Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 17 March 2017

Committee:
Health and Adult Social Care Scrutiny Committee

Date: **Monday, 27 March 2017**
Time: **10.00 am**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Head of Legal and Democratic Services (Monitoring Officer)

Members of Health and Adult Social Care Scrutiny Committee

Gerald Dakin (Chairman)	Tracey Huffer
Madge Shineton (Vice Chairman)	Heather Kidd
Peter Adams	Pamela Moseley
John Cadwallader	Peggy Mullock
David Evans	Peter Nutting

Your Committee Officer is:

Amanda Holyoak Committee Officer
Tel: 01743 252718
Email: amanda.holyoak@shropshire.gov.uk

AGENDA

1 Apologies for Absence and Substitutions

2 Declarations of Interest

Members are reminded that they must not participate in the discussion or voting on any matter in which they have a disclosable pecuniary interest and should leave the room prior to the commencement of the debate.

3 Minutes of the Last Meeting (Pages 1 - 12)

To confirm the minutes of the meetings held on 30 January 2017 and 20 February 2017 as a correct record, attached marked: 3

4 Public Question Time

To receive any public questions or petitions from the public, notice of which has been given in accordance with Procedure Rule 14. Deadline for notification is 5.00 pm on Wednesday 22 March 2017.

5 Member Questions

To receive any questions of which Members of the Council have given notice. Deadline for notification is 5.00 pm on Wednesday 22 March 2017.

6 Young Carers (Pages 13 - 18)

To consider a report on support available for young carers and plans for future support. Report attached marked: 6

Contact: Val Cross, Health and Wellbeing Officer, tel 01743 253994

7 Mental Health Services (Pages 19 - 60)

To receive and consider the recommendations of the Regional Commission on Mental Health Report, particularly in relation to delayed discharges from hospital.

Contact: Rod Thomson, Director of Public Health, tel 01743 252003

8 Shared Lives and Community Living (Pages 61 - 98)

To consider a progress report on two accommodation services for adults with learning disabilities -Shared Lives and the Community Living Service

Contact: Andy Begley, Director of Adult Services, 01743 258911

9 Work Programme (Pages 99 - 100)

To receive and consider proposals for the Committee's future work programme.

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SHOPSHIRE COUNCIL

HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

Minutes of the meeting held on 30 January 2017
10.00 - 11.34 am in the Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Responsible Officer: Amanda Holyoak
Email: amanda.holyoak@shropshire.gov.uk Tel: 01743 252718

Present
Councillor Gerald Dakin (Chairman)
Councillors Madge Shineton (Vice Chairman), Peter Adams, John Cadwallader, David Evans, Roger Evans, Heather Kidd, Pamela Moseley, Peggy Mullock and Peter Nutting

45 Apologies for Absence and Substitutions

Apologies were received from Councillor T Huffer. Councillor R Evans substituted for her.

46 Declarations of Interest

Members were reminded that they must not participate in the discussion or voting on any matter in which they had a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

47 Minutes of the Last Meeting

The minutes of the meeting held on 21 November 2016 were confirmed as a correct record.

48 Public Question Time and Petition

The Committee received details of a petition submitted by Shropshire People's Assembly Against Austerity containing 475 signatures regarding the Sustainability and Transformation Plan. They also received the response to it from the Portfolio Holder for Health who reported that lobbying continued for the county's health and social care service to receive fair funding. Details of the petition and the response to it are attached to the signed minutes.

49 Member Questions

There were no questions from Members.

50 Adult Social Care Local Account 2015 - 2016

Members received a report, copy attached to the signed minutes, presenting the Adult Social Care Local Account 2015-2016, which remained a draft but was close to completion. The Director of Adult Social Care reminded Members of the purposes of the Local Account, the production of which was not a statutory obligation but good practice.

The Making it Real Board had encouraged a magazine style publication which featured real life Shropshire stories and individuals, creating a report that was inviting and easy to read.

In response to questions from Members it was explained that:

- Advocacy and support arrangements were put in place to support responses to the annual user survey
- Valuable qualitative feedback and challenge was obtained from the Making It Real Board.
- The report was designed to be easily readable on websites and using tablets but advice was taken from the voluntary and community sector about where it would be best placed to circulate hard copies.

Officers acknowledged that the pages showing details of performance were complex and confirmed that discussion had been undertaken with the Making it Real Board about the best way of sharing this information. Some changes in performance were not as statistically significant as others and the construction of some targets changed year on year meaning that comparison was difficult.

In discussion of the numbers of people on long-term sick leave in Shropshire, the Portfolio Holder for Health referred to work underway in Oswestry on a pilot designed to prevent long term conditions developing. Information about this would be made available through Local Joint Committees.

The Performance, Intelligence and Policy Team Leader confirmed that the Council worked more with local indicators, as the user survey questions and format were prescribed. He agreed to let Members know the number of respondents to the User Survey. *[It was confirmed following the meeting that for the 2015/16 survey – the user pool was 3244 of which 887 were randomly selected and sent surveys of which 434 were returned]*

Members agreed that the Local Account provided an informative and accessible read and along with the Shropshire Choices website was a source of valuable information. The Chair thanked officers for the report.

51 **Carers Support Shropshire**

The Committee had requested a report on Carers Support, (copy attached to the signed minutes), particularly in the light of the Council appearing to be an outlier in performance with a 77% performance for England, as opposed to 2% for Shropshire.

The revised Adult Social Care operating model meant that resources had shifted from post to pre-assessment. The Carers offer in Shropshire focused on prevention with universal access to commissioned carers services. This had an impact on national ASCOF/SALT performance target reporting requirements which recorded only on post assessment for carers. People were now supported much earlier with better outcomes, before an assessment was needed. 70% - 75% of contacts were resolved at the First Point of Contact, avoiding the need for a complex assessment

The Council was confident that supporting carers earlier on and in a better way led to better outcomes for people. The Director said that his recommendation was not to change the model in use in order to align with that particular reporting metric. He reported that the directorate was developing local indicators in order to record and evidence current performance.

Members of the Committee agreed that they would not wish to amend an approach which was working to fit a metric. They asked if other authorities were in a similar position and heard that this was an issue that the Director had raised both regionally and nationally. A number of authorities were very interested in Shropshire's approach and had asked to visit and find out more.

