workers have been co-located with the Crisis Team at Penn Hospital so as to divert a crisis better through integrated care planning. A&E Delivery Board funds are funding a Social Worker in urgent and planned mental health care pathways to improve patient flow.

3.5.4 With regard to the Transforming Care Together programme, the Health Scrutiny Panel received a report from the Black Country Partnership NHS Foundation Trust at its meeting of 19th July 2018. This updated the Panel on the end of the programme and how the Trust is working with the Dudley Walsall Mental Health NHS Trust to develop areas of mutual interest within the framework of the wider Sustainability and Transformation Partnership (STP) where mental health service development is a priority in line with the Five Year forward View as previously highlighted.

3.5.5 Work to develop a protocol for the consistent management of people receiving aftercare on discharge from psychiatric hospital under Section 117 of the Mental Health Act 1983 is underway. At the time of writing, this work remains on-going but steps are in place to update current arrangements.

3.6 ***"So what?" - How effective are the commissioned services for individuals?***

3.6.1 As requested by the Scrutiny Review, the recommendation relating to inclusion of specific features of the 2011 "*No Health Without Mental Health*" will be incorporated into the review of the Commissioning Strategy alongside any new related government guidance or best practice.

3.6.2 In 2017 the Council commissioned a new provider, Starfish Health and Wellbeing, as an important contribution to its mental health preventative offer. More information is available at: http://win.wolverhampton.gov.uk/kb5/wolverhampton/directory/service.page?id=nq9Q5o8j5Vk&adultchannel=1_1 The aim of the provision is to improve and maintain the mental wellbeing of adults which helps prevent them from entering or re-entering higher level/statutory services wherever possible by promoting: independence; empowerment (choice and control) and personal resilience skills for those who have/have had or who are at risk of mental ill-health. The Service offers an easily accessible provision which takes into account the wider determinants that impact upon mental health including poverty, debt, social contact and relationships, physical health & activities, employment, training (including volunteering) and housing & tenancy support. Starfish delivers activities directly through structured and self-help groups, one-to-ones and drop-ins and also works closely with other appropriate organisations to develop a cohesive approach to service delivery.

The Service is delivered to adults aged 18 years and over using a range of locations across Wolverhampton.

Quality assurance of the Starfish service is undertaken through the structured approach to quality monitoring by the Council Commissioning Unit. Quality monitoring covers a range of factors and the provider is meeting its contract commitments. Performance remains steady with Starfish maintaining the delivery of 32 support group sessions per month and is meeting the specification. The next performance update is due mid-October 2018.

Following a meeting held on 9th August between Starfish and Adults Commissioning, a number of organisational changes were discussed which will have a positive impact upon local service delivery. Specific issues about partnership and involvement with the LGBT Community were also discussed during the meeting and the following actions have been undertaken by Starfish:

- Attendance at Wolverhampton Pride October 2018 - A stall has been reserved
- Obtain membership of the Wolverhampton LGBT+ Alliance - Starfish are now on the circulation list for Alliance meetings. The date of the next meeting will be forwarded to Starfish by Kelly Walker-Reed (LGBT+ Alliance Contact) shortly. During the meeting Membership of the Alliance, the addition of organisation logos etc. will be discussed.
- Ensure LGBT training for staff - All staff, existing and new, have now undertaken LGBT specific training
- Information displayed on the Starfish website - Information relating to LGBT has now been added to the website. WIN has also been updated to include the same information to ensure consistency

3.7 ***Raising awareness of mental health and promoting the importance of mental wellbeing***

3.7.1 The commitment to raising awareness of mental health through a campaign particularly in October for National Mental Health Day is a welcome one. The Director of Public Health will work with appropriate colleagues to mark this as recommended.

3.7.2 With regard to self-help resources, some are now in place for citizens such as the "Healthy Minds" provision at http://www.wolverhamptonhealthyminds.nhs.uk/ This includes information about the availability of further advice. The Wolverhampton Information Network also sign-post enquirers to a range of other self-help resources. A Joint Directory produced in 2015 is still available but some up-dating as part of the mental health strategy implementation will be undertaken be undertaken as previously highlighted.

3.7.3 The recommendation that the Councillors Guide to Mental Health be included in the annual indication is being integrated into planning for the induction programme 2019 subject to consultation with the development group.

4.0 Financial implications

4.1 The Scrutiny Review referred to the importance of resourcing for all parts of the continuum relating to mental health, from prevention, community-orientated provision as well as those who live with serious and enduring mental health challenges. The CCG has a requirement to meet the NHS England Mental Health Investment Standard and invest in the Five Year Forward View model accordingly. The CCG is monitored / performance managed on this by NHS England monthly.

4.2 Whilst there are no direct financial implications arising from this report, the strategies indicate the direction in which resource allocation will need to be directed by partners in order to achieve stated objectives. [DD/20092018/F]

5.0 Legal implications

5.1 The Council's social care activity for adults with mental health needs is underpinned by the Care Act 2014, the Mental Health Act 1983 and its amendment in 2007. The work of the NHS is underpinned by the 2009 Health Act introduction of the NHS Constitution and most recently by the Health and Social Care Act 2012. [RB/25072018/L]

6.0 Equalities implications

6.1 The Mental Health Scrutiny review drew attention to people's experience of mental health from a variety of perspectives such as their experience as children and young people or with reference to sexuality amongst other factors. The Mental Health Commissioning Strategy is explicit in the attention it gives to the specific needs of a variety of groups cf. p.8, for instance.

