Wolverhampton City PCT and City Council
Mental Health Commissioning Strategy (18-65)

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## Contents

Introduction ........................................................................................................................................................................... 3
Principles .................................................................................................................................................................................. 5
Stepped Care .............................................................................................................................................................................. 6
Key Elements of Strategy .......................................................................................................................................................... 11

1. Cross Cutting Initiatives .......................................................................................................................................................... 12
   i. Cultural Competency .......................................................................................................................................................... 12
   ii. User and Carer Involvement development – individual care and planning level ........................................ 12
   iii. Communication with Referrers ....................................................................................................................................... 13
   iv. Employment Support ......................................................................................................................................................... 14
       Develop/Commission a more comprehensive treatment/support regime across the system ................................. 16
   vi. Promote a culture that supports open debate about managing and sharing risk ........................................... 18
   vii. Implementing personalisation ....................................................................................................................................... 19
   viii. Integrated psychology and psychotherapy services .............................................................................................. 20
   ix. Care co-ordination ............................................................................................................................................................ 20
   x. Information, brokerage and advocacy ............................................................................................................................. 21

2. Prevention and Mental Health Promotion .......................................................................................................................... 22

3. Strengthen Core Primary Care .............................................................................................................................................. 23

4. Further Investment in Healthy Minds ................................................................................................................................ 27

5. Community Recovery Service ................................................................................................................................................ 29

6. Improve Access to the Secondary Specialist System ........................................................................................................ 31

7. Refocus Secondary Community Services to Provide More Intensive Complex Care .................................................. 31
   i. Review out-patient clinics .................................................................................................................................................. 31
   ii. Increasing the productivity and quality of existing specialist NSF services and further integration of these services .......................................................................................................................... 32
       iii. Redesigning existing CMHTs ...................................................................................................................................... 33

8. Reduce Capacity in In-patient Wards .................................................................................................................................. 36

9. Reduce Forensic Activity and High Cost Placements ............................................................................................................ 36
Introduction

This commissioning strategy is the product of a joint Mental Health Commissioning Project undertaken by Wolverhampton City PCT and Wolverhampton City Council. The first draft of this strategy was developed with support from Humana and RDMH during the course of 2009. This final draft has been developed with significant involvement from Wolverhampton City PCT Provider.

A multi-agency Project Steering Group, chaired by Dr Tim Crossley (Wolverhampton GP), has had oversight of the project and development of the strategy. An extensive local data collection and analysis was undertaken comprising a population needs assessment, benchmarked quantitative activity and resource data, caseload audits and qualitative data from stakeholder engagement. The results of this process are written up in the Phase One report from this project and form the local evidence base upon which this strategy has been developed. A parallel review of governance processes and commissioning skills has been undertaken and is written up in separate reports.

Attitudes and approaches to the provision of health and social care are going through a period of radical change. Across the country, services are moving from a system characterised by a focus on treating illness and ill health to one where there is promotion of health, wellbeing and independence; from a focus on doing things to or for people to enabling people to do things for themselves; from care provided in institutional settings to a greater focus on prevention, early intervention and support for self care. There is also an increasing recognition, borne out by evidence from research, that concepts of mental and physical health do not exist in silos but are inextricably bound together. This demands a much more integrated approach to health care than has traditionally been the case. In the commissioning of services – that is – the planning, purchasing and monitoring of care, there is a shift away from a system of commissioning for volume and price to one that focuses on quality, efficiency and value.

In mental health care, these shifts present many challenges, not least because of the range of skills to which people with mental health problems may need access. Commissioning co-ordinated services for individuals whose needs cross organisational boundaries between health, social care and physical and mental health services, requires that all services work together to ensure that people don’t “fall between gaps” in the system.

The aim of this strategy is to ensure that adults with mental health problems, and their carers, have their mental wellbeing needs identified and met wherever they are in the service system or in the community, without encountering discrimination or barriers to access to timely and effective interventions.
Our work to improve mental health services began because patients, carers, clinicians and partner organisations wanted a better service. After completing our needs assessment we identified that it would be possible to have a better service at no long term increased cost. This strategy will require short term (up to 3 years) investment to deliver long term quality improvements and financial efficiency. It builds on national best practice and Wolverhampton’s previous mental health joint commissioning strategy, achievements of the National Service Framework implementation, as well as early work in Improving Access to Psychological Therapies (IAPT) in Wolverhampton. It explicitly focuses on all the elements of the Quality, Innovation, Productivity and Prevention (QIPP) agenda. As the NHS moves forward in a time of financial uncertainty it is important that any new strategy is developed from a thorough needs analysis which includes these aspects. This strategy provides a rigorous platform to transform Mental Health services in Wolverhampton.
Principles

The core principles of this commissioning strategy have been derived from national policy and local engagement. The guiding principle is that the provision of care is fair, personalised, safe and effective\(^1\). This sits alongside emerging national mental health policy for the next ten years which focuses on tackling the root causes of poor mental health and getting support to people where and when they most need it\(^2\). From these core drivers, other principles and values follow:

- Recognise the need to prevent as well as treat mental health problems and promote mental health and well being
- Develop the ethos of the service to be proactive, outward looking, engaging communities
- Create responsive, flexible and inclusive services – minimise the emphasis on exclusion criteria. In particular ensuring inclusion for people with dual diagnosis, learning disabilities and physical health problems.
- Strengthen the focus on social inclusion; tackle stigma and discrimination wherever they occur
- Strengthen partnerships especially with third sector organisations with a focus on Black and Minority Ethnic groups.
- Prioritise appropriate, up to date, evidence based treatment and support, as close to home as possible
- Design pathways that will care for the whole person
- Facilitate informed choice on services, location, provider and treatment
- Build good practice in user and carer involvement
- Link health and well being to individuals’ wider social context particularly housing, employment and education
- Reduce variation in access to services and remove barriers related to age
- Make education available to the whole workforce including acute sector, carers, users and families

\(^1\) DH(2008) High Quality Care for All (Darzi)

\(^2\) DH (2009) New Horizons
Stepped care

Mental health services and support in Wolverhampton will be commissioned and provided using a stepped care model.

Stepped care is a model of delivering and monitoring the intensity of interventions according to need, based on the principle of Least Intervention First Time. A stepped care model promotes choice and open access. It embodies a philosophy which builds on strengths and avoids dependence³. A stepped care model is one in which:

- there are interventions of different levels of intensity available to the service user
- the intensity of the intervention is matched to the service user’s needs
- there is careful monitoring of service user outcomes, allowing interventions to be ‘stepped up’ or ‘stepped down’ if required.
- service users usually move through less intensive interventions before receiving more intensive interventions (if necessary)
- there are clear referral pathways between the different levels of intervention
- the direction of travel is two way - people can step down, with appropriate support, as well as up.
- the importance of supporting self care is recognised as an important aspect of managing demand

There is good evidence for both the clinical and cost effectiveness of stepped care models⁴. Potential benefits include:

- increased recognition and recovery rates
- reduced disability and impairment related to work, family and social participation
- reduced socioeconomic and ethnic inequalities in mental health and addiction
- economic and social benefits associated with fewer patients developing more severe mental health and addiction problems
- a more cost-effective way of delivering services
- shorter waiting times

³ New Ways of Working for Primary Care Mental Health: a briefing document. DH 2009

- reduced demand for specialist mental health and addiction services
- reduced stigma for service users
- a more holistic and integrated model to treating health problems
- greater opportunities for promotion, prevention, and early intervention in mental health and addiction
- increased chances of a person accepting a psychiatric assessment if it does not involve going to the hospital
- enhanced communication between GPs and specialists.

The diagram below shows a visual representation of a stepped care model for Wolverhampton:

**Figure 1**

**Proposed model of care**

- Step 1: Expectations of care primary care in mental health in context of RCGP competences defined. Sufficient flexibility in time and length of appointment. Consider onward referral. Recovery maintenance. For those not engaged in primary care, develop protocols between third sector services and mental health specialists considering self-referral and/or provide advice support.