Members asked if the new Social Care IT system would be able to separate figures related to spending on carers. They also asked if a carer could insist on having an assessment, and about support available for young carers.

In response the Director confirmed that the new IT system would be able to extract that information and this requirement was in the tender specification. He confirmed that all carers had a right to an assessment but in the first instance were advised of the choices available to them. The Council was currently in discussion with the Carers Trust about the possibility of them attending Let's Talk sessions.

Members asked about support available for young carers and heard that the Red Cross no longer provided this support but that discussions were underway with the Carers Trust.

The Committee wished to be assured of the services available and asked for a report back on support available to young carers. As this was an area also falling into the remit of the Young Person's Scrutiny Committee it was agreed that its members should be invited to be present for this discussion.

52 **Delayed Transfer of Care (DToC) Review to November 2016**

Members considered a report, copy attached to the signed minutes, on Delayed Transfers of Care.

Officers explained that results for Shropshire showed that the number of patients facing delayed transfer of care according to a snap shot survey had stabilised and were slightly better than the previous year. However, the number of delayed days was increasing, although at a slower rate than the national average.

Members also noted that the latest available data was for November 2016, and that comparatively small numbers made it appear that there were great fluctuations. NHS England determined which organisation was deemed to be causing a transfer of care being delayed, the options being the NHS, Adult Social Care or a joint responsibility. Delays attributed solely to the NHS had seen a decrease whilst those attributed solely or jointly with social care continued to increase. This was mirrored across the country where social care departments faced budgetary pressures, exacerbated in Shropshire due to the rural nature of the county and above average rate of elderly population.

Members noted that an unusually high numbers of delayed days occurred in Shropshire during August 2016, accounting for the majority of the annual increase. The reasons for this fluctuation were unknown.

It was confirmed that each month as the data was issued the dashboard was circulated to Directors. The Director also confirmed that he looked at DTOC figures on a daily basis at individual patient level.

A member drew attention to delays at hospitals, some of which were attributed to people registered with GPs in Wales, but whose social care was provided by Shropshire. It was confirmed that the data was based on a person's normal home address.

Members observed that Shropshire was doing relatively well at not increasing patient numbers but that patients in hospital were in for longer. They asked what was being doing to address this. The Committee were reminded of the work of the ICS team at the hospital and the brokerage service which was now also being used for admission avoidance work. Avoiding delayed transfers of care was a focus of the entire health and social care economy. The figures fluctuated constantly, demand was ever increasing and the pressure in the whole system was increasing on a daily basis. A plethora of initiatives was underway to find ways to reduce stays in hospital.

Members asked if there were enough care providers in the county. The Director explained that although progress was good, more providers were needed. This would be a focus of activity for the year as it had been surprising that the visibility of brokerage had not led to more providers. Work was underway with Shropshire Partners in Care to identify the reasons for that and to help businesses to develop.

Members wondered if providers were not stepping up due to the costs of training staff. Officers explained there was a significant issue around recruitment into the care industry both nationally and particularly in Shropshire. Those who might work in care often turned to retail employment, especially in a rural county where travelling could be difficult in winter. The Council continued to work with Shropshire Partners In Care on these issues, paid for training for staff and was offering support for collective recruitment initiatives.

A member asked for a more up to date picture than the November figures were able to provide but this was not yet available. The Director was able to say that 27 people were awaiting domiciliary packages that day, some of which were related to admission avoidance. He viewed a report every morning first thing and at noon.

The Director commented that the national reporting metric was a blunt tool and did not account for reasons for the delays in the system. It was important not to just focus on the point of discharge, there were many reasons for delays and differences in organisations managing risk. The increase was reflective of the demand on the system as a whole.

A Member referred to the lack of affordable housing particularly in the south and west of the county. She asked whether this evidence of local housing need for carers would be input into the Local Plan Review. The Director referred to his responsibility for both housing and social care which meant those connections could be made. He confirmed issues around affordable housing for carers were being considered, along with developing

a career pathway. Members requested that the submission to the Local Plan Review be shared with the Committee.

Members also felt it important to encourage the education establishments in the county to provide relevant training at the appropriate level.

Members acknowledged the tremendous pressure Council and NHS staff were working under and the change and improvements which had taken place. More people were being helped now than ever had been previously.

The Director welcomed the challenge from the Committee. He spent a significant amount of time looking for solutions both in the region and nationally, there were many different models of care. The Committee noted that one region could be performing well one day but not the next. No configuration had solved the problem to date and other faced the same challenges.

The Portfolio Holder for Health said it was very interesting to reflect on measuring performance nationally and locally and asked if it might be possible for the Committee to influence how national measures evolved. The Committee noted that the officers raised these issues at both the regional Directors group and the regional Performance Group. Issues with the way the figures were constructed and informed by a number of different organisations would also be raised at a national level.

Members agreed the recommendations in the report and wished to add an acknowledgement of the excellent work of Social Care and NHS colleagues in very difficult circumstances.

53 **Work Programme**

It was agreed that an extra meeting be held on 20 February 2017 to receive the CCG's new Investment Priority Strategy and to ask West Midlands Ambulance Service about the proposed withdrawal from the Physician Referral Unit, progress on working with the Fire and Rescue Service and to provide performance information for Shropshire by postcode.

It was agreed to add Mental Health to the work programme for the 27 March 2017 meeting, particularly in relation to the recommendations of the Regional Commission on Mental Health Report and delayed discharges from hospital. It was also agreed to add Young Carers to the work programme and ensure that Members of the Young Person's Scrutiny Committee be present for the discussion.

Signed ..... (Chairman)

Date: .....

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SHOPSHIRE COUNCIL

HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

Minutes of the meeting held on 20 February 2017
10.00 am - 12.26 pm in the Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Responsible Officer: Amanda Holyoak
Email: amanda.holyoak@shropshire.gov.uk Tel: 01743 252718

Present
Councillor Gerald Dakin (Chairman)
Councillors Madge Shineton (Vice Chairman), Peter Adams, Tracey Huffer, Pamela Moseley, Peggy Mullock and Peter Nutting

54 Apologies for Absence and Substitutions

Apologies were received from Councillor J Cadwallader.

55 Declarations of Interest

Members were reminded that they must not participate in the discussion or voting on any matter in which they had a disclosable pecuniary interest and should leave the room prior to the commencement of the debate.

