Wolverhampton City Council

Community
Health, Well Being and Disability

NHS

Wolverhampton
Clinical Commissioning Group

MENTAL HEALTH COMMISSIONING STRATEGY

2014-2016

CONTENTS

1. INTRODUCTION

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 and 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 experience as outlined in our Wolverhampton Health and Well-Being Board Strategy, the CCG's Operational Plan and the CCG's 5 Year Strategic Plan.

The Wolverhampton City Council and Wolverhampton Clinical Commissioning Group Mental Health Strategy 2014-2016 is a joint commissioning re-fresh of the Wolverhampton City Primary Care Trust and Wolverhampton City Council Adult Mental Health Commissioning Strategy 2011 – 2015 wherein we outline our commissioning plans to develop our mental health whole system model and to deliver improved outcomes for the people of our City in line with local needs and local and national priorities.

This follows a review period and responds to key local priorities highlighted as an outcome of the review and other local imperatives including plans that form part of the Better Care Fund initiative, and the implementation plans for the Wolverhampton Mental Health and Psychological Wellbeing Services Strategy for Children and Young People 2013-2016.

National statistics show that mental illness is the largest disease burden upon the NHS, up to 23% of the total burden of ill health and the largest cause of disability within the United Kingdom (Royal College of Psychiatry 2010). There are significant personal,

social and economic costs (the latter estimated as £105 million per annum for England alone), with particular risks from birth, into childhood and as young people move into adulthood and as they enter periods of physical and psychological change and development. There is a strong economic case to provide early intervention and prevention mental health services for children and young people especially, to prevent up to 25-50% of adult mental illness (Kim-Cohen et al 2003). We know that physical health is inextricably linked to mental health. Poor mental health is associated with obesity, alcohol and substance misuse and smoking, and with diseases such as cardio-vascular diseases and cancer (HM Government, 2011).

In 2010/11, £12 billion was spent on NHS services to treat mental disorder, equivalent to 11% of the NHS budget. Treatment costs are likely to double in the next 20 years as by 2026, the number of people in England who experience a mental disorder is projected to increase by 14%, from 8.65 million in 2007 to 9.88 million(Royal College of Psychiatry 2010) .

In Wolverhampton our current annual joint commissioning health and social budget for Mental Health services is £35.7 million. Benchmarking data suggests that in Wolverhampton investment in mental health services is comparable with the England average. Our Strategy implementation plan will align our service re-design and development with our plans to ensure value for money across the system however and re-align our investment in services to improve early intervention and prevention, urgent care and re-ablement and recovery. This is to achieve 'parity of esteem' for mental health compared with physical health in terms of access to services, quality of service user and carer experience and service user outcomes within an 'all age' context.

The strategy re-fresh includes a wider all age mental health approach to improve outcomes for all people requiring support from mental health services. This is in keeping with the cross government mental health outcomes strategic guidance for people of all ages detailed in 'No Health without Mental Health' (2011), 'Preventing suicide in England' (HM Government, 2012), 'Closing the Gap' (HM Government 2014), which adopt a life course approach.

Our strategy prioritises the delivery of the 6 key outcomes of 'No Health without Mental Health' (2011) as overarching themes. These are:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Our mental strategy re-fresh outlines the required commissioning actions to achieve all of the 6 key outcomes described above.

2. INFORMATION REGARDING PREVALENCE AND NEED

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 social and health inequality 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.

