NHS
Solihul
Clinical Commissioning Grou

Solihull
METROPOLITAN
BOROUGH COUNCIL

Solihull Mental Health Strategy

2015-2020

"I am a person not a mental health problem"

"Caring for the mind is as important and crucial as caring for the body. In fact one cannot be healthy without the other"

"Mental illness is nothing to be ashamed of, but stigma and bias shame us all"

"Your present circumstances don't determine where you can go they merely determine where you start"

"Just because today is a terrible day doesn't mean that tomorrow won't be the best day of your life. You just gotta get there."

We are clear about the responsibility that our organisations have to help shape and deliver a better model of health and social care for the people of Solihull who have, or may develop, a mental illness. As leaders of our organisations we commit to work together, in partnership with the people of Solihull, to create this model and ensure that it meets the needs of people with a mental illness and their families and carers; that it delivers better outcomes for people and reduces inequality.

Chief Officer, Solihull Clinical Commissioning Group

Chief Executive, Solihull Metropolitan Borough Council

Chief Executive, Birmingham and Solihull Mental Health Foundation Trust

Director of Public Health, Solihull Metropolitan Borough Council

Chief Executive, Heart of England Foundation Trust

Health and Wellbeing Board, Solihull

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OUR VISION FOR THE MENTAL HEALTH AND WELLBEING OF PEOPLE IN SOLIHULL

To commission integrated mental health services that are effective, evidence based, equitable, safe and delivered by staff who inspire confidence and hope and who help the people they are supporting to take control of their own lives and their recovery.

Metal health services delivered within Solihull will have a strong focus on:

- The person
- Lives not services
- Prevention & early intervention
- Recovery
- Strong partnerships
- Outcomes
- Service quality
- Evidence based practice

We will commission a mental health system that improves access to:

- Information about services and support
- Support to develop meaningful relationships and participation in community activities
- Support for carers
- Support to address both mental and physical health needs
- Early diagnosis and intervention
- Evidence based assessment, treatment and support
- Support for people during acute phases of illness
- Housing with flexible support
- Support to find meaningful occupation or employment and to maintain income

There will be more:

- Involvement of service users in decisions about service planning, commissioning and review.
- Control and choice in care planning
- Attention to the mental health and wellbeing of carers
- Co-ordinated care
- Effective use of resources in secondary care
- Parity of esteem for MH

There will be less:

- Stigma and discrimination associated with mental health problems
- Inequality in the treatment of people with a mental illness in the physical health system.
- Avoidable harm and injury
- Time spent away from home by adults with mental health problems

There will be fewer:

- Incidents of self harm
- Avoidable crises and admissions to hospital
- Adults with mental health problems who feel alone and unsupported
- Adults with mental health problems who are excluded from the communities in which they live.

Introduction

Improving the outcomes and experiences of people with a mental illness is everybody's business. People with a mental illness have the same basic needs as those without a mental illness, such as the need for a stable place to live, the need to have a job or to engage in meaningful activity, the need to have financial security and the need to feel part of, and valued by, their local community. To achieve these outcomes for people with a mental illness requires a whole system response requiring a focus on:

- Helping the local economy to grow in a way that provides long-term stability and quality jobs
- Making communities stronger
- Improving people's health and wellbeing.

These all work together. When people are better off, they're healthier and have a greater sense of wellbeing, as they do if they feel part of a strong and connected local community. This therefore can not just be a mental health strategy for health and social care but a strategy for all living and operating within Solihull.

The Borough of Solihull

There are many advantages to living in Solihull. Solihull has a strong economy and a population that is quite affluent with above average levels of income and home ownership. Solihull is however challenged by a prosperity gap with high levels of deprivation in the regeneration areas of Chelmsley Wood, Kingshurst and Fordbridge and Smiths Wood. The impacts of this are felt across a broad range of outcomes including educational attainment, employment, crime and health. The regeneration of these areas seeks to bring about long term sustainable benefits, working with the communities in the determination of local priorities which will support the area to:

- become more prosperous
- ensure a brighter future for children and young people
- support the community to be safer and stronger
- support the community in the improvement of their health and wellbeing.

The mental health and wellbeing of people living in these areas is poorer than that of those living in the more prosperous areas of Solihull. Poor mental health and wellbeing will be a barrier to achieving the priorities listed above. High quality, effective mental health services and support are therefore vital if we are to deliver significant improvements to the health and prosperity of Solihull.

How do mental health services for the people of Solihull compare to other areas?

In comparison with areas that have a similar profile, Solihull CCG spends slightly more on mental health and achieves significantly higher outcomes against a number of key measures such as: the number of suicides, the numbers of people with a mental illness in stable accommodation and the percentage of people with a comprehensive care plan. However, Solihull is worse than like areas for the number of 16-18 year old not in education, employment or training, it is higher than like areas in the numbers of families who are homeless and higher for inequality in life expectancy. Solihull is about average for hospital admissions for mental health conditions and below the average for the numbers of people attending accident and emergency departments for self harm. This however masks a small number of people who have exceptionally high levels of self harm and use of acute hospital services and we are working in partnership with a range of organisations to improve the support that we can offer these people locally.

Why a new strategy?

The mental health strategy upon which the previous re-design of services was based was produced in 2010 and expires this year (2015). Since the last strategy legislation has changed and the financial environment within which we are operating is now very different. It is a good time to take stock of what has already been achieved and to look at where mental health services are still not delivering the best outcomes and experiences for the people using them.

What did we achieve? (further detail is provided in appendix 2 attached)

- We re-tendered third sector services against a service specification that was outcomes based
- We have supported the Council in the development of the web-portal which provides information about the services and support available in Solihull.
- We have supported the commissioning of information and advice hubs within Solihull to make it as easy and as quick as possible for people to access the support that they need ranging from help in sorting out benefits and finances to knowing what is available in the local area.
- We now have an organisation, Independent Advocacy, supporting the development of peer support groups and providing opportunities for people with lived experience to become qualified as advocates or personal assistants.
- We worked with Solihull Mind supporting them to develop and deliver training programmes at their horticulture project that will lead to accredited qualifications for people attending this service.
- We have worked with Stonham Home Group to replace a mental health residential care home with a new scheme of supported one bedroom flats. This has made a significant difference to the lives of the people previously living at the care home and is supporting people who are currently living outside of Solihull to return.
- We worked with the Birmingham and Solihull Mental Health Trust to develop a single point of access into mental health services making it easier for people to be referred and to ensure that people were seen by the right service at the right time. Waiting times from referral to assessment and intervention have been reduced as a result of the establishment of the single point of access.
- We worked with the BSMHFT to enhance Home Treatment Team provision, identifying dedicated Consultant psychiatry support to this service.

- We worked with the Police, Ambulance Services, the BSMHFT and Birmingham commissioners to develop the street triage service which is a pilot until end March 2016.
- We worked with the Birmingham Commissioners and the BSMHFT in the development of a psychiatric decision unit (PDU). This has meant that people in crisis can get a proper assessment of their mental health in a more appropriate setting and has supported people in stabilising their mental health and avoiding admission for some people who, without the PDU, would have been admitted.
- We bid for 111 Learning and Development monies to pilot a mental health crisis line embedded within 111. This means that people with mental illness as their chief complaint can speak to a mental health specialist and get the most appropriate recommendation of, or referral to, the support required.

What didn't we achieve?

- We were not able to progress the move of inpatient assessment and treatment services out of Bruce Burns to a facility that is fit for the future. The current service does meet regulations and does deliver high quality treatment and care but all agree that it cannot continue in its current form for much longer. We will be working with the BSMHFT to identify options for inpatient assessment and treatment services for the people of Solihull.