- **Public Health/Mental Health Promotion**: Engage local community organisations in mapping and communication exercise 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 partnerships e.g. through Wolverhampton GP Partnership, social enterprise type step front project. Public Health leadership. Evidence based interventions using NICE public health guidance and APHS evidence.

- Step 2: Routine information, self-help, physical interventions (exercise, nutrition), and physical health treatment. Tailoring therapies to: workbooks, computerised CBT, Stress Groups (Healthy Minds), Medication Social intervention (posting, Recovery support (Community Recovery Team – direct interventions and coordination of other support services).

- Step 3: Evidence based interventions as at step 2 but with increased intensity targeting more complex patients (Healthy Minds). Recovery support (Community Recovery Team – direct interventions and co-ordination of other support services).

- Step 4: Complex community interventions. Access specialist services (Complex Care Team including Assertive Outreach Function/Young Persons Team including Early Intervention).

- Step 5: Forensic Residential and Acute in-patient care.

**Employment Support**

- Emergency referral (within 4 hours)
- Assessment Team (including urgent referral – within 48 hours)
- GP Referral

**First point of contact**

- Collaborative approach between primary, secondary and third sector practitioners

- Local primary care service

- Complex and long term care

Stepped care has two principles:

1. Treatment should always have the best chance of delivering positive outcomes while burdening the patient as little as possible

2. A model of scheduled review that detects and acts on non-improvement must be in place to enable stepping up to more intensive treatments (or stepping down where a less intensive
treatment becomes appropriate and stepping out when an alternative treatment or no
treatment becomes appropriate).

The importance of scheduled review cannot be overstated. Stepped care cannot be effective in
meeting people’s changing needs unless health and social outcomes are recorded accurately,
regularly and frequently for each patient. A data collection system can be adapted from local existing
systems or bought in from a private service provider.

The two principles may be implemented in more than one way. In a pure stepped model, almost all
patients are offered a low intensity treatment as the initial step in a treatment programme. Higher
intensity treatments are reserved for those patients who do not benefit from the initial low intensity
step. In contrast, a stratified model assesses patients and allocates them to either low or high-
intensity steps as an initial treatment option.¹

It is not possible to operate a stepped care model unless all steps are resourced and functioning
optimally across the model. The proposed care pathway for Wolverhampton, from which the strategy
components are derived, is shown below:

Figure 2

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¹ DH(2008) Improving Access to Psychological Therapies Commissioning Toolkit
Action plan for redesign of current mental health service model

Evidence gathered from phase one of the mental health commissioning project showed that the current model has most of the service elements you would expect to see in a whole system. There is a notable gap in relation to a step 3 mental health service but much of the key foundations are in place with some innovative services and good practice models present. However there are a number of pressure points within the system particularly around timely and appropriate access, and a crisis reactive approach with corresponding over reliance on longer hospital admissions, tertiary and forensic services including residential and nursing care placements.

There are four key elements to the emerging hypotheses on redesign opportunities. These are:

- **Support a recovery approach in the stepped model of care** by building on the development of the Community Recovery Service (Navigation Bridge Building and Social Inclusion Recovery Service – developed through the redesign of day services). The next step for this service is to develop closer working relations with Healthy Minds to meet the needs of individuals stepping down from secondary care. The enhanced Community Recovery Service will provide an alternative to referral into secondary care, support transition out of secondary care and facilitate transition in to secondary care. This is a crucial development in achieving a more balanced and effective model of care. Care pathways should more readily respond to the diversity of culture and need within the local population.

- **Strengthen and integrate community services**, as an alternative to in-patients, for people with more complex and long term mental health needs. Through developing specialist complex care and long term care services reliance on acute care, residential and forensic care placements will be reduced. The working hypothesis – based on evidence from phase one – is that a significant proportion of current step 4 activity in psychiatric out-patients could be undertaken within step 2-3 services (Healthy Minds and Community Recovery Service). Support and intensive treatment for people with long term and/or complex needs (including dual diagnosis (substance misuse and learning disability) and personality disorder could then be provided through a new complex and long term care team drawn from the existing resource in Community Mental Health Teams. The Assertive Outreach function should be incorporated into this team with resources allocated on the needs of the individual rather than team role.

- **Improve and clarify access routes across the system**. This will ensure that individuals are able to access services in the most efficient way to meet their need and avoid inappropriate use of resources. The model will proactively encourage referral at the lowest steps of care and gate keep referrals to higher steps of care.

- **A reduced reliance on forensic and other high cost individual placements** would free up significant resources to fund the redesign and refocus of community services in both primary
and secondary care over the longer term. The role of the local recovery house will be reviewed to continue to offer an alternative to hospital admission.

These four elements are interdependent on each other. The current Community Mental Health Teams cannot create additional capacity and develop expertise in complex care without reducing out-patient activity. This current activity cannot be supported in an alternative way without the development of an enhanced primary care service and associated wider community support services. In order to develop a holistic approach and integrated care pathways which enable joint working and greater access, fairness and choice to individuals services will need to be more responsive and productive, for instance, the Crisis Resolution/ Home Treatment. The investment that will be necessary to develop primary care and wider community support services is currently locked into forensic services and into low productivity within the existing services.
Key elements of strategy

Based on the proposed new stepped care model and using the evidence from the engagement processes and data analysis, the key elements of the mental health commissioning strategy for Wolverhampton are:

1. Cross Cutting Initiatives
2. Prevention and mental health promotion
3. Strengthen core primary care
4. Further investment in Healthy Minds
5. Expand role of the Community Recovery Service
6. Improve access across the system based on application of stepped care principles
7. Refocus secondary community services to provide more intensive community complex and long term care
8. Reduce capacity in in-patient wards
9. Reduce forensic and other tertiary, high cost activity

These key elements will be underpinned by a number of cross cutting initiatives.
1. Cross cutting initiatives

A number of initiatives that cut across all steps of the pathway will be fundamental to implementation of the new model of care:

i. Cultural competency

National policy and the local needs assessment for Wolverhampton demand a recognition that people from certain Black and Minority Ethnic backgrounds are currently over represented in inpatient settings and high cost placements under detention of the Mental Health Act\(^6\). The principles underpinning this strategy demand that people be treated with humanity and with recognition of diverse needs, contexts and determinants in individual presentations of mental health problems. An understanding and a prioritisation in practice of cultural competency development agendas across all services will be a fundamental prerequisite to the provision of services appropriate to the diverse population of Wolverhampton and to reducing health inequalities and social exclusion. Mechanisms for achieving this will derive from strengthened partnership approaches with third sector organisations focussing on Black and Minority Ethnic groups, building on their understanding of and connection with local communities.

All provider services will need to satisfy commissioners that they recognise the challenge of this agenda in Wolverhampton and can demonstrate proactive approaches to partnership building and workforce development initiatives. Progress will need to be tracked through a combination of data including accurate ethnicity monitoring against use of the Mental Health Act and qualitative feedback from local stakeholders.

ii. User and carer involvement development – individual care and planning level

A core aspect to developing the quality of the service and evidence of the standards to which the service is being provided will be development of user and carer involvement. This is a theme running through all relevant national policy, is a core competency in the World Class Commissioning framework and is central to good clinical and social care practice at an individual level.

Evidence derived from the engagement processes and data collection underpinning this strategy suggests that, despite strong efforts by some individuals, user and carer involvement is not embedded currently into the practice or culture of the statutory organisations in Wolverhampton.

\(^6\) Department of Health (2005) Delivering Race Equality in Mental Health Care
A culture which is open to involving service users will be reflected in:

- a focus on therapeutic alliance as the basis for interaction
- practice that develops and promotes self-management and control; for example, through service user management of the Care Programme Approach (CPA) process, and other types of planning and goal setting
- support available in a range of ways to allow for different choices; for example, providing access to alternative therapies and individual as well as group work
- arrangements to ensure that service users’ views are sought regularly and are part of the decision-making process
- involving service users in shaping and operating the day-to-day service; for example, in supporting new clients, developing leaflets and written material, organising day or group activities, and supporting or organising out-of-hours support arrangements
- involving service users in shaping the whole service; for example, through membership of steering committees and boards, in research and evaluation, in recruiting and training new staff and in developing and extending services
- service user views and feedback forming an essential part of the commissioning process
- ex service users being involved alongside commissioners in needs assessment, development of commissioning plans and service reviews\(^7\).