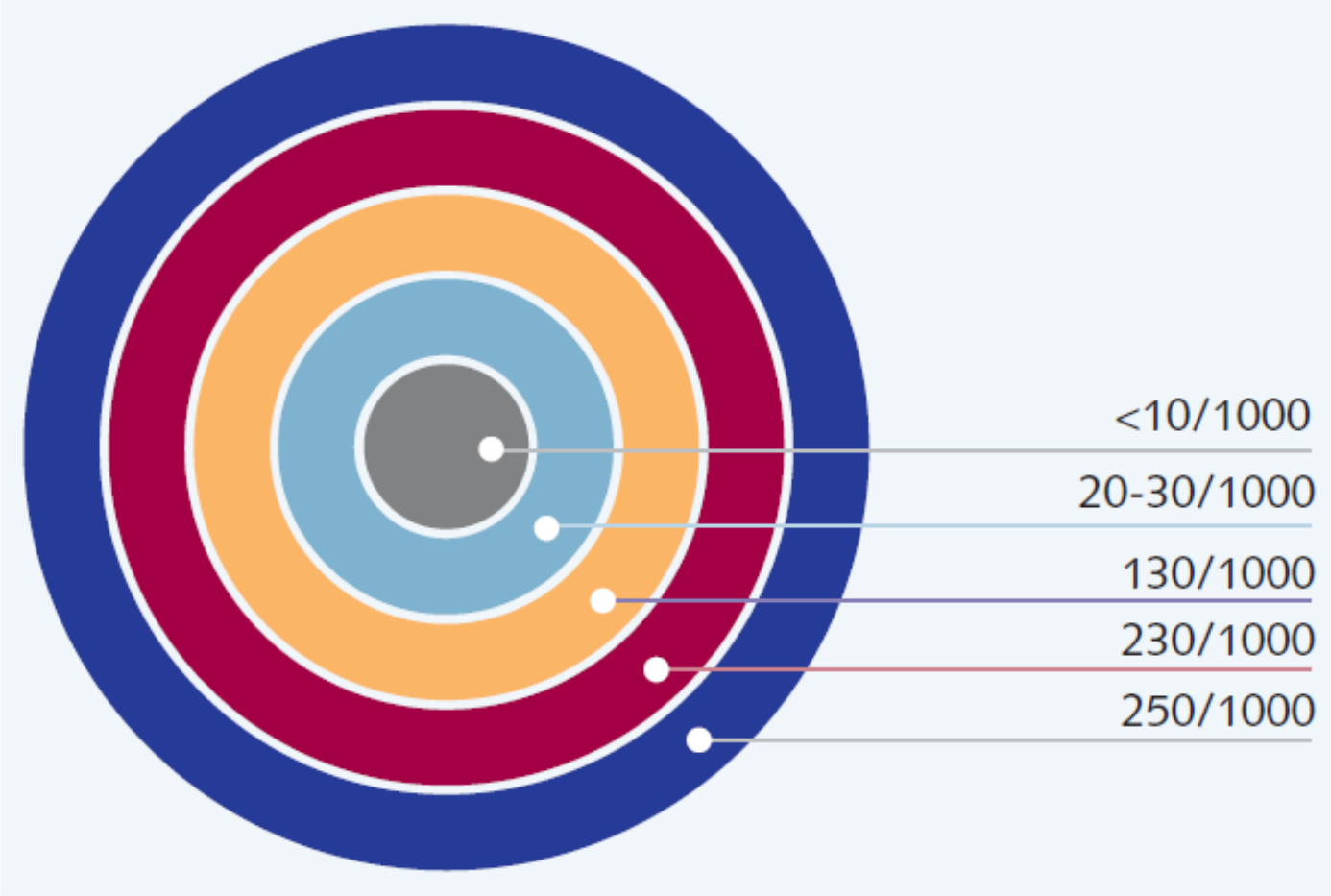
'No Health without Mental Health' (HM Government, 2011) describes three aspects to reducing mental health inequality:

- tackling the inequalities that lead to poor mental health

- tackling the inequalities that result from poor mental health such as unemployment, poor housing, and poor levels of educational achievement and poorer education and physical health
- tackling the inequalities in service provision – in access, experience and outcomes

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.

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

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

- Substance misuse
- Victims of violence, abuse and crime

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 for example). Particular focus should be placed upon the needs of people of all ages with conditions such as Autism and Attention Deficit Disorder who are at risk of falling between gaps in services, ('No Health without Mental Health', 2011). 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).

The over representation of people from BME 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 BME 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 BME groups and communities of new arrivals.

Learning from the needs analysis from our Wolverhampton Emotional and Psychological Well-Being Strategy for Children and Young People has also identified the following key issues in 2012/13:

- An under use of universal and targeted services, an over use of specialist services and a significant increase in the use of in-patient hospital provision.
- Requests for hospital admissions rose by over 100% (75 % of in-patient admissions were related to self-harm)
- The Crisis Support and Home Treatment Service received a 25% increase in routine referrals.

A recent 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.

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).

The Community Mental Health Profile 2013 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 2013 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
- Numbers of people using adult & elderly NHS secondary mental health services (significantly lower)
- 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)
- Directly standardised rate for emergency hospital admissions for self-harm (significantly better)
- Indirectly standardised mortality rate for suicide and undetermined injury
- Hospital admissions caused by unintentional and deliberate injuries in <18s
- Improving Access to Psychological Therapies - Recovery Rate
- Excess under 75 mortality rate in adults with serious mental illness (significantly better)

3. Vision

Our vision for mental health services in Wolverhampton is an integrated 'whole system' of health and social care pathways and services that will deliver early intervention and prevention, assessment, treatment and intervention and re-ablement and recovery across the life course.