- We were not able to develop mental health respite provision within Solihull during the life of the last strategy. We have a plan for 4 respite flats which will provide early help for people becoming unwell who need time away from their current situation and also to support people who no longer require inpatient treatment but who are not yet well enough to return home by stepping them down into a respite flat. We believe that this will improve the flow through inpatient services and thereby reduce/prevent the numbers of people having to travel significant distances to be admitted.

Our vision

Our **vision** is to commission integrated mental health services that are effective, evidence based and safe delivered by staff who inspire confidence and hope and who help the people they are supporting to take control of their own lives and their recovery.

To deliver this vision will require us to commission services that:

- build resilience in our population through mental health promotion, prevention and early help
- deliver high quality treatment and support for when people are unwell
- help people to live well with their mental illness

This vision needs to be underpinned by shared values across Solihull where mental health is seen as everybody's business, where there is a focus on the whole person and where all sectors are focusing on people's lives and not just the services that are available. Although we have come a long way it does still feel like people are being fitted into services rather than services being fitted around the people. This strategy looks at how a lives not services approach can be embedded within any future service developments and re-design.

The scope of the strategy

The scope of this strategy is adults with a functional illness but this strategy has an inter-dependency on the emotional health and wellbeing strategy for children and young people and the Joint Birmingham and Solihull Dementia Strategy.

The recent tender of emotional health and wellbeing services for children and young people in Solihull was awarded to the Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) in partnership with Barnardos. The BSMHFT now deliver whole life mental health provision within Solihull which will make it easier for the Trust to place more of an emphasis on the development of preventative provision in childhood by supporting parents, schools and looked after children and their foster parents so that children and young people will be able to easily access high quality mental health treatment and support reducing the burden of mental ill health when they become adults.

The Case for Change

What people using the services have told us.

The people best able to tell us what is good about the services that we commission and what needs to change to make them more effective are the people using them. This strategy is therefore based upon what people have told us that they want from mental health services and the support that they have said will help them to live well with their mental illness.

People using services and their carers have told us that service quality and the quality of the relationships with staff supporting them are key. Continuity of staff is important to people as this helps to build trust and the confidence to work with the staff to achieve recovery. People using the services and their carers have told us that they want:

- easy access to good information and advice,
- easier access to meaningful activities
- better communication,
- easier, quicker access to services,
- only having to tell their story once,
- more choice and control over their care and
- more opportunities to actively direct their own support through user led services.

These are not unreasonable expectations and the strategy therefore needs to ensure that these are central to all discussions and decisions about future service models and pathways.

We sourced the views of people who use the services and their carers through stakeholder engagement events both individually as Solihull and through the engagement events in support of the BSMHFT New Dawn programme. Solihull has also ensured that there has been carer and service user representation at the Solihull Re-design Project Board so that information from this Board can be cascaded out to service user and carer forums.

National Policy and Guidance:

Closing the Gap: Priorities for essential change in mental health (February 2014)

Closing the Gap identified 25 aspects of mental health care and support where the government, along with health and social care leaders, academics and a range of representative organisations, expect to see tangible changes *in the next couple of years*: changes that will directly affect millions of lives for the better. Solihull has benchmarked itself against these priorities and has identified key areas of action which have been incorporated into this strategy and the commissioning action plan which is attached as appendix 1.

Mental Health Crisis Care Concordat:

The Concordat is a shared agreed statement, signed by senior representatives from all organisations involved, which include Health, Social Care, Police, 3rd Sector and other organisations who come into contact with people in crisis. It covers what needs to happen when people in mental health crisis need help - from ensuring that it informs strategic priorities and spending decisions, anticipating and preventing mental health crises wherever possible, and in making sure effective emergency response systems operate in localities when a crisis does occur.

The Concordat is arranged around:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

Benchmarking against the outcomes included in the Crisis Care Concordat have helped inform this strategy and the commissioning action plan which is attached as appendix 1.

Five Year Forward View : NHS England

In the document 'Five Year Forward View' produced by NHS England in October 2014 it states that although the NHS has dramatically improved over the last 15 years the quality of care can still be variable, preventable illnesses are widespread and health inequalities deep rooted.

Mental health is a particular challenge especially the need to achieve parity of esteem with physical health which is a key national priority.

The NHS and Social Care are operating within extremely challenging financial environments. Monitor, NHS England and Independent Analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding, would produce a mismatch between resources and service demands of nearly £30billion a year by 2020.[1] So to sustain a comprehensive high quality NHS, action will be needed on three fronts: demand, efficiency and funding. We therefore need to look at how we can reduce demand through prevention and early help services, improve the efficiency of services

[1] Five Year Forward View: NHS England October 2014

commissioned/delivered and ensure that we are getting best value from every pound spent on health and social care within Solihull. This will be achieved through:

- greater focus on prevention – particular action to tackle obesity, smoking, alcohol and other health risks
- better understanding of medicines management where there is a dual diagnosis of physical and mental ill health to ensure that medication does not contribute to key conditions such as diabetes, heart disease etc.
- developing and supporting new workplace incentives to promote employee health and cut sickness related employment.
- Giving people who need health services greater control of their own care such as through shared budgets combining health and social care
- Improved partnerships with voluntary organisations and local communities – developing less medicalised approaches in the care and support of people locally.
- Improving integration between GP's and hospitals, between physical and mental health and between health and social care.

Improving integration between urgent care services such as A&E, GP Out of Hours, Urgent Care Centres, NHS 111, ambulance services, police and mental health providers.

What are our main priorities?

- **Promotion, prevention and early help** are key priorities for Solihull Council and Solihull Clinical Commissioning Group (CCG). Much has been done locally to improve access to information and advice services, to support people to find meaningful activities through social prescribing and to break down the stigma and discrimination of mental health. Building resilience in people is essential as we will no longer have the resources to be all things for all people. People will need to become experts in the management of their health conditions and to keep themselves well. The Council and CCG will do all they can to help people to adopt healthier lifestyles and will do this through Public health commissioned programmes such as the Health Trainer service, smoking cessation services and social prescribing.

  Third sector contracts have been re-tendered against three outcomes based prospectuses and new contracts, supported by new outcome focused service specifications, have been developed.

  We have included performance metrics within the CCG Operating Plan that set targets to improve the satisfaction of service users in being able to access good information and advice, meaningful activities and peer support services locally. Satisfaction nationally against these has been low and service users accessing BSMHFT services have said that their experiences are on a par with, or worse than, the national survey ratings.

  We will know that we have got this right when people can say:
  "I will have access to appropriate information, advice, advocacy and support to help me to remain independent and enable me to play a more active role in finding my own solutions and/or support me in my caring roles."
  "I will have more involvement in planning my own support."
  "I will feel less isolated and vulnerable and more connected with my local community."
  "I will be able to talk to someone who understands my condition, is tolerant, flexible, patient and persistent and who will help me to understand my strengths and my opportunities for a more fulfilled life."

