DRAFT

Dudley Adult Mental Health Joint Commissioning Strategy 2010-2013

NHS Dudley

Dudley Metropolitan Borough Council

Between 1998-2008, patients with psychiatric disorders occupy around 15% of total bed days in the NHS and have a longer length of stay than people with other medical conditions.
Pillay P & Moncrieff J (2009)

The NHS spends 14% of its annual budget on mental health services.
(DH 2009)
Recent estimates put the full economic cost at around £77 billion, mostly due to lost productivity.
Sainsbury's (2003)

The World Health Organisation has recently undertaken the largest ever population based study on the physical effects of several illnesses. The results showed that depression had more impact on sufferers than angina, asthma, arthritis or diabetes. When depression co-existed with these other conditions the score was worse than with any other combination of conditions.

Moussavi et al (2007)

Good mental health is more than the absence or management of mental health problems: it is the foundation for well being and effective functioning both for individuals and their communities.

Mental well-being is about our ability to cope with life's problems and make the most of life's opportunities: it's about feeling good and functioning well, as individuals and collectively.
New Horizons (2009)

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1. Introduction

1.1 The Joint Commissioning Strategy for Mental Health sets out the commissioning intentions of Dudley Council and Dudley Primary Care Trust (PCT) in respect of specialist services for people with mental health.

1.2 This strategy has been developed through the Dudley Mental Health Partnership Board - working together with people with mental health support needs, carers and providers of services in Dudley. The Dudley Mental Health Partnership Board role is to develop the strategic direction for commissioned services and monitor its implementation.

1.3 This strategy is based on a new approach to whole population mental health. The focus on prevention and maintaining good mental health is particularly relevant today with people leading more hectic lifestyles and going through the economic downturn.

1.4 **Mental health is 'everybody's business because**:

- Around one in four people will suffer from a form of mental illness at some point in their lives;
- One sixth of the population suffers from a common mental health problem at any time;
- 1 in 100 people suffers from a serious mental illness such as psychosis;
- More than 1.3 million older people suffer from depression or other mental illness;
- 6 million people in Britain have depression and/or anxiety disorders - few get effective treatment;
- One in ten mothers suffers from post-natal depression

Dept of Health (2009)

1.5 The strategy acknowledges that people can be helped to protect themselves against mental illnesses like depression and anxiety and that mental ill health not only causes untold personal suffering and distress, but also affects people's relationships, ability to work, family life. It can lead to a range of physical health problems.

1.6 The strategy also addresses the needs of those who experience disproportionately high levels of mental ill health including older people, those living in poverty and people from black and minority ethnic communities.

2. Scope and Purpose of the Joint Service and Commissioning Strategy

2.1 The Commissioning Strategy explains how the Council and the PCT plan to develop mental health that comes within the commissioning responsibilities of the two agencies.

2.2 Dudley PCT has the lead commissioning role for mental services across the two agencies but there is no section 75 agreement in place. The Council commissions all care and support services whilst the PCT retains responsibility to provide specialist health services and to ensure access for people with a mental health issues to mainstream primary and secondary NHS provision.

2.3 This strategy is intended to fit with the strategies for children and young people, dementia, mental health promotions, the older people with mental health strategy, substance misuse strategies, as well as the PCT Commissioning for Health strategy and DACHS.

2.4 It has also been developed in line with the strategic direction of the Dudley Strategic Partnership, and alongside strategies covering Supporting People, Housing, Leisure and Regeneration.

2.5 The Strategy builds upon the previous Joint Mental Health Strategy 2005 – 2010 and the National Service Framework for mental health - widely acknowledged as the catalyst for a transformation in mental health care over the last ten years - which comes to an end in 2009.

2.6 The main policy drivers for Adult Mental Health in the next few years are:

- ‘New Horizons’, which is currently undergoing a period of consultation
- The Transformation of Social Care

- West Midlands Care Pathways/Yorkshire Care Pathways
- Payments by Results

2.7 The strategy covers the following people with mental health conditions:

- Adults aged between 18-64 for Dudley Primary Care Trust services and 18-64 for Dudley DACHS services except for Early Intervention and Eating Disorders services only the strategy covers the age group 14+.
- People in *transition* from child to adult and from adult mental health services into services for those aged 65 and over.
- Adults with a mental health condition and a *dual diagnosis* of drug or alcohol problems.

3. Vision

- To promote good mental health and well-being, whilst improving services for people who have mental health problems. Good mental health should be an achievable goal for everyone.
- Help people to look after their mental health and prevent them from becoming ill.
- Tackle the stigma that's associated with mental ill health by focussing on whole population mental health.
- Recognising that individuals, employers and all sorts of organisations have a role to play in helping to achieve good mental health for all.
- To work in partnership with service users and their carers throughout the commissioning process.
- Commissioned services will be of a high quality and will needs to needs of the service users.
- Mental Health services will become more closely integrated with ordinary health services, as well as with services provided through Dudley Council.
- Services will be closer to home, where every possible.
- Care will be well planned and will aim to support people in achieving recovery.
- There will be a personalised care plan for people assessed as needing services.
- Service users will be encouraged to purchase some or all of their social care services through Direct Payments or an Individual Budget.

4. Dudley

4.1 Dudley is a large metropolitan Borough (98 square kilometres / 38 square miles) located on the western part of the West Midlands conurbation, approximately 9 miles west of Birmingham and 6 miles south of Wolverhampton. Dudley is composed of a number of townships, each with its own identity and culture. The main town centres are Dudley, Stourbridge in the south west, Halesowen to the south east and Brierley Hill in the centre.

4.2 There are 24 wards in Dudley and the current GP responsible population as of April 2007 is approximately 314,000. The responsibility for commissioning and providing the health care of the population lies with 55 GP surgeries.

4.3 Dudley is the second largest area, in terms of population in the West Midlands:

- West Midlands - 2,555,592
- Birmingham - 977,087
- Dudley - 305,155
- Coventry - 300,848
- Walsall - 253,499
- Wolverhampton - 236,582
- Solihull - 199,517

2001 census- National Statistics office

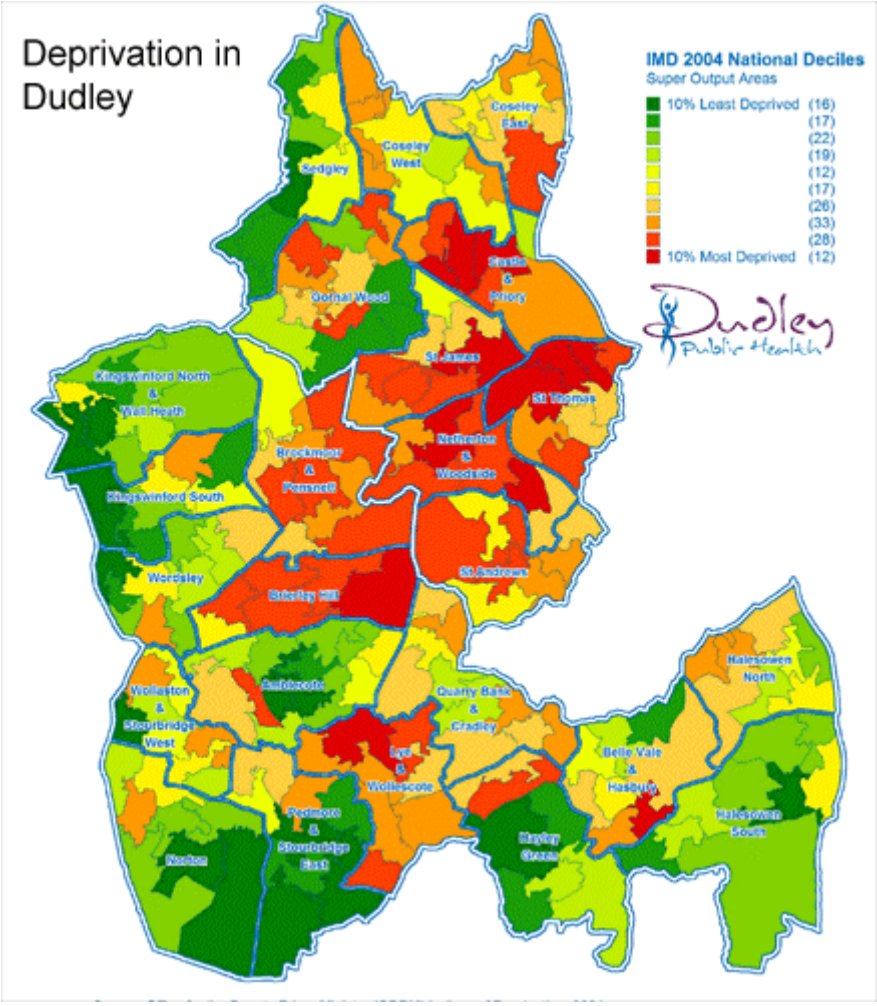
4.4 According to the 2006 Mid Year Estimates, the gender split of the Dudley population is even with males accounting for 49.1% of residents and females 50.9%, with the overall ethnicity split at 92% white and 8% BME.

4.5 Deprivation

4.5.1 The deprived areas are largely found in an area from Brierley Hill, through Netherton to Castle and Priory, with some also in Lye and one or two small pockets elsewhere. Conversely the most affluent areas are found on the southern and western edges of the Borough.

4.5.2 Dudley's overall deprivation status differs little from the national average.

- Deprivation is concentrated in an inner urban core
- 8 wards fall into the most deprived 25% nationally



Population-weighted average rank per LSOA for Index of Multiple Deprivation by PCT

- *30% of GP first consultations and 50% follow ups consultations are related to mental health issues.(Sainsbury Centre 2002)*
- *In 2003 the Sainsbury Centre calculated the total cost of mental health problems to be:*

❖ *health and social care costs £12.5 billion*

❖ *cost to individuals £41.8 billion*

❖ *lost employment opportunities £23.1 billion*

❖ *total cost of £77.4 billion pounds per annum*

Sainsbury Centre (2003)

5 Local Drivers

5.1 The Strategy also takes account of the local Joint Health and Social Care Commissioning Framework and the Joint Strategic Needs Assessment (JSNA). This sets out the broader context in which we are commissioning mental health services.