Our aim is to prevent people entering statutory services where possible and to provide care pathways into and through services to provide the right type and level of intervention, when this is required, including within primary care and non-statutory services and with a focus upon public mental health as part of our Resilience Strategy.

Our commissioned model will support the delivery of aligned health and social care outcomes to promote independence, improve physical health, optimise recovery and increase social inclusion at all stages of the care pathway and across the 'whole system' of integrated care.

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 2013 Mandate to NHS England sets the Government's commitment to give mental health parity of esteem with physical health, including a commitment to:

- Removing the stigma attached to mental illness.
- Implementing access and/or waiting times standards for mental health services in 2015.
- A specific focus on mental health and wellbeing from Public Health England.
- A dedicated transformation programme for children and young people's services to enhance access to evidence-based therapies.
- Providing settled accommodation for people with mental illness to support their recovery.

- 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.
- Pro-active crisis support.
- Initiatives to reduce the inequalities in life expectancy for people with severe mental illness.
- Further roll out of improving access to psychological therapies.
- Improved offender mental health.
- 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.

The recommendations and actions of the key reports that have informed the development of our Strategy are detailed in Appendix 1.

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, Specialised and Secure Services and 'out of area' placements. 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 'whole system' to work effectively each service will have a clear role; understand how it relates to other elements of the system and work to 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).