There are a number of models of good practice for involving service users around the country that might be referenced in developing involvement initiatives in Wolverhampton.

**iii. Communication with referrers**

Through stakeholder engagement, referrers have identified that they lack understanding about their patients care. The referrer will generally still be involved in the patient’s wider care and therefore it is important they understand the support the patients is receiving from mental health services. Therefore communication with the referrer, including the referrer in the care planning and considering discharge back to the referrer when appropriate will be addressed at all steps of the model.

\(^7\) Adapted from DH Commissioning guidance for personality disorder services (2009)
iv. **Employment support**

There is a powerful evidence base pointing to a strong association between employment and health, particularly mental health. **‘Work is extremely important both in maintaining mental health and in promoting the recovery of those who have experienced mental health problems. Enabling people to retain or gain employment has a profound effect on more life domains than almost any other medical or social intervention.’**

‘Work’ means paid employment, education/training, voluntary work or other occupation meaningful to the individual concerned.

Health Work and Wellbeing is a cross government programme working in England across the Department of Health, the Department for Work and Pensions and the Health and Safety Executive. This cross agency approach must be replicated at a local level through appropriate joint/partnership working. Partnerships and interagency working are crucial to developing employment services for people with mental health problems. Mental health and wellbeing considerations should be a core component of all city wide employment initiatives. The City Council, in particular, should take steps to ensure that initiatives relating to other groups of people with disabilities are joined up with and inclusive of consideration of the needs of people with mental health problems.

The significance of work and/or meaningful occupation needs to be understood by professionals at every step of the care pathway. This raising of awareness and associated activity will need to be matched by the development of specialist employment support services modelled on the elements of successful work projects and ensuring fidelity to models of known effectiveness and adherence to accepted quality standards. Research evidence suggests that specialist vocational services are more effective at getting people into work when integrated with mental health teams. The Individual Placement and Support (IPS) model of supported employment has strong evidence in its favour though may not suit everyone at all times.

There are a number of established initiatives that will support this element.

- Navigation Bridge Building Officers – funded through the city council and based in CMHTs is considered a good resource by local stakeholders. This offers a strong building block for future developments.

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The newly commissioned Community Recovery Service (in response to day service redesign) is concentrating on opening up new opportunities for people in education, employment, volunteering and leisure. The services will also work with other people to increase the profile of mental health within the City in order to reduce stigma around mental health issues. The service will work with individuals to raise their awareness of social exclusion, as well as ‘tackling’ the stigma individuals’ experience.

Healthy Minds has been commissioned to develop a vocational leads role. This post started in October 2009.

The Joint Commissioning Unit is developing a local employment service for all adults – with a view to supporting the service to develop into a social enterprise. This will promote innovation and creativity which will lead to greater independence, choice and control for individuals who have used or currently use mental health services.

Further steps that will be key to implementing this initiative include:

- Immediate investment in employment within Healthy Minds. A vocational lead was appointed in October 2009. This role will be supported by further resource for employment advisors.
- The Community Recovery Service will be made available across wider steps of care. This will provide consistency around education/ employment/ social inclusion support when patients are stepping up or stepping down in the pathway.
- In the longer term, the Healthy Minds employment resource will be merged with the Community Recovery Service providing a more robust employment resource across all steps of care. They will work closely with mental health teams at all steps of care ensuring specific attention to employment and occupation in all care planning processes.
- The existing services and new developments will work together to promote knowledge of the evidence base and create a positive culture and attitudes amongst professionals about the employability of people with mental health problems. This will include communication and liaison between GPs, mental health professionals and occupational health staff and is an essential part of keeping people with psychiatric disabilities in work or getting them back to work.
- Through the strengthening core primary care element, the role of General Practitioners in employment will be enhanced to ensure:
  - Consideration is always given to how clinical management would support a patient back into work;
  - There are positive expectations about patients’ return to work;
  - Progress is emphasised and appropriate therapy offered where possible;
- The risk of losing an existing job is differentiated from the problems of getting back into work after a long absence;
- Communication with the employer occurs within the constraints of ethics and confidentiality\textsuperscript{11}.

v. Develop/commission a more comprehensive treatment/support regime across the system

Local stakeholder feedback suggests that the PCT’s statutory provider is still dominated by a heavy reliance on a medical or medication based model of intervention, reflected in the operation and organisation of the workforce. Many stakeholders have also commented that the current model is unjustifiably risk averse. Such a model has been shown to have inherent inefficiencies and to be suboptimal in supporting recovery\textsuperscript{12}. Nationally there is clear guidance for the development of mental health workforces through the New Ways of Working programme. This describes a well balanced skill mix in terms of the holistic model of care that is envisaged in this strategy, with particular prominence given to new or extended roles, including support, time and recovery (STR) workers, non-medical prescribers, staff delivering psychological interventions, supporting people back/into employment, etc., based on need and purpose of the service.

Many services are now proactively recruiting people with direct experience of services into the workforce, in professional roles or as peer supports, according to skill profiles. Specialist mental health service providers can reasonably be expected to take a lead in this regard in local communities as part of initiatives to reduce stigma and extend employment opportunities for people with lived experience of mental ill health.

New Ways of Working and the concept of recovery demand a different relationship between service users and Mental Health professionals. This has been characterised as a shift from staff who are seen as remote, in a position of expertise and ‘authority’, to someone who behaves more like a personal coach or trainer: “offering their professional skills and knowledge, while learning from and valuing the patient, who is an expert by experience”\textsuperscript{13}.

The skills, knowledge and experience of consultant psychiatrists are used to best effect by concentrating on service users with the most complex needs and acting as a consultant to

\textsuperscript{11} RCP (2002) As above
multidisciplinary teams. The cultural shift that is needed in services will be achieved by implementing the guidance in New Ways of Working, in particular promoting distributed responsibility and leadership across teams\textsuperscript{14}.

A comprehensive workforce strategy is being developed in order to ensure that the workforce reflects the needs of the population and have a robust set of skills, knowledge and value base to deliver a high quality service, as well as demonstrating value of money. Some of the changes will involve:

- Dedicated medical staffing teams for in-patients, CRHT and Complex Care Teams.
- An assessment system in Complex Care that will gate keep patients referred to out-patients.
- A health element of the Community Recovery Service which in the short term will focus on supporting non-CPA patients who currently receive out-patient support but no care co-ordinator support to step down.

It is anticipated that these changes will also enable medical staffing resource to be further reduced by 2012. The savings made will be reinvested in staff that can support an individuals’ recovery.

\textsuperscript{14} Department of Health (2005) New Ways of Working for Psychiatrists.
vi. **Promote a culture that supports open debate about managing and sharing risk**

Many stakeholders have commented on a perceived ‘risk averse’ culture in current statutory mental health services in Wolverhampton, and on the negative impact that this has on the quality of care for individuals and the use of resources across the mental health system. There are a number of aspects of national policy that collectively demand a more open debate about the management and sharing of risk. These include the national commitment to promoting choice in public care services, the focus in Lord Darzi’s Next Stage Review on working with people in partnership, and the focus on personalised services that is central to New Horizons. None of these aspirations will be implemented in practice unless there is a shift away from risk averse practice and a collective articulation of an acceptance of certain risks in mental health – as in all other areas of health and social care. Better mental health care for all, especially for those about to relapse and irrespective of the risk of violence, is more likely to prevent incidents occurring than simply targeting resources on those assessed as being a high risk.\(^{15}\) Initiatives that will support this shift in culture will include:

- Embedding learning from Serious Untoward Incidents. This needs to be balanced with designing services for the typical patient as opposed to the exceptional patient.
- Implementing national guidance on recovery and personalisation
- Implementing New Ways of Working
- Implementation of Advance Directives, particularly with people known to present risks when unwell
- Involvement and employment of service users in peer support and staff training across services

vii. **Implementing personalisation**

Independent living, participation, control, choice and empowerments are key concepts of personalisation – they have their origins in the independent living movement, as well as the social model for people with a mental illness.