56 Minutes of the Last Meeting

It was agreed that the minutes of the meeting held on 30 January 2017 be confirmed at the next meeting of the Committee.

57 Public Question Time

Two public questions had been submitted by Mr J Bickerton as follows:

'Why haven't West Midlands Ambulance Service met the commitment they made at the introduction of Make Ready on 30 June 2011 when they said we would get a better service in Shropshire'

'It said in the Oswestry Advertiser that WMAS had been classed as outstanding. How does that apply to Shropshire and how are you going to get up to that standard'

In response the West Mercia General Manager explained how the Make Ready system improvements meant that there would be an ambulance ready for the crew to come back to after a job to get straight back into.

In response to the second question, it was confirmed that the CQC visit had been very thorough and had covered the whole region, including Shropshire. WMAS was the only ambulance service in the country to have been rated as outstanding.

In response, Mr Bickerton referred to poor response times in rural areas. WMAS officers said that for most patients, clinical outcome would be a more important measure than speed.

58 **Member Questions**

A Member question had been received from Councillor K Pardy –

'Can the chair tell me how many paramedics have resigned from the service in the eight months up until and including the 31st January 2017'

In response, WMAS officers reported that leavers in that time period had numbered 15. One had transferred to another ambulance service, 12 had gone to Shropdoc, one had left for personal reasons and one had retired.

Councillor Pardy expressed concern about the service losing paramedics to Shropdoc and asked if better working conditions had attracted them to that organisation and if so, what was WMAS doing to retain staff.

The Director of Clinical Commissioning and Strategic Development said there were pressures on staff retention throughout the NHS and all ambulance services. Having said that, he reported that ambulance staff did traditionally stay in service for a long time and many received long service awards. People were now having to work harder than ever and were out on calls for the entirety of their shift. WMAS had established a new career framework for paramedics and within two years this made them some of the best paid NHS staff compared to other health professions, including junior doctors. He referred to the frustration felt by staff when they were delayed for long periods of time at the hospital.

59 **West Midlands Ambulance Service**

The Chairman welcomed Michelle Brotherton - General Manager West Mercia, Mark Docherty – Director of Clinical Commissioning and Strategic Development and Pippa Wall, Head of Strategic Planning, West Midlands Ambulance Service (WMAS) to the meeting. He congratulated the service on achieving 'excellent' in the recent CQC inspection.

The Chairman said there some concern that this was not reflected in the more rural areas of the WMAS area. The Director reported that WMAS was the only acute organisation in the West Midlands to achieve the rating of excellent and was the only ambulance service to achieve all mandated targets in 2015 – 2016.

The aspiration was to have a paramedic in every front line vehicle for 95% of the time and the figure for Shropshire was 95.2%. He went on to present the information pack which had been supplied for the Committee and this provided: an overview of the service, CQC rating, Vision Strategic Objective and Strategic Values, detail of the two year operational plan; draft Quality Account priorities; activity, demand and performance information.

In response to a series of questions from Members, WMAS officers explained:

- At the peak time of day there would be 24 double crewed ambulances in Shropshire.

- There were no current paramedic vacancies and if one was to occur it would be filled immediately.
- The front line resource was being increased and there were 300 people in paramedic training
- Staff were not moved between areas for the purpose of hitting targets.
- The amount of ambulance resources coming into the county was always greater than that going out.
- 80% of the area covered by WMAS was classified as rural and issues around sparsity were recognised, the challenges in Shropshire being greater than other rural areas.
- The Air Ambulance helicopter was the asset of the Air Ambulance Charity and raised money for the platform, running costs and pilot, but WMAS supplied the clinical resource.
- The demand on the service was increasing, but major trauma cases were declining. It appeared that people were using the service in a different way and the conveyance rate was declining. If the service was used as it should be, the conveyance rate would be 100%

In response to a question about Mangar Elk lifting equipment, it was confirmed that there was one on every front line ambulance and that two people were required to use it. A Member suggested that this might be something that nursing homes could buy and then train their staff to use which might help avoid ambulance call outs.

A Member said it sounded as if WMAS was doing as well as it could internally and questioned why public perception was not more positive. The Director emphasised that the Service was under great pressure and additional winter pressures had been high this year despite the mild weather and absence of a big flu or norovirus outbreak. There were simply not enough resources and finances were stretched to the limits.

The Chairman asked if there was anything the Scrutiny Committee was in a position to help with WMAS officers said that the education of the public on appropriate use of the service was essential and any help in spreading that message would be appreciated. Access to primary care was a factor, also younger people demanded a more immediate response than had ever been expected before.

Vanessa Barrett, Healthwatch representative, commented that one of the services priorities of last year had been ‘to engage with rural communities’. Healthwatch was very keen to be involved with this work but not as much progress had been made as it would have liked. She added that Healthwatches across the region were well placed to help in developing dialogues in local communities around response times. The Director agreed that variation in response times was an important issue as was variation in conveyance rates.

A member asked if it was thought that changes to Minor Injury Unit availability and services might increase demand on WMAS, particularly as people often did not have transport to take them to Shrewsbury or Telford. The Director said that there was more of a link between access to GP services for frail elderly people particularly at weekends and Bank Holidays.

Members heard that activity was increasing at a rate of 4.7% a year but that WMAS was ready for this. The Director of Performance and Delivery, Shropshire CCG, confirmed that for 2015/16 the activity increase had been predicted at 4.5% and this had been fully funded. She expressed concern about the neighbouring CCGs who did not fully fund growth and the need for issues with regional commissioning to be addressed. The Director of Clinical Commissioning, WMAS reported that Shropshire CCG did a good job in commissioning and estimating growth in activity.

WMAS officers went on to explain the Ambulance Response Programme, a national response programme linking response times to clinical outcomes. The view was that the right response to the patient first time was the most important factor, even if this meant not attaining an 8 minute target. WMAS had been asked not to share the data in public until after the end of the pilot. The Committee looked forward to receiving more information once the trial was complete.

Members asked about handover challenge at the acute hospitals, and the reasons for the different performance at Royal Shrewsbury Hospital and Princess Royal Hospital. The Shropshire CCG Director of Performance and Delivery explained that there were different pressures on each hospital site and a shortage of beds at RSH.