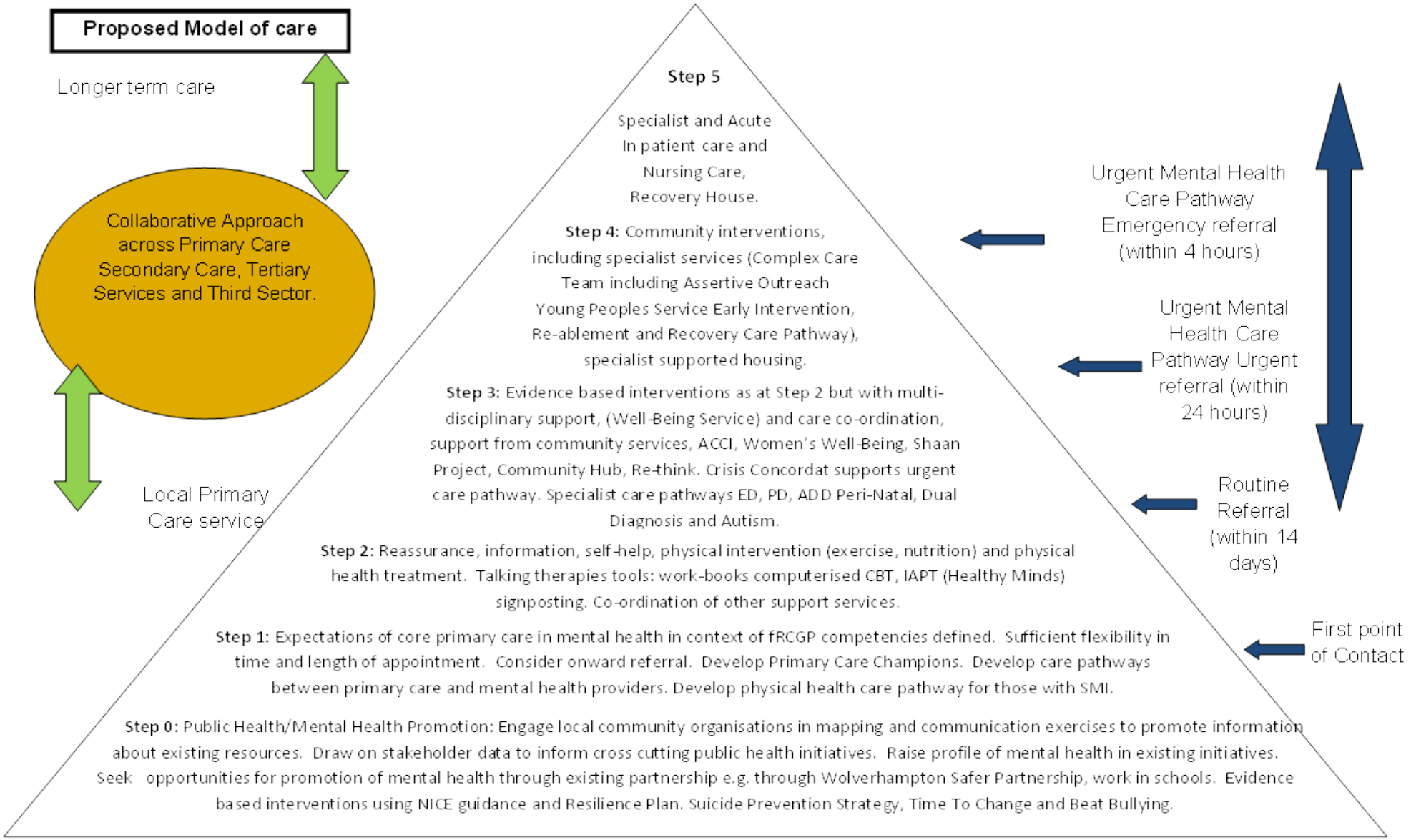
Stepped Care Model

Mental Health services will be commissioned across the 'whole system' using the 'Stepped Care' Model which has formed the basis of previous service re-design in Wolverhampton.

The 'Stepped Care' model allows 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 'whole system' of services and providers delivering recovery orientated interventions and support.
- Improved integrated health and social care pathways within existing services using the Better Care Fund.
- Improved communication between primary care, secondary and tertiary mental health services.
- Clear access and / or referral criteria.
- Transition into and out of services as appropriate and in keeping with the Care Programme Approach.
- Access to services 24/7 and improved urgent care.
- Greatest level of service provision for those with the highest levels of need.
- Promoting independence 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.

The refreshed Stepped Care Model is described in the diagram below.