Self-directed support is the route to living independently. The key characteristics of self-directed support are defined as:

- The support is controlled by the individual
- The level of support is agreed in a fair, open and flexible way

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- Any additional help needed to plan, specify and find support – as agreed by the individual – be provided by people who are as close to the individual as possible
- The individual should control the financial resources for their support in a way they choose. For instance through individual budgets.

The new model will increase choice and control by encouraging individuals to self-direct their own care. The aim of the model is to ensure that individuals are enabled to live independently. The services will demonstrate high quality, as well as ensuring personal safety. The new model will also ensure that social inclusion is promoted and tackles inequalities.

Wolverhampton recognises that to meet this goal, the system will need to undergo further significant redesign in process, practice and culture to ensure people have access to high quality information and support to enable informed decision making. Wolverhampton’s allocation of the Social Care Reform grant is £1.1m in 09/10 and £1.3m in 10/11 (all client groups) in order to ensure that the Putting People First Agenda is delivered locally. Wolverhampton is currently developing a ‘blueprint’ which will set the strategic vision and journey of travel. Mental health social care services will be commissioned in line with the blueprint and this strategy.

It will be important to ensure that initiatives under this funding are designed to be inclusive of the needs of people with mental health problems and consistent with the direction of service development envisaged in this strategy.

viii. Integrated psychology and psychotherapy services

Early indications from the implementation of Healthy Minds (Improving Access to Psychological Therapies) in Wolverhampton are that it will reduce the demand for secondary psychology services. From the perspective of the patient journey, a core driver in this strategy is to offer holistic and integrated service responses that minimise waiting times. The current Integrated Psychology and Psychotherapy Service (IPPS) appears to stand apart from the other statutory community services, in terms of referral, assessment and governance processes. The demand for and resource within this service, needs to be better understood within the context of Healthy Minds developments. It is difficult to understand the justification for a separate service. It is recommended that IPPS is decommissioned and some of the psychology resource is integrated into existing and new specialist teams, within appropriate professional supervision arrangements (as for other specialist disciplines in the multi-disciplinary team) – as set out in the model care pathway.

ix. Care coordination
Proactive care coordination/case management, informed by the underpinning principles of the stepped care model and by relevant advice in the CPA guidance, provides a more satisfying and relevant service to the user, frees up time for the clinician who is not seeing those who are well, and provides better continuity of care. It is central to improving efficiency and quality of patient experience. Care co-ordination should ensure both that needs appropriate interventions are organised when required and that individual journeys across the stepped care model are timely relative to changing needs.

x. Information, brokerage and advocacy

At all steps of the model of care, the importance of information and signposting cannot be over emphasised. A statutory right to Independent Advocacy is now part of mental health law for people detained under the Mental Health Act. The PCT will need to be confident that current provision of Independent Mental Health Advocacy (IMHA) services is sufficient to meet its statutory duties in this regard.

Fundamental to the implementation of Putting People First Agenda and the delivery of individual budgets is the existence of a range of brokerage systems and processes. Although increasingly access to social care and some health care will be through personalised budgets which will require, in future, new forms of brokerage and advocacy. It will be important in commissioning the new model of care to ensure that pathways and ‘rules of engagement’ across the system reflect the underpinning intentions of the stepped care model. The example that has recurred through stakeholder engagement is the need to eradicate the current ‘rule’ whereby access to certain services is dependent upon receipt of treatment from a psychiatrist. New Ways of Working, the recovery model and the stepped care model demand a much more flexible, needs led approach to access to all services.
2. Prevention and mental health promotion

It is recognised that prevention and mental health promotion are a key part of the whole mental health system. However, proactive work in this area has the potential to increase demand at higher steps of care and therefore it is important to ensure that capacity at these steps is assured.

Investment at step 0/1 is currently minimal and in the short term there is still little ring fenced funding. However, in the longer term, as resources are released at higher steps of care the resources available for step 0/1 will increase.

Through stakeholder events a number of proposals have been generated. These will be further explored as and when opportunities arise.

- Actively seek opportunities for promotion of mental health for all through existing partnerships. Look at wider opportunities for preventative work e.g. though employment strategy, ASBO Forum, Wolverhampton Safer Partnerships work on guns and gangs – need to recognise the link with drug misuse.

- In partnership with appropriate third sector Black and Minority Ethnic organisations, develop a programme targeted specifically at young Black males – the group most at risk of detention under the Mental Health Act in acute and forensic services.

- Develop a social enterprise type shop front project (like Age Concern)
  - Partnership between third sector organisations
  - Charity shop/cafe/advice
  - Employment/volunteering opportunities

- Public health leadership to campaign on mental wellbeing; implement evidence based interventions using NICE public health guidance and Association of Public Health Observatories (APHO)\(^\text{16}\) evidence.

- Strengthen the quality of and access to information about mental health problems, solutions, local resources.

- Link with schools/education service to raise awareness/reduce stigma about mental wellbeing. Include families. Schools may have under-used budgets for this.

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\(^{16}\) APHO Indications of Public Health in the English Regions 7: mental health
- Build on the partnership approaches around the Common Assessment Framework for children and young people – the relationships between the services are not good. Family interventions could be preventative and are recognised in the Bradley report as an important preventative measure.

- Some stakeholders suggest that Wolverhampton needs a Violence and Abuse Strategy because violence and abuse is such a significant problem across the city. There are high numbers of referrals to Domestic Violence services. A VVAP (Victims of Violence and Abuse) programme was recently piloted and is seen to have potential locally.

- The social inclusion agenda demands that all cross agency work on tackling the wider deprivation indices in the city must recognise and address the strong association between deprivation and mental ill health/lack of emotional well being. This will be particularly significant in addressing:
  
  - The City’s employment strategy – this needs to be made inclusive to people with mental health problems. High rates of unemployment, particularly amongst young people, will have a negative impact on individual mental health and longstanding repercussions for the mental health system.
  
  - teenage pregnancy
  
  - family interventions at an early stage in child/adolescent problems

3. Strengthen core primary care

Fundamental to developing mental health care at steps one to three of the model is clarifying the PCT’s expectations of primary care practitioners through existing contracts. It is envisaged that the implementation process will incorporate an assessment of how this might best be achieved in terms of awareness raising, skill development and incentivisation e.g. through the Quality and Outcomes Framework (QOF).

The PCT is committed to improving the quality of core primary care practice in mental health across Wolverhampton. New Ways of Working identifies increasing confidence in mental health issues for primary care team members as one of five key practice changes that would make a real difference to the primary care mental health workforce. The Department of Health has recently suggested that ‘a more rigorous approach to the world class commissioning competencies in relation to access and

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responsiveness, combined with the huge value patients place on their family doctor services has enormous potential for continual improvements and innovation.\textsuperscript{18}

It is important to recognise that the GP surgery provides the most visible, accessible and least stigmatised entrance to personal health and social care help seeking. One consequence of this is that GP practices attract attendance from people with a very wide range of needs – not all of which will be best met through the NHS. However, the medical context encourages a medical presentation and consequent ‘diagnosis’ or onward referral. There is an inherent risk that social care issues and activities of daily living become ‘medicalised’. Social stigma surrounding mental ill health combined with professionals’ under-developed skills and confidence in identifying and addressing mental health issues may encourage a focus on physical symptoms. Short consultation times and lack of continuity between healthcare professionals compound this risk. These factors need to be taken into consideration when addressing the issue of primary recognition and identification of mental health issues at step one-two of the stepped care model.

There are significant patient care and cost benefit implications to strengthening mental health practice in primary care. This includes all primary care practitioners (e.g. Midwives, Health Visitors, Practice Nurses), not just GPs. Commissioning of initiatives under this umbrella will be led by a mental health sub group of Practice Based Commissioning as part of a new Mental Health Commissioning Forum.

Changes over time might be achieved through a combination of levers, service development and softer approaches particularly educational and relationship building. Proposals under each of these categories have been made in consultation with the two local GPs leading on mental health.