5.2.1 The Dudley Joint Strategic Needs Assessment (JSNA) is a detailed analysis of the population demographics, need, demand, capacity and resources and how the PCT and Local Authority will plan for the future health, care and well-being needs of our population. The aims of the Joint Needs Assessment are:

i) to build a picture of current services i.e. baseline

ii) to gather information to plan, negotiate and change services for the better and improve outcomes for the population

5.2.2 Key messages from the JSNA:

- The Population in Dudley is projected to increase by only about 1% overall by 2020.
- The population aged 65+ is projected to increase by 24% by 2020.
- The number aged 85+ are projected to increase by 52% over the same time.
- Births are currently projected to remain relatively static up to 2020.
- In and out migration is small in relation to the total population, but is the major contributor to the projected population rise.
- Black ethnic group are 3x and Mixed ethnic group 4x more likely to be lone parent households (15% & 20% vs 5% of White households).
- 43% of Asian households have 2 or more children (compared to 16% for White).
- 15% of white, 5% of Mixed, 3% of Asian and 8% of Black households are lone pensioners.
- In the future the ethnic minority groups are likely to move closer to the white figure, which will itself increase.
- Life expectancy in Dudley has risen in the last 20 years, but at a slower rate than nationally in more recent years.
- There has been some narrowing of within Borough differences in life expectancy over the last 20 years.
- There is still a gap of 6.6 years between the Dudley wards with the highest and lowest life expectancy.
- Alcohol-related diseases have risen rapidly in recent years.
- Soon more people in Dudley will die from alcohol-related diseases than die from all strokes.

5.3 The PCT Strategic Plan (2009-10) picks up some of the key health issues identified in the JSNA and sets out the key goals for health improvement in the borough. These are:-

Goal 1	-	Tackling Obesity
Goal 2	-	Reducing Alcohol Misuse
Goal 3	-	Improving Mental Health Well Being
Goal 4	-	Providing Systematic and Targeted Prevention
Goal 5	-	Providing Care at the appropriate setting
Goal 6	-	Developing and implementing our Urgent Care Strategy
Goal 7	-	Managing Long Term Conditions
Goal 8	-	Improving Patient Quality and Outcomes
Goal 9	-	Strategy to Improve Patient Experience
Goal 10	-	Championing Innovation and Excellence

5.4 The Supporting People Strategy 2005 -10 outlines how Dudley MBC provides housing related support which complements existing care services, including mental health. Housing-related support is defined on a statutory basis in the Supporting People Grant Conditions 2007 as follows: - “Support services which are provided *to* any person for the purpose of developing that person’s capacity to live independently in accommodation or sustaining his capacity to do so”.

5.5 The ultimate purpose of housing support is to support vulnerable people to develop or sustain their capacity to run their own home as independently as possible: by preventing problems in the first place; by early intervention; and helping people to maximise choice and control over their lives.

6. National Drivers

6.1 New Horizons - Towards a shared vision for mental health (2009).

New Horizons is a consultation document which sets out the next stage of the Government's strategy for improving mental health in England. It takes a cross Government approach and aims to:

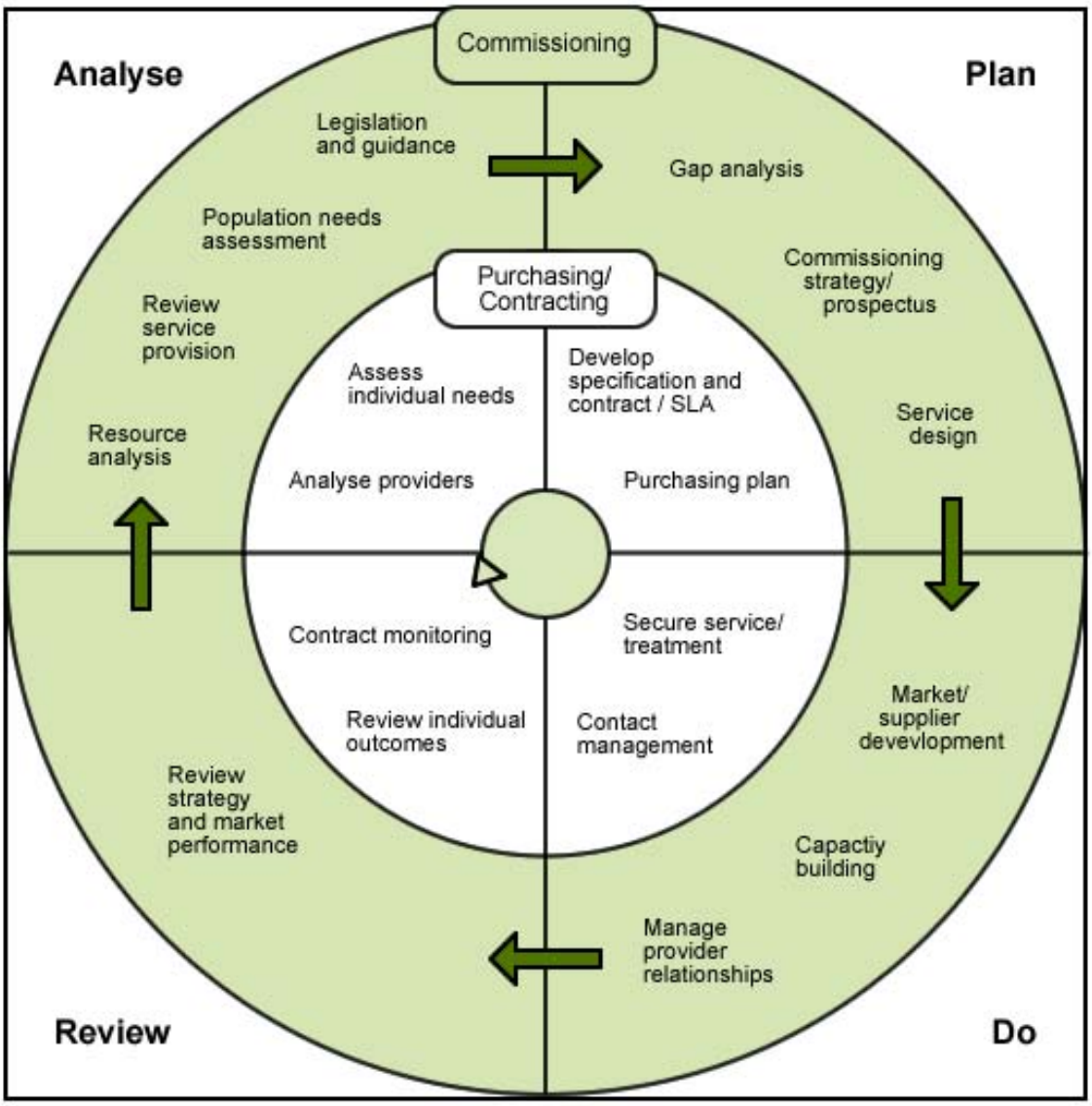
- Take forward what was learnt in the lifetime of the National Service Framework 1999-2009 (NSF) about what works, and broaden our scope to include all groups in society, including children and young people and older people.

- Build on the principles and values set out in the NHS Constitution • support the delivery of the NHS Next Stage Review (the Darzi report17) and its vision of local commissioners working with providers, the public and service users to devise local approaches to mental health and mental health care.
- Use the growing understanding of the wider determinants and social consequences of mental health problems and mental well-being to influence priorities in other parts of central and local government.
- Reinforce commitment to key mental health policy aims, including delivering race equality and improving access to psychological therapies.

6.2 The Commissioning Process

6.2.1 The model of commissioning used in Dudley is based on the following model of Commissioning, which is from the Institute of Public Care

6.2.2 Joint commissioning model for public care

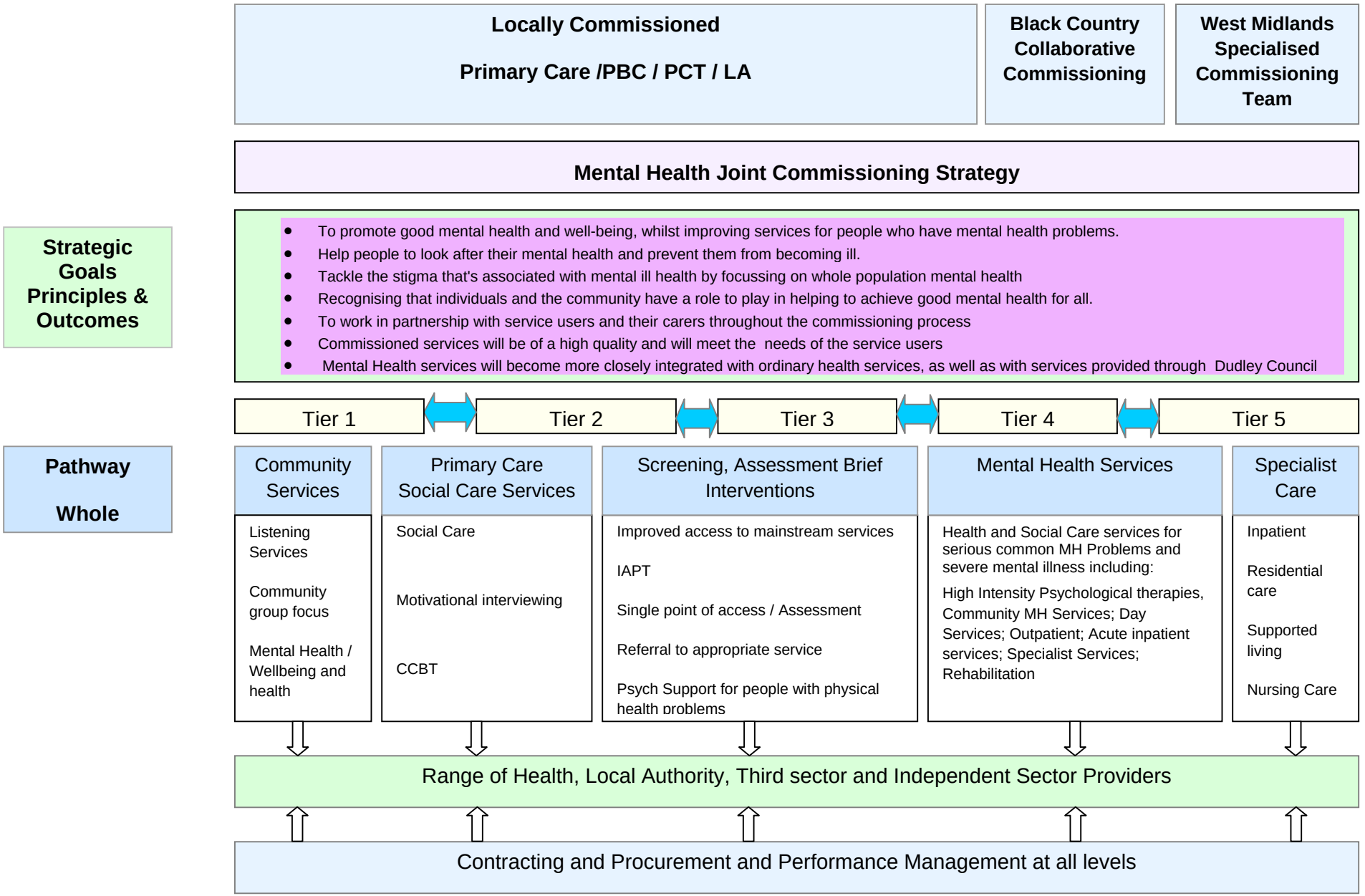


6.2.3 The principles of the model are :

- That all of the four elements of the commissioning cycle (analyse, plan, do and review) are sequential and of equal importance.