7.0 Environmental implications

7.1 The wider work of the Council on education, skills, work, housing and wider environmental factors all have contributory role to play in supporting people to experience positive mental health. Specific issues would be addressed through current work group arrangements.

8.0 Human resources implications

8.1 Developing capacity and capability in the local mental health work force is a key deliverable in line with *Stepping forward to 2020/21: The mental health workforce plan for England (July 2017).* An STP-wide plan is in development.

9.0 Corporate landlord implications

9.1 Any joint accommodation matters relating to mental health services are being dealt with through the One Public Estate programme

10.0 Schedule of background papers

10.1 None.

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Agenda Item No: 10

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

20 September 2018

Report title	Draft Joint Health and Wellbeing Strategy	
Cabinet member with lead responsibility	Councillor Hazel Malcolm Public Health and Wellbeing	
Wards affected	All	
Accountable director	Mark Taylor, Strategic Director	
Originating service	Public Health	
Accountable employee(s)	John Denley Tel Email	Director of Public Health 01902 550148 John.denley@wolverhampton.gov.uk
Report to be/has been considered by	Strategic Executive Board Health and Wellbeing Board	26 June 2018 11 July 2018

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

1. Support the Health and Wellbeing Board's approach to the strategy, and to comment on the plans for consultation and involving the public and patients in the development of the priority workstreams going forward.

1.0 Purpose

1.1 To present a draft of the new Joint Health and Wellbeing Strategy 2018 – 2023, as endorsed by the Health and Wellbeing Board.

1.2 To present plans to consult on the document and to involve residents and patients in the priority workstreams identified.

2.0 Background

2.1 Health and Wellbeing Boards (HWB) are a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government. They have a statutory duty, with Clinical Commissioning Groups (CCGs), to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS) for their local population.

2.2 The priorities for the new strategy were based on intelligence from the JSNA, local and national strategies, Board member priorities, and insight from Healthwatch. It was felt that if the HWB priorities were anchored back to the City 2030 vision and the Public Health vision, this would enable the Board to be free to drive the health agenda from a city wide perspective using a thematic approach. The HWB needs to be able to respond quickly to emerging needs, and a narrow focus on Joint Health and Wellbeing strategy priorities would hinder this, so the priority areas have been deliberately described at a high level; the detail of work programmes and indicators would be agreed in sub-groups.

2.3 The purpose of the Board, through its strategy, is to provide collective systems leadership across the health and care economy. However, the Board would set itself up to fail if it tried to address the full breadth of health and wellbeing (much of which would continue as business as usual without the Strategy or Board). The strategy focuses on areas in which the Board can add value and unlock the potential for transformational change through system leadership.

3.0 Consultation and Public Involvement plans

3.1 Public and patient involvement should be integral to the JSNA and JHWS process; it is proposed that the JHWS process should provide a useful platform to engage with the public in a debate about the big issues we are facing, such as integrating health and social care. As well as formal consultation, it is recommended that public involvement should be built into each ongoing theme of the strategy moving forwards.

3.2 An online survey has been launched to seek feedback from residents on the approach to strategy development, the priority themes, and how to involve residents and patients in the workstreams going forward. This is in addition to engagement and consultation that has already taken place for some of the themes.

3.3 In addition, in order to boost the quantity and quality of feedback, further in-depth research has been commissioned to expand on the views around the priority themes, to find out what level of awareness there is in the community for these issues, and to explore the best ways to get more people involved in the development of the workstreams.

4.0 Questions for Scrutiny to consider

4.1 Are there any suggestions to improve the approach to consultation and involvement?

4.2 What can Panel members do to help to raise the profile of the consultation and ensure that we receive as much feedback as possible?

5.0 Financial implications

5.1 There are no financial implications associated with this report. [MI/19062018/Q]

6.0 Legal implications

6.1 There are no legal implications associated with this report. [RB/15062018/D]

7.0 Equalities implications

7.1 A reduction in health inequalities is an overarching aim of the Board. Equalities impact assessments will be carried out as appropriate for each priority area during the process of developing the associated workplans.

8.0 Environmental implications

8.1 There are no environmental implications associated with this report.

9.0 Human resources implications

9.1 There are no human resources implications associated with this report.

10.0 Corporate landlord implications

10.1 There are no corporate landlord implications.

11.0 Schedule of background papers

11.1 Draft Joint Health and Wellbeing Strategy attached.

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City of Wolverhampton
Health & Wellbeing Together

Wolverhampton Joint Health & Wellbeing Strategy 2018 - 2023

Contents

Foreword

Health and wellbeing is about more than health and care services. The environments we live in, our lifestyles, the opportunities we have throughout our whole lives, education, family, good jobs, and community - all have an impact our health.

We have a vision that by 2030 Wolverhampton will be a thriving City of opportunity, where we are serious about boosting the health and wellbeing of the people who live and work here. The year 2030 may seem distant, but the plans we already have in place for the next five years will mark a step change in achieving this vision. Aligned to this is the Vision for Public Health 2030, which has set ambitious targets to improve the health and wellbeing of our residents over the twelve years.