4. Further investment in Healthy Minds

Whilst there is increasing guidance\textsuperscript{19,20}, there is no national blueprint or specification for a primary care or step 3 mental health service. Evidence from the early implementation sites for “Improving Access to Psychological Therapies” does not support strongly one model over another. This element of the strategy therefore focuses on the functions and interventions that should be offered at the level of primary care. The way in which these functions are managed and organised will be determined by the selected procurement route which in turn will, unless additional resources are available, be

\textsuperscript{18} Department of Health(2009) Primary care and community services: Improving GP access and responsiveness
\textsuperscript{19} Raistrick H, Richards D (2006) Designing Primary Care Mental Health Services. CSIP
determined by progress in managing activity and costs downwards in the stepped care model across existing services.

Consistent with the principles of stepped care, the intention is both to provide timely support that has the best chance of delivering positive outcomes while burdening the individual user as little as possible and to increase the capacity of the whole system to support step down where a less intensive treatment becomes appropriate.

Key to this element of the mental health commissioning strategy is improved access to psychological or talking therapies. The importance of this element is highlighted in the PCTs Strategic Plan where it contributes to priority 3: remodel care pathways and increase access and choice to community services that aim to prevent ill health and reduce avoidable hospital care. This element features as goal 8 and initiative 6 with a target of providing 6,000 completed interventions by 2013/14.

The PCT is currently in the second year of its “Improving Access to Psychological Therapies” implementation programme. However, the evidence of demand for these services from existing service waiting lists and other sources\(^{21}\) indicates that effective deployment will depend on providing sufficient resource at this step and an ability to identify and target those most in need. It will also require a collaborative approach with relevant community organisations to ensure that psychological needs are met in tandem with interventions to address the social, family and economic determinants that may have contributed to the development of the identified mental health problem. The British Association for Counselling and Psychotherapy is a useful resource here\(^{22}\).

Therefore, further resource is being invested into the Healthy Minds service to enable the workforce to expand with a particular focus on step 2 workers, psychological wellbeing practitioners and employment advisors. This will enable a number of initiatives to be explored that could improve the quality and efficiency of mental health support at steps 2-3:

\(^{21}\) HCC/CQC patient surveys
\(^{22}\) [www.bacp.co.uk](http://www.bacp.co.uk)
- **Improved access at step 2.** Currently the majority of referrals to Healthy Minds are made by GPs with a minority of self-referrals through third sector partners. Self-referral as an ultimate goal at step 2 is being considered. There are pros and cons to this model. The positives are it will ensure access for those not engaged with primary care. However, the negative is that these patients would miss the GP step of the pathway and therefore only the mental health perspective in their care will be addressed.

- **Effective advice giving and triage.** Evidence suggests that the use of telephone triage can reduce the number of immediate visits to doctors, does not appear to increase visits to Accident and Emergency departments and achieves good satisfaction levels from users.\(^\text{23}\) The Healthy Minds service has already started to develop a telephone triage system.

- **Enable flexibility in length of appointments** – time is needed to explore mental health issues. With further resource, the service will be able to offer more flexibility.

- **Service user communication programmes** to improve awareness about self help strategies, services and influence patient and carer expectations. Healthy Minds has piloted and is rolling out Stepping Forward groups. This is run over six sessions in a classroom environment and teaches participants the tools to manage their own anxiety and/or depression. Carers are also welcome to attend. The pilots have demonstrated that this type of intervention does not appeal to all clients. However, those who do attend respond very positively with a large proportion “moving to recovery”. In addition, significant numbers of friends and family have accompanied clients to the group.

- **Self management tools for low level mental health problems.** Ensure that attention to mental health is included in all self help interventions for management of all conditions.\(^\text{24}\) Healthy Minds in conjunction with the PCTs mental wellbeing lead and Lifestyle services are developing a website that will provide self help resources. Promotional campaigns will be developed to make these resources accessible to those who can take advantage of them.

- **Parenting support.** Integrate mental health and wellbeing considerations into all parenting support initiatives including the work done by health visitors. Consider the development of

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\(^{24}\) NHS primary care commissioning (2009) Primary Care Service Framework: Support for Self Care in Primary Care
specialist parental mental health initiatives modelled on those developed by the Changing Minds Centre in Northampton.\textsuperscript{25}

- \textit{Employment advice and support.} For adults of working age with common mental health problems, consultation with the GP is needed to validate their inability to work through the signing of a sickness certificate.\textsuperscript{26} This should be considered an opportunity to offer support both around the patients mental health but also around their employment. A vocational lead role has been developed and further resource will be invested for advisors. These roles will work closely both with Healthy Minds and with the Community Recovery service to ensure that continuous employment support is offered to patients whatever their current step of care.

- \textit{‘Social’ prescription schemes.} Examples include exercise referral schemes, books, arts therapies, education schemes. Books on prescription and the DH’s “Lets Get Moving” resources for physical activity are already utilised by Healthy Minds. These will be promoted further to be used outside this service at step 3 and below. Other schemes will also be explored for development.

- \textit{Integration with long term condition initiatives.} Evidence\textsuperscript{27} suggests that depression (and associated anxiety) is at least twice as common in the physically ill as in the healthy, and that appropriate treatment for depression improves both physical and mental health outcomes. Psychological therapies therefore are an important component of interventions to support people with long term physical conditions and people with repeated presentations of medically unexplained symptoms.

- In recognition of the need to integrate the social inclusion agenda with more prescriptive interventions such as those delivered through Healthy Minds, some areas are developing ‘wellbeing services’ that offer holistic evaluations and interventions.\textsuperscript{28} This model of service focuses on promoting self directed support through such interventions as peer support, parental mental health support and education based initiatives.

- \textit{Develop carers’ support using the National Carers’ Strategy allocation}

\begin{flushleft}
\textsuperscript{25}http://www.changingmindscentre.co.uk/v/parental_mentalhealth_team
\textsuperscript{26}Sainsbury Centre for Mental Health (2007) Work and wellbeing: Developing primary care mental health services. SCMH briefing paper no. 34
\textsuperscript{27}Lyons C, Nixon D and Cohen A (2006) Long Term Conditions and Depression. Considerations for Best Practice in Practice Based Commissioning. CSIP/Department of Health
\textsuperscript{28}See particularly Changing Minds in Northamptonshire www.changingmindscentre.co.uk
\end{flushleft}
- **Strengthen access to practical advice and support**, for example in relation to housing and benefits. This will be done through close working with the Community Recovery Service which is discussed in the next section.

These interventions, in total, represent a comprehensive step 3 mental health service. They might be provided directly through existing providers, a specialist wellbeing mental health service, 3rd sector providers, or most realistically - through some combination of these.

A wider range of appropriate premises will be explored to make specific interventions as accessible as possible. The intention would be to draw on a range of resources including those in primary care practices, the 3rd sector, community buildings and other existing health or local authority owned premises.

5. **Community Recovery Service**

There has been a recent change in Wolverhampton around day services provision. Day services have been decommissioned and two new services have been commissioned to meet the need of individuals through day services. The newly commissioned Community Recovery Service (Navigation Bridge Building Service and Social Inclusion Recovery Service) concentrates on opening up new opportunities for people in education, employment, volunteering and leisure. The services will also work with other people to increase the profile of mental health within the City in order to reduce stigma around mental health issues. The service will work with individuals to raise their awareness of social exclusion, as well as ‘tackling’ the stigma individuals’ experience.

- **Flexibility around steps of care** - Currently this service is focussed at step 4 clients. In the new model, the Community Recovery Service will not be provided at a specific step of care. It will be provided across steps 2, 3 and 4. This will allow the service to support transition of patients through the steps.

- **Case management**. The service will be enhanced with a case management role.

The case management model has been an integral component of the Doncaster “Improving Access to Psychological Therapies” implementation programme (demonstration site). It is key to managing the high volume of referrals, ensuring that people gain access to required interventions in a co-ordinated and timely way and providing service coordination for people stepping down from specialist services. Case management introduces new skills for staff in managing volume, multi-dimensional case management and telephonic intervention. The
model can provide integrated support across mental and physical health targeted at those with the highest levels of need. The model of case management introduced in Doncaster has been supported with a specific training programme and has significant resource implications in that it requires state of the art computer system to support the model.