- ❖ A written joint commissioning strategy per user group should be developed, which focuses on need.
- ❖ The commissioning cycle (the outer circle in the diagram) should drive the purchasing and contracting activities (the inner circle). However, the contracting experience must inform the ongoing development of commissioning.
- ❖ The commissioning process should be equitable and transparent, and open to influence from all stakeholders via an on-going dialogue with patients/service users and providers.

6.2.4 For commissioning to be effective it has to be integral to the Local Authority and PCT, how this is achieved, in Dudley is outlined in the next diagram.


Locally Commissioned
Primary Care /PBC / PCT / LA
Black Country Collaborative Commissioning
West Midlands Specialised Commissioning Team
Mental Health Joint Commissioning Strategy
Strategic Goals Principles & Outcomes
To promote good mental health and well-being, whilst improving services for people who have mental health problems.
Help people to look after their mental health and prevent them from becoming ill.
Tackle the stigma that's associated with mental ill health by focussing on whole population mental health
Recognising that individuals and the community have a role to play in helping to achieve good mental health for all.
To work in partnership with service users and their carers throughout the commissioning process
Commissioned services will be of a high quality and will meet the needs of the service users
Mental Health services will become more closely integrated with ordinary health services, as well as with services provided through Dudley Council
Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
Pathway
Whole
Community Services
Listening Services
Community group focus
Mental Health / Wellbeing and health
Primary Care Social Care Services
Social Care
Motivational interviewing
CCBT
Screening, Assessment Brief Interventions
Improved access to mainstream services
IAPT
Single point of access / Assessment
Referral to appropriate service
Psych Support for people with physical health problems
Mental Health Services
Health and Social Care services for serious common MH Problems and severe mental illness including:
High Intensity Psychological therapies, Community MH Services; Day Services; Outpatient; Acute inpatient services; Specialist Services; Rehabilitation
Specialist Care
Inpatient
Residential care
Supported living
Nursing Care
Range of Health, Local Authority, Third sector and Independent Sector Providers
Contracting and Procurement and Performance Management at all levels

6.3 World Class Commissioning

6.3.1 All PCTs have signed up to World Class Commissioning, which has been developed by the Government (2008) to achieve better health and wellbeing for all, better care for all and better value for all.

6.3.2 The principles of World Class Commissioning are that commissioned services will be evidence-based and of the best quality. People will have choice and control over the services that they use, so they become more personalised. It will deliver better value for all as Investment decisions will be made in an informed and considered way, ensuring that improvements are delivered within available resources

6.3.3 For World class commissioning to be effective the involvement and collaboration of people with knowledge of services from across the spectrum – commissioners, providers, service users and carers is required. It requires an understanding of people's needs at the individual level; greater emphasis on the role of primary care; integrating mental and physical health; stronger joint working between public and voluntary services; creative approaches to workforce development; and better performance management.

6.3.4. The 11 competencies of world class commissioning are:

1. World class commissioners are recognised as the local leader of the NHS.
2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities.
3. Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health.
4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation.
5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements.
6. Prioritise investment according to local needs, service requirements and the values of the NHS.

7. Effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes.
8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration.
9. Secure procurement skills that ensure robust and viable contracts.
10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes.
11. Make sound financial investments to ensure sustainable development and value for money.

6.4 Darzi Review – Key Themes

6.4.1 In 2008 Lord Darzi the Health Minister set out the vision for the NHS for the next 10 years, which is to ensure that the NHS works towards: preventing ill health, improving access, saving lives and improves the quality of people's lives, whilst taking account of changing demography and opportunities shaped by new technologies. This is to be achieved by empowering staff and giving patients' choice, to ensure that health care will be personalised, effective and safe treatments to help patients to stay healthy.

6.4.2 The vision set out in Lord Darzi's interim report "Our NHS Our Future" (Department of Health, 2007) has key elements to deliver an NHS that is:

Fair	–	equally available to all, taking full account of personal circumstances and diversity.
Personalised	–	tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of choice.
Effective	–	focussed relentlessly on improving the quality of services and outcomes for patients until they are amongst the best in the world.

Safe	–	as safe as possibly can be, giving patients and the public the confidence they need in the care they receive.

6.4.2 The NHS Next Stage Review was organised regionally around 8 clinical pathways including mental health. In each Strategic Health Authority, clinicians were selected for Clinical Pathway Groups which identified examples of good practice, the barriers to service development, and key priorities for future service improvement and innovation.

6.5 Care Pathways

6.5.1 Introduced to support the Darzi plans for the introduction of Payment by Results in mental health and is based on Care Pathways work originally developed in Yorkshire mental health trusts.

6.5.2 The model, originally established to support clinical decision making and effective care delivery, includes:

- A standard needs assessment tool;
- Standardised aims for interventions and activities;
- Set of 21 care pathways/clusters for all people who use adult and older people's mental health services. All new referrals are assessed using a form of HoNOS.

6.5.3 The allocation of a service user to a cluster should lead to them entering a pathway where the services and treatment that will be offered is clear, as is the exit from that pathway. The service user will be told what clinician they will be working with, such as psychologist, social worker etc and which team that the clinician is a member of such as a CMHT or Assertive outreach team. For this to be implemented will require a redesign of some services in Dudley.

6.5.4 The 21 clusters are as follows:

1 **Common Mental Health Problems (Low Severity)**
This group has definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any psychotic symptoms.

2 **Common Mental Health problems (Low Severity with Greater Need)**
This group has definite but minor problems of depressed mood, anxiety or other disorder but not with any psychotic symptoms. They may have already received care associated with cluster I and require more specific intervention or previously been successful symptoms related to their substance misuse. It is possible that this group will suffer from cognitive impairment and/or physical problems as a result of long-term substance misuse.

3 **Non-Psychotic (Moderate Severity)**
Moderate problems involving depressed mood, anxiety or other disorder (not including psychosis)

4 **Non-Psychotic (Severe)**
This group is characterised by severe depression and/or anxiety and/or other and increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.

5 **Non-Psychotic (Very Severe)**
This group will be severely depressed and/or anxious and/or other. They will not present with hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for suicide and they may present safeguarding issues and have severe disruption to everyday living.

6 **Non-Psychotic Disorders of Overvalued Ideas**
Moderate to very severe disorders that are difficult to treat. This may include treatment resistant eating disorder, OCD etc, where extreme beliefs are strongly held, some personality disorders and enduring depression.

7 **Enduring Non-Psychotic Disorders (High Disability)**
This group suffers from moderate to severe disorders that are very disabling. They will have received treatment for a number of years and although they may have improvement in positive symptoms considerable disability remains that is likely to affect role functioning in many ways.

8 **Non-Psychotic Chaotic and Challenging Disorders**
This group will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other

impulsive behaviour and chaotic, over dependent engagement and often hostile with services.

9 **Substance Misuse**
The main problem of this group is their misuse of alcohol or drugs. They may have some anxiety or depression and transient psychiatric symptoms related to their substance misuse. It is possible that this group will suffer from cognitive impairment and/or physical problems as a result of long-term substance misuse.

10 **First Episode in Psychosis**
This group will be presenting to the service for the first time with mild to severe psychotic phenomena. They may also have depressed mood and/or anxiety or other behaviours. Drinking or drug-taking may be present but *will* not be the only problem.

11 **Recurrent Psychosis (Low Symptoms)**
This group has a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are currently experiencing a period of recovery where they are capable of full or near functioning. However, there may be impairment in self-esteem and efficacy and vulnerability to life.

12 **Ongoing or Recurrent Psychosis (High Disability)**
This group have a history of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation.

13 **Ongoing or Recurrent Psychosis (High Symptom and Disability)**
This group will have a history of psychotic symptoms which are not controlled. They will present with moderate to severe psychotic symptoms and some anxiety or depression. They have a significant disability with major impact on role functioning.

14 **Psychotic Crisis**
They will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present as vulnerable and a risk to others or themselves.

15 **Severe Psychotic Depression**
This group will be suffering from an acute episode of moderate to severe depressive symptoms. Hallucinations and delusions will be present. It is likely that this group will present a risk of suicide and have disruption in many areas of their lives.

16 **Dual Diagnosis**
This group has enduring, moderate to severe psychotic or affective symptoms with unstable, chaotic lifestyles *and coexisting* substance misuse. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired.

17 **Psychosis and Affective Disorder Difficult to Engage**
This group has moderate to severe psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol not severe enough to warrant dual diagnosis care. This group have a history of non-concordance, are vulnerable & engage poorly with services.

18 **Cognitive Impairment (Low need)**
People who may be in the early stages of dementia (or who may have an organic brain disorder affecting their cognitive function) who have some memory problems, or other low level cognitive impairment but who are still managing to cope reasonably well. Underlying reversible physical causes have been rule out.

19 **Cognitive Impairment (Moderate Need)**
People who have problems with their memory and or other aspects of cognitive functioning resulting in moderate problems looking after themselves and maintaining social relationships. Probable risk of self-neglect or harm to others and may be experiencing some anxiety or depression.

20 **Cognitive Impairment (High need with functional complications)**
People with dementia who are having significant problems in looking after themselves and whose behaviour may challenge their carers or services. They may have high levels of anxiety or depression, psychotic symptoms or significant problems such as aggression or agitation. They may not be aware of their problems. They are likely to be at high risk of self-neglect or harm to others, and there may be a significant risk of their care arrangements breaking down.