WMAS officers added that handover delays presented a considerable challenge in Shropshire and far too much ambulance resource was being lost in these delays which were the result of complex circumstances. It was possible to cope with a long delay every now and again but these delays had been going on too often and for too long and the percentage of delays over 1 hour was significantly greater in Shropshire than other in areas.

Members heard that a root cause analysis was carried out on every single ambulance delay. Although Shrewsbury and Telford Hospital Trust had declared zero tolerance on over one hour ambulance delays there had been little progress. This was a priority area for all concerned. Corridor nurses did operate at the hospital when staffing levels permitted and there were also HALOs but this had still not been enough to cope with the unprecedented pressure. .

Members felt that in the face of the handover delays and inappropriate call out of ambulances, WMAS was doing well within the constraints it faced.

Physician Referral Unit

The Committee asked for an explanation as to why WMAS had withdrawn from the Physician Referral Unit which appeared to have been a scheme that was working well. The Director of Clinical Commissioning explained that although the scheme had been successful there had been concerns around doctors going beyond the scope agreed and attending trauma cases. WMAS had a well established and successful trauma model which was very tightly governed. It had offered to run a similar model to that in Worcestershire in which doctors would respond to calls in their own cars, blue lights would not be used and the response model would predominantly be a secondary response.

The Director of Performance and Delivery, Shropshire CCG, said the scheme had worked very well with some 300 – 400 hospital admissions prevented. She added that advice was

being sought in relation to the PRU appointments made and a decision would be made by the CCG on the scheme's future in mid-March.

Fire and Rescue Service

Ambulance service officers reported that the Chief Executive of WMAS had hosted a meeting before Christmas of Chief Fire Officers from the region and proposals had been discussed with regard to retained fire and rescue locations becoming part of the Community First Responder Service. Another meeting was planned for mid-March.

The Director of Public Health reported that Shropshire Fire and Rescue Service had indicated that it would be willing to pilot a scheme at no cost to others. Concerns had been expressed at the slow progress in taking proposals forward. WMAS officers commented that the scheme would not provide any financial benefit to the ambulance service and queried what would happen if Fire Officers were acting as CFRs at the time of a fire. One way of working together could be for the Ambulance Service to handle Fire and Rescue calls. The Committee said that they would want a progress update on developments in the near future.

WMAS officers went on to explain substantial developments with the Electronic Patient Record which were transformational and very much welcomed by the Committee. The CCG Director of Performance and Delivery identified some potential useful links to the High Intensity User Project.

The Committee thanked WMAS for all of its good work and the Chairman also expressed appreciation to WMAS officers for attending the meeting and answering questions.

It was agreed that the following areas be considered by the Committee in future:

- Physician Response Unit update
- Update on working with the Fire and Rescue Service
- Ambulance Response Programme - results be made available once evaluation is complete
- Handover times at hospitals (CCG, WMAS and SATH to be in attendance)
- Consideration of whether the Council had a role to play in encouraging the public to make correct use of WMAS

60 Shropshire CCG - Prioritisation and Value for Money Methodology

Julie Davies, Director of Performance and Delivery and James Aker, Associate Director of Commissioning, Shropshire CCG, circulated an update to the Committee on CCG Prioritisation and Value for Money methodology (a copy is attached to the signed minutes). In taking the Committee through the report, the significant financial constraints facing the CCG were outlined and particular attention was drawn to the CCG's aim to increase public, patient and stakeholder engagement.

The Structured approach taken to prioritisation was set out in the paper before members. It explained how the evidence base would be established and used as a basis for decision making. This information would be made available on the website to increase

transparency around decision making and give stakeholders and the public an additional opportunity to comment on accuracy or additional information needed.

Members asked how engagement would take place and heard that as broad an evidence base as possible would be sought. The CCG would link in with Healthwatch and Patient Groups and service providers to collect information. All the information normally required for a service review would be collected. A member suggested using Shropshire Association of Local Councils and the voluntary sector to pull strands together and contact hard to reach groups.

Members were referred to the scoring process using the Portsmouth Scorecard to help robust decision making and the fifteen categories of information to be collected. The approach would be used and modified as necessary once feedback was received.

The Director of Adult Social Care commented that it was heartening to hear about the involvement of stakeholders in the prioritisation process and asked if there was an opportunity to formally name co-commissioners in the methodology, for example in appendix 4. .

A member asked if the CCG had the financial resilience to deliver its priorities. CCG officers said that it did and referred to NHS England and Deloitte help in forming those initial priorities.
Another member asked if the methodology had been discussed or agreed with stakeholders. CCG officers referred to a difficult period of time when initial proposals were made in 2016. The new approach was an outcome of feedback received at that time, not least from the local authority. CCG officers confirmed that it was intended to work proactively with the Council's Director or Adult Services.

The Director Adult Services said it was fair to say that the Council and CCG were now working together more closely, but that it was right for Members to challenge this relationship and input of stakeholders into the methodology.

The Associate Director of Commissioning said he would be happy to respond to any questions or comments outside of the meeting.

The Chairman expressed the Committee's appreciation to the Director of Performance and Delivery and Associate Director of Commissioning for attending the meeting and responding to questions.

61 **Work Programme**

A member suggested looking at the location of Midwifery Led Units in the county.

Signed ..... (Chairman)

Date: .....

Committee and Date	Item
Health and Social Care Scrutiny Committee 27 March 2017 10.00 am	 Public

Update for Scrutiny - Young Carers in Shropshire

Responsible Officer Val Cross, Health and Wellbeing Officer
e-mail: val.cross@shropshire.gov.uk Tel: 01743 253994

1. Summary

1.1 This paper identifies measures that are currently in place to support young carers in Shropshire, and describes work that has been happening to listen to their voices and to embed into the new All Age Carers strategy and Action Plan.

2. Background

2.1 The 2011 census shows us that there are around 34,000 carers in Shropshire**.** Of these, it is estimated that there around 650 young carers. However, we know that there are many 'hidden' young carers, who may feel that they are simply carrying out ordinary responsibilities as part of a family, or be caring for someone with stigmatised conditions such as drugs and alcohol and be reluctant to make their needs known.[1]

2.2 The Local Authority response to a freedom of information request from the Children's Commissioner for England[2] showed that between the 01/04/15 and 31/3/16, 55 young people were referred to the young carer support provider and 198 individuals were being supported. Out of this 198, over 75% were supporting someone with mental health problems and between 50 and 75% with drug or alcohol issues. Between 10 and 49% were caring for someone with physical health difficulties or learning difficulties. The majority of young carers were in the 10-15 year age group, and 28 fell into the 5 – 9 year age group.