A case management role will be developed within the Community Recovery Service. These roles will further develop the service to ensure an integrated health and social care service is delivered.

- **Supporting patients stepping down** - Initially this service will focus on supporting patients who are discharged from out-patient clinics. The case management role will liaise with general practice to identify medicines management support in primary care, as an alternative to out-patients where appropriate. The across step nature of the Community Recovery Service will mean that other support that the patient has previously received will continue as they step down. This role will continue to support patients to step down but it is anticipated that overtime this focus will become less intensive.

- **Supporting patients stepping up** - The case management role will offer health related support to service users and liaison with primary care professionals to reduce the need to refer patients to step 4 specialist mental health services. This service will work closely with WHM and have a psycho-social approach. However, where the need is there, the case management role will work closely with step 4 services to facilitate proactive step up referrals.
6. Improve access to the secondary specialist system

Feedback from stakeholders has indicated the need for clear referral routes into the different points of access. Amongst the principles underpinning this strategy, several are particularly pertinent in designing access processes and practice:

- Create responsive, flexible and inclusive services – minimise the emphasis on exclusion criteria
- Strengthen partnerships especially with third sector organisations focusing on Black and Minority Ethnic groups
- Prioritise appropriate, up to date, evidence based treatment, as close to home as possible
- Design patient pathways that will care for the whole person
- Facilitate informed choice on services, location, provider and treatment
- Build good practice in user and carer involvement
- Reduce variation in access to services and remove barriers related to age

The threshold, in terms of clinical presentation and level of need, for referral to different parts of service (step 2, step 3, step 4 – routine, emergency (48 hour) and urgent (4 hour) is likely to vary significantly as a function of the confidence and skill/competence of individual GPs in supporting people with mental health needs. This level of variation will need to be accepted as inevitable until such time as it becomes possible to specify a minimum set of interventions in mental health expected of primary care practitioners. It also needs to be recognised that some people will choose not to access care via a GP. Access must accommodate this reality and have systems in place to assess people’s needs promptly and effectively regardless of referral route. The following recommendations are made to improve access:

1. Referral and referrer criteria at each step of care should be clear. Greater ‘gate-keeping’ at higher steps of care and a goal of open access at lower steps of care with processes to ensure efficient stepping up where need is demonstrated.

2. Access to step 2 needs to be increased and a strategy to achieve this needs to be developed. Self-referral at step 2 has been considered but this is still under debate.

3. There will be GP referrals to Step 3. It is anticipated the number of patients referred at step 3 will reduce over time as capacity increases at Step 2. Increased capacity at step 2 will encourage early referral.

4. The case management role in the Community Recovery Service will facilitate individual stepping up or down between step 3 and step 4 when appropriate.
5. Direct referral into step 4 will be gate kept through an assessment team. This will include management of the urgent (within 48 hours) pathway. This team will develop the care plan in conjunction with the referrer. This could include care remaining with the referral where advice around diagnosis is needed, through to admission into in-patient where appropriate.

6. Emergency referral mechanisms have already been developed through a 4 hour pathway managed by the Crisis Resolution/Home Treatment Team. This has been developed over the last 9 months by the provider and reviewed by commissioners. GP confidence in this pathway is significantly higher than before this was introduced.

7. Each access point will need to be resourced with appropriate capacity and skills to undertake this role on a flexible basis, with access to senior clinical advice and support as required. The location of the assessment in individual cases should be determined according to need and risk. On occasions it may be most appropriate to undertake the assessment in a referring GP’s practice.

8. The provider will need to address the issue of access to services out of hours. It will need to work with the Crisis Team and other out of hours services to ensure that effective processes are in place within the system to signpost or support people safely and in a manner appropriate to their needs regardless of time of day.

9. Assessors at each step should undertake an appropriately comprehensive assessment, including social circumstances and risks. Assessment documentation should be compatible across steps and should follow the patient regardless of onward referral route.

10. People with complex needs for whom there is no obvious resolution should be referred to a care coordinator for assistance in establishing an appropriate onward referral or source of support.

11. Good communication systems and practice will be critical to the effectiveness of this service for patients, assessing clinicians and referrers. Protocols should be established, in consultation with referrers, to determine mutual requirements and practicable solutions – mindful of the need to burden the patient as little as possible.

12. Primary care practitioners will form the majority of referrers to this service. It will therefore need to be orientated to primary care in terms of its understanding of stakeholders, development of processes and capacity to support primary care colleagues through advice, consultation and joint assessments as required.
7. Refocus secondary community services to provide more intensive complex care

It is important to recognise that strengthening this part of the pathway for people with complex needs will be fundamental to reducing the numbers of people currently referred into high cost placements.

There are 3 elements to this re-focus –

i. Review the existing out patient appointment system. Several stakeholders have suggested that this is unproductive.

ii. Increasing the productivity and quality of existing specialist NSF services (Crisis Resolution and Home Treatment, Assertive Outreach and Early Intervention).

iii. Redesigning existing CMHTs to refocus capacity into primary care services and to strengthen support and intensive treatment for people with long term and/or complex needs (including personality disorder and dual diagnosis). The strategy envisions a new complex and long term care team drawn from the existing resource in CMHTs and integrating the role of the Assertive Outreach Teams.

i. **Review out-patient clinics**

Several stakeholders suggested that the existing out-patient system is unproductive and should be reviewed. A review has identified that the majority of patients seen in out-patients are not on CPA (i.e. the least unwell), not being supported by a care co-ordinator and therefore having low continuity of care. In addition there are high DNA rates.

The referral process for outpatient clinics used to operate outside the SPA system – which exacerbates inequities in access and care pathways. The SPA has been stopped due to other problems around delivery and commissioning.

Evidence from New Ways of Working suggests that routine outpatient appointments are neither an effective nor a patient centred way of organising care for people with complex needs.

Therefore an assessment system will be developed for all new referrals. Patients can then be directed to the most appropriate support. One option would be out-patients either as a single intervention or with others co-ordinated by the patients allocated care co-ordinator. This new system will reduce the number of new referrals who will be seen solely in out-patients. This system will incorporate responsibility for the urgent (within 48 hour) care pathway currently provided through the duty rotas in the three CMHTs. This will release care co-ordinator capacity that can be reinvested into the new Complex Care Team.
Out-patient caseloads are high and somewhat static. This suggests a significant percentage of patients on current caseloads who do not need specialist support and could be stepped down to primary care if a suitable service existed at this level. Proactive recovery focused care appears compromised by a lack of capacity and skill/confidence within the CMHTs to support a discharge process for people whose needs are no longer acute and to case manage higher complexity of need.

Therefore, a project will be undertaken to discharge those patients currently being seen infrequently in out-patients with no other step 4 services. Where appropriate these patients will be stepped down to step 3 services and offered appropriate support through the new Community Recovery Team (including a health element to provide case management support) and Healthy Minds.

These projects will be facilitated through changes in medical staffing which were discussed earlier.

ii. Increasing the productivity and quality of existing specialist NSF services and further integration of these services

The evidence from the phase one data collection shows that some NSF teams have low caseloads in comparison with benchmarked localities.

Non-recurrent investment has already been made into the Crisis Resolution Home Treatment team. This investment will be made recurrently and a quality improvement project undertaken to ensure that the proportion of patients admitted to in-patients gate-kept by this team are increased. Work will also be undertaken to reduce the length of episode of this team, providing further additional capacity to support more patients both as an alternative to admission or to support discharge.

Indications from the Department of Health are that future implementation of Payment by Results in mental health will be designed around the framework of the Yorkshire Care Pathway Clusters. Analysis of current activity against these Clusters shows teams working with patients with mixed levels of severity of need.

The Assertive Outreach team will be merged into the Complex Care Team and the workload will be ‘ring-fenced’ and monitored using Yorkshire Care Pathway Clusters. This merger will lead to a reduction in management costs and medical input. The Early Intervention Team will merge with a ‘ring-fenced’ part of the Complex Care team targeting young people. The aspiration is that these resources will be combined with resources from Child and
Adolescent Mental Health Service to develop a Young Persons Mental Health Service which would support transition between child and adult services.

iii. Redesigning existing CMHTs

Against the Yorkshire Care Pathway Clusters, those with severe/complex needs account for only a small proportion of the CMHT returns. However, the non CPA caseloads are largely held in out-patients. The care co-ordinators caseloads only account for about a fifth of the CMHT case load. The majority of these patients are CPA patients as recommended.