Often health and wellbeing issues are complex, multifaceted and require partners to work together around the needs of people. There are clear areas of work that can be done better in partnership, across the whole system. These are the things that we have chosen to focus on.

Working collectively, we want to support independence and empower everyone to look after their own health and wellbeing by using the assets available in communities. We aim to create environments and opportunities for people to thrive and stay well, making Wolverhampton a City where people want to live and work. And when health and care services are required, we will ensure they are built around the people who need them - focussed on improving their experiences and their outcomes.

This is our commitment to the people of Wolverhampton.

To make the most difference, we need the support of all - partners, members of the public and service users. This is the start of our journey to the 2030 City vision and we are committed to meaningful partnership working. In fact, it is one of the things we will measure ourselves on.

Councillor Roger Lawrence,
Leader of the Council
Chair of the Health and Wellbeing Board

Dr Helen Hibbs,
Chief Officer, Wolverhampton Clinical Commissioning Group, Vice Chair of the Health and Wellbeing Board

Introduction

In developing this document we have considered:

- the bigger picture of health and wellbeing outcomes across the whole population in Wolverhampton, as summarised in our Joint Strategic Needs Assessment
- relevant local and national strategies and plans
- the views of local residents, via the Wolverhampton Lifestyle Survey, Healthwatch, and a consultation on the strategy document
- the views of all the organisations represented on the Health and Wellbeing Board

Priorities have been chosen based on the Board's ability to make transformational change happen through system leadership.

We have adopted a life-course approach, grouping people into stages of their life. This helps us to look more holistically at the needs of people, rather than purely services or medical conditions.

The priority themes are deliberately high level, because we recognize that the action plans under these themes may need to evolve over the next five years according to changing local needs. The detail of the workstreams that contribute to the high level priorities will be developed in sub groups and reported back to the Board for assurance.

This strategy does not reflect everything we will consider as a board or that the partners will deliver, but focuses on what we can do better together and provides strategic direction.

You can find more information about population health and wellbeing in the Joint Strategic Needs Assessment at ***www.wolverhampton.gov.uk****.*

1. Theme - Growing Well

In 2030 we will

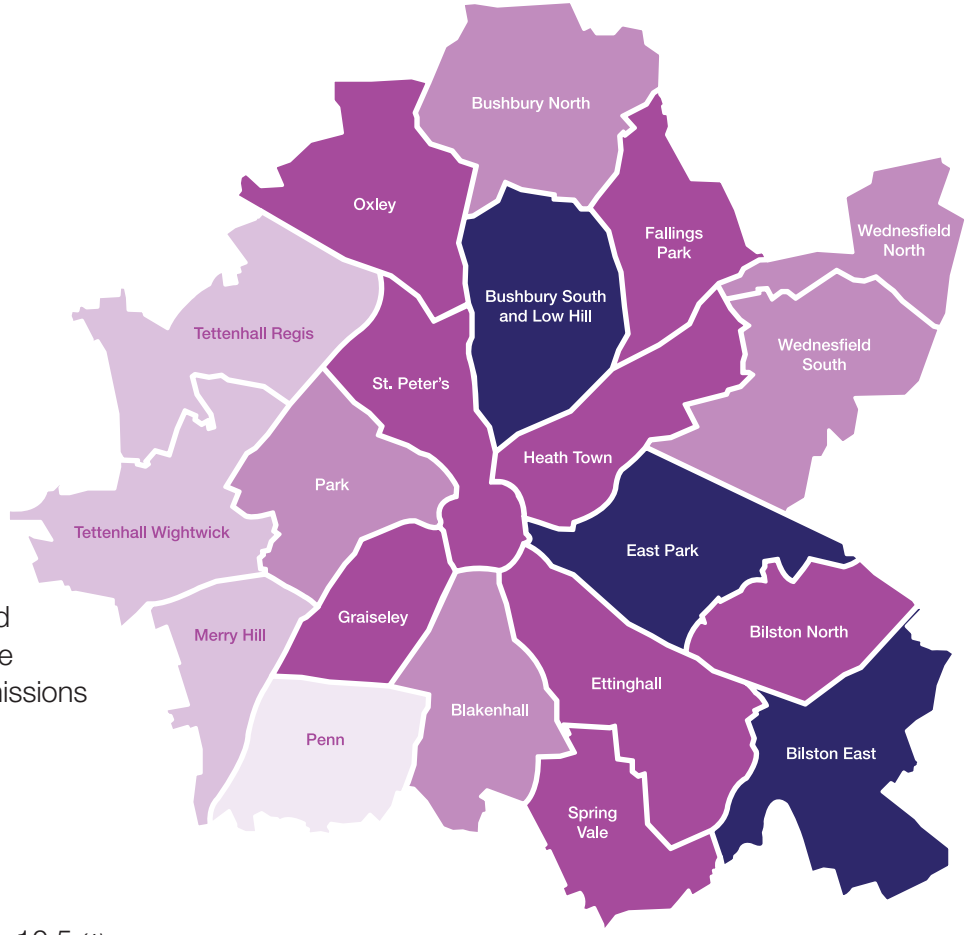
CELEBRATE ENTERPRISE EDUCATION & SKILLS

have world class public services that **continually improve** and have collaboration and co-production at their heart

What do we know?