2.3 This report provides an update on services available to young carers and young adult carers in Shropshire.

3 Recommendations

An All Age Carers Strategy update is provided to Scrutiny in 18 months' time to evaluate progress, particularly in relation to young carers

4 Risk Assessment and Opportunities Appraisal

[1] http://www.scie.org.uk/publications/guides/guide09/section1/hidden.asp
[2] Children's Commissioner Young Carers The support provided to young carers in England December 2016

4.1 Risk Assessment has identified potential threats as;

4.1.1 Financial constraints across the whole system has been kept in mind when formulating the Action Plan for the Carers Strategy, and outcomes focus more on changing ways of working, reviewing policies and pathways and making information available.

4.1.2 Opportunities exist through implementation of the Carers Strategy and Action Plan, for health and social care services to work more closely together and collectively improve the early identification and improved outcomes for young carers.

REPORT

5.0 This report identifies measures that are currently in place to support young carers in Shropshire, and describes work that has been happening to listen to their voices and to embed into the new All Age Carers strategy and Action Plan.

5.1 *New All-Age Carers Strategy for Shropshire 2017-2021*

5.1.1 A new carers strategy has been produced for Shropshire, which now covers all ages including young carers and young adult carers. The Family Carer Partnership Board and the Health and Wellbeing Board have approved this.

5.1.2 The priorities identified are:

1. Carers are listened to, valued and respected.
2. Carers are enabled to have time for themselves.
3. Carers can access timely, to up to date information and advice.
4. Carers are enabled to plan for the future.
5. Carers are able to fulfil their educational, training or employment potential

5.1.3 The Strategy and Action Plan has been developed by using information from local and national sources, legislation, (The Care Act 2014 and the Children and Families Act 2014) local surveys and by talking to carers, including young carers and young adult carers. A multi-agency strategy group agreed the content and priorities.

5.1.4 Identified leads for the four out of the five priority areas have been allocated, with a fifth to be identified from Children's Services. The leads will meet bi-monthly, then report on progress at each Family Carer Partnership Board meeting.

5.1.5 Examples of actions being progressed are; a system being in place, to ensure the carer is able to care for the person they look after upon hospital discharge. - This includes if that person is a child or young person, and carer involvement in medication discussions, so side effects etc. are understood.

5.2 *Young Carer Health Assessments with school nurse – Pilot project*

5.2.1 This assessment tool has been developed by the Shropshire and Telford and Wrekin School Nurse Team and with input from young carers themselves. Currently, known young carers seeking support are offered an assessment from a school nurse.

5.2.2 The assessment is a three part process;

- Consent to share information

- The assessment itself, which contains questions to which responses are rated red, amber or green. Safeguarding is embedded throughout.
  Questions focus around whom the young person is caring for and responsibilities they undertake, any effect on school and education, specific caring activities carried out such as lifting or carrying heavy things. (A Multidimensional Assessment of Caring Activities (MACA-YC18) score for this section is allocated), and emotional welfare and physical health including checking the young person is registered with a GP and dentist.

- A Young Carers Individual Health Care Plan is put in place following the assessment outcome.

5.3 Commissioned provider – Carers Trust 4 All

5.3.1 Carers Trust 4 All (CT4A) provide:

- Monthly young carer peer support meetings in Oswestry, Ludlow, Whitchurch and two in Shrewsbury (one Junior and one Senior)
- One to one young carer support and advocacy
- Large activities and residentials throughout the year.
- A new resource around young carers has just been developed and distributed to all Shropshire Primary schools. CT4A are able to support schools to deliver this.
- Linked to Secondary Schools through PSHE lessons and through assembly delivery.

5.4 Consultation with young carers

5.4.1 Consultation was carried out with young carers, young adult carers and young people between November 2016 and January 2017. This was a joint piece of work between Shropshire Council and Telford and Wrekin Council.

5.4.2 The purpose was to inform the new 2016-2021 All Age Carers Strategy and Action Plan for Shropshire, which had previously been an Adult Carers Strategy only.

5.4.3 It was important to gather the views of young carers and young adult carers, and ensure their needs were included, as this group were under-represented in surveys and consultation.

5.4.4 Although Telford and Wrekin's strategy is already in place, the consultation was equally beneficial to identify any potential gaps in young carer work.

5.4.5 The work was also part of the NHS England 'Carer Voice' pilot, which is collecting the views of all carers to inform national strategies. More information on this is further in this report.

5.4.5 Two focus groups were facilitated, and views were collected during young peoples' youth sessions. The themes focussed on assessments, education and accessing information and support.

5.4.6 Approximately 45 young people were involved; At least 19 were known to be young carers. Young people who weren't young carers were included to gauge their knowledge and raise awareness of young carers as their peer group.

5.4.7 Key findings were:

- Young carers want to understand more about the medication the person they care for takes, and any side effects.
- Many young carers are still not having assessments
- Young people who were not carers, felt awareness should start in primary schools – year 5/6, and support in school was important such as mentoring programmes (including at sixth form) and good support in school in general.
  Schools should be made aware of who their young carers are- if YP don't get help and support from school, they are not going to do well at school!
- Where appropriate young people want to be involved in assessments of the person they are caring for, and it should be done when they are there if possible.
  There is a lot we don't know about, and should.
  Care assessment should listen to what we have to say
- The importance of treating young carers as a young person first and an individual in his or her own right. What support may be appropriate to one may not be for another.
- The importance of a consistent approach to young carers in schools, to enable a better understanding of managing schoolwork and access to further support as needed. Some young people spoke of having a trusted member of staff they could approach whereas others did not.
- People were cited as the main source of information, young carer staff in particular.

5.4.8 The Information gathered will now inform action plans to take forward.

5.5 *NHS England Carer Voice project*

5.5.1 Shropshire and Telford and Wrekin have been involved in an NHS England pilot called the 'Carer Voice'. This project has been gathering views of all carers to feed into a national report and to influence national strategies.