Stakeholders have suggested that the existence of many teams has lead to patients being bounced from service to service. This is particularly true for patients with dual diagnosis (learning disability and substance misuse).

It is recommended that the current non-medical caseload is maintained. A new complex care team will be developed from the existing CMHT resource, with additional expertise supplied by integration with elements of the existing addiction services and the decommissioned IPPS to provide intensive support for people with complex needs including those with dual diagnosis and those with a personality disorder (as described in relevant NICE Guidance)\(^29\). The intention is to develop a recovery model of care for people with more complex and challenging mental health needs by refocusing current secondary care services to develop community capacity and expertise thereby reducing crisis presentations, reliance on in area acute care and out of area tertiary and forensic care.

There is an aspiration to develop a Young Persons Team to provide more intensive support to people aged 14-25. This is the stage of life where most mental health problems begin and therefore appropriate intervention at this time could be highly effective. In the long term, identifying resources from CAMHS will be considered. In the short term, resources targeting 18-25 year olds in the Complex Care Team will be ‘ring fenced’ and aligned with current resources around Eating Disorders and the Early Intervention Service.

The teams will not work with a vastly different target group to the CMHTs. The target group for this service will largely, but not exclusively, be defined by the characteristics described in current CPA guidance.\(^30\) It is important to note that the guidance clearly states that these characteristics should

\(^{29}\) National Institute for Health and Clinical Excellence (2009) Borderline Personality Disorder. NICE clinical Guideline 78 and Antisocial Personality Disorder NICE Clinical Guideline 77

not be used as indicators of eligibility for secondary mental health services. It is critical to stress that clinical and professional experience, training and judgement will always be necessary to evaluate which service users will need the support of this specialist service. CPA is a process, not a measure of eligibility.

The CPA guidance highlights concerns that some key groups who should meet the characteristics of new CPA are not being identified consistently and that services are sometimes failing to provide the support they need. The key groups are service users:

- who have parenting responsibilities
- who have significant caring responsibilities
- with a dual diagnosis (substance misuse)
- with a history of violence or self harm
- who are in unsettled accommodation

The default position for individuals from these groups should normally be referral to this service under (new) CPA unless a thorough assessment of need and risk shows otherwise.

The decision and reasons not to include individuals from these groups should be clearly documented in care records. Local stakeholders should also consider whether there are other groups who should be identified as particularly vulnerable and included in this list.

It is recognised the resources invested in a patient will vary depending on need. This is currently recognised for patients who meet Assertive Outreach criteria but not for other groups. The specification for the Complex Care Team will utilise the Yorkshire Care Pathway Clusters and provide guidelines for resource per patients based on the needs defined by these groups. This should also facilitate transition to Payment by Result contracts.

Core functions of the Complex Care team will include:

a. The provision of intensive multidisciplinary therapeutic interventions and practical support for people with complex needs, including those with a dual diagnosis and those with personality disorder at tiers 1-3 as defined by the national commissioning guidance\(^{31}\)

b. Support to the Community Recovery Service to ensure provision of effective rehabilitation and recovery services across steps 3 and 4, to promote social inclusion, user empowerment and independence.

c. Forging stronger links between mental health services and providers of employment and accommodation services to provide greater access to ordinary living and employment opportunities

d. Proactive care coordination/case management, informed by the underpinning principles of the stepped care model and by relevant advice in the CPA guidance.

e. Assessment, active management and review of medication issues, in line with the principles of the stepped care model and good practice guidance including GMC guidance on consent.\textsuperscript{32}

f. Forging effective links and referral protocols with learning disability services to ensure that the needs of people with learning disabilities including autistic spectrum disorder are met across the relevant services. This will require recruitment/development of additional specialist skills in the complex care teams, consistent with the principles of mainstream access for people with learning disabilities as set out in Valuing People Now\textsuperscript{33}.

g. Assessing and addressing the physical health needs of service users in partnership with general practice.

h. Assessment of carers' needs and support and provision of appropriate support

i. Increasingly access to social care and some health care will be through personalised budgets which will require new forms of brokerage and advocacy.

\textbf{Quality indicators}

Include:

\begin{itemize}
  \item Evidence of meaningful user and care involvement initiatives in service and individual care planning
  \item Entry into education and employment
  \item Improved quality of life measures
  \item Physical health checks (in partnership with primary care)
  \item Reduced use of high support and crisis services
  \item Development of social networks and relationships
\end{itemize}

\textsuperscript{32} General Medical Council (2008) Consent: patients and doctors making decisions together

\textsuperscript{33} Department of Health (2009) Valuing People Now: a new three year strategy for people with learning disabilities
8. Reduce capacity in in-patient wards

There are currently two adult in-patient wards – Jasmine and Juniper. Both have 22 beds and run at high bed occupancy. With the philosophy to introduce a comprehensive stepped care service, supporting patients at the lowest step of care possible, one of the goals of this strategy is to reduce capacity in these two wards.

This will be achieved through further developing the gate-keeping and early discharge role of the Crisis Resolution Home Treatment Team.

Bed occupancy will be reduced month on month from April 2010 until March 2011. This will bring bed occupancy down allowing four beds on each ward to be closed. Closing four beds allows staffing to be reduced leading to significant cost savings that can be reinvested at lower steps of care.

In addition, medical staffing will be reorganised to provide dedicated in-patient medical staffing teams. In the past, patients have kept the same psychiatrist whatever their step of care to try and provide greater continuity of care. This has caused difficulties in in-patients including high numbers of ward rounds. This change will remove these difficulties and the continuity of care will be provided through the care co-ordinator role who will be proactive throughout the patient’s admission.

9. Reduce forensic activity and high cost placements

Forensic and other high cost residential placements have been indentified as a particular pressure for services in Wolverhampton, both in terms of activity and cost. A number of reasons have been identified for this, many of which relate to service gaps and operational practice across the current pathway in the lower tiers of the stepped care model. An additional hypothesis developed through stakeholder events is that additional demand is placed on services across the system by the high number of bail hostels, homeless hostels and specialist housing providers in Wolverhampton. These hypothesis needs to be scoped further.

The report of Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system makes a number of recommendations for improvements in the pathway of care with a focus on links between criminal justice settings, forensic mental health and general mental health services\textsuperscript{34}. The Government, in accepting this report, recognised the need for further work to establish the potential impact of these recommendations, particularly on resources. A widely held view amongst local and national stakeholders is that the recommendations of this report will create

\textsuperscript{34} Department of Health (2009) The Bradley Report - Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System.
significant additional pressures on mental health services as they are implemented. Thus, whilst this strategy identifies a number of opportunities for improving the pathway within a stepped care model and reducing the time spent by individuals in high cost care, any modelling of potential savings must be offset by consideration of projected increases in demand as people transfer across from the prison service.

Lord Bradley recommends the establishment of a national model of Criminal Justice Mental Health Teams but recognises that further detailed work will need to be undertaken to assess realistically what resources might be necessary to support their development. This development will be overseen, against an as yet unspecified timetable, by a new National Programme Board.

The commissioning intentions in this strategy are designed to be consistent with the direction of travel in national policy, notwithstanding the fact that detailed implications for local services have yet to emerge. Wolverhampton has an excellent and nationally regarded foundation for a Criminal Justice Mental Health Team in the existing forensic liaison service. The focus in this strategy is both on proactive management/review of existing placements and on strengthening the pathway to prevent future high cost placements, building on the foundation of the current forensic liaison team. The proposals are informed by stakeholder engagement and by the recommendations of the Bradley review. The closer integration with substance misuse services that is described in Section 5 on Complex Care will also be a core component of the development of a Criminal Justice Mental Health Team.

a) Existing placements

Stepped care
The stepped care principle of scheduled review is critical in managing high cost placements. For patients who are not on restriction orders, patient centred, needs led reviews may demand a challenge to existing services to innovate and plan creative packages of care. ‘We need to recognise that sometimes people are only seen as ‘complex’ because the service doesn’t have staff with the right skills’ (stakeholder feedback). A specific example identified during the course of stakeholder engagement has been the potential contribution of colleagues from the fire service in designing packages of care for individuals at risk of fire setting.