There are areas within the City that have high levels of child poverty and deprivation is associated with a number of health outcomes, including childhood obesity, tooth decay, and poor mental health. There are also higher rates of children's emergency hospital admissions from deprived areas of the City.

% of children in poverty 2015 - income deprivation affecting children



- 39.6 to 43.6 *(3)*
- 29.6 to 39.5 *(8)*
- 19.6 to 29.5 *(5)*
- 10.6 to 19.5 *(3)*
- less than 10.5 *(1)*

Growing Well

Teenage pregnancies down from 56.8 per 1,000 in 2010 to 28 per 1,000 now

- rapid improvement since 2010
- higher average than England (17.7) and West Midlands (21.1)

5.3% of young people are not in **education, employment or training**

- Better than the England average of 6%

secondary school age pupils who were drunk in the previous week **less likely to rate mental health as good or excellent**.

School readiness rise from 44.2% in 2012/13 to 62.4% in 2017/18

- 18% improvement in last 4 years
- lower than national average of 69.3%

18%

39% of **secondary school aged pupils** had at least one drink in the last week

- Reduced from 47% in 2014

35.6% of pupils achieved grade 9-5 English and Maths GCSE

- trend recently improved
- lower than 39.6% in England, and 39.8% for the West Midlands

Emergency hospital admissions for under 19s

8,703 per 100,000 in **Tettenhall Regis** *(affluent)*

Compared to **13,060** in **Fallings Park** *(deprived)*

At 5.6 per 1,000 our INFANT MORTALITY RATE is 7th highest of our 16 nearest neighbours

- improved in recent years
- higher than England average of 3.9 per 1,000

16% **of secondary school age pupils have tried smoking**

- improved from 21% in 2014

Priority 1 - Early Years

What happens during the early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing - from obesity, heart disease and mental health, to educational achievement and economic status.

Research shows social class, income, living conditions and parent's own education levels are directly related to child development outcomes. However, the quality of the home environment acts as a significant modifying factor.

From the point of conception through to the first day at school, parents, babies and young children have regular contact with a range of different services including midwifery, health visiting, GPs, children's centres, childcare and early education provision.

All services need to be focused on delivering an approach that supports parents to develop good parenting skills, and be an active participant in their child's health and development, enabling the child to become an active learner with a strong attachment and healthy relationships. Children who need additional support will be identified at an early stage and have appropriate support put in place, focussing on improving outcomes for the child and the family.

Priority 2 - Children & young people's mental wellbeing and resilience

More than half of all mental health conditions in adulthood begin before the age of 14. Schools and primary care settings have traditionally been seen as part of the first port of call for support in addressing the common problems of childhood. Currently mental health services are able to provide support for only one in four children and young people who need it. Too often children, young people and their families are unable to access early support which could help them through a difficult point in their lives and could potentially cure mental health problems at an early stage.

Children exposed to *Adverse Childhood Experiences (ACEs)* - such as living with an adult experiencing alcohol or drug use problems, being a victim of abuse, or having a parent with a mental health condition – are at risk of increased rates of suicide and mental illness later in life. Disadvantaged and vulnerable children and young people are at greater risk of exposure to adverse childhood experiences. In addition, some groups of children and young people, including young carers, refugee and asylum-seeking families, disabled, LGBT and looked-after children, are more vulnerable to mental health problems.

A proportionate universal response is required, balancing improved access to support for all with an additional focus on those most vulnerable to poor mental health. We are committed to creating a pathway that supports children and young people at all levels of access, and work is needed to ensure that there is an adequate workforce available to meet the needs of children and young people. We will ensure that our mental health services for children and young people are fit for the future and provide the extensive range of care pathways and services spanning health, social care, education and the criminal justice system. We are committed to ensuring there are no gaps in provision and that entry points to services are both timely and easy to navigate.

2. Theme - Living well

Premature mortality (under 75y) is improving but there are still significant inequalities between men and women, and between affluent and deprived areas.

Males	Gap between local and national healthy life expectancy (years)	7	Gap between richest and poorest wards life expectancy in Wolverhampton (years)	11.3
Females	Gap between local and national healthy life expectancy (years)	4.6	Gap between richest and poorest wards life expectancy in Wolverhampton (years)	9.5

4.1% claimed **unemployment benefits** in November 2017

- improved from a high of 8% at the beginning of 2013
- higher than England average of 2%

Adult obesity

28.5% of adults are classified as obese

- higher than England average of 24.4%

Top employment sectors in Wolverhampton

18% Wholesale and retail trade

15% Human health and social work activities

14% Manufacturing

Alcohol admissions rise to 897 per 100,000

- rates stabilising
- upward trend
- higher than rate of 647 admissions nationally