- **High quality treatment and support.** Following an extensive inquiry into failings at Mid-Staffordshire NHS Foundation Trust, Robert Francis QC published his final report on 6 February 2013. It told a story of appalling suffering of many patients within a culture of secrecy and defensiveness. The inquiry highlighted a whole system failure. A system which should have had checks and balances in place, and working, to ensure that patients were treated with dignity, respect and suffered no harm. The report had 290 recommendations with major implications for all levels of the health service across England. It called for a whole service, patient centered focus. The detailed recommendations did not call for a reorganisation of the system, but for a re-emphasis on what is important, to ensure that this does not happen again. [2]

  We will therefore continue to work closely with all providers of mental health services to ensure that people accessing mental health services and support will:

  - have access to the right, evidence based treatments
  - receive care from the right staff who will be trained to deliver the right care in the right way
  - receive their care at the right time and in the right location

[2] http://www.nhsemployers.org/your-workforce/need-to-know/the-francis-inquiry

- have a care plan based on the outcomes that are important to them
- be confident that the services they access meet the requirements of the 6Cs- Care, Compassion, Competence, Communication, Courage & Commitment
- know that their complaints are taken seriously and action plans developed to ensure that such issues do not occur in the future
- know that staff who witness poor care are confident to report it without fear of reprisal

We will know that we have got this right when people can say:

"I have been supported to become an expert in the management of my physical and mental health"

" I have been supported to achieve the outcomes that are important to me"

"given my risks of ill health I am given priority care to prevent my illness developing"

"I get the best treatment that I need for my condition and my life"

"I can be confident that the services that I access are of high quality, delivering effective outcomes and that they are safe"

"that I will only be admitted as a last resort and that this will be for the shortest possible time"

- **Living well with a mental health problem.**

"Getting a diagnosis was kind of a relief. It helped me start to make sense of the harmful things I was doing to cope with what I was experiencing. Now I had no choice but to move forward and learn how to live with it …" Demi Lovato.

Moving forward following a diagnosis of mental illness can be hard. In the past a diagnosis of mental illness tended to dictate the life that the person would then have. This strategy looks at how Solihull CCG and Solihull Council will support people living in Solihull to live well with their mental illness. This will be achieved by supporting people:

- to feel confident about talking about their mental illness.
- to help inform the wider population of Solihull about mental illness through programmes such as 'Time to Change' and 'Time to Talk'
- to live independently in stable accommodation
- to have a recovery plan that identifies the goals that are important to the individual
- to access training, education, and employment
- to make choices about, leisure activities, physical wellbeing and home support
- for their care to be joined up and planned together with partners

We will know that we have got this right when people can say:

"I know what I can do to help myself and my life"

"I know what I can do to maintain my recovery and prevent relapse"

"My family and friends are supported to help me"

"I have somewhere that I can call home"

"I continue to be part of my community and contribute to it"

"I will feel empowered to take responsibility for my own recovery."

"I will feel that I have value."

"I will have the opportunity to use the expertise that I have gained in managing my own mental illness to help others and I know that this could lead to formal training and future employment

Investment in Mental Health Services

Current spend on adult mental health services

The current commissioning resource for mental health services and support for both Solihull Council and the Solihull Clinical Commissioning Group is £21,081,914.

Included within this figure is:

- spend on dementia within NHS contracts as it is not easy to separate out the spend on dementia from older adult functional mental health.
- It also includes continuing healthcare spend on clients with a functional mental health diagnosis.
- The Mental Health Social Work and Promoting Social Inclusion and Independence Teams.

What is not included is:

- the spend on mental health clients in acute hospitals
- the spend on Solihull Integrated Addiction Services

The adult functional mental health budget for Solihull CCG is £17,966,915 which accounts for 6.6% of the total programme budget spend. Solihull Council has a budgeted spend for mental health of £3,115,000 which is c6.1% of the total Adult Social Care budget – this excludes the spend on dementia.

Mental health services in Solihull need to be delivered within this resource envelope. Analysis of the value achieved out of all of the spend on people with mental health conditions is essential if we are to improve outcomes.

Mental ill health represents up to 23% of ill health in the UK and is the largest single cause of disability.

Are we getting best value from these commissioning resources?

There are many indicators that show that in Solihull we are achieving higher than average outcomes in relation to our spend on mental health services.[3]

That said we know that there are still areas of spend where we are not getting as good outcomes as we should. For example, last year we spent over £400,000 on 25 people having to go out of area for acute mental health inpatient services. We think that this money can be better invested in developing local service capacity such as respite and extended day hospital services which will provide more intensive support earlier to people at risk of being admitted. Such services would also support discharge thereby freeing up the flow through local inpatient units.

Our aspiration is to have no one having to travel great distances to access the inpatient assessment

[3] http://www.yhpho.org.uk/quad/pdfs/05P%20Solihull%20SPOT%202014%20Full%20Briefing.pdf

and treatment services that they require unless it is clinically indicated or in the best interest of the patient.

Another example is the spend on specialist personality disorder (PD) placements. Last year we spent in excess of £900,000 on such placements and in addition to this at any one time between 1 and 2 mental health acute assessment beds are occupied by a person with a PD at a cost of c£132,000[4] per annum. The length of stay following admission for a person with a PD tends to be far longer than for a person without PD as their presentation is often made worse by the admission, increasing the risks and making it harder to discharge them. People with a PD often make high use of A&E and acute hospital services as a result of self harm behaviours. Therefore the cost to the system of treating people with a personality disorder is significant yet the outcomes currently being achieved are poor.
Our aspiration is to change the way that we think about and understand the needs of people with borderline and emotionally unstable personality traits and to improve service user outcomes and experiences when accessing services. By establishing more intensive community based provision that enables people to access the specialist help that they need earlier we aim to reduce the impact on, and demand for, services. We aim to do this by increasing the range of evidence based psychological interventions available to support people with a personality disorder within community provision in Solihull.

There are still people accessing secondary care services provided by the BSMHFT who are stable and who could be managed within primary care. We need to be looking at how we can support GPs to do this through improved access to psychiatrists for advice and guidance, rapid access back into secondary care if the person is becoming unwell and access to advanced nurse practitioners who will provide more direct support to GPs in the management of patients in primary care. Improved early signposting to psychological services, information and advice services, meaningful activities and peer support will help to reduce the numbers of people requiring access to secondary care mental health services and will help people to maintain their recovery.
Our aspiration is to have the primary, community and secondary care sectors working well together in the delivery of care and support for people with a mental illness in Solihull.

Economic benefits realised from people having 'better mental health'

There are significant economic benefits to be realised from better mental health with many reports highlighting the cost benefits of evidence based mental health interventions. A paper entitled 'Mental Health promotion and Prevention: The Economic Case' produced by the Personal Social Services Research Unit of the London School of Economics[5] identified and analysed the costs and economic pay-offs of a range of interventions in the area of mental health promotion, prevention and early intervention.

The report concluded that investing in prevention and early intervention makes economic sense. For every £1 spent the following whole system savings can be achieved:

[4] BSMHFT Price Cluster Matrix Month 7 snapshot
[5] Mental Health Promotion and Prevention: The Economic Case Martin Knapp, David McDaid and Michael Parsonage 2011

- £10 from work-based mental health promotion (after 1 year)
- £ 5 from early diagnosis and treatment of depression at work
- £18 from early intervention in psychosis
- £10 from early intervention in pre-psychosis
- £12 from screening and brief interventions in primary care for alcohol misuse
- £ 4 from debt advice services

The Economic impact of Mental Health Promotion Prevention and Early Intervention report provides greater detail about how the above savings can be achieved and in which sectors the benefits are realised.

Analysis such as this helps us to identify where we can get the greatest returns thus releasing resources to invest in other areas of mental health.

In developing the strategy we have looked at what we need to do locally to maximise the potential whole system benefits identified above as this will help us to support more people, more effectively, within the current mental health resource.

NEEDS ASSESSMENT

Needs Assessment – key national statistics

The National strategy for mental health 'No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages[6] shows why tackling mental illness and promoting wellbeing is essential not only for individuals and their families but to society as a whole:

Mental health problems are common

- At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time.
- Almost half of all adults will experience at least one episode of depression during their lifetime.
- About half of the people with common mental health problems are no longer affected after 18 months but poorer people, the long term sick and unemployed people are far more likely to still be affected than the general population.
- Depression affects one in 5 older people living in the community and two in five living in care homes.
- One in ten new mothers experiences postnatal depression.