Risk
It is also important to recognise that ‘risk’ may be perceived differently in relation to specific individuals, depending on the perspective, skills and culture of the assessor. This must be controlled
through collaboration with appropriate partners, for example in third sector organisations focusing on Black and Minority Ethnic groups, when planning and undertaking reviews.

_Urgent review - forensic_

The PCT is engaging in a regional Quality Innovation Productivity and Prevention programme to understand and manage the demand for Medium and Low Secure Psychiatric Services. Wolverhampton City PCT is one of five PCTs involved in the first phase of this project. This will involve between July and September 2010, reviewing all patients admitted or discharged from secure care retrospectively for 12 months and prospectively for 3 months. This scoping exercise will identify recommendations for improved gate keeping and reduction of length of stay. These will be implemented through a new Criminal Justice Mental Health Team.

_Urgent review – non forensic_

In September 2009, the residential and nursing care budget was predicted to be significantly overspent in 2009-2010. A project was initiated to review all existing placements. At present 50% of existing placements, have been reviewed. This project is to continue to review the remaining placements and domiciliary care packages.

In other areas, savings have been made by developing a procurement framework. This would provide standard contracts for residential providers depending on the patients assessed level of need. It is intended to identify procurement support to develop a framework.

_Involvement of carers_

Discharge planning is supported if a Nearest Relative or next of kin has been identified and involved – consider how carers are supported and involved in reviews of care and placements.

_Mental impairment_

Information supplied by the forensic liaison service suggests that approximately 30% of those currently funded in forensic placements (19 people at the time of writing) are people with a primary classification of mental impairment rather than mental illness. A project to define the secure placement budget for mental health and the secure placement budget for learning disabilities separately has been instigated. A parallel project to review secure learning disabilities placements has been initiated by the learning disability commissioner.

_Data management_
The forensic liaison service currently holds considerable assessment information on existing forensic placements which is passed to the Specialised Commissioning Group. Updates on this information do not routinely get fed back to the PCT. A mechanism needs to be established to enable PCT commissioners and the Joint Commissioning Unit to develop an overview of all current placements including formal status of patient, identified step down requirements if appropriate – in order to track relevant information and work proactively with providers to identify timely and appropriate step down opportunities.
b) Preventing future placements

A fundamental prerequisite for prevention of high cost placements will be implementation of the stepped care model across the service – with effective, inclusive and integrated (particularly with substance misuse services) pathways across the steps, as described in this strategy. In addition, a number of more targeted initiatives have been identified by stakeholders and/or are recommended in the Bradley Report:

**Prison services**

1. *‘NHS commissioners should seek to improve the provision of mental health primary care services in prison..... Primary mental health care must include a range of non-health activities to support well-being in prison..... The involvement of non-health agencies, including statutory and third sector providers, should be urgently considered in order to improve the support for prisoners with mental health problems or learning disabilities’ (Bradley).* The PCT should raise the priority given to the commissioning of mental health interventions to the City’s prison population through strengthening its relationship and influence with the specialist prisons commissioner. In partnership with neighbouring PCT commissioners, the intention should be to develop robust models of primary mental health services, ensuring an appropriately skilled workforce to assess and treat those with mild to moderate conditions.

2. *‘Improved continuity of care for prisoners subject to the Care Programme Approach should become a mandatory item in the standard NHS contract for mental health’ (Bradley).* This refers to strengthened care coordination and should also be regarded in respect of all individuals in high cost placements. This requirement might be included as part of the raft of quality improvements specified through the CQUIN.

**Diversion services**

3. *‘All police custody suites [and all courts, including current specialist courts,] should have access to liaison and diversion services. These services would include improved screening and identification of individuals with mental health problems or learning disabilities, providing information to police and prosecutors to facilitate the earliest possible diversion of offenders with mental disorders from the criminal justice system, and signposting to local health and social care services as appropriate.’ (Bradley).* In Wolverhampton, a diversion at the point of arrest service is currently provided by the Forensic Liaison Service but is not directly commissioned. A national court diversion pilot is the subject of current planning and draft specification – but again not commissioned. The court diversion service might combine with addiction diversion services and a CAMHS pilot that is currently under discussion.
Commissioning and development of these services is a high priority in the context of local pressures and the national evidence base.

**Partnership working with the emergency services**

4. Strengthen links between community mental health services and the police to raise awareness about the needs of people with mental health problems and ensure the police can refer people into community services with maximum access. Opportunities for closer working across stepped care need to be explored.

5. The contribution that the local fire service, in partnership with the West Midlands Fire Service mental health liaison post can make needs to be considered. There is recognition of the increased risks from fire faced by people with mental health problems. For those people identified as presenting particular risks through fire setting behaviour, the fire service should be included in assessments of need and identification of appropriate packages of care.

**S136 suite**

6. National guidelines on place of safety indicate that a police station should be used only on an exceptional basis under Section 136 of the Mental Health Act. S136 is a prime example of why the police and health services need to work so closely together. It is understood that proposals are underway to establish a S136 suite at Penn Hospital. Commissioners must be assured that the development of this facility is expedited as a matter of urgency and that access to a place of safety other than the police station is built into current acute care pathways, pending the availability of this facility.

**Step down and low secure accommodation**

7. The creation of appropriate step down facilities across the city will depend on identifying and specifying appropriate services from existing Registered Social Landlords (RSL) in partnership with Supporting People.

8. Work is underway to review people currently living in Victoria Court – a local rehabilitation facility, with a view to stepping people down where appropriate. This facility can accommodate people on S37/41 is envisaged as future step down accommodation from secure care, with support provided through the (appropriately specified) provider and the new complex care team and/or the Assertive Outreach Team with consultation and advice from the forensic liaison service as

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required. In the context of this provision, it is not envisaged that Wolverhampton will have a requirement for new low secure accommodation.

**PICU**

9. Local consultation with commissioners and providers has confirmed the need for an ongoing Psychiatric Intensive Care Unit (PICU) rather than the development of an alternative low secure facility. There is an ongoing debate about whether or not this should include a seclusion facility and about gender based provision.

10. A short piece of work has been undertaken locally
   a. Understand the gender split in the last year’s referrals - The gender split in 2009-2010 was approximately 50:50. If PICU was made a male only ward and activity remained the same in future years, high numbers of bed days for female patients would need to be purchased out of areas.
   b. Undertake a literature review of the evidence base on seclusion - The literature around benefits of a seclusion facility is inconclusive.
   c. Research national recommendations – e.g. from the Royal College of Psychiatrists – on provision of PICU beds/population. The current PICU facility meets national recommendations.

11. On the basis of this piece of work, the view is that although there may be clinical benefits to a smaller unit, this is not financially viable in the short term. However, this should be revisited following the implementation of Transforming Community Services (TCS). TCS is likely to lead to a larger provider organisation that would be able to explore more flexible provision across a larger population.

**Healthcare provision to the police service**

12. It is understood that responsibility for healthcare provision to people detained in police custody is currently provided by an external organisation (PRIME Care) with funding from the PCT mental health provider. This is viewed locally as an entirely inappropriate use of PCT mental health funds. There are particular concerns about the lack of links between local services and the external clinicians providing this service and the concomitant risks that individuals will not be diverted into local services appropriate to their needs. The PCT should review this matter including any guidance about responsibility for funding this service. If responsibility must be retained by the PCT it should sit with the commissioner not the provider arm, with funding drawn down from all relevant budgets.
Residential and nursing care placements – non forensic

13. In September 2009, the terms of reference for the residential and nursing funding panel were amended. This aimed to improve decision-making for new placement application. This has lead to a reduction in the number of new placements accepted with many more clients being offered creative packages of care to support them in their own home through existing services. Through this change and the project to review existing placements, the overspend on residential and nursing placements was reduced.