22.5% of **adults smoke**

- rates improving
- higher than national average

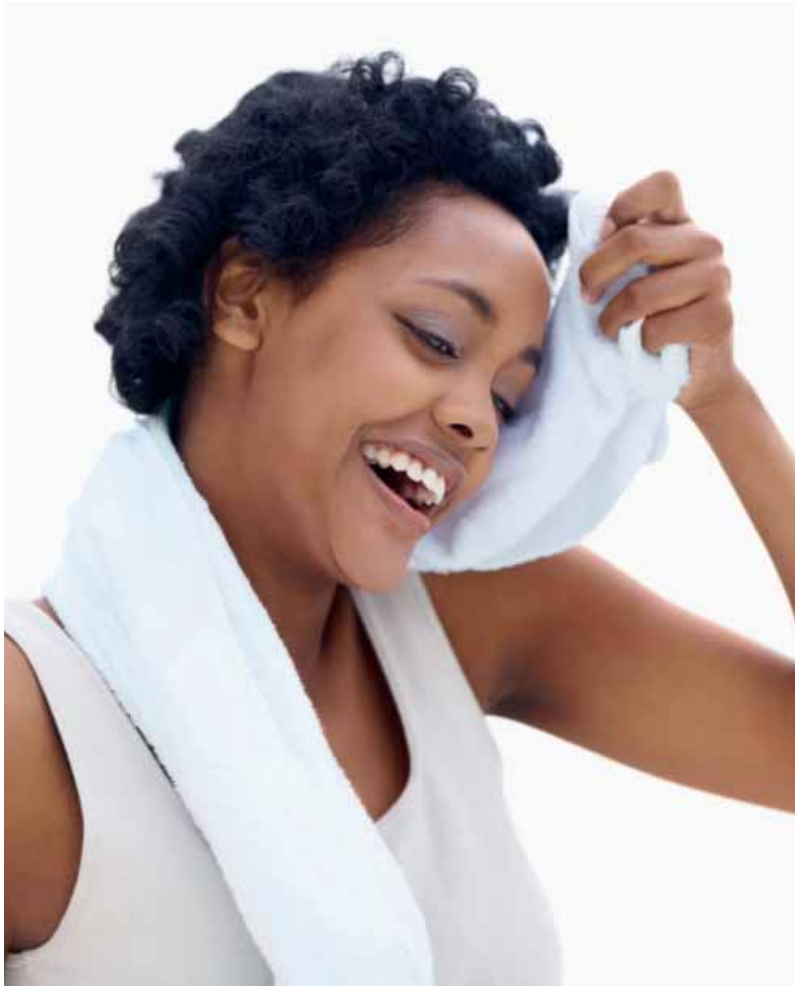
In 2030 we will

are committed to **sustainability** for future generations

HAVE A **CITY CENTRE** WE'RE PROUD OF

CELEBRATE **ENTERPRISE EDUCATION & SKILLS**

Priority 3 - Workforce



It is our ambition to develop, attract, and retain high quality staff and support them to stay healthy and well throughout their working lives. Health and social care is the second biggest sector for employment in the City of Wolverhampton, providing around 15,000 jobs.

The skills required across the system are now different, because the population is changing, technologies are advancing, and expectations about what public services can provide are shifting. We are increasingly seeing more people with multiple long term conditions and social care needs, and the workforce has been evolving to meet these changing needs. This includes the greater use of allied health professionals e.g. nurse prescribers, pharmacists, and a wider range of social care provision such as social prescribers, and domiciliary support to keep people independent in their own homes.

We also need to consider our responsibilities towards our own staff; many of whom are Wolverhampton residents too. We know that the most common causes of sickness absence are mental health problems and musculoskeletal problems.

Priority 4 - City Centre

The City Vision for 2030 describes a buzzing, vibrant City centre, with good transport links and a strong night time economy. Through our collective influence, we aim to ensure that this development is done in a way which maximises health and wellbeing;

- where active transport such as walking and cycling is made easy and safe,
- where the development of the night time economy does not increase problems with alcohol misuse or public safety,
- where there are smoke free environments that minimise second-hand smoke exposure, especially for children.

We are also committed to providing integrated support for people who are sleeping rough, to ensure that wherever possible they are supported into appropriate accommodation and access support from relevant services.

Priority 5
Embedding prevention across the system

Many people are now living for a longer time in poor health and wellbeing at the end of their lives, due to musculoskeletal problems, long term conditions like hypertension and diabetes, and low wellbeing. These conditions contribute to sickness absence but don't show up in admissions or mortality statistics, but are a cause of self rated poor health. Many of these can be modified or prevented through small changes to lifestyles, and health promoting environments. We must invest in prevention of smoking, obesity and alcohol misuse now to reduce the future demands on health and social care.

Small systematic changes add up. We are committed as a system to make it easier for people to choose healthy options, and to ensure that professionals are equipped to provide good quality brief advice on keeping healthy at all stages of life. Prevention will be built into all parts of the health and social care system and become part of everyday business across the City.

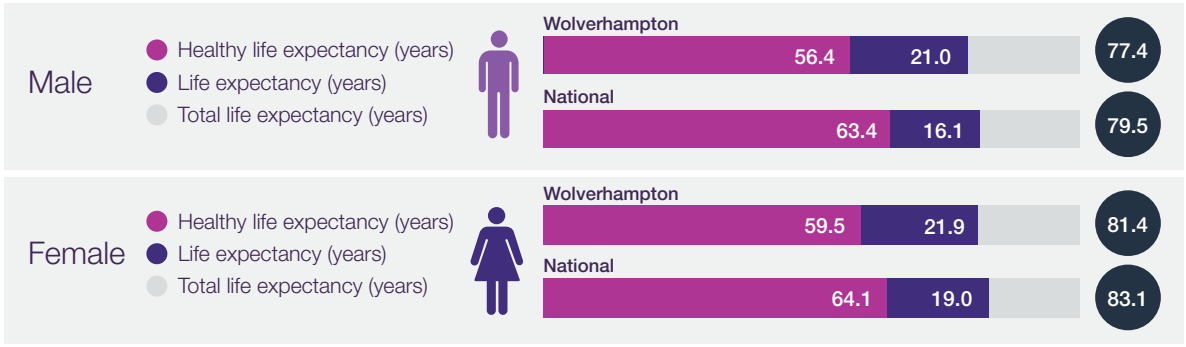
3. Theme - Ageing well

it is predicted that there will be a **42% increase** in OVER 65 population by **2039**