21 **Cognitive Impairment (High need with physical complications)**
People with cognitive impairment or dementia who are having significant problems in looking after themselves, and whose physical condition is becoming increasingly frail. They may not be aware of their problems and there may be a significant risk of their care arrangements breaking down.

6.5.1 Introduced to support the Darzi plans for the introduction of Payment by Results in mental health and is based on Care Pathways work originally developed in Yorkshire mental health trusts.

6.6 Transforming Social Care/Personalisation

6.6.1 Across Government, the shared ambition is to put people first through a radical reform of public services. It will mean that people are able to live their own lives as they wish; confident that services are of high quality, are safe and promote their own individual needs for independence, well-being, and dignity.

6.6.2 This holistic approach is set out in 'Putting People First: a shared vision and commitment to the transformation of adult social care', the ministerial concordat launched on 10 December 2007.

6.6.3 Personalisation, including a strategic shift towards early intervention and prevention, will be the cornerstone of public services. This means that every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings.

6.6.4 The expectation is that by 2010/11 councils will have made significant steps towards redesign and reshaping their adult social care services, with the majority having most of the core components of a personalised system in place. Councils should be able to demonstrate to their partners' better use of resources across the entire system by investing in early intervention to ensure that the new systems are embedded at a local level.

6.6.5. Personalisation comprises a number of key elements:

- A common assessment of the person's social care needs, based on a self-assessment wherever possible.
- The assessment identifies care and support needs, which relate to an allocation of funding known as the personal budget. The client takes control of the personal budget or may ask that this be administered by a relative, carer, an organisation or the Council.
- Knowing the money available, the person takes control of their own care through a support plan to be funded within the available personal budget. This is sometimes called 'self-directed' support.
- Self directed support allows more choice and control for people, identifying what is personally important to them and how they would like to see their support delivered in a way which best suits their individual needs, priorities and circumstances.
- The role of social workers will change emphasis from assessment and gate keeping of resources to advocacy, information, advice and 'brokerage', helping people to arrange their own services.

6.7 Social Inclusion

6.7.1 The Government has introduced a requirement for Local Partnerships to ensure that the most socially excluded adults are offered the chance to get back on a path to a more successful life by increasing the number of adults who are in contact with secondary mental health services who are in settled accommodation and in employment, education or training (PSA16).

6.7.2 This is because people with mental health problems experience a greater degree of social exclusion than the general population. For example, only 24% of adults with long-term mental health problems are in work.

6.7.3 Many people experience their first episode of mental ill health in their late teens or early twenties, with serious consequences for education and employment prospects. People with mental health problems are nearly 3 times more likely to be in debt than the general population.

6.7.4 For people with more severe and enduring mental health problems, the experience of social isolation is greater. In general people with severe mental health problems are much more likely to be unemployed, have lower educational attainment, are more likely to be separated or divorced and less likely to own their own home

6.8 NICE Guidelines

6.8.1 The National Institute for Health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

6.8.2 NICE set out clear recommendations based on the best available evidence, for health care professionals on how to work with and implement physical, psychological and service-level interventions for people with various mental health conditions.

6.8.3 The guidelines currently available, in relation to mental health include:

- antenatal and postnatal care
- antisocial personality disorders
- anxiety
- bipolar disorder
- Borderline personality disorder (January 2009)
- dementia
- depression
- drug misuse- opiod
- drug misuse- psychological interventions
- eating disorders
- Medicines concordance and adherence
- obsessive-compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)
- Schizophrenia
- Self harm
- Violence

6.8.4 The following guidelines are in development

- NICE is updating its schizophrenia and depression in 2009
- Depression in chronic health problems (June 2009)
- When to suspect child maltreatment (July 2009)
- Alcohol use disorders (March 2010)
- Delirium (April 2010)
- Pregnancy and complex social factors (June 2010)
- Nocturnal enuresis in children (August 2010)
- Autism in children and adolescents (May 2011)
- Alcohol dependence (tbc)
- Severe mental illness with problematic substance misuse (tbc)

6.9 Measuring Outcomes in Mental Health

6.9.1 HoNoS (Health of the Nation Outcome Scales).

6.9.1.1 In 1993 the UK Department of Health commissioned the Royal College of Psychiatrists' Research Unit (CRU) to develop scales to measure the health and social functioning of people with severe mental illness. The initial aim was to provide a means of recording progress towards the Health of the Nation target 'to improve significantly the health and social functioning of mentally ill people'

6.9.1.2 These are the 12 scales used to rate mental health service users of working age adults. They consider different aspects of mental and social health, each on a scale of 0-4. They are designed to be used by clinicians before and after interventions, so that changes attributable to the interventions (outcomes) can be measured.

6.9.1.3 The scales are as follows:

1. Overactive, aggressive, disruptive or agitated behaviour
2. Non-accidental self-injury
3. Problem Drinking or Drug-taking
4. Cognitive Problems
5. Physical illness or disability problems
6. Problems associated with hallucinations and delusions
7. Problems with depressed mood
8. Other mental and behavioural problems
9. Problems with relationships

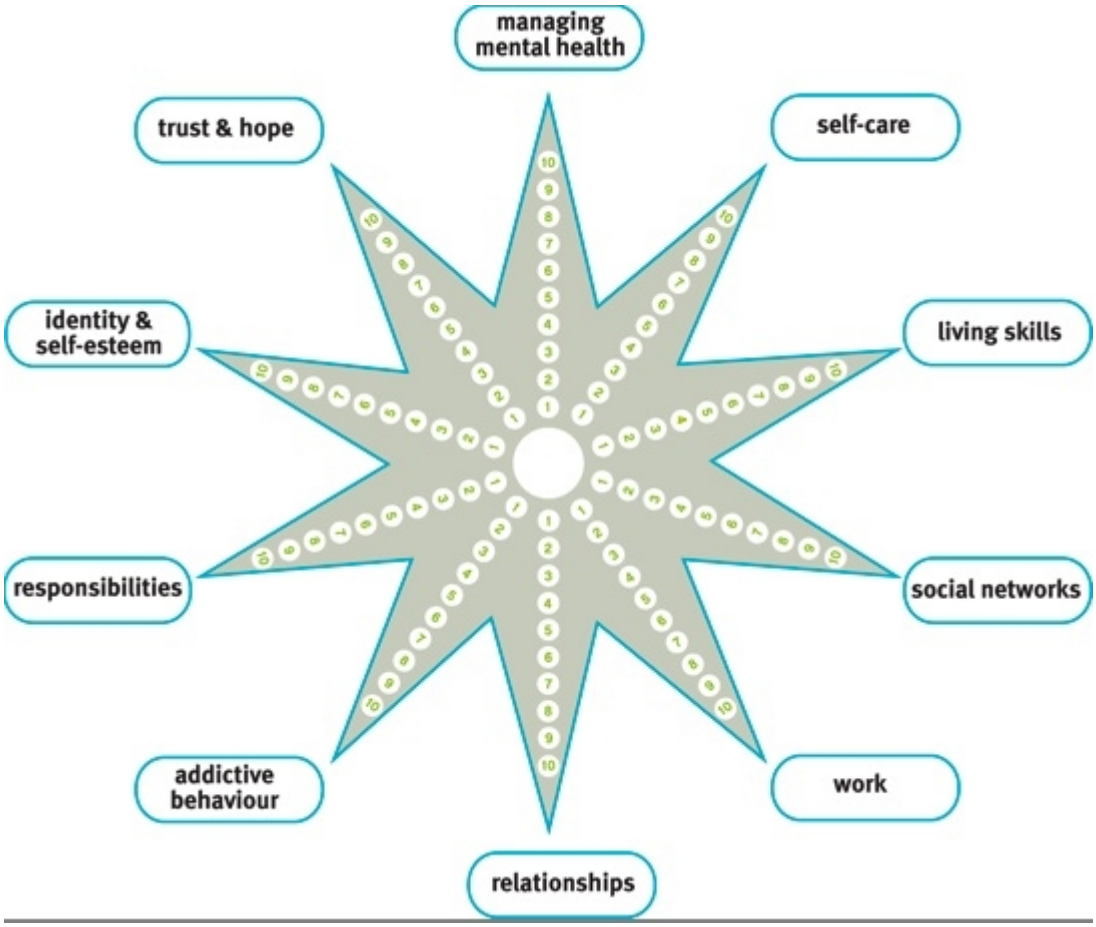
10. Problems with activities of daily living
11. Problems with living conditions
12. Problems with occupation and activities

6.9.1.4 Each scale is rated as follows:

0 No problem
1 Minor problem requiring no action
2 Mild problem but definitely present
3 Moderately severe problem
4 Severe to very severe problem

6.9.2 The Recovery Star

6.9.2.1 The Recovery Star is a tool for supporting and measuring change when working with adults of working age who are accessing mental health support services. As an outcomes measurement tool it enables organisations to measure and summarise:



6.9.2.2 The Recovery Star identifies and measures ten core areas of life:

1. Managing mental health
2. Self-care
3. Living skills
4. Social networks
5. Work
6. Relationships
7. Addictive behaviour
8. Responsibilities
9. Identity and self-esteem
10. Trust and hope

7. The Extent of Mental Health

7.1 The National Perspective

7.1.1 Estimates of the prevalence of mental health problems in Britain are difficult to determine. The latest figures, which are available, come from the Adult Psychiatric Morbidity Survey (APMS) 2007, the third survey of psychiatric morbidity among adults living in private households and was commissioned by The NHS Information Centre for health and social care.

7.1.2 The main aim of the 2007 survey was to collect data on mental health among adults aged 16 and over living in private households in England. It is the primary source of information on the prevalence of both treated and untreated psychiatric disorders

7.1.3 Suicidal thoughts, suicide attempts and self-harm

- Overall 16.7% of people reported in the self-completion that they had thought about committing suicide at some point in their life,
- 5.6% said that they had attempted suicide and 4.9% said that they had engaged in self-harm.
- 63% of men and 58% of women who reported having attempted suicide said that they had sought help following the last attempt. The most common sources of help sought were a GP or family doctor; hospital or other specialist medical or psychiatric services and family, friends or neighbours.
- Younger adults were more likely than older adults to have sought help after their most recent suicide attempt: 70% of those aged 16-34 reported that they had sought help, compared with 51% of those aged 55 or over.
- Of those who reported self-harm, 42% of men and 53% of women received medical or psychiatric help as a result.