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

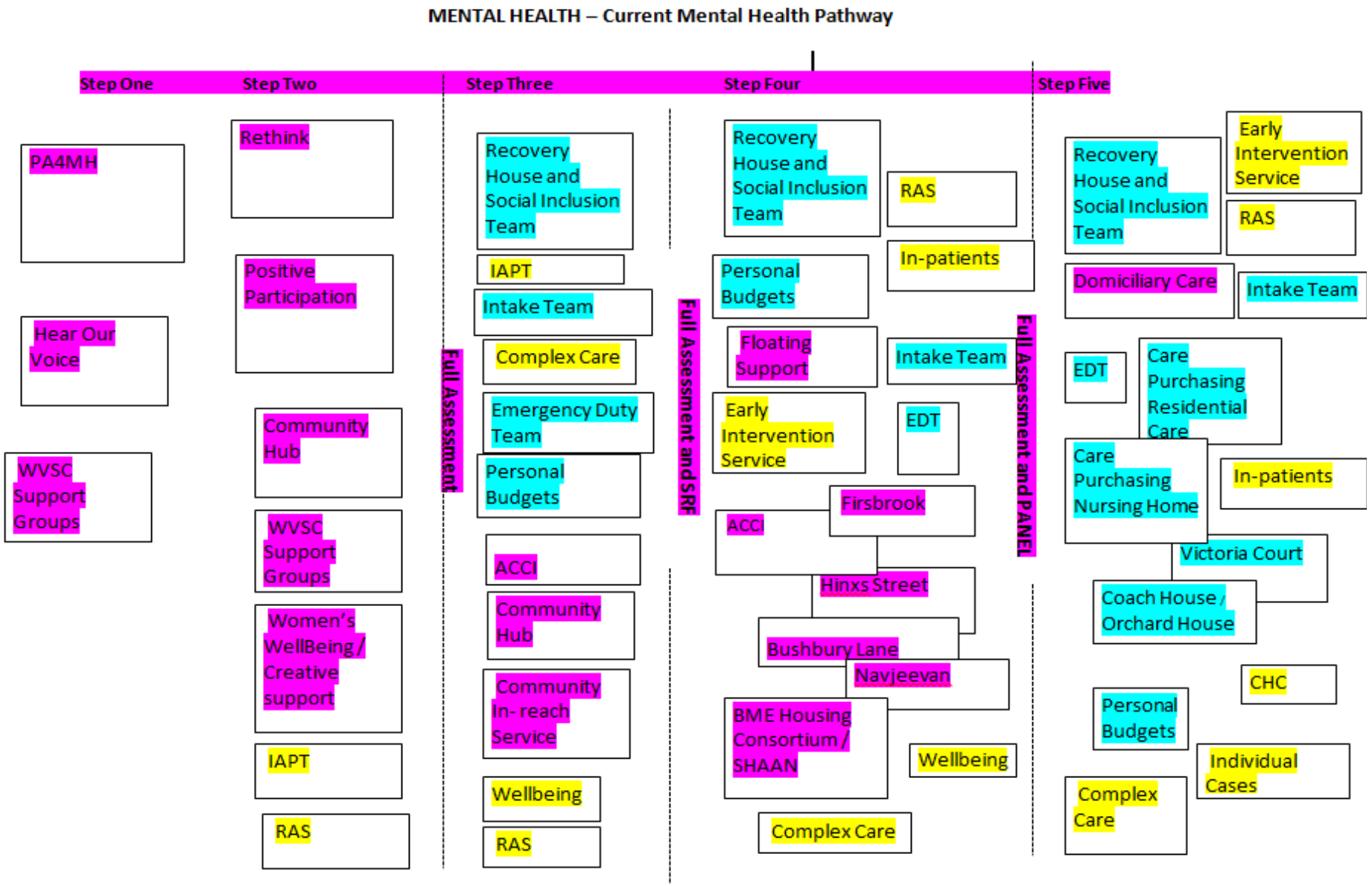
The Better Care Fund

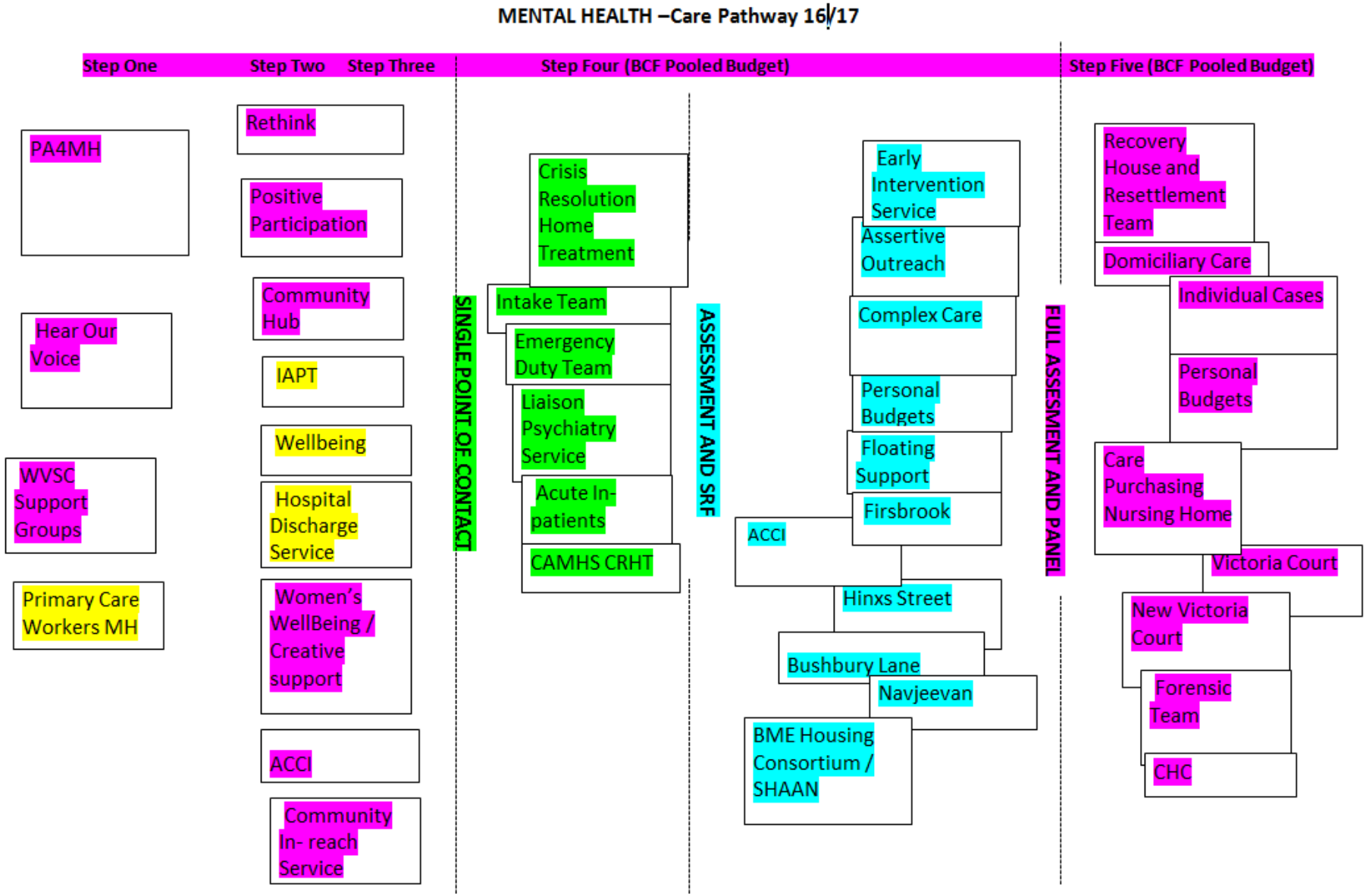
The Better Care Fund provides an opportunity to develop a single pooled budget to allow health and social care services to work together more closely. Wolverhampton's Better Care Plans are an integral and important component of our vision for mental health services in Wolverhampton. Wolverhampton's Better Care Plans include two integrated care pathways in mental health services, the Integrated Re-ablement and Recovery Care Pathway and the Integrated Urgent Mental Health Care Pathway.