Mental Health problems in children and young people

- One in ten children and young people ages 5-16 suffer from a diagnosable mental health disorder.
- Over 8,000 children in the UK aged under 10 suffer from severe depression.
- Between one in every twelve children and one in every 15 young people deliberately self harm.
- There has been a 68% increase in the number of young people being admitted to hospital because of self harm.
- More than half of all adults with mental health problems were diagnosed in childhood. Less than half were treated appropriately at the time.
- 72% of children in care have behavioural or emotional problems – these are some of the most vulnerable people in our society.

Burden of mental ill health

- Nationally the NHS spends around 11% of its budget on mental health.
- Mental ill health represents up to 23% of ill health in the UK and is the largest single cause of disability.

Mental ill-health can have a devastating impact

- People with severe mental illness die on average 15-20 years earlier than the general population.
- Schizophrenia accounts for approximately 30% of the expenditure on adult mental health and social care services.
- Only one in ten prisoners has no mental disorder.
- Suicide remains the most common cause of death in men aged under 35.
- The UK has one of the highest rates of self harm in Europe at 400 per 100,000 population.

The overall number of people with mental health problems has not changed significantly in recent years, but worries about things like money, jobs and benefits can make it harder for people to cope.

[6] No Health Without Mental Health: A cross-government outcomes strategy for people of all ages (DoH 2011)

The Local Picture – level of need in Solihull

The Solihull Joint Strategic Needs Assessment (JSNA) and the Mental Health Needs Assessment provide information on the current and future health and wellbeing needs of the population of Solihull. The current JSNA (2012) can be found at: http://www.solihull.gov.uk/About-the-Council/Statistics-data/JSNA.

The mental health needs assessment report produced for the last strategy has been refreshed and this is attached as appendix 3.

Table 1 below identifies the expected prevalence of specific mental health conditions for Solihull.

Table 1: Expected Prevalence for the different types of mental health conditions in Solihull

Type of Mental Illness	Solihull Prevalence ages 15-64
Common Mental Health Problems : depression, anxiety, OCD, Phobias	21,645
Self Harm (c 400 per 100,000 population)	980
Personality Disorder (between 4% and 5% of population – calc. based on people aged 20-64)	5,500 - 6,500
Bipolar Disorder (between 0.9% and 2.1% of adult population 20-64 years of age)	1178 – 2,749
Schizophrenia and schizoaffective (between)	800 and 1,033
Conduct disorder:	
- Children	390
- **Young people**	560

Areas for specific consideration:

- The quality Outcome Framework 2012/13 and 2013/14 mental health register which includes people with schizophrenia, bi-polar affective disorder and other psychoses identified 1,633 and 1,699 people with such conditions on Solihull GP registers. This accounts for 0.69% (2012/13) and 0.71% (2013/14) of the registered population. This is a gap of between 279 and 2,083 when compared to the estimated prevalence rates for Solihull.
- The number of suicides in Solihull is small and much lower than the national average and that of comparable CCGs. The overall rate of male suicides has decreased markedly in Solihull since 1995, although the female suicide rate has stayed the same. The number of suicides is higher in the regeneration area (Chelmsley Wood, Kingshurst and Fordbridge and Smiths Wood).

- There were 52 adults with a mental illness living in permanent residential care at the end of 2014 this is a rise of 33 over the life of the previous strategy. Some of this is due to a drive to ensure that people who no longer need inpatient services, particularly inpatient rehabilitation services, are discharged to more appropriate care settings. More work is being done to understand why there has been such a big increase and to reverse this through the commissioning of more supported living services within Solihull. One such scheme is coming on stream in May 2015 (Aviary House) and there are discussions with other organisations to look at the opportunities to develop similar schemes in other parts of the Borough.
- Personality disorder is an area that we need to focus on with this strategy. The expected prevalence for Solihull is between 5,500 and 6,500 for the adults of working age population although there is a significant range of complexity and impact within this cohort. The impact of personality disorder is felt across all sectors mainly health, social services and criminal justice as well as to the economy more widely as a result of the inability to work or premature deaths.
- In 2014 Solihull had the 7th highest (out of 332 LA's) rate of homelessness acceptances. Violence and harassment) is the most notable reason for homelessness in Solihull with this being recorded in 33% of cases compared to 20% for comparator LA's. Mental illness in terms of priority of need accounts for 20% of Solihull homelessness acceptances compared to 29% within comparator local Authorities. A key priority to be addressed during the life of this strategy is to support homeless people with a diagnosed mental illness to find stable accommodation.
- Mental health problems in children are common, affecting up to 1 in 10 of the younger population, depending on age. 7.3% of children aged 5–10 and 10.1% of those aged 11–15 have a mental health problem. Emotional disorder and conduct disorder are the most frequently occurring conditions. It is estimated that in Solihull in any one year we will have in excess of 390 and 560 children and young people with conduct and emotional disorders respectively. Untreated conduct disorder can lead to the development of a personality disorder in adults so by treating children with conduct disorders will reduce the burden of mental ill health in adults.
- Currently there are 328 looked after children in Solihull which includes 49 unaccompanied asylum seeking children. The number of children by age is as follows:

0-4 years of age	56 children
5-9 years of age	69 children
10-15 years of age	132 children
16-17 years of age	71 children

  Poorer outcomes and additional needs do exist for looked after children but this relates mainly to specific sub-groups of the looked after children cohort, particularly those accommodated in mid to late teens or those who are victims of severe harm. In Solihull many of the looked after children will outperform their demographic peers – those in stable long term placements and some of the unaccompanied asylum seeking children. Solihull

does however have significant numbers of unaccompanied asylum seeking children compared to the rest of the west midlands.

Further information about mental health diagnoses, at risk groups and Solihull statistics can be found in the Solihull JSNA.

Taking this strategy forward

What do we want to achieve during the life of this strategy?

Our commissioning plan is attached as appendix 1 and this details the key actions that we are intending to deliver during the life of this strategy. Our key aims are:

- to promote awareness of mental illness and to break down the stigma associated with it so that people are willing to access the help that they need early thereby making it easier for them to recover.
- to commission services that help people to become more resilient and to become experts in the management of their illness.
- to work with our partners to bring about long term sustainable benefits in housing, education, employment, health and wellbeing recognising that mental health is everybody's business.
- to commission services that support people to stay well through the delivery of enhanced community and primary care services supported by improved partnerships with the third sector and local communities.
- that all of the services that we commission have a strong focus on recovery, working in partnership with the service user in the identification of the outcomes that are important to them and agreeing how best to support them in the achievement of them.
- for there to be a strong focus on both the mental and physical health of people being supported within the services that we commission and for this over time to reduce the inequity that currently exists in life expectancy for people with a severe mental illness.
- for carers to feel valued and for them to have every opportunity to get the information, advice and support to enable them to feel confident in their caring role. We want carers to know who to contact when the person they are caring for becomes unwell and to be confident that this help and support is available when they need it.

It has to be recognised though that, as with the previous strategy, events happens that we could not have predicted at the time of writing the strategy which may impact on our plans. We may therefore need to review and amend this strategy if such events do occur however we will consult with stakeholders if changes are required. Examples of such impacts may include:

- ***impact of New Dawn***. As part of the development of the proposed new service models and pathways the expected impact of these new models has been calculated. An example of this would be the impact on the numbers of people moving to crisis and requiring admission following the development of enhanced primary and community services. These new services may have a far better impact than anticipated and as a result the number of inpatient beds that we will need to commission may reduce. This may then mean that certain options for the replacement of our current inpatient provision may no longer be viable.
- Government austerity Measures. It may be that the current resource envelope that we are depending on to implement the commissioning action plan is reduced during the life of the strategy thereby requiring us to make difficult decisions based on what we can afford.

This uncertainty requires commissioners, providers and wider stakeholders to work much more collaboratively, looking at how we can maximise the value from every pound spent.

Next steps:

- To consult on the strategy and commissioning action plan during October through to December 2015
- To amend the strategy in light of feedback received.
- To publish final strategy and begin implementing the action plan.