5.5.2 Joint working has taken place to gather the voices of young carers and young adult carers, and the young people will be presenting at the conference to celebrate this work on the 25th May 2017.

5.6 *Referral processes*

5.6.1 Examples of referral routes include to Carers Tust4All and via the Early Help referral process

5.6.2 Schools offer pastoral support, but young carers experiences of this were mixed.

5.7 Transition process at 16 to 18 years

5.7.1 Between 16 and 18 years of age, Adult Social Care works jointly with colleagues in the Children and Young People's Directorate to ensure young carers receive the appropriate support. At this stage, Adult Services also start the transition assessments where young people support siblings.

5.7.2 When reaching 18, the young person will be entitled to a Carers Assessment and any identified eligible needs met, which may result in a personal budget for the young person. Adult services would also signpost to relevant services provided by Carers Trust 4 All.

6. Conclusions

6.1 Measures are in place for young carers in Shropshire, but there is still more to do. The new Carers Strategy and Action Plan is an opportunity for services to work together and take joint responsibility to improve outcomes for young carers Caring has a known emotional, physical and life chances impact on young people and any steps to alleviate this are vital.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Councillor David Minnery – Portfolio Holder for Children and Young People
Local Member All – this is a countywide matter.
Appendices None

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THRIVE
WEST MIDLANDS

An Action Plan to drive better mental health and wellbeing in the West Midlands

WEST MIDLANDS COMBINED AUTHORITY

MENTAL HEALTH COMMISSION

West Midlands Combined Authority Mental Health Commission

The West Midlands Combined Authority Mental Health Commission was established in October 2015. Rt. Hon. Norman Lamb MP, former coalition government Minister of State for Care and Support and Liberal Democrat MP for North Norfolk chaired the Commission.

This Action Plan is the result of work carried out by the Commission.

Please cite this document as: Thrive West Midlands: An Action Plan to drive better mental health and wellbeing in the West Midlands (2017). Lamb, N. Appleton, S. Norman, S. Tennant, M. (Eds.).

Independence and funding

The Commission's work has been funded by the West Midlands Combined Authority with additional resource provided by NHS England.

Commissioners and members of the steering group all have, or have had, some engagement in the field of mental health or related fields. All Commission members are independent of the West Midlands Combined Authority.

CONTENTS

OUR COMMITMENT

The following Concordat for Action statement demonstrates the commitment of key organisations from across the West Midlands to improving the mental health and wellbeing of people within our region:

"WE WILL work together to improve mental health and wellbeing, to reduce the burden of mental ill health across the West Midlands. We will work to improve people's lives and to encourage healthy communities.

WE WILL ensure services meet the needs of people with mental ill health and are provided with empathy and compassion. We will involve people who have experienced mental ill health and their carers at the earliest opportunity in decisions about services.

WE WILL work together to develop and deliver the actions in this Action Plan across the West Midlands Combined Authority area"

STAKEHOLDERS AND PARTNERS

WHO HAVE DEVELOPED AND SIGNED UP TO THIS ACTION PLAN ARE:

- the West Midlands Combined Authority (WMCA)
- the Police and Crime Commissioner
- Local authorities in the West Midlands
- NHS Trusts (mental health and acute providers)
- NHS England Midlands and East
- Public Health England
- Clinical Commissioning Groups (CCGs)
- Sustainability and Transformation Plan system leaders
- West Midlands Ambulance Service NHS Foundation Trust
- West Midlands Police, Probation and the courts, including Community Rehabilitation Companies
- West Midlands Fire Service
- Housing Associations
- People with lived experience and their carers
- The West Midlands Cooperative (the Citizens Jury)
- Those working in the community and voluntary sector
- The charity, Mind
- Universities
- Local Enterprise Partnerships in the West Midlands
- Chambers of Commerce
- Chartered Institute of Personnel and Development
- Business in the Community

LETTER FROM
NORMAN LAMB MP

People with mental ill health get a raw deal. Too often, people suffer in silence, unable to get help. Many people across the West Midlands are touched by mental ill health and the impact on families is sometimes overwhelming. Some of our communities suffer disproportionately. Tragically, too often people end up taking their own lives.

The cost of mental ill health to the West Midlands is estimated to be £12.6 billion per year. We now have the knowledge and understanding to address this, to make better use of public and private resources to achieve better results for people. So the moral and the economic case for acting is unanswerable.

When we started this work, the Commission felt we should be more ambitious than simply producing a report with more recommendations. I have seen so many commission reports which come up with good ideas but which change nothing. Instead, we decided to develop an Action Plan which key organisations across the region have signed up to.

In this document, we have mapped out the way forward for each of the actions. We have also ensured that the necessary leadership is in place to implement the Action Plan. And there will be governance arrangements to hold organisations to account in delivering the actions.

We have directed our actions to other areas of public services and the wider community, not just the NHS and social care. We know that to reduce the impact of mental ill health in this region, we not only have to improve the treatment of those who are already ill, but we must seek to prevent ill health and a deterioration of health, and promote good mental health and wellbeing.

I want this to be a start of a journey for the West Midlands.

I want to challenge this region to lead the way in demonstrating how we can use public money and private resources more effectively to build strong, happy communities.

We recognise that this Action Plan cannot address all the deficits in mental health services, or achieve the necessary improvement in mental health and wellbeing in one go. Our work and this Action Plan is the start of a process to identify areas that can have a positive impact, so that we begin a longer term programme of improvement. This first set of actions can be built upon to create an ongoing process that brings organisations and the public together to improve mental health and wellbeing in the region.

To build this Action Plan, we have drawn upon research, evidence, professional opinion and expertise. We have considered the views and experience of people who use services and the wider public and applied those to stimulate and support work at a local level.

Public and patient involvement has been central to our approach. We have engaged with members of the public, people who use or have used services, and people who care for others using services. Establishing a Citizens Jury, holding listening events and enabling comments via the West Midlands Combined Authority (WMCA) website are ways we have reached out beyond the confines of professionals and 'experts' to ensure that our thinking has been grounded in the reality of the experience of those living with mental health problems and the wider public who use local services.

We have sought, wherever possible, to begin the groundwork necessary to ensure that the actions happen and that they really make a difference to people's lives. We have worked with others to attract investment, brought partners together and laid the foundations for more detailed work to take place. We didn't want to just make recommendations and walk away. We wanted to get change under way. In most of the areas which we have addressed, we have already started to develop plans to implement the agreed actions.