The integrated Mental Health Re-ablement and Recovery Care Pathway will provide specialist re-ablement and recovery focussed assessment, interventions and support for adults with severe and enduring mental illness (SMI). This will include nursing and residential care, step-down, specialist community support and intervention, specialist mental health supported accommodation and floating support and day services and also individualised packages of care for people with high levels of need.

The integrated Urgent Mental Health Care Pathway will provide emergency and urgent assessment, treatment, intervention and care and support within an integrated health and social care model for adults and children with acute and severe mental health difficulties who require high levels of care and support in urgent and / or emergency situations.

Illustrations describing the current and future service mental health 'whole system' models are described below.


MENTAL HEALTH – Current Mental Health Pathway
Step One
Step Two
Step Three
Step Four
Step Five
PA4MH
Hear Our Voice
WVSC Support Groups
Rethink
Positive Participation
Community Hub
WVSC Support Groups
Women's WellBeing / Creative support
IAPT
RAS
Full Assessment
Recovery House and Social Inclusion Team
IAPT
Intake Team
Complex Care
Emergency Duty Team
Personal Budgets
ACCI
Community Hub
Community In- reach Service
Wellbeing
RAS
Full Assessment and SRF
Recovery House and Social Inclusion Team
RAS
In-patients
Personal Budgets
Floating Support
Intake Team
Early Intervention Service
EDT
ACCI
Firsbrook
Hinxs Street
Bushbury Lane
Navjeevan
BME Housing Consortium / SHAAN
Wellbeing
Complex Care
Full Assessment and PANEL
Recovery House and Social Inclusion Team
Early Intervention Service
RAS
Domiciliary Care
Intake Team
EDT
Care Purchasing Residential Care
Care Purchasing Nursing Home
In-patients
Victoria Court
Coach House / Orchard House
CHC
Personal Budgets
Individual Cases
Complex Care


MENTAL HEALTH –Care Pathway 16/17
Step One
Step Two
Step Three
Step Four (BCF Pooled Budget)
Step Five (BCF Pooled Budget)
PA4MH
Hear Our Voice
WVSC Support Groups
Primary Care Workers MH
Rethink
Positive Participation
Community Hub
IAPT
Wellbeing
Hospital Discharge Service
Women's WellBeing / Creative support
ACCI
Community In- reach Service
SINGLE POINT OF CONTACT
Crisis Resolution Home Treatment
Intake Team
Emergency Duty Team
Liaison Psychiatry Service
Acute In-patients
CAMHS CRHT
ASSESSMENT AND SRF
Early Intervention Service
Assertive Outreach
Complex Care
Personal Budgets
Floating Support
Firsbrook
ACCI
Hinxs Street
Bushbury Lane
Navjeevan
BME Housing Consortium / SHAAN
FULL ASSESMENT AND PANEL
Recovery House and Resettlement Team
Domiciliary Care
Individual Cases
Personal Budgets
Care Purchasing Nursing Home
Victoria Court
New Victoria Court
Forensic Team
CHC