APPENDICES

1 Commissioning Action Plan

2 What we achieved during the life of the last strategy

3 Mental Health Needs Assessment

Commissioning Action Plan

	Commissioning Outcomes	How will we achieve this?	By when?	Measured by:
1	**Promotion, Prevention and Early Help**			
1a	Reducing the stigma associated with mental illness. **Aspiration: that Solihull is a mental health friendly Borough where people feel confident about discussing their mental illness without fear that this will have a negative impact on their life.**	• By signing up to "Time to Change" – to encourage all agencies, providers and organisations within Solihull to sign up to, adopt and develop their action plans for Time to Change to support the reduction of the stigma associated with mental illness. Public Health led objective. • By committing to activity on key dates in the MH calendar such as world MH day and time to Talk day. • By developing external awareness campaigns using local media, community events etc. • By working with communities to ensure that they have a better understanding of mental health in order to reduce the stigma associated with it. • To promote emotional health and wellbeing so that people understand that this is just as important as keeping themselves physically healthy.	**December 2015** **Annually** **On-going** **On-going** **On-going**	• Pledge and action plans loaded onto the Time to Change website. • Evidence of communication plans • Evidence of external awareness raising initiatives.
1b	To seek to gain a better understanding of, and identify how best to address, the known triggers of poor mental health. **Aspiration: through Solihull working as a whole system to bring about long term sustainable benefits in housing, education, employment, communities and health and wellbeing**	• By working with public health and linking public health commissioned provision formally to the mental health pathway. • To work with the community and voluntary sector directorate and local providers to increase the number of volunteers who can provide support through befriending/peer support programmes. • To support wider non MH agencies and community groups to know how to access MH support for people they are in contact with.		• Evidence of increased referrals to social prescribing. • Evidence of increased referrals to information and advice services • Increase in the number of volunteers working with people with a MI. • Increase in the referrals to MH services and support by other agencies.
1c	Improved access to information and advice services and support within Solihull. **Aspiration: to improve service user reporting by 94% by 2016/17**	By continuing to market: • Information and Advice Hubs • Mental health drop in services	**On-going**	• Performance data provided by the third sector • Service user and carer feedback • Annual service user survey
1d	Improved access to meaningful activities and participation in community activities. **Aspiration: to improve service user reporting by 81% by 2016/17**	• Continued marketing of social prescribing • Continued marketing of information and advice services • Opening up referral rights for social prescribing to CPNs and MH social workers.	**On-going** **On-going** **July 2015**	• Performance data provided by the third sector • Service user and carer feedback • Annual service user survey

		• Continued marketing of third sector mental health befriending and 'drop in' services		
	Commissioning Outcomes	**How we will achieve this?**	**By When?**	**Measured by:**
1e	Improved partnership working **Aspiration: that by working together we can alleviate the impact of mental health problems on families and communities within the Borough.**	• Mapping of mental health services to ensure wider awareness of what services and support are available locally. • Developing clear pathways through primary and secondary care mental health services. • Using this information to inform how best peoples needs can be met – right service, right time, right place. • Eradicating multiple assessments where much of the information is already known. • Working with providers to look at how best they can work together sharing facilities and expertise to deliver improved outcomes for people with mental health needs within Solihull. • Working with other commissioners to ensure that opportunities for identifying and supporting people with mental health problems are proactively considered in all major work streams. • Ensuring clear and robust interfaces with learning disability services. • Continue to promote and embed safeguarding mechanisms locally.	**March 2015** **April – November 2015** **April – November 2015** **April 2016** **During 2015-16** **On-going** **Ongoing** **Ongoing**	• Service map produced • Development of integrated MH Pathway • Evidence of change in referral patterns and via performance data submissions. • Service user reporting. • Provider reports • Evidence of MH issues being highlighted within other strategies and commissioning action plans. • Evidence of active adherence to the Green Light Tool Kit • Safeguarding Board Reporting
1f	Improved support for carers **Aspiration: that carers report feeling knowledgeable, confident, valued and supported.**	• Continuing to enhance and expand carer training programmes within Solihull. • Access to assessments for carers of their own health, wellbeing and support needs. • Enhancing opportunities to expand the number of carer forums locally through peer support programmes being developed within Solihull.	**During 2015** **On-going**	• Increase in the number of carer training programmes offered. • Increased numbers of carers receiving a carers assessment Carer feedback • Evidence of numbers of carers forums running within Solihull.

	Commissioning Outcomes	How we will achieve this?	By when?	Measured by
2	**High quality treatment and support**			
2a	To improve the physical health of people with a mental illness **Aspiration: to reduce premature mortality in people with severe mental illness living within Solihull.**	• Encouraging GP's, MH services and other community health and social care providers to work closely together to ensure that the physical health of people with a MI is prioritised. • To maximise the opportunities afforded by access to public health commissioned services such as the health trainers, social prescribing and exercise on prescription • To commission smoking cessation programmes from mental health service providers to support more people to quit smoking. • To ensure that mental health staff are aware of what healthy lifestyle services and support are available locally and for them to encourage the people they are supporting to access them. • To monitor the success of the BSMHFT and primary care in delivering the CQUIN which seeks to 'improve physical healthcare to reduce premature mortality in people with severe mental illness'.	**On-going** **On-going** **On-going**	• Evidence of GPs maintaining and updating their MH registers. • Evidence of annual health checks for people with a MI • Evidence of the sharing of tests results between primary and secondary care to avoid duplication and encourage shared care arrangements. • Analysis of acute hospital data.
2b	To improve the mental health of people with a physical health problem. **Aspiration: that people living within Solihull understand that good mental health helps to secure good physical health**	• To encourage all services to promote the importance of good mental health in the management of physical health conditions. • Through our work to build a 'MH is everybody's business' culture we will ensure that relevant chronic disease work streams consider opportunities for better integrating mental health support with primary care and chronic disease management programmes, with closer working between mental health specialists and other professionals. • To ensure that mental health is at the heart of plans for integrated care and that it is properly considered in strategies and commissioning action plans being developed across all key work streams within Solihull. • Making it as easy as possible for wider clinical teams to have information about where they	**On-going** **On-going** **On-going**	• Evidence of approaches being used. • Evidence of an integrated approaches including opportunities for shared care arrangements. • Evidence of MH being referred to within other commissioning strategies and action plans.

		can signpost people to for support for emotional health or social issues that may be impacting negatively on the management of their physical health condition.		
	Commissioning outcomes	How will we achieve this?	By when?	Measured by
2c	Early diagnosis and intervention **Aspiration: That people have a good understanding of the early signs of mental ill health, that they can be confident that their concerns will be taken seriously and that they are referred or signposted early for the most appropriate intervention.**	• To develop and deliver on-going training for GP's and primary care staff to improve their knowledge of MH and to know how best to support people with a mental illness within primary care. • For primary care staff to be fully aware of more appropriate alternative support options such as self help, social prescribing, information and advice support etc. • To develop clear, robust pathways with clearly articulated access criteria, to make it easier for referrals to go to the right service. • Increasing numbers of people seeking IAPT services. • To work with the Trust to reduce current waiting times from referral to assessment and intervention. • Early Intervention in Psychosis waiting times targets met.	**On-going** **On-going**	• Evidence of MH training programmes • Information included within map of medicine • MH Pathways updated on map of Medicine • IAPT performance data • Waiting times from referral to assessment reported at Contract review Group. • Monthly reporting of early intervention in psychosis waiting times via the performance dashboard.
2d	Evidenced based assessment, treatment and support delivered across all services within Solihull. **Aspiration: that all services commissioned have a good evidence base supporting them.**	• To review all services commissioned against evidence base practice and to work with the provider to deliver the required changes where this is not currently being delivered.	• **During 2015-16**	• Implementation of new service specifications and pathways.
2e	People are supported by the right service at the right time. **Aspiration: That service users have confidence that at all times they will be supported by the most appropriate service in helping them to achieve their desired outcomes.**	• To scope the implications with primary care of patients no longer requiring secondary care input being discharged back to the GP. • To agree model for how secondary care will support primary care in their management of more people with a mental illness. • To ensure that GPs have easy access to Psychiatrists and advanced nurse practitioners for advice and support in the management of patients in primary care. • To continue to promote to GPs	• **During 2015-16** • **During 2015-16** • **During 2015-16** • **On-going**	• Through analysis of the clusters that patients are assigned to. Monthly cluster matrix reporting • Model developed • GP reporting • Communications plan