25.2%

of carers get as much social contact as they desire and this is the 2nd worst compared to our neighbours

- decreasing trend
- lower than 35.5% average for England



In 2030 we will

have **world class public services** that **continually improve** and have collaboration and co-production at their heart

have a vibrant civic society that's focussed on the future, empowers local communities and is supported by local businesses and institutions

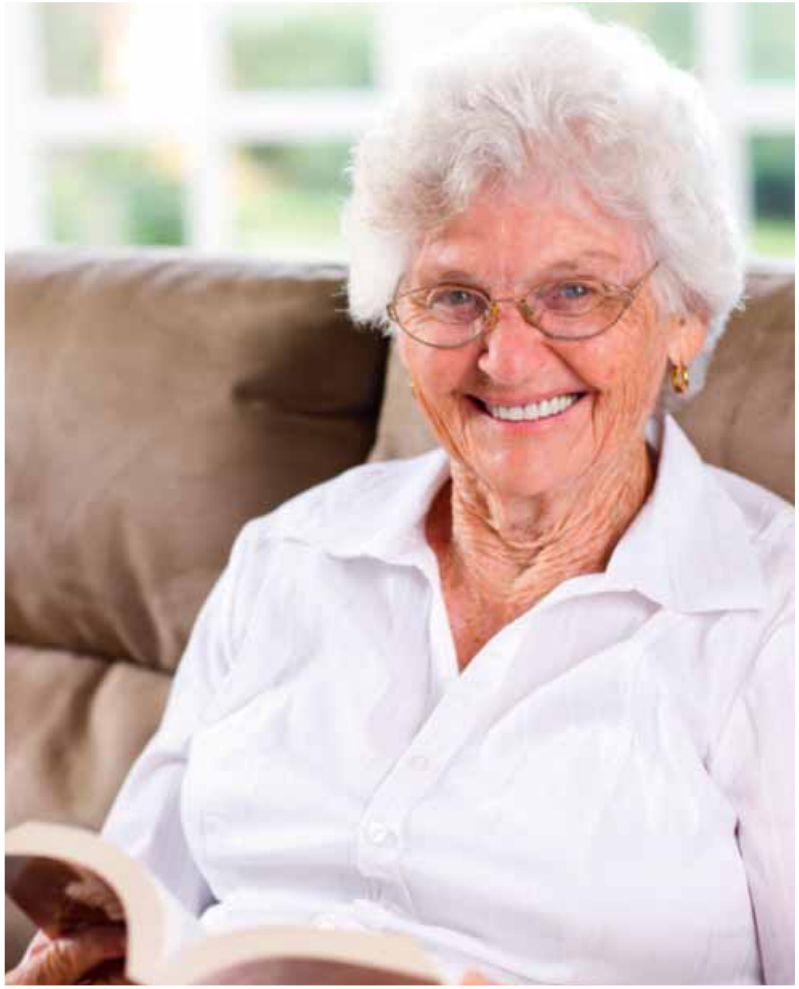
Priority 6
Integrated Care; Frailty and End of Life

An Integrated Care Alliance has been set up in Wolverhampton, which brings together partners across the health and social care system to work on better integration of services. This will improve outcomes, improve people's experiences of services, and ensure that the system is financially sustainable. Initially, the focus will be on frailty and end of life care.

We will explore how we can proactively work together to look at the needs of people who have become frail; their bodies have lost built-in reserves, which makes it harder to bounce back when they are faced with an illness or an event such as a fall, and so people who are frail tend to have more contact with health and social care services.

We are committed to ensuring that people who are reaching the final years or months of their lives are identified, that open conversations are held with them and their families about their preferences, and that care is planned and coordinated around their needs.

Priority 7
Dementia friendly city



Cases of dementia increase with age, and as life expectancy increases, more and more people will be affected. Currently, one in 50 people between the ages of 65 and 70 have a form of dementia, compared to one in five over the age of 80. Diagnosis is often made at a later stage of the illness and this can affect the person's ability to make choices and decisions.

Dementia does not just have a devastating effect on the individual, but also their families and friends. Nearly half the population know a close friend or family member with dementia and it's important that they get the help and support they need to carry out their caring role. Life should not stop because of dementia. People with Dementia and their family and carers may need support to enable them to carry out activities and engage in relationships in a positive way, so that they can continue to lead a full and active life.

The Alzheimer's Society granted Wolverhampton Dementia Friendly Community Status for 2017-18. This is a great start, and we are committed to continuing this valuable work so that everyone will share responsibility for ensuring that people with dementia feel understood, valued and able to contribute to their community.

3. Demonstrating impact

This strategy seeks to address the Board priority areas identified in the City 2030 Vision and underpinned by the Joint Strategy Needs Assessment (JSNA) and thematically grouped around the life course.