As this region builds on the foundation stones we lay, it will be important to develop a whole life approach, recognising that to reduce the impact of mental ill health in this region, we have to start at the very beginning of life, supporting parents and building strong communities.

We recognise that addressing these issues will be challenging. But the scale of need means that we have to act. Business as usual is not acceptable. We can all play our part in helping to end the injustice suffered by those with mental ill health. If we have the will, we can have a massive impact on the lives of people and communities across the West Midlands.

Rt. Hon. Norman Lamb MP
Chair of the Mental Health Commission

MESSAGE FROM THE **CITIZENS JURY**

On behalf of the Citizens Jury, it has been a great pleasure to help achieve this Action Plan. It has been a fantastic opportunity to meet new people from various backgrounds and to work together to change attitudes towards mental health.

As members of the Citizens Jury, we have worked extremely hard by pushing ourselves out of our comfort zones and taking on many challenges such as public speaking. We all felt that with the right building blocks and information that our recommendations should be taken on board by the West Midlands Combined Authority.

Each of the actions in this plan will make a significant difference to improving the current mental health system within the West Midlands.

We would like to thank the West Midlands Combined Authority for allowing us to be a part of this project as it gave us the chance to voice our opinions and to have our views listened to. We would like to say a huge thank you to Peter Bryant, Nick Beddow and Jenny Willis for facilitating and organising the sessions we attended, and for supporting our ideas.

We are continuing to work as a group (now known as The West Midlands Cooperative) to make sure these actions are implemented.

Holly Moyse, Member of the Citizens Jury

On behalf of the Jury members

SECTION ONE

THRIVE WEST MIDLANDS – A PLAN FOR CHANGE

Poor mental health and wellbeing is a significant problem for the West Midlands. It impacts on individuals and families, and more widely on communities and the economy, costing our region over £12 billion per year.

Too often, people with mental health needs feel let down. They either don't receive adequate care, or it is simply not designed to meet their individual needs.

The West Midlands Combined Authority's Mental Health Commission chaired by Rt. Hon. Norman Lamb MP, has worked with organisations within the WMCA including the Police and Crime Commissioner, Public Health England (West Midlands), local NHS organisations, the local Department for Work and Pensions, the voluntary sector, police, fire service, courts, housing agencies, employment organisations, and people with personal experience of mental ill health. Together, we have developed this Action Plan for change – called Thrive West Midlands.

This Action Plan sets out how the region will seek to reduce the impact of mental ill health. We want to build happy, thriving communities and to support those who experience mental ill health.

Together, we will deliver these actions that will make a real, positive difference to people's lives in the West Midlands.

"There is no joined up service that is accessible to all. This needs to change. urgently"

Member of the Citizens Jury

SECTION TWO

ACTION PLAN SUMMARY

OUR PLAN OF ACTION

THEME 1

SUPPORTING PEOPLE INTO WORK, AND WHILST IN WORK

WE WILL:

Launch a three year programme in 2017 to trial expanding **Individual Placement and Support (IPS)** provision for people with severe and enduring mental health issues, demonstrating how IPS could achieve employment outcomes at a significant scale. We will also trial extending the IPS model to people with common mental health issues, and potentially people with chronic physical health issues, who are being treated in a primary care setting. We will be working with the Government's Work and Health Unit, NHS England and others to deliver this project.

Launch a **'West Midlands Workplace Wellbeing Commitment'** in Spring 2017, where public and private sector employers sign up to demonstrate their commitment to the mental health and wellbeing of their staff.

Encourage companies bidding for public sector contracts to **sign up to the West Midlands Wellbeing Commitment**, or demonstrate an equivalent commitment to the wellbeing of their staff. We will encourage large companies in the region to secure commitment from their supply chain to also commit to such standards.

Work with the Government to trial an innovative **'Wellbeing Premium' - a tax incentive that rewards employers demonstrating their commitment to staff wellbeing.** The trial will reveal if such a financial incentive, accompanied by an employer action plan, reduces staff sickness absence, improves productivity and prevents people leaving work due to ill health.

THEME 2

PROVIDING SAFE AND STABLE PLACES TO LIVE

WE WILL:

Build on great work already happening on our region by trialling an innovative scheme to **offer a Housing First service with intensive mental health support** in the West Midlands. This scheme will support those with complex needs or who are homeless to move into good quality housing and where possible, into work.

THEME 3

MENTAL HEALTH AND CRIMINAL JUSTICE

WE WILL:

Help to implement a programme to make more regular and widespread use of the **Mental Health Treatment Requirement** in the Magistrates and Crown Courts, which offers offenders with mental health problems the option of a treatment plan that addresses the underlying causes of offending. This programme should help recovery, reduce reoffending, and reduce the cost and impact of crime on the local community.

THEME 4

DEVELOPING APPROACHES TO HEALTH AND CARE

WE WILL:

- launch a Zero Suicide Ambition approach, which together with the recently launched National Suicide Prevention Strategy, aims to prevent and reduce suicides across the region
- establish a group of local and national experts to recommend a primary mental health care model for the region that ensures people's mental health needs are more effectively supported
- help to ensure the region meets national access and waiting time standards for early intervention in psychosis services
- establish a group of local and national experts to examine how the principle of early intervention should be applied to other areas of mental health care, so we support people much earlier, whatever their age
- end out of area mental health hospital placements for acute mental health care in the region by the end of 2017. Occasionally, patients need specialist inpatient care that is only available elsewhere
- help to explore effective alternatives to inpatient care that meet the individual needs of people with mental ill health, and test which work best before implementing them
- building on existing progress, apply for a grant from the National Institute for Health Research (NIHR) for a major project to substantially reduce the use of restraint in inpatient settings
- help to trial 'Integrated Personal Commissioning', a new approach to joining up health, social care and other services, in the region for those with mental ill health
- establish a group to ensure access to specialist 'perinatal' mental health services across the region for women during pregnancy and after they give birth
- examine why detentions under the Mental Health Act are rising in the region, particularly repeat detentions, and if inequalities need addressing