		self help and voluntary and third sector support opportunities that exist within Solihull, which if accessed by patients early enough may prevent the requirement for a referral to secondary care.		
	Commissioning outcomes	**How will we achieve this?**	**By when?**	**Measured by**
2f	Fewer people experiencing crisis **Aspiration: to reduce the numbers of people requiring admission by 10% by 2016/17 from the 2014/15 baseline.**	• Commissioning mental health service models which have a strong focus on community and third sector support solutions. • Identifying key services that, if available 7 days a week, would reduce the numbers of people moving to crisis and requiring admission.	• **April 2016** • **During 205-16**	• Evidence of new service models and pathways • Performance data from BSMHFT and the Third Sector.
2g	That people requiring admission will be able to access a bed when they need it from within BSMHFT capacity. **Aspiration: to have no one having to travel significant distances to access inpatient assessment and treatment services unless this is in their best interest or clinically required.**	• To develop the plan for the replacement of Bruce Burns. • To model the expected impact on the numbers of people requiring admission in light of the enhanced primary and community services being developed through New Dawn. • Using the resources currently being spent on people accessing inpatient services outside of Birmingham and Solihull to develop increased local capacity such as respite provision and enhanced HTT provision. • To agree a risk sharing agreement with the BSMHFT. • Improving the flow through inpatient services by significantly reducing patients who are delayed in inpatient services. • To identify people who no longer require inpatient treatment but who are not yet ready to go home and stepping these people down into respite provision to help prepare them for discharge.	• **During 2015-16** • **On-going** • **During 2015-16**	• Pilot new approach and evaluate impact. • • Monthly reporting of delayed transfers of care. • Pilot of new approach and evaluate impact.
2h	That people in the acute phase of their illness know how to access the support that they need and that such support is easy to access. **Aspiration: that service users and carers can say that they were able to access the help and support that they needed easily at the time that it was required.**	• Contingency plans agreed with all people in contact with MH services. • MH specialists working within 111 • All emergency services aware of the services available to support people and how to access them. • The Directory of Service to include information on more mental health services locally and how they can be accessed.	• **During 2015-16** • **Currently being piloted** • **On-going**	• Service user and carer reporting • Targets included within the performance dashboard and monitored monthly. • Data on frequent callers • MH services identified on the DOS • Frequent caller data.

		• More proactive support for frequent users of services.		
2i	Development of a new inclusive approach to the treatment and management of service users with Personality Disorder within Solihull. **Aspiration: To significantly improve the outcomes being achieved for people with a personality disorder living within Solihull.**	• Development of a multi-agency strategy for personality disorder. • Development of a new service model that is innovative and which has been informed by people with lived experience. • Development of training programmes delivered by clinicians with expertise in PD and people with lived experience. • Deliver training to staff within agencies and services who come into contact with, or who provide support/treatment to, people with a personality disorder.	• **During 2015-16** • **During 2015-16** • **2016-17** • **2016-17**	• Strategy document • Evidence of new pathway and service model • Copy of training programme and training plan.
	Commissioning outcomes	**How will we achieve this?**	**By when?**	**Measured by?**
2j	People with a mental illness will recover. **Aspiration: For people to have hope and the belief that they can recover and that it is possible to have a life that is not defined by their mental illness** .	• Continue to commission the provision of flexible preventative support, education and treatment pathways, providing service users with the tools and confidence to manage and maintain their recovery and wellbeing. • Ensuring that all care plans are recovery focussed • Continue to work with partners to consider opportunities for developing and commissioning a shared decision making approach to ensure that services users have choice and control over their care and support options. • look to pilot personal health budgets in mental health in light of emerging national evidence of he benefits of such an approach. • enhance peer support services locally in light of the emerging evidence base that peer support is an effective and cost effective means of delivering support for mental health service users.	• **On-going** • **On-going** • **20116/17** • **During 2015/16**	• Use of outcomes tools to measure the effectiveness of services delivered. • Service user and carer reporting. • Take up of personal health budgets • Number of peer support groups operating locally and feedback from users to assess their effectiveness
3	**Living well with a mental illness**			
3a	People with a mental illness have a stable place to live – a home. **Aspiration: that no one with a mental illness will be homeless unless this is a personal lifestyle choice.**	• To identify people with a mental illness who are homeless or in accommodation that is not stable and which is having a negative impact on their mental health and support them to find a place to live. • To work with housing providers in the development of housing with support.	• **2015-16** • **On-going**	• Number of people with a mental illness recorded as homeless. • New housing schemes/opportunities available locally

		• To explore the opportunities for shared lives services in support of people with a mental illness.	• **2015-16**	• Shared lives service operating within Solihull.
	People with a mental illness will have access to meaningful activities or employment.	• Continuing to develop employment support opportunities locally. • Working with employers to increase the number of work placements locally. • Making it easier for people to know what activities are available in their local area and to feel confident in accessing them. • Working with employers through initiatives such as the Workplace Wellbeing Charter to help them to improve the mental health of their workforce.		

Appendix 2 – What we achieved during the life of the last strategy

What did we say we would do?	What did we achieve?	How can the new strategy develop this further?
That we would look to develop, with the BSMHFT, a single point of access (SPoA) into secondary care mental health services with a single assessment process.	• The Single Point of Access (SPoA) was launched in April 2014. • A new referral form co-produced between GP's and Consultants was produced to support the SPoA to aid onward referral. • Single assessment process introduced so that people only have to tell their story once.	• More needs to be done to improve the links between the SPoA and the GPs referring. • We will scope the potential benefits of there being a SPoA for Solihull and whether this should be for mental health services only or part of a wider Solihull SPoA for access to all health provision locally.
That we would Improve access to psychological therapies (IAPT)	• More people are accessing psychological therapies delivered by Solihull Healthy Minds. Increased numbers of people moving to recovery and back to work (supported by Solihull Mind Employment Support Service). All national targets are being delivered. • IAPT services were expanded to support young people aged 16 and above and has also been working with Age UK to promote psychological services to older people living within Solihull. • Books on prescription were made available at all libraries within Solihull, the IAPT website contains self help materials and audio files. These can be found at: http://www.covwarkpt.nhs.uk/iapt/Pages/default.aspx • During the life of the strategy an IAPT pilot looking at the benefits of supporting people on the virtual ward service who had both physical and wellbeing difficulties was implemented. Although the results were good for the people who accessed this service it was not well used and it was therefore an expensive service for a few people so was not continued post the pilot.	• IAPT initiatives were originally designed to get people off sickness/unemployment benefits and back into employment. However the development of IAPT services has identified a need for improved access to psychological therapies for young people, older people, people with long term conditions and those with medically unexplained symptoms (MUS). There are significant wider system benefits achievable though IAPT interventions for these cohorts of the poulation and this needs to be further explored during the life of this strategy. • We will also be evaluating the current psychological and counselling services pathways within Solihull during 2015 to assess how well the current pathways work, how they can be improved and to scope the benefits of a single pathway. There are currently long waiting times for the Solihull Mind Counselling Service which the review will need to address. • We are still not using all resources as effectively as we could. Are patients with low PHQ9 and GAD7 scores being encouraged to try self help first? Are we taking up assessment time with people who do not meet 'caseness'? Do GPs require further training in supporting their patients to access the most appropriate service? Are we making best use of universal services through social prescribing, peer support etc? Are we supporting people to address other aspects of their life which are impacting on their mental health such as debt, benefits etc.? All of these issues need to be explored as part of the re-design of the counselling and psychological services pathway during 2015.