The impact of the Board itself in progressing strategic and cross-cutting priority issues will be measured by self-assessment rating on a selection of statements that reflect the Board's role in forming strategy and allocating resource, rather than delivery of operational workstreams (see Figure 2). This rating will be re-assessed annually to allow the Board to focus their efforts on where it will deliver the biggest impact across the whole system, illustrate our achievements so far and identify goals for the following year.

This approach will enable the evolution of the Board towards being a system leadership forum with clearly defined links to other city and regional partnership boards, jointly committed to moving from service silos to system outcomes, and empowering communities to engage with the challenges and develop solutions.

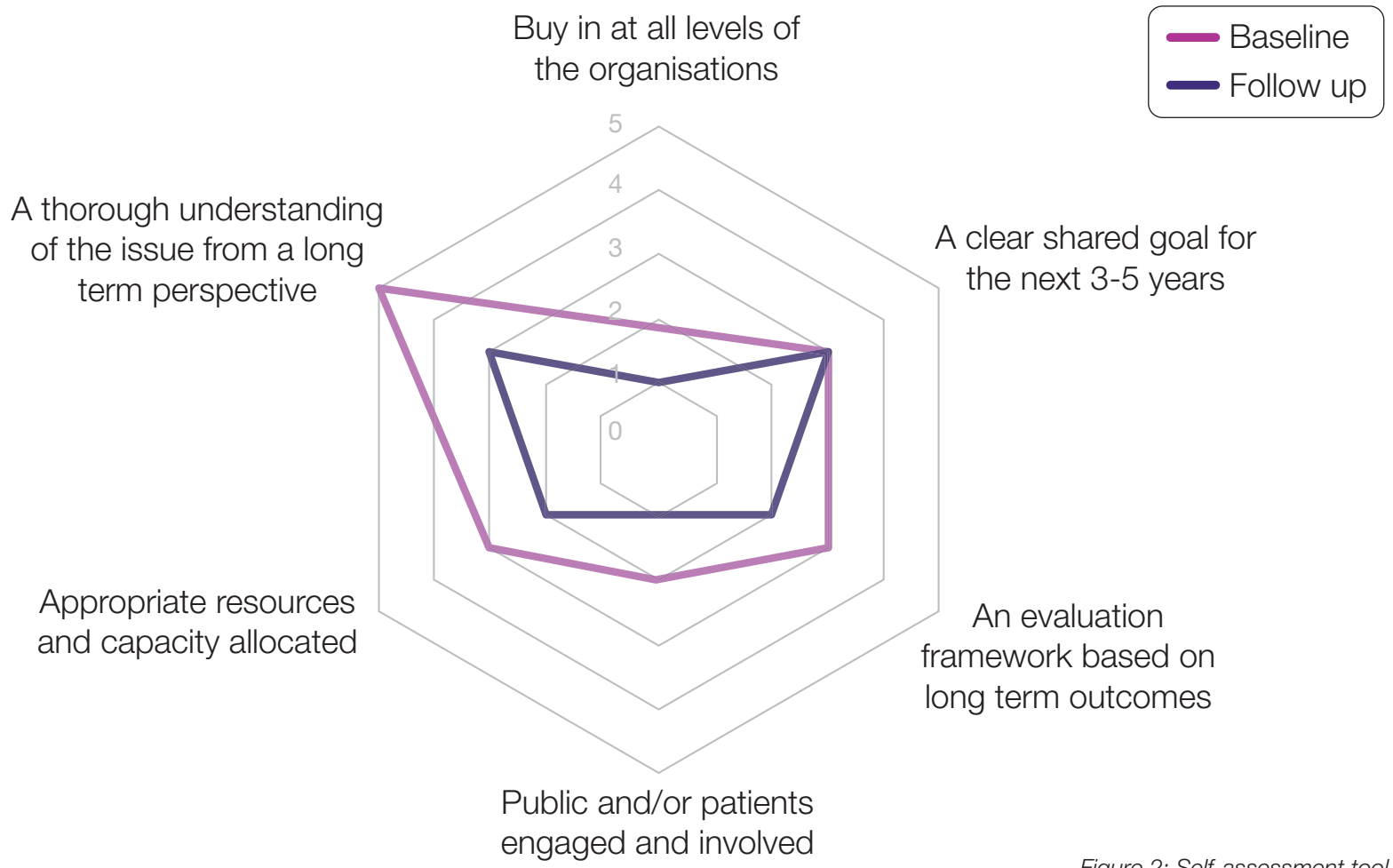


Figure 2: Self-assessment tool

Working better together

The Wolverhampton Health and Wellbeing Board is made up of the following representatives:

Councillor Roger Lawrence *(Chair)*
City of Wolverhampton Council

Councillor Sandra Samuels OBE
City of Wolverhampton Council

Councillor Paul Sweet
City of Wolverhampton Council

Councillor Hazel Malcolm - Labour

Councillor Wendy Thompson

Jo-Anne Alner - NHS England

Emma Bennett - City of Wolverhampton Council

Helen Child - Third Sector Partnership

Brendan Clifford - City of Wolverhampton Council

John Denley - City of Wolverhampton Council

Dr Helen Hibbs
Wolverhampton Clinical Commissioning Group

Dr Alexandra Hopkins - University of Wolverhampton

Tim Johnson - City of Wolverhampton Council

Steven Marshall
Wolverhampton Clinical Commissioning Group

Chief Supt Jayne Meir - West Midlands Police

Elizabeth Learoyd - Healthwatch Wolverhampton

Tracy Cresswell - Healthwatch Wolverhampton

David Loughton CBE
The Royal Wolverhampton Hospitals NHS Trust

Linda Sanders - Wolverhampton Safeguarding Board

Sarah Smith - City of Wolverhampton Council

Mark Taylor - City of Wolverhampton Council

Jeremy Vanes
The Royal Wolverhampton Hospitals NHS Trust

David Watts - City of Wolverhampton Council

Lesley Writtle
Black Country Partnership NHS Foundation Trust

Ben Diamond - West Midlands Fire Service

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audio or in another language by calling 01902 551155

wolverhampton.gov.uk 01902 551155

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City of Wolverhampton Council, Civic Centre, St. Peter's Square,
Wolverhampton WV1 1SH

WCC 1659 07/18

Health Scrutiny Panel

The Panel will have responsibility for Scrutiny functions as they relate to:-

- All health-related issues, including liaison with NHS Trusts, Clinical Commissioning Groups, Health and Wellbeing Board and HealthWatch.
- All functions of the Council contained in the National Health Service Act 2006, to all regulations and directions made under the Health and Social Care Act 2001, the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002,
- The Health and Social Care Act 2012 and related regulations.
- Reports and recommendations to relevant NHS bodies, relevant health service providers, the Secretary of State or Regulators.
- Initiating the response to any formal consultation undertaken by relevant NHS Trusts and Clinical Commissioning Groups or other health providers or commissioners on any substantial development or variation in services.
- Participating with other relevant neighbouring local authorities in any joint scrutiny arrangements of NHS Trusts providing cross border services.
- Decisions made by or actions of the Health and Wellbeing Board.
- Public Health – Intelligence and Evidence
- Public Health – Health Protection and NHS Facing
- Public Health - Transformation
- Public Health – Commissioning
- Healthier City
- Mental Health
- Commissioning Mental Health and Disability
- HeadStart Programme

Date of Meeting	Item Description	Lead Report Author	Specific Questions for Scrutiny to consider
20.09.2018	• Urgent and Emergency Care 7-day Services* • Wolverhampton Joint Health & Wellbeing Strategy 2018-2023* • Draft Joint Public Mental Health and Wellbeing Strategy 2018 – 2021* • Transforming Care Plans (TCP) for adults, children and young people with Learning Disabilities and/or Autism across the Black Country* • Mental Health Commissioning Review Update on Recommendations* • Black Country Sustainability and Transformation Plan - update	Dr Odum, The Royal Wolverhampton NHS Trust John Denley, Director of Public Health Lina Martino,CWC/Sarah Fellows, WCCG Kate Wilkins – Black Country Transforming Care Partnership City of Wolverhampton Council - Brendan Clifford • Dr Helen Hibbs, WCCG	
23.10.2018 (Special Meeting)	• Mortality Rates	John Denley, Director of Public Health	

25.10.2018 (Special Review Meeting)	• Death certification process	Julia Goudman (Registration Service), The Royal Wolverhampton NHS Trust (Dr Julian Parkes, Elaine Roberts)	
15.11.2018	• Refreshed CAMHS Local Transformation Plan • Winter planning/resilience plans - update • Integrated Care Alliance in Wolverhampton • Patient Advice and Liaison Service (PALS)	Margaret Courts Children's Commissioning Manager, WCCG Dr Odum, The Royal Wolverhampton NHS Trust The Royal Wolverhampton NHS Trust Alison Dowling | Head of Patient Experience and Public Involvement The Royal Wolverhampton NHS Trust	Primary Care Vertical Integration Presentation will be given.
24.01.2019	• Black Country Partnership NHS Foundation Trust – Transforming Care Partnership – update and Quality Accounts 2018/19 – progress against priorities • Eye and hearing checks	Lesley Writtle, Black Country Partnership Andrea Smith,Head of Integrated Commissioning,Wolverhampton CCG	

	• Cancer treatment services – performance against national targets • RWHT – staff recruitment and retention	The Royal Wolverhampton NHS Trust The Royal Wolverhampton NHS Trust	performance against local and national targets maintaining staff levels to deliver safer care and better patient experience
21.03.2019	• Hospital Mortality Statistics – update • Public Health Vision – Review of Progress against national performance targets • GP appointment waiting times – involve Wolverhampton Healthwatch	Dr Odum, The Royal Wolverhampton NHS Trust John Denley, Director of Public Health Wolverhamton CCG and Healthwatch	http://www.wolverhampton.gov.uk/health

List of potential topics - dates and method of scrutiny to be agreed by the panel

1. West Midlands Ambulance Service - Quality Accounts 2017/18 - May 2019 (tbc)
2. RWHT - Quality Accounts 2017/18 – 23 May 2019 (tbc)
3. Black Country Partnership NHS Foundation Trust – Quality Accounts – May 2019 (tbc)
4. Walsall CCG - Reconfiguration of hyper acute and acute stroke services
5. Ward sizes,age,transition arrangements for a young person moving to an adult ward