7.1.3 Psychosis

7.1.3.1 Psychoses are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. Symptoms include auditory hallucinations, delusional beliefs and disorganised thinking. The main types are schizophrenia and affective psychosis, such as bipolar disorder and manic depression.

- The overall prevalence of psychotic disorder in the past year was 0.4% 789 (0.3% of men 0.5% of women). In both men and women the highest prevalence was observed in those aged 35 to 44 years (0.7% and 1.1% respectively).
- 80% of service users aged 16-74 with probable psychosis received some form of treatment (medication or counselling) for a mental or emotional problem.
- The prevalence of psychotic disorder varied by household income, increasing from 0.1% of adults in the highest income quintile to 0.9% of adults in the lowest income quintile. This trend was more prominent among men than women.
- Two-thirds (65%) of adults with a psychotic disorder in the past year were receiving some form of medication and/or counselling at the time of the phase one interview, compared with 7% of those without a psychotic disorder. Levels of medication use were about ten times higher in adults with psychotic disorder than in those with no psychotic disorder (56% and 6% respectively).

7.1.4 Antisocial and borderline personality disorders

7.1.4.1 Personality disorders are longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships. Antisocial personality disorder (ASPD) and borderline personality disorder (BPD) are two types with particular public and mental health policy relevance.

7.1.4.2 ASPD is characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. BPD is characterised by high levels of personal and emotional instability associated with significant impairment.

People with BPD have severe difficulties with sustaining relationships, and self-harm and suicidal behaviour is common.

- ASPD was present in 0.3% of adults 592 aged 18 or over (0.6% of men and 0.1% of women).
- 1.7%of men aged 18-34 had ASPD, while no cases were identified in men aged 55 or over. 0.4%of women aged 16-34 had ASPD, while no cases were identified in those aged over 35.

7.1.5 Eating disorder

7.1.5.1 Eating disorders, including anorexia nervosa, bulimia nervosa and related conditions, generally have an onset in childhood or adolescence. They include a variety of types of disordered eating, and range greatly in severity. People with eating disorders often experience acute psychological distress, as well as severe physical complications.

- Overall, 6.4% of adults screened positive for an eating disorder. The proportion who screened positive and also reported that their feelings about food had a significant negative impact on their life was 1.6% 3158.
- At 9.2%, women were more likely than men (3.5%) to screen positive for an eating disorder.
- The prevalence of screening positive for an eating disorder decreased with age, and the pattern was particularly pronounced for women. One woman in five (20.3%) age 16-24 screened positive, compared with one woman in a hundred (0.9%) aged 75 and over.

7.1.6 Autism including Aspergers

Autism is a lifelong developmental disability. It is part of the autism spectrum and is sometimes referred to as an autism spectrum disorder, or an ASD. The word 'spectrum' is used because, while all people with autism share three main areas of difficulty, their condition will affect them in very different ways. Some are able to live relatively 'everyday' lives; others will require a lifetime of specialist support.

The three main areas of difficulty which all people with autism share are sometimes known as the 'triad of impairments'. They are:

- difficulty with social communication
- difficulty with social interaction
- difficulty with social imagination.

While there are similarities with autism, people with Asperser's syndrome have fewer problems with speaking and are often of average, or above average, intelligence. They do not usually have the accompanying learning disabilities associated with autism, but they may have specific learning difficulties. These may include dyslexia and dyspraxia or other conditions such as attention deficit hyperactivity disorder (ADHD) and epilepsy.

The prevalence of autism is around 1% of the population.

7.2 Dudley Data

7.2.1 Prevalence of Mental Health in the Dudley Population aged 16-74.

Estimated Prevalence of Neurotic Symptoms in Dudley as % and number of total population aged 16-74 (2005)

	Sleep Problems	Fatigue	Irritability	Worry	Depression	Concentration & Forgetfulness	Depressive ideas	Anxiety	Somatic symptoms	Worry physical health	Obsessions	Phobias	Compulsions	Panic
Men	22%	18%	17%	15%	9%	8%	7%	7%	6%	4%	3%	4%	3%	0%
Men	23900	19900	18700	16300	9900	8900	7600	7800	6700	4300	3200	4400	3200	0
Women	38%	27%	22%	24%	8%	8%	8%	7%	9%	8%	6%	5%	5%	1%
Women	42800	30100	24000	26200	8700	8700	8600	7700	9800	8600	6500	5500	5500	1200

Key Health data for W Midlands 2005 (Birmingham University)

Estimated Prevalence of Neurotic Disorders in Dudley as % and number of total population aged 16-74 (2005)

	Mixed anxiety & depression disorder	Generalised anxiety disorder	Depressive episode	All phobias	Obsessive compulsive disorder	Panic disorder	Any neurotic disorder
Men	7.00%	3.60%	1.20%	1.20%	0.30%	0.20%	11.90%
Men	7700	3900	1300	1300	300	200	13100
Women	10.40%	3.70%	2.30%	1.70%	1.30%	0.10%	17.00%
Women	11600	4100	2500	1400	1500	100	1900

Key Health data for W Mids 2005 (Birmingham University)

Estimated prevalence of Personality Disorder Dudley as % and number of total population aged 16-74 2005

	Obsessive compulsive	Avoidant	Schizoid	Paranoid	Borderline	Antisocial	Dependent	Schizotypal	Histrionic	Narcissist	Any PD
Men	2.60%	1.00%	0.90%	1.20%	1.00%	0.90%	0.20%	0.00%	0.00%	0.00%	5.50%
Men	2850	1050	1030	1290	1100	1020	180	0	0	0	6010
Women	1.40%	0.70%	0.80%	0.30%	0.40%	0.20%	0.00%	0.10%	0.00%	0.00%	3.50%
Women	1560	770	940	320	480	180	30	110	0	0	3930

Key Health data for W Mids 2005 (Birmingham University)

7.2.2 Extimated Prevalence of Probable Psychotic in Dudley as % of total Population aged 16-74, 2005

Men	0.30%	300
Women	0.40%	400

7.2.3 Activity data from services commissioned by Dudley PCT Dudley & Walsall Mental Health Partnership Trust, Activity 2008/9

1	Total Outpatient first attendance	2866	15.81%
2	MI day care attendances	9325	51.44%
3	Number of people receiving Assertive outreach services	116	0.64%
4	Number of people receiving Home Treatment services	644	3.55%
5	Total number home treatment assessments made	4406	24.31%
6	New cases of psychosis served by Early Intervention Teams	141	0.78%
7	Number of patients on enhanced CPA who were discharged from psychiatric in-patient care	629	3.47%
		18127	**100.00%**

7.3 Activity data from services commissioned by DACHS

Xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxxxxxx

8. Mental Health Services in Dudley

8.1 The modernisation of mental health services in Dudley commenced with the implementation of the National Service Framework for Mental Health (1999). In general this involved a move away from hospital based service to community based services including services provided through primary care, including GPs. For example the number of Psychiatric beds for adults aged 16-65 in Dudley in 2000 was 75 and by 2009 it was 48. A number of patients also access beds outside Dudley, for example specialist beds or if theiy have a Dudley GP but live in Sandwell.

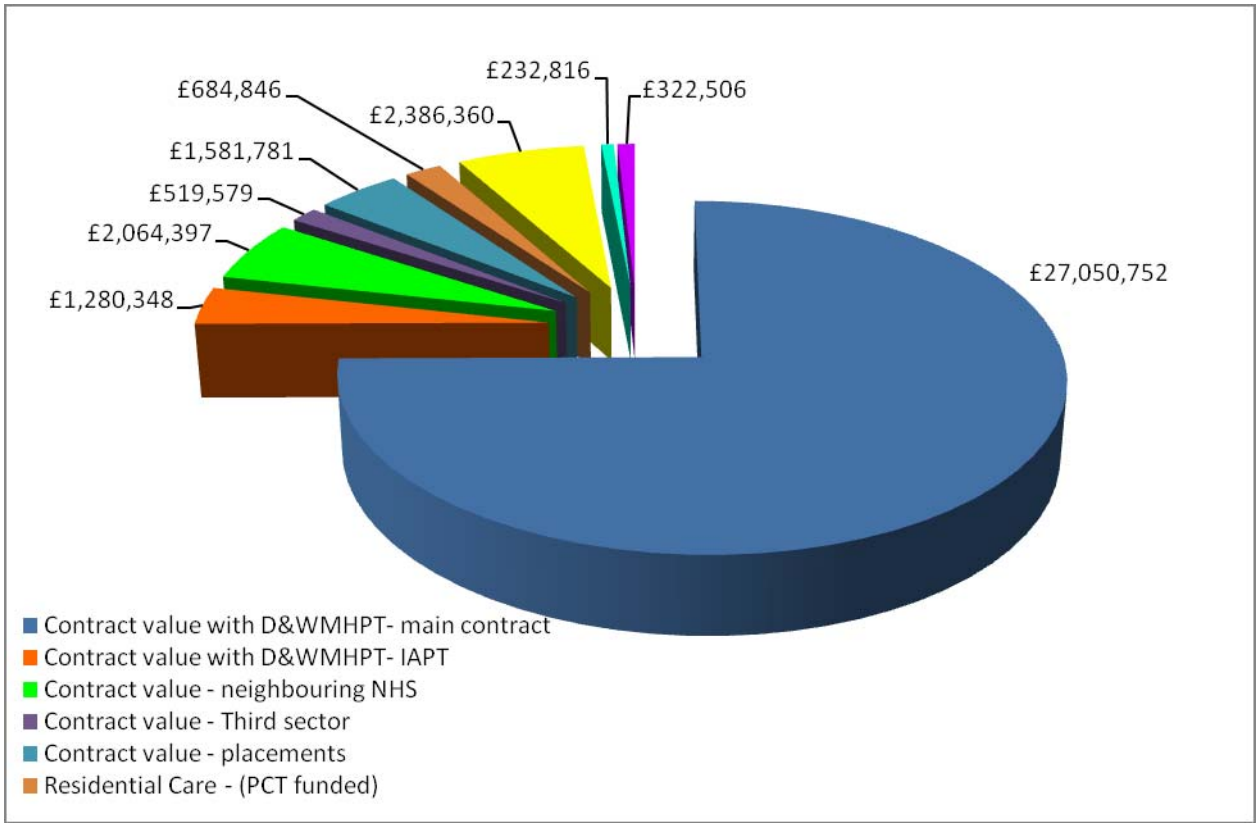
8.2 Over the past few years Dudley Primary Care Trust and Dudley Council have established well-integrated mental health services, which was initially based with the PCT (April 2005) and from 1st October 2008 through the newly formed Dudley and Walsall Mental Health Partnership Trust.