What did we say we would do?	Did we achieve this?	How can the new strategy develop this further?
That we would ensure that people with longer term mental health problems have better access to mainstream services such as housing, education and employment.	• We have worked with Stonham Homegroup to develop a new scheme comprising 28 individual flats, replacing what was currently a 15 bedded mental health care home. This will provide people with their own flat with access to 24/7 support. • Much has been done to link up the various employment support schemes across Solihull for example Solihull Mind Employment Support service with Solihull Economic Development Schemes such as 'Hot Jobs' • We have worked with Solihull Mind to develop the Horticultural site to be able to deliver recognised qualifications to support people back into employment. • We have worked with the BSMHFT and BITA Pathways to try and develop the previous Express Signs service into a sustainable business.	• There is a shortage of accommodation for people with a mental illness especially accommodation that has access to support. We are working with a range of organisations locally to develop more accommodation within Solihull that is at affordable rent levels. • We are working with local providers and the Economic Development team at the Council to bid for European Social Funds to expand employment support activities locally. Services developed using these funds will be expected to support people to get relevant training and qualifications and to help them move into permanent employment. • We will be looking to local providers including the BSMHFT, HEFT, Solihull CCG and the Council to provide work experience opportunities to people wanting to get into, or back into, employment.
That we would ensure more individual choice and control within care planning including the use of personal budgets.	• Much work has been done within Solihull to encourage people to take a personal budget and for this to be in the form of a direct payment as this offers people more choice, flexibility and control about how their needs are met. • This helps to ensure that people are not expected to fit into existing services but have the opportunity to use their budget to develop support plans which are tailored to their individual needs and preferences within their assessed budget. • The percentage of people living in Solihull who are directly commissioning their support through a direct payment now stands at 51.3% this is a significant increase from the levels recorded at the start of the strategy which was 23%	• Further development of the care and support market is required within Solihull. • Many people would like to use their budget to employ a personal assistant but these are a scarce resource locally. One of the schemes to be developed by a local provider 'Independent Advocacy' is to train up people with 'lived experience' to become either advocates or personal assistants. This gives a further route into employment for people having recovered from a mental illness and to use their experiences to help support other people to achieve recovery.
In patient assessment provision will be in fit for purpose accommodation with the right level and skill mix of staffing to enable active treatment and discharge	• We failed to achieve this during the life of the previous strategy and it therefore needs to be carried over into this new strategy. The decision about the future of this unit has been further delayed because of the potential impact of the 0-25 tender in Birmingham. The Trust may have too much inpatient provision if they do not win the tender and may not be in a position financially to invest	• We will continue to work with the BSMHFT on potential options to replace the Bruce Burns Unit. • We will continue to enhance the capacity within existing services, or develop new specialist community provision that will provide earlier help and support to reduce the numbers of people moving to crisis and requiring admission. • We will work with providers to scope the

	in a new inpatient facility in Solihull. • In line with the Francis Report the BSMHFT has increased the ratio of the number of staff to beds to ensure higher quality, safer inpatient services.	benefits of developing step down provision, such as residential respite and extended day hospital. This will support people to be discharged as soon as they no longer require inpatient treatment.
What did we say we would do?	What did we achieve?	How can the new strategy develop this further?
That recovery services and the support workers within them will be able to flexibly support people to achieve independence including opportunities to seek education and employment	• The role of the Community Recovery Team was reviewed in 2013. The review identified a requirement for a more goal focused recovery approach and once the person had been supported to achieve their goals they were discharged. People requiring a longer term support service were signposted to other provision outside of secondary care unless they had complex, unstable needs, were at higher risk of relapse or were involved in safeguarding. The service was renamed the Promoting Social Inclusion and Independence Team (PSII). • The Express Signs service which was being delivered by the BSMHFT is now being managed by BITA Pathways who we hope will be able to breathe new life into this service and ensure that it is a sustainable business going forward.	• This strategy will facilitate closer working with professional staff to enable PSII workers to deliver recovery support services earlier in the service users' pathway. This will include increased use of alternatives to formal support using community services such as social prescribing, the third sector and the information and advice hubs. • Improving the employment opportunities for people with a mental illness is a key priority within this strategy. We will work with third sector organisations to develop bids for ESF monies to enhance employment support services locally enabling more people with MH problems to move into employment.
That we would proactively consider both mental and physical health needs through active liaison and joint working.	• Public Health commissioned smoking cessation and weight management services that are delivered by health trainers. • Social prescribing another newly commissioned public health service offers opportunities for people to access local clubs and activity groups to support them to become more active and less socially isolated. • The Rapid Assessment Interface and Discharge Service (RAID) operates out of all acute hospitals, supporting the management of both the physical and mental health needs of patients attending A&E or those admitted. • Street Triage – people identified as potentially requiring access to a place of safety will be assessed by the street triage team which comprises paramedic, CPN and Police officer. This results in the person getting a robust assessment of both their physical and mental health needs to determine most appropriate service response. • IAPT – supports people with depression and/or anxiety. People with poor mental health will most likely have poor physical health and vice versa. Supporting the person to improve their	• We will work with Public Health to open up referral to the social prescribing service to CPN's and MH Social Workers. • We will seek to strengthen the partnership working between the BSMHFT and the Public Health Commissioned Health Trainers. • We will continue to promote the Making Every Contact Count programme, encouraging providers to look at the whole person and not just the presenting condition. To spot early signs of mental illness or distress and to be proactive in signposting/supporting the person to get the help that they require. • We will support the development of more robust shared care arrangements between primary and secondary care for those in contact with mental health services. • We will monitor the delivery of the National CQUIN – improving physical healthcare to reduce premature mortality in people with severe mental illness.

	mental health will therefore improve their physical health. • Physical Health monitoring – this is particularly important for people with psychosis and such monitoring has been significantly improved over the life of the last strategy.	
What did we say we would do?	Did we achieve this?	How can the new strategy develop this further?
That we would promote recovery and independence by supporting people where they live in their local communities through flexible 24/7 services across health and social care	• A dedicated Home Treatment Team Consultant was appointed to lead the team. This has supported more people to be able to remain at home and not be admitted. • MH Crisis Line Pilot started in March 2015 and provides BSMHFT specialist staff working in the 111 call centre at times of peak call volumes. The Crisis Line is also supported by Solihull Mind who provide information advice and listening services for people with lower level mental health needs who have called 111. • Solihull Mind provide drop in services 7 days a week – this is an existing service not newly commissioned during the life of the strategy but a lot of work has been done to raise the awareness of this service so that it can support more people to get the help that they need. • Supported living scheme developed in Smithswood which provides 28 flats for people with mental health needs. Fifteen of the flats will support people who are currently living in a residential care home and will provide a more enabling environment to promote greater independence for the people living there.	• We will work with Housing Providers to develop more supported living schemes locally. • We will develop respite provision within Solihull • We will work with the Birmingham Joint Commissioning Team to scope the likely benefits of a 'Peer House' and to jointly commission this provision if such a model is seen to deliver better outcomes for patients and better value to the health and social care system. • We will scope the separation of crisis resolution from home treatment – looking at how home treatment can be more pro-active, intervening earlier and preventing crises occurring. • We will evaluate the Mental Health Crisis Line linked to 111 and develop a business case to secure recurrent funding if proving to deliver expected outcomes and better value. • We will continue to promote the benefits of social prescribing, third sector provision and the information and advice hubs to people with a mental illness and the staff supporting them. • We will ensure that organisations providing support for people with a mental illness are formally linked to the mental health pathway.
That we would work with wider partners to ensure that people who need help in a crisis or who urgently need assessment and support from specialist mental health services will be able to access this on a 24/7 basis.	• A MH Crisis Care Concordat Action plan has been produced for Solihull identifying what we are already doing well and what we still need to improve and by when. The Health and Wellbeing Board will oversee the implementation of this action plan. • The MH Crisis Line Pilot linked to 111 (as described above) • Street Triage (as described above.) • RAID (as described above) • Psychiatric Decision Unit – new service established late 2014 and which is the mental health equivalent of emergency departments within Acute Hospitals. Ensures robust MH assessment to determine most appropriate treatment and support. This has had significant	• We will implement the Crisis Care Concordat Action Plan. • We will continue to evaluate the wider system impact of the 111 crisis line and identify recurrent funding if it continues to deliver expected outcomes. • We will work with the Birmingham Joint commissioning team to ensure that the street Triage be formally commissioned from April 2016. • As with Street triage above the funding for RAID still sits outside of the main contract and this now needs to be formalised as a key service to be commissioned recurrently. • We want to scope the opportunities for a second MH psychiatric decision unit for North East Birmingham and Solihull based at Heartlands Hospital.