4. KEY ISSUES / PRIORITIES

The final report of the adult mental health strategy review is attached as Appendix 2. The priorities for implementation will be aligned with those outlined in the CCG Operational Plan, the CCG Five Year Strategic Plan, Wolverhampton City Council Strategic Plan and the Joint Health and Well-being Strategy. Key priorities for future mental health commissioning have been drawn from the strategy review recommendations and key other local and national imperatives. 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 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 differing requirements to achieve parity of esteem. This will require dedicated mental health support in primary care and primary care champions in all secondary and tertiary services.
- Consultant Psychiatry and medical support and expertise requires re-focussing and balancing across the secondary, tertiary and primary care facing elements of the system. Our re-commissioned model will require increased access to Consultant Psychiatry expertise across the 'whole system' to improve access to assessment and treatment interventions and to achieve parity of esteem.
- 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.
- The application of the Care Programme Approach must be re-focussed across the 'whole 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.
- There is a need to improve access to assertive support and treatment at home, and increase capacity and capability within 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 care pathways including those providing access to specialised services 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, Eating Disorders, Personality Disorders and Peri-Natal 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 re-ablement and rehabilitation 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.

- To achieve parity of esteem improved waiting times and improved patient and carer experience in terms of emergency, urgent and routine response times and improved access to multi-disciplinary support in a crisis are required. This will involve some service re-modelling to provide dedicated support within the Acute Urgent Care Pathway at RWT. This will require local development of the Crisis Concordat with key local partners.
- Access to local female psychiatric intensive care is required.
- A refreshed approach to both the stepped care and 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.
- A 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.
- In line with the Mental Health and Psychological Wellbeing Services Strategy for Children and Young People 2013-2016 there is a requirement re-commission services for children and young people to extend the upper age limit to 25 years where appropriate to provide access to care pathways and services that are age sensitive to prevent or facilitate transition to adult services as required.
- Improved access to and recovery rates within IAPT for people of all ages and specifically for children and young people aged 14-25 years and for people aged over 65 years is required. This should include re-commissioning to deliver value for money and improved access to e-cbt.

- 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.
- 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.

In response to the above identified key issues an implementation plan is included as Appendix 3.

5. IMPLEMENTATION

For the purposes of delivery of a 'whole system' model the implementation plan attached as Appendix 3 is structured across the stepped care model, as described below.

STEPS 0-5 DEVELOP AN ALL AGE APPROACH ACROSS SERVICE MODEL THAT INCORPORATES THE NEEDS OF PEOPLE UNDER 18 YEARS AND OVER 65 YEARS

We will develop a commissioning plan / care pathway/s that align all initiatives within the implementation plan with existing and future plans regarding CAMHS and Older People's Services so that services are consistent, seamless, age related and inclusive. This will also be aligned with simple tele-health and FLO and the Emotional and Psychological Health and Well-Being Strategy (2013-2016) and Dementia Strategy re-fresh.

STEP 0 - DEVELOP A LOCAL RESILIENCE PLAN (MENTAL HEALTH PROMOTION, EARLY INTERVENTION AND PREVENTION)

We will develop a local multi-agency Resilience Plan with key stakeholders described in Wolverhampton's Health and Well-Being Strategy. 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 involved in education, employment, leisure and housing, for example to focus initiatives upon the wider determinants of health . This will include initiatives to address 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 (BME, LGBT/Q)
- Debt Advice
- Un-employment
- Educational attainment
- Ending stigma attached to mental health

STEP 1 DEVELOP A LOCAL SUICIDE PREVENTION STRATEGY

We will develop a local multi-agency Suicide Prevention Strategy with key stakeholders. This will be aligned with the local 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/Q community and people who misuse substances.

STEP 1 - DEVELOP PRIMARY CARE PATHWAYS

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, peri-natal mental health, depression and personality disorder 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 and deliver the resilience plan as described above.

STEP 2 - REVIEW COMMISSIONING MODEL OF INTEGRATED ACCESS TO PSYCHOLOGICAL THERAPIES

We will review our current commissioning model of IAPT services for patients clusters 1-3 to improve waiting times and access, so that all routine referrals are offered an appointment within 14 days for those patients meeting 'caseness' and within 28 days for those who do not. This will include increasing the accessibility of the service for targeted groups and to extend provision to children and young people aged 14-25 years and older people and people with co-morbid mental and / or physical health needs. We will look for opportunities to commission on an economies of scale basis and will seek to achieve cost efficiency savings for re-investment elsewhere in the mental health system and to balance the proportion of spend across the mental health 'whole system'. We will look for opportunities to commission E-CBT packages, with access to peer support and signposting and information and communication online. The model will also be reviewed to include primary care gateway workers to facilitate pathways for engagement with primary care to support the mental and physical health patients with differing levels and types of need.