8.3 Although the PCT are the Lead strategic commissioners for mental health Services in Dudley there is no pooled budget therefore the Local Authority and the PCT have separate budgets and separate contracts. Current mental health services in Dudley-

8.3.1 Mental Health services financed by Dudley PCT –

	Total Mental Health budget from Dudley PCT 2009/10	£36,123,385	
1	Contract value with D&WMHPT- main contract	£27,050,752	74.88%
2	Contract value with D&WMHPT- IAPT	£1,280,348	3.54%
3	Contract value - neighbouring NHS	£2,064,397	5.71%
4	Contract value - Third sector	£519,579	1.44%
5	Contract value - placements	£1,581,781	4.38%
6	Residential Care - (PCT funded)	£684,846	1.90%
7	Drug Treatment	£2,386,360	6.61%
8	CAMHS	£232,816	0.64%
9	Other	£322,506	0.89%
		£36,123,385	100.00%

Total Mental Health budget from Dudley PCT 2009/10



8.3.2 Services Commissioned from Dudley & Walsall Mental Health Partnership Trust

1. Assertive Outreach
2. Child & Adolescent Mental Health service (CAMHS)
3. Community mental Health Teams (CMHTs)
4. Criminal Justice
5. Crisis Resolution/Home Treatment
6. Day services
7. Dual Diagnosis
8. Early Interventions
9. Eating Disorders
10. Electro-convulsive Therapy
11. Employment
12. Improved Access to Psychological Therapies (IAPT)
13 In-patients

14. Older Adults
15. Primary Care
16. Psychology

8.3.3 Dudley commissioned specialist mental health services from other NHS providers in the West Midlands which include: Mother & Baby, Deaf services; Psychiatric Intensive Care (PICU).

8.3.4 Services commissioned from the Third sector include day services; home care; advocacy. The current Third sector providers are

- ❖ Alzheimer's Society
- ❖ Dudley Advocacy
- ❖ MIND
- ❖ Rethink

8.4 The Total Mental Health Budget for Dudley Adult & Community Services (DACHS), for 2009/10 was £6.3m which funded services:

- Alzheimer's Society
- Family Care Trust
- MIND
- Rethink
- Residential
- Nursing Care

8.4.1. The aim of social care services are to provide help and support to adults and those who care for them so hat they can live independently in the communities of Dudley.

8.4.2. FACS (Fair Access to Care Services) provides a framework for all Councils as to how they should undertake assessments and reviews, support individuals through these processes and provide or purchase in service to meet the needs of adults, subject to available resources.

8.4.3 There are four bands of eligibility criteria: critical; substantial; moderate; low. Dudley provides services for the first three and offer advice and information to the 'low' group.

9. User & Carer Involvement

9.1 Patient experience of mental health services – Review of the literature.

9.1.1 Engagement with the general public has illustrated mental health services require noticeably more consideration in healthcare improvement; indeed, over three consecutive years, the Dudley Citizen's Panel identified mental health services as one of the five top services requiring additional funding (DCP, 2005; 2006; 2007). Furthermore, in the Annual Telephone Survey (NHS, 2008), 6% of respondents ranked mental health services as most important to improve – making this the seventh most important service in need of development. Clearly, it is widely acknowledged that mental health services require attention; however, identifying specific service areas for remediation requires analysis of feedback from mental health service users per se.

9.1.2 Unfortunately, there is little evidence detailing the patient or service user perspective of the mental health sector. However, the little information that is available suggests that among mental health patients, personalised care has been identified as lacking most, and this largely depends on the attitudes of staff and the perception that a healthcare professional is accountable for each individual patient (DH, 2003). These findings are corroborated by the Community Mental Health Services survey (Healthcare Commission, 2008). Specifically, the score from Dudley PCT for patients receiving a copy of their care plan was within the worst performing 20% of trusts nationwide. Continuity of care has improved generally since 2007; however, for Dudley these scores remain within the worse performing 20% of trusts with the upper confidence limit bordering amber.

9.1.3 It is widely acknowledged that deprivation positively correlates with prevalence of mental ill health. Given that Dudley has varying degrees of multiple deprivations (Annual Report of the Director of Public Health, 2007), it is of no surprise that residents of Dudley have raised concerns over the perceived inconsistency and inequitable access to mental health services across the Dudley Borough (Dudley PCT, 2008).

9.1.4 Furthermore, access to mental health services for particular sectors of the population have also been identified as problematic, including carers of people with mental health problems and deaf people experiencing mental health problems (DCP, 2007; NHS, 2007; respectively). National research has identified some differences between ethnic groups as well (see DH, 2009). Results from the Community Mental Health surveys indicate that Asian respondents were significantly less likely to have received the talking therapies despite wanting this service and were significantly less likely to have received information about local mental health support groups. In addition, results indicate that Asian and Black respondents are significantly less likely to have a number on which to contact the crisis resolution team. Reiterating issues regarding continuity of care, Chinese respondents were more likely to have seen different psychiatrists for their previous two appointments, and these results are generally similar to previous surveys.

9.2 User Involvement

9.2.1 User involvement in mental health services can and should operate at an individual and or at a collective level.

9.2.2 At an individual level Users

- Every service user to be in receipt of a care plan, reviewed and updated at least very 3 months
- All users to be involved in the completion of the care plan and understand and agree actions and have ownership.

9.2.3 At a collective level:

- Information –users providing information to wider stakeholders regarding how well the organisation is involving people
- Feedback - on service user experience
- Influence - user groups' involvement in policy and planning; adapting processes to become more inclusive.

9.3. Carers

9.3.1 Carers involvement in mental health services can and should operate at an individual and or at a collective level.

9.3.2 At an individual level carers

- Information - about treatments and services to support their involvement in care planning
- Feedback- feed back to care coordinators about users care and treatment, and raise issues of concern
- Influence - Shared decision making between service users, carers and professionals

9.3.3 At a collective level:

- Information – carers providing information to wider stakeholders regarding how well the organisation is involving people.
- Feedback - on service user / carer experience; a strategy for gaining feedback and reporting to the wider partnership.
- Influence - carer groups' involvement in policy and planning; adapting processes to become more inclusive.

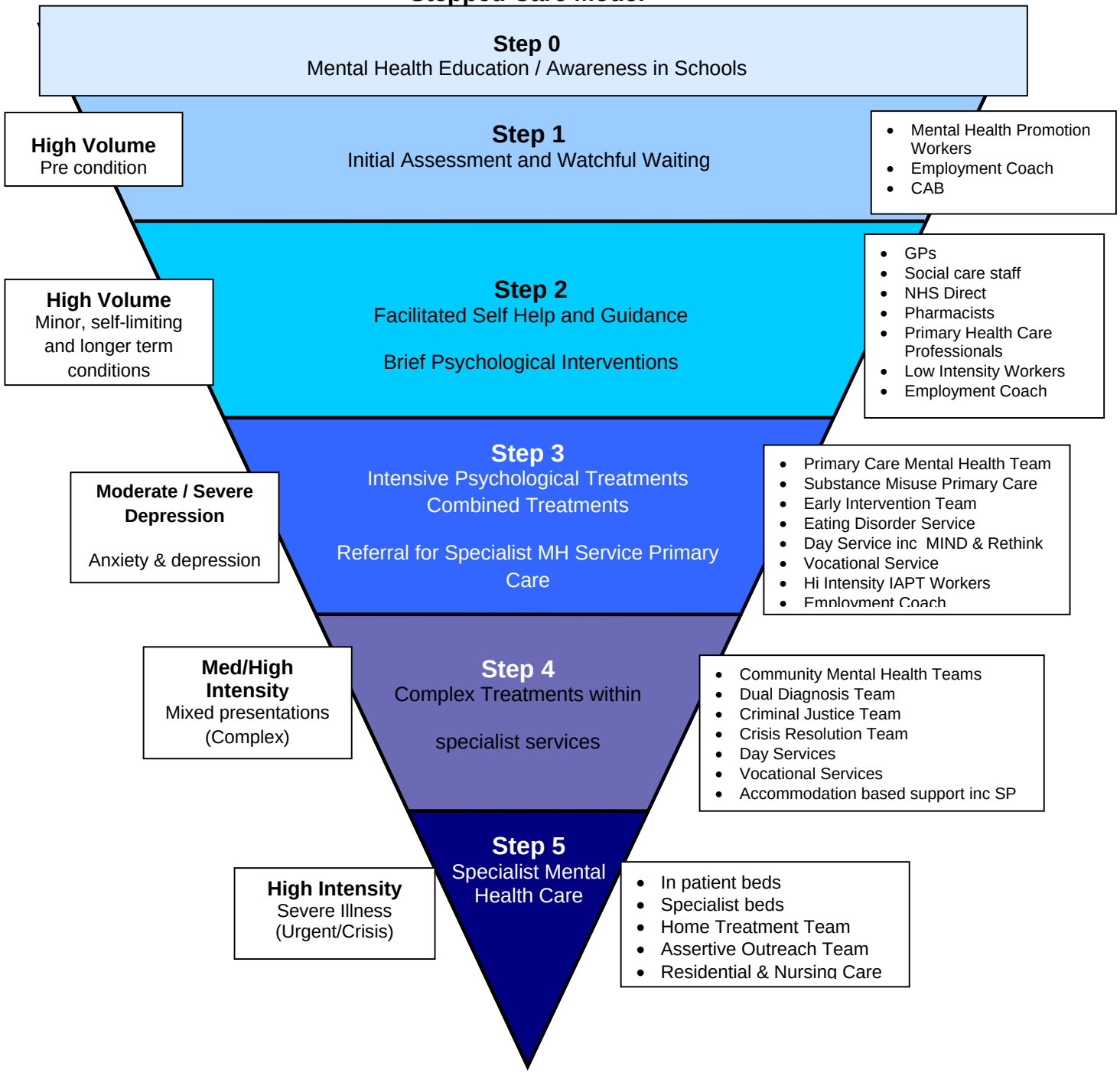
9.3.4 On 19th June 2009 70 carers and carers' workers, from Dudley, representing 25 groups and organisations that offer support to carers got together to review the Dudley Carers Strategy 2007-12

9.3.5 The issues that need to be addressed /improved include:

Information; Assessments; Breaks; Young Carers; Emotional support; Housing

9.3.6 From June 2009 the Commissioners have begun to hold bi-monthly Carers group to share information with carer representatives and to undertake both goal setting and action planning.