THEME 5

GETTING THE COMMUNITY INVOLVED

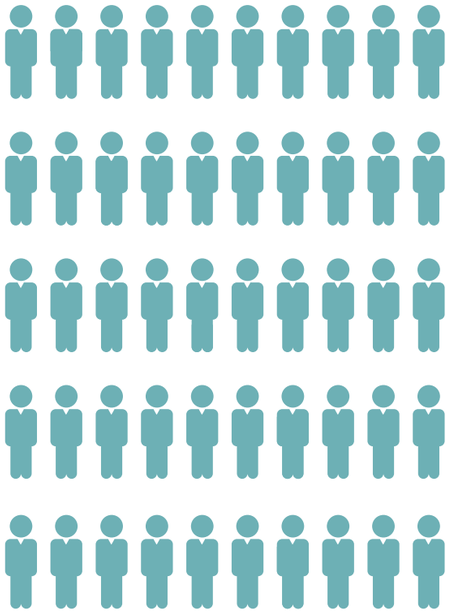
WE WILL:

- Launch a programme of **community initiatives to raise awareness of mental health and wellbeing**, guided by people with experience of mental ill health and driven by the community.

This includes:

- an annual 'Walk out of Darkness' - a 10 mile sponsored walk through the region to raise funds for organisations supporting people with mental ill health and raising awareness of mental health
- an annual awards ceremony to recognise people in local communities who do amazing work supporting others
- exploring if a community art initiative such as that carried out in Philadelphia could help to improve public mental health and wellness in our region

- Launch a large public health programme to **train up to 500,000 people across the region in Mental Health First Aid** or other equivalent programmes over the next ten years, that will improve people's knowledge of mental health and how they can support each other. We'll campaign for Government to amend First Aid legislation for employers, to include mental health first aid



SECTION THREE

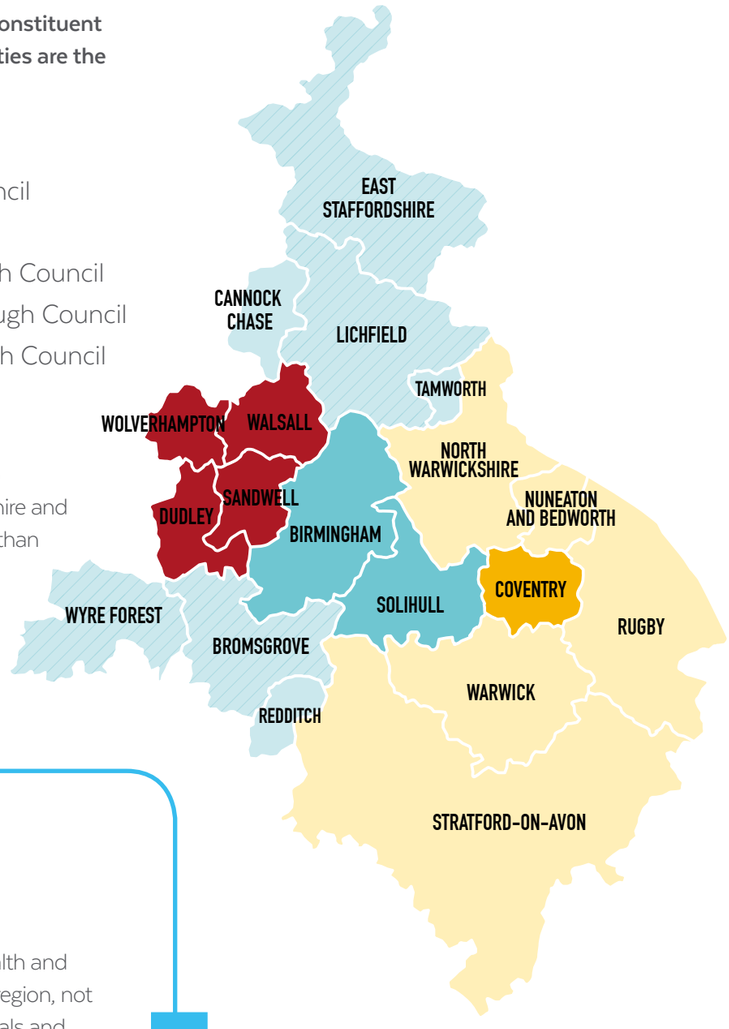
ABOUT THE WEST MIDLANDS COMBINED AUTHORITY (WMCA) AND THE MENTAL HEALTH COMMISSION

The West Midlands Combined Authority (WMCA) became a substantive body in July 2016. The WMCA is using the benefits of devolution to use their resources so that it more effectively meets the needs and challenges of the West Midlands region.

It consists of constituent and non-constituent authorities. The constituent authorities are the seven metropolitan councils:

- Birmingham City Council
- City of Wolverhampton Council
- Coventry City Council
- Dudley Metropolitan Borough Council
- Sandwell Metropolitan Borough Council
- Solihull Metropolitan Borough Council
- Walsall Council

Non-constituent authorities reach into South Staffordshire, North Worcestershire and Warwickshire, have fewer voting rights than constituent members, and may sign up to more than one combined authority if they wish. Constituent members may only be signed up to one combined authority.



MENTAL HEALTH IS A PRIORITY FOR THE WEST MIDLANDS

The WMCA identified poor mental health and wellbeing as a significant issue for the region, not only in terms of the effects for individuals and families, but more widely on the communities and the economy of the area. It results in enormous distress for people, greater demand for public services and reduced productivity, and so has been identified as a priority area where the WMCA could deliver public sector reform.

THE MENTAL HEALTH COMMISSION

WHO WE ARE

The WMCA Mental Health Commission was established to work out how the opportunities of devolution could help to address poor mental health and wellbeing across the region.

The plan was that we would make recommendations to the WMCA (and to government) about ways to improve mental health and wellbeing services and improve outcomes, for people in our region and across the country.

THE COMMISSIONERS

RT. HON. NORMAN LAMB MP (CHAIR OF THE COMMISSION)
Former coalition government Minister of State for Care and Support at the Department of Health (September 2012 – May 2015). Liberal Democrat health spokesperson and MP for North Norfolk.

PAUL ANDERSON
Managing Director – Deutsche Bank Birmingham

PROFESSOR KEVIN FENTON
Director of Health and Wellbeing – Public Health England

PROFESSOR DAME CAROL BLACK
Advisor to government on employment and health and Principal of Newnham College, Cambridge

STEVE GILBERT
Serious Mental Illness