STEP 3 – COMMISSION THE YOUNG PERSONS SERVICE MODEL

We will work with the providers of health and social care services to implement the service model changes required to complete implementation of the Young Person's service which will extend children's services and pathways to accommodate young adults up

to 25 years. This will allow young people to receive dedicated treatment and support from a designated team of clinical experts supporting their transition from CAMHS to adult services and care pathways up to the age of 25 years if required.

STEP 3 – REVIEW COMMISSIONING MODEL OF THE COMMUNITY WELLBEING SERVICE

We will review our current commissioning model of the Community Wellbeing Service for patients clusters 4 and above to improve waiting times and access, so that all routine referrals are offered an appointment within 14 days. This will include reviewing the capacity and capability of the service to offer support and interventions beyond a psychological based therapies service and to increase access within the service to multi-disciplinary and Consultant Psychiatry expertise. The model will 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 intervention that are compliant with the national guidance regarding the Care Programme Approach. The model will also be reviewed to include primary care gateway workers to facilitate pathways for engagement with primary care to support the mental and physical health patients with differing levels and types of need. This will be aligned with the review of the complex care service (as per Step 4).

STEP 3 – COMMISSION AN INTEGRATED MENTAL HEALTH URGENT CARE PATHWAY

As part of our Better Care Fund development plans to implement the Integrated Mental Health Urgent Care Pathway we will review the health components of the current model. We will re-commission Liaison Psychiatry to provide an all age model. We will review the current model of Crisis Resolution and Home Treatment to provide an integrated Crisis Resolution / Home Treatment Team. We review pathways and referral criteria into each service within the health system to improve waiting times so that waiting times (not including Wolverhampton Healthy Minds) are up to 4 hours (emergency), up to 24 hours (urgent) and up to 14 days (routine).

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.

STEP 4 – REVIEW COMMISSIONING MODEL OF THE COMPLEX CARE SERVICE

We will review our current commissioning model of the Complex Care Service, for patients clusters 5 and above to improve waiting times and access, so that all routine referrals are offered an appointment within 14 days. 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.

STEP 4 – COMMISSION AND IMPLEMENT AN INTEGRATED RE-ABLEMENT AND RECOVERY CARE PATHWAY

We will re-commission and implement an integrated re-ablement and recovery pathway as part of 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' and complex care to recovery and re-ablement in the mid to long term.

STEP 4 – REVIEW COMMISSIONING MODEL OF LOCAL SPECIALIST CARE PATHWAYS

We will work with providers of health and social care services to commission and implement specialist care pathways for the following:

- Eating Disorders
- Personality Disorder
- Peri-natal Mental Health
- Dual Diagnosis (Substance Misuse)
- Attention Deficit Disorder
- Autism

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.

STEP 5 – REVIEW COMMISSIONING MODEL OF FEMALE PIC AND OUT OF AREA ADMISSIONS FOR URGENT AND PLANNED MENTAL HEALTH CARE

We 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 within re-ablement and recovery 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.

STEP 5 - REVIEW THE COMMISSIONING MODEL OF POND LANE AND OTHER LEARNING DISABILITY IN-PATIENT SERVICES

As part of the mental health strategy implementation plan we will review the current commissioning of all LD in-patient admissions to optimise resources available within local services as alternatives to admissions to BCPFT In-patient services and out of area admissions. We will also commission to optimise the available capacity and capability within community 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. This will be to develop the capacity and capability of locally commissioned services to meet the needs of people with LD who are discharged and / or transferred from secure and specialised services. Identify opportunities for collaborative commissioning. We will identify opportunities for collaborative commissioning (e.g. SWBCCG) and others and align our commissioning plans with with Autism Strategy and Winterbourne Plans.

Summary

The priorities outlined in our re-freshed joint commissioning mental health strategy have been developed from our knowledge of local need and national best practice and policy implementation guidance. The priorities outlined above will commission a 'whole system' of integrated health and social care fit for the future which operates across the stepped care model 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 community resilience and a programme of investment in evidence based services, care pathways and initiatives to deliver improved access to early intervention and prevention, urgent and crisis care and re-ablement 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 services, quality of service user and carer experience and service user outcomes.

6. LIST OF APPENDICES

- Appendix 1 - Final Report of the Strategy Review
- Appendix 2 – Strategy Implementation Plan