Stepped Care Model



10. Safeguarding

10.1 In Dudley Safeguarding is coordinated, by the Adult Safeguarding Unit.

10.2 Safeguarding of vulnerable adults is based on the premise that all adults should be able to live their lives that are free from fear or harm and have their rights and choices respected. It is acknowledge that some people are more vulnerable to abuse and so need additional protection

10.3 Vulnerable adults include: older people, people with mental health needs; people with physical disability or illness; people with a learning disability.

10.4 Abuse can take many forms and includes:

- Physical
- Sexual
- Financial
- Psychological
- Discriminatory
- Neglect or acts of omission

10.5 Abuse can occur in the home, care homes, nursing homes, hospital, day centres; abusers (perpetrators) are often known to the person they abuse .

11. Workforce

11.1 For mental health services to grow and develop, the key is the workforce. It is vital to recruit and retain good quality staff, which reflects the make up of the community they serve.

11.2 The Mental Health workforce must have the competencies to provide person-centred, socially inclusive and recovery-oriented services, primarily in a multi-disciplinary setting and provide a clear pathway for the service user and carer.

11.3 Furthermore in aiming to develop the skills and knowledge of staff who work with people with mental health problems the emphasis must be on placing the service user at the centre of the process and recognising that their perspective is of equal importance to that of the practitioner.

11.4 Where there is an insufficient supply of professionally qualified staff traditional practice must be reviewed to ensure that the best use is being made of highly trained professionals. It is important that all staff, in whatever sector or setting, look at the functions they perform and consider alternative ways that some of these can be delivered.

11.5 The expectation of the commissioners is that each provider will develop their own workforce strategy.

12 Strategy Implementation and Governance

12.1 The implementation and review of the Strategy will be undertaken by the Mental Health Partnership Board.

12.2 The membership of the Board consists of PCT and Local Authority commissioning staff as well as users, carers and providers- their role is to enable their experience to influence commissioning as well as the provision of services.

12.3 Within Adult Social Care there is a clear vision around enabling people to remain as independent as possible, and this is reflected in the support and services that are offered and delivered.

12.4 The recent creation of the Dudley and Walsall Partnership NHS Trust provides the opportunity to potentially reducing duplication and benefiting from economies of scale.

13. Commissioning Intentions - Dudley 2009/10

	Commissioning priorities for 2010/11	Business Plan	Milestones
1	Continue to Improve patients access to mental health services through primary care	MH services have been redesigned to improve access to primary care by increasing investment and a stepped care approach.	Monitored through the contract Review of all services by commissioner and provider - Dec 10
2	Improved access to Psychological Therapies (IAPT)	Dudley was in the first wave of implementation sites for IAPT and thus secured additional funding of @£1m for 3 years, commencing autumn 2008. 33 additional workers (trainees) in post to deliver CBT in primary care and community settings. The trainees will be fully trained by 2010.	Monitor role of IAPT and how it fits in with the wider primary carer mental health services
3	Monitor the implementation of the Joint MH strategy 2010-13		To be monitored at the bi-monthly Mental Health Board
4	Collaborative commissioning (Black Country)	To develop a collaborative approach to the commissioning of MH services across the Black Country, if appropriate and monitor and review services which are collaboratively commissioned.	Bi-monthly meetings
5	Improve outcomes and quality from MH Providers	Contract in place Joint working by all MH providers.	Monthly contract meeting with D&WMHPT with Walsall PCT Quarterly Quality meetings Quarterly Provider Forums
6	MH Services for Young Adults	The intention is to develop services to meet the needs of 16-25 year olds. In 2010 this will mean that the CAMHs service to be extended to cover u18s	Project plan to be developed and reviewed at bi-monthly meetings
7	Dual Diagnosis- MH and substance misuse	Joint approach to Strategic development by DAAT/Public Health/Commissioning. Well developed dual diagnosis in place but limited capacity	Monitored through D&WMHPT contract meetings and through the Substance Misuse Implementation Group (SMIG) at the Drug & Alcohol Action Team (DAAT)

	Commissioning priorities for 2010/11	Business Plan	Milestones
8	Dual Diagnosis- MH and Learning Disability	Ensure LD users with MH needs have their needs met. Also monitor/develop services for users with LD who are not eligible for LD services	Traffic Light meetings to continue
9	Personality Disorders	Monitor the new service	Monitored through D&WMHPT contract meetings
10	Older Adults MH and dementia	Strategy to be developed and implemented. Service re-design	Monitored through D&WMHPT contract meetings
11	Care closer to home	To continue to work with Independent sector providers and DACHS to ensure a whole systems approach ;value for money; care closer to home. Issues with DACHS as to who monitors their placements	Joint DMBC & PCT Monthly meetings to monitor placements
12	Aspergers	Growing prevalence of patients presenting with Aspergers and whose needs are not being met by D&WMHPT and/or DMBC which put pressures on PCT placement budget	Need to develop local and effective Aspergers service
13	Court Liaison/Criminal Justice Liaison	Review implementation of the Bradley report which includes an emphasise on improved joint working Management of the Court diversion service to be sited in Dudley	Review of the CJ service Monitored through the Criminal Justice Implementation Group (CRIG)
14	Individualisation/ Personalisation	Work with DACHS to ensure individualisation agenda is implemented	
15	Continue the review of Out of Hours/Emergency care inc relationship with DGOH inc A&E	Through service redesign and shared understanding	Regular meeting with D&WMHPT and DGOH
16	Walsall MH Commissioners	Joint approach to the commissioning of D&WMHPT with Walsall PCT and LA	New structure to be implemented Joint Meetings dates to be arranged and individual roles and responsibilities to be developed

	Commissioning priorities for 2010/11	Business Plan	Milestones
17	New Horizons	Implementation of New Horizons	Through the Mental Health Board and primary Care Mental Health Group
18	Carers	Continue to work with Carers – both information sharing and policy development	Through the bi-monthly group Carer reps at MH meetings
19	Service users	Ensure Users are central to the delivery of MH services	Monitoring of the CPA process Use of Direct payments/Personal Budgets Involvement in decision making
20	Payments by results (PbR)	Implementation of PbR including Yorkshire care pathways	This project is lead by SHA and D&WMHPT

14. Strategy Implementation Plan for Mental Health Services for Adults of Working Age 2010-13

Objective 1: Promoting mental health and well-being and reducing inequalities

No.	PRIORITIES	ACTIONS	RESPONSIBLE LEAD	TARGET DATE
1.1	Information, advice and guidance will be accessible to people with mental health problems and their families.	• Review current information materials and access to services with partners and service users • Develop a strategy to make information more accessible and remove barriers to take up • Design and commission appropriate materials in accessible formats where needed, with particular focus on BME and hard to reach groups.	NHS Strategic Commissioner MH	July 2010
1.2	Services will become preventative by focusing on early intervention, preventing deterioration and reducing hospital admissions.	• Develop a Psychiatric Liaison Service to enable early identification and diversion of MH service users from Acute General Hospital care. • Ensure a clear care pathway from Primary Care MH services and other locally-based preventative and self-help services. • Work closely with the DWMHPT to monitor the performance of the Early Intervention in Psychosis Service (EIPS) to ensure vital sign targets are met.	NHS Strategic Commissioner MH DGoH NHS Urgent Care Lead D&WMHPT	2010

No.	PRIORITIES	ACTIONS	RESPONSIBLE LEAD	TARGET DATE
1.3	Services will promote healthy lifestyles and improve the health and well-being of people with mental health problems.	• Audit health promotion initiatives to ensure accessibility for people with mental health problems, and especially for BME and hard to reach groups. • Establish joint working with primary care services regarding health and well-being initiatives to ensure the inclusion of people with mental health needs • Establish a system of physical health checks/screening for MH service users on CPA and people with learning disabilities /MH problems • Ensure that exercise and leisure advice is incorporated into assessments and CPA plans • Inpatient services conduct a physical health/ healthy lifestyle assessment for every patient admitted.	NHS Strategic Commissioner MH Public Health	2010
1.4	Challenge the stigma of mental illness to support the inclusion of people with mental health problems in community life.	• Dudley Strategic Partnership to engage public and private sector partners in initiatives to include MH service users in mainstream services.	NHS & DMBC representatives on the Partnership	July 2010
1.5	Ensure Carers receive the support required to enable them to continue in their caring role	• Carers assessment to be available for carers • Packages of care and support to be available, based on need	DMBC Carers Lead MH providers	2010

Objective 2: Transforming care and personalising services

No.	PRIORITIES	ACTIONS	RESPONSIBLE LEAD	TARGET DATE
2.1	Services will become more user-centred and based on individual needs. People with mental health problems will be offered greater choice and control over the support they receive	• Providers will review the current practice of MH teams to identify changes required to meet personalisation goals • Training needs analysis will identify training required to deliver new best practice • Providers to arrange appropriate inputs to meet training requirements identified • Increase the numbers of user-controlled services through Direct Payments and Personal budgets • Through commissioning, support the growth of advocacy services, including IMCAs working under the Mental Capacity Act	DMBC MH Provider services NHS Strategic Commissioner MH,	September 2010
2.2	Services will be delivered in local, non-stigmatising settings	• Services/clinics currently provided in specialist settings will be reviewed to identify if alternative, less stigmatising settings are available • Identify available venues in each locality with Primary Care and other partners	NHS Strategic Commissioner MH, MH Providers	2010

No.	PRIORITIES	ACTIONS	RESPONSIBLE LEAD	TARGET DATE
2.3	We will promote access to mainstream community opportunities for people with mental health problems.	• Continue to review all existing day services with partners and service users • Ensure a joint approach by all MH providers of day opportunities to ensure: ⇨ programmes are linked to mainstream community services providers, employment agencies etc, ensuring accessibility for groups currently excluded ⇨ use personal budgets to support access to opportunities focused on meeting the user's individual needs and choices	NHS Strategic Commissioner MH	2010
2.4	Care pathways will be clarified to improve access to services for patients and carers.	⇨ Implementation of the West Midlands Care Pathways Programme	NHS Strategic Commissioner MH, D&WMHPT	2010

Objective 3: Service Improvement

No.	PRIORITIES	ACTIONS	RESPONSIBLE LEAD	TARGET DATE
3.1	Provide timely access to a range of effective clinical services	• Review access arrangements for each locality in the Borough and ensure care pathways comply with the West Midlands Pathway model.	NHS Strategic Commissioner MH	2010
3.2	Implement effective Safeguarding practice	• Establish a section 136 Suite at Bushey Fields, inc policies and procedures to offer protection for vulnerable offenders in a safe and appropriate setting. • Ensure Safeguarding Adults procedures are effectively implemented by provider services and through partner agencies.	NHS Strategic Commissioner MH D&WMHPT DMBC	2010
3.3	Increase opportunities for paid employment for people with mental health problems	• Further develop partnerships with employment services and voluntary sector organisations to create increased employment opportunities for people recovering from mental illness.	NHS Strategic Commissioner MH	2010
3.4	The range of accommodation available for adults with mental health problems will increase to promote choice, control and independence.	• In partnership with Supporting People and DACHS, ensure a strategy is in place to identify and meet the housing needs of people with mental health problems.	NHS Strategic Commissioner MH Supporting People Lead DACHS	2010

Objective 4: Building the capacity of local services

No.	PRIORITIES	ACTIONS	RESPONSIBLE LEAD	TARGET DATE

4.1	Develop good quality local treatment and support services within the Borough	• Commission a specialist low secure in-patient service for Walsall patients through a budget pooled with Black Country commissioning partners
		• In partnership with other Black Country Commissioners, broker the development of a specialist Eating Disorders Resource able to work intensively with patients for a minimum of 6 months.
		• Develop services for those Mental Health users who have Dual Diagnosis – ie Mental Health and substance Misuse or Learning Disabilities such as ASD
		• Ensure that the mental health needs of offenders are met especially for those in custody
		• Develop services for young adults 16-25
		• Ensure effective Governance arrangements to:
		  • implement in local services the findings &recommendations of inspections and reviews
		  • monitor outcomes of services to ensure quality and safety are maintained
		  • disseminate best practice from NICE Guidance and other sources
			NHS Strategic Commissioner MH	2010
				
				2011

No.	PRIORITIES	ACTIONS	RESPONSIBLE LEAD	TARGET DATE
4.2	Promote Primary Care Services as the access point for the identification, treatment and support people with mental health problems.	• Work with Primary care colleagues to ensure that the wide range of services currently available through the primary care mental health teams are known and utilised	NHS Strategic Commissioner MH	2010
4.3	Increase community support available: ⇨ to reduce care home placements ⇨ to make home-based care the norm	• Work with DACHS to ensure services and funding available , such as domiciliary care to prevent users from having to enter residential, nursing or in-patient care	DACHS	2010
4.4	Extend the range of treatment options available	• Conduct a scoping exercise to identify the range of treatment options currently available in Dudley • Review and disseminate through clinical services the best practice guidance available through NICE • Identify gaps in locally available service	NHS Strategic Commissioner MH DMBC	2010
4.5	Continue the integration of services to create seamless care pathways for service users and carers	• Embed the West Midlands Care Pathway as the basis for integrated service delivery in Dudley's mental health care.	Strategic Commissioner MH D&WMHPT SHA	2010

No.	PRIORITIES	ACTIONS	RESPONSIBLE LEAD	TARGET DATE
4.6	Enable service users placed out of borough to return to live closer to their local communities	• Continue with the current arrangement of the Joint Short Term Placement panel supported by the role of the Short Term Placement Manager- who ensures that only those requiring an out of area placement are moved out of area and works with clinicians to ensure a safe return for those currently placed outside Dudley • Work with the west Midlands Specialised Commissioning Team to ensure that Dudley residents placed by them have reviews etc • Through commissioning/procurement practice, stimulate the local market to provide placements for other residents for whom there is currently no local provision • Work with local managers and clinicians to review and revise protocols on future out of Dudley placements to minimise their use. • Develop joint commissioning practice with Dudley MBC budget holders to ensure a joint approach to care	Strategic Commissioner MH/ Short Term Placement Manager	2010
4.7	Ensure the workforce is equipped to deliver the services required for the future	• Ensure providers undertake a training needs analysis of their workforce • Ensure providers develop and deliver recruitment and training necessary to meet the challenges for future services	All MH providers	2010

Objective 5: Improving Commissioning for mental health and well-being

No.	PRIORITIES	ACTIONS	RESPONSIBLE LEAD	TARGET DATE
5.1	Develop commissioning capacity in partnership, to: ❑ meet the challenges of World Class Commissioning ❑ re-shape services ❑ ensure the most effective use of resources	• Achieve the change from block contracted services to cost and volume contracts • Review the Dudley MH Strategic Plan to ensure the objectives of "New Horizons" are fully incorporated and addressed • Work collaboratively with Black Country Commissioning partners to commission services jointly where this is beneficial • Support contract monitoring processes with clinical quality audits	NHS Strategic Commissioner MH MH Commissioning & Contract Manager NHS Finance Manager	2010
5.2	Strengthen the involvement of people with mental health problems in commissioning, service delivery and monitoring to ensure quality	• Develop the role of the Dudley MH Partnership Board in leading on consultation and user involvement in commissioning. • Develop with service users, advocates and carers a plan for the improvement of user/carer involvement processes. • Meet regularly with Users and Carers to share information and ideas • Develop mechanisms for the inclusion of BME communities, people with learning disabilities and other excluded groups in consultation processes. • Review the options for embedding the findings of the user survey from 2009/10, to monitor and evaluate the service user experience in mental health services.	NHS Strategic Commissioner MH MH Commissioning & Contract Manager MH Partnership Board	2010

No.	PRIORITIES	ACTIONS	RESPONSIBLE LEAD	TARGET DATE
5.3	Improve the performance management of all contracted providers	• Ensure all provider provide robust data that reflects the activity and quality of all services provided	MH Commissioning & Contract Manager	2010

Appendix 1: Glossary

The following terms are highlighted in the text in italics.

Acute Care
The treatment of an illness for a relatively short period of time for a severe episode of illness.

Bi-polar disorder
A psychiatric condition that causes recurrent episodes of significant disturbance in a person's mood, energy, and ability to function. Also known as manic-depressive illness

Care plan
A plan of the treatment for an individual who is receiving health or social care. It will normally follow an assessment and be agreed between the person receiving care and the assessor.

Care Programme Approach
*(CPA)*A way of co-ordinating community health services for people with mental health problems in which one person co-ordinates all aspects of your care -including health and social care.

Carer/ carers
A person who provides support and looks after someone. In this document we only refer to informal carers (e.g. a member of the family) not paid carers.

Direct payments
A payment for people assessed as needing help from social services, who then arrange and pay for their own care and support.

Dual diagnosis
This term applies to people who have both mental heath and drug or alcohol problems.

Economically Inactive
People who are not in work, but who do not satisfy all the criteria for unemployment i.e. wanting a job, seeking a job in the last four weeks and available to start in the next two. The main groups classed as economically inactive are those looking after the family and home, students and those who are long-term sick or disabled.

Enabling/enable
To make possible or give support to help make something happen

FACS (Fair Access to Care Services)
Provides a framework for all Councils as to how they should undertake assessments and reviews, support individuals through these processes and provide or purchase in service to meet the needs of adults, subject to available resources. There are four bands of eligibility criteria: critical; substantial; moderate; low.

Individual budget
A scheme that allows people needing social care and associated services to decide the nature of the services they need. A key feature is a transparent allocation of resources that gives the individual a clear cash or notional sum for them to use on their care or support package.

Intervention
An action that is intended to alter the course of an illness.

Partnership board
A forum that brings together statutory and non statutory representatives together with user, carer and provider groups in order improve the experience of needs assessment, planning, delivery and service performance assessment for improvement. There are four partnership boards for health and social care for Learning Disabilities Services, Older People Services, Physical Disabilities and Sensory Impairment and Mental Health Services.

Outcome
The consequence of an intervention. (See above)

Pathway or integrated care pathway
A multi-disciplinary outline of planned care designed to help a patient achieve a positive outcome during and after treatment.

Personalised
Services that are delivered to people in line with their wishes and their convenience.

Personality Disorder
Features of an individual's personality that forms a pattern of behaviour that does not help an individual adjust and function well within a social environment. A personality disorder can create problems for the individual because it causes conflict between that person and others or causes conflict within themselves.

Promoting Independence
A principle that underpins the delivery of health and social care services and stresses that care should aim to maintain and develop independence and respect people's dignity.

Provider
An agency that provides services to people – in this strategy it will normally refer to an agency offering health, social care or housing services. The agency can be a public sector, voluntary or private sector organisation.

Psychosis/Psychoses
A mental health disorder/s that produces disturbances in thinking and perception severe enough to distort an individual's perception of the world and of events within it.

Purchaser
An agency that purchases services on behalf of the population for which they are responsible. It may refer to a GP practice, a primary care trust, or a social services department.

Review
The periodic re-examination of a client's case to consider what changes to services or treatment are desirable.

Schizophrenia
A mental illness characterized by impairment in the perception or expression of reality, most commonly manifesting as auditory hallucinations, paranoid or bizarre delusions or disorganized speech and thinking in the context of significant social or occupational dysfunction.

Third Sector
Organisations that are independent of the Government, that work to achieve social, environmental or cultural aims, mainly reinvest any profits they make to help achieve those social, environmental or cultural aims. It includes community groups, co-operative, voluntary groups, charities and social enterprises.

Social exclusion
The government has defined social exclusion as "what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, bad health and family breakdown".

Stigma/stigmatised
The prejudice or bigotry experienced by an individual who has a condition that society at large finds difficult to accept.

Transition
A time of significant change for a person e.g. where a person is moving from childhood (and being at school) to adulthood (and going to work or college)

Wellbeing The state of feeling healthy and happy

Appendix 2: Voluntary Sector Organisations

The following are some of the organisations that contract with the PCT and/or DACHS delivering a wide range of mental health services.

Alzheimer's Society

Dudley Mind

Dudley Advocacy Service

Dudley Voluntary Service Council

Crossroads

Familycare Trust

Humdard

Rethink

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Mental illness affects us all. Whether it is ourselves, a family member or a friend, lots of us will experience a mental health problem at some point in our lives.

Mental ill health not only causes untold personal suffering and distress, but also affects people's relationships, ability to work, family life. It can lead to a range of physical health problems.