	impact on numbers of A&E breaches and also on the numbers of people being admitted into a mental health acute assessment service. • Home treatment service – providing more intensive support to people at risk of requiring admission.	• We want to scope the potential benefits of splitting the crisis resolution element from the home treatment element.
What did we say we would do?	Did we achieve this?	How can the new strategy develop this further?
People in crisis will be supported at home and/or in local short term facilities including crisis or respite beds which enable them to return home after a short period	• support at home to people in crisis is delivered by services such as - the Home Treatment Team - Street triage - MH Crisis Line • We were not able to develop short term facilities such as access to respite/crisis house services locally during the life of the previous strategy although the development of Aviary House gives us the opportunity to commission 4 respite units within this scheme.	• We will establish a pilot for MH respite provision in Solihull and evaluate outcomes • As part of the urgent and acute work stream we will identify a better model of crisis resolution and home treatment services locally. This approach will be piloted in a number of teams across Birmingham and Solihull and the system impact evaluated.
Social inclusion services (employment, work, meaningful activity /day opportunities) will be provided from mainstream universal environments such as third sector organisations which can offer choice and personalisation	• Social prescribing service established in 2014. • Mind horticultural service supported to develop and deliver recognised qualifications to support people into permanent employment. • The re-tendering of third sector provision within Solihull has resulted in some new innovative services to be delivered within Solihull such as the training of people with lived experience to train to become personal assistants or advocates.	• We will open up referral to the social prescribing service to CPNs and social workers. • We will continue to look with our partners, including the DWP and Job Centre Plus at how we can best support people with a mental illness to secure employment. • We will use this knowledge to develop bids for ESF funding to expand employment support services within Solihull. • We will promote partnership working across the sector. • We will scope opportunities for time banking, peer support and other such initiatives that would help people to engage in meaningful activities and develop a sense of belonging within their local community.
Rehabilitation and recovery services will be commissioned from providers who can offer flexible packages which are not buildings based but provided in normal environments with opportunities to test out skills in step down houses and supported living options	• During the life of the previous strategy we worked with the Trust to support people no longer requiring inpatient treatment to be discharged to more appropriate community provision. Most people moved into residential care, hence the increase in the numbers of people in permanent care from the 2010 position. • We wanted to scope the development of a community rehabilitation team to reduce the numbers of people moving into inpatient rehabilitation services. This was not delivered and therefore needs to be addressed within the life of this strategy. • The respite beds that we are looking to commission from Aviary House will support this new approach.	• We will scope the potential to reduce the numbers of inpatient rehabilitation beds commissioned and to use the resource freed up to develop a community rehabilitation team. • We will pilot 4 units within Aviary House as respite units which can support step down and admission avoidance.

Services for adult Attention Deficit Hyperactivity Disorder (ADHD) will be developed alongside CAMHS and GPs	• We extended the age for ADHD assessments with the CAMHS service up to 18th Birthday. This had previously been a gap. • Adult ADHD services commissioned for people aged 18 and above.	• We will review the outcomes being achieved and the experiences of people accessing these services and use this to re-shape ADHD service models and pathways locally. • We will review the level of demand and service capacity requirements so that waiting times from referral to intervention remain appropriate.
What did we say we would do?	Did we achieve this?	How can the new strategy develop this further?
Services for people with mental ill health and substance misuse issues will be more coordinated alongside the new services being put in place by the Alcohol Strategy	• Substance misuse services delivered via Solihull Integrated Addiction Service (SIAS) are now really well embedded within Solihull and delivering improved outcomes for people. • SIAS works well with mental health services working in partnership with them to meet the dual needs of people within Solihull. • The RAID service supports people with mental health and or substance misuse disorders who attend A&E or who have been admitted. • The majority of people with an alcohol problem are now detoxed in the community and there is also a local rehabilitation service so fewer people need to go out of Solihull unless this is in their best interests or clinically advocated.	• Development and implementation of the dual diagnosis pathway.
Services for people with a personality disorder will be further developed in the community	• We commissioned a community personality disorder (PD) service for people within Solihull.. • The service delivers Dialectical Behavioural Therapy a form of therapy designed to help people change patterns of behaviour that are not helpful, such as self harm, suicidal thinking and substance abuse. • We commissioned the service to support people aged 14 and above with young people under 18 years of age continuing to be case managed by the child and adolescent mental health services.	We will work with the BSMHFT and the third sector to: • Develop a 2 - 3 year re-design plan • Change our thinking and understanding of the needs of people with borderline and emotionally unstable personality traits • Improve outcomes and service user experience • Reduce impact on and demand for services • Increase range of, and access to, evidence based psychological and psychologically informed interventions and environments

What did we say we would do?	Did we achieve this?	How can the new strategy develop this further?
That we would improve the transitions experiences of children and young people moving out of Child and Adolescent MH services	• We reviewed and revised the transitions protocol • We commissioned a place of safety for children and young people • We reduced the eligibility age to 14 for access to community dialectical behavioural therapy services. • We extended the age eligibility for access to CAMHS ADHD services to 18. • We developed a new service model for emotional health and wellbeing services for children and young people and tendered out this service. • We awarded the new contract for emotional health and wellbeing services to the BSMHFT in partnership with Barnados. • We agreed to develop a separate mental health crisis care concordat for children and young people	• We will improve emotional wellbeing and mental health for children, young people and their carers so that they are more resilient, able to manage their mental health needs and have a life which is not defined by their mental illness. • Children and young people with emotional wellbeing and mental health needs will be identified early and supported in community settings including schools, reducing the need for access to more specialist mental health services. • Children and young people will receive mental health services locally, within their own community and close to home, reducing the need to be admitted to inpatient services. • Young people will experience a seamless transition to adult services. • Parents and carers will promote the emotional wellbeing of their children. • Children, young people and their carers feel well informed and supported. • Parents and professionals in universal services such as schools and primary care will feel more confident about responding to emotional wellbeing needs and are clear about when and how to refer on for additional help. We will deliver improved outcomes for children and young people who are Looked After and adopted through reduced placement disruption and breakdown. • Children, young people and families will design and influence the arrangements for emotional wellbeing and mental health services.

The above identifies that although much was delivered during the life of the previous strategy there is still a lot more to do if we are going to really improve the experiences and out comes of people, and their carers, accessing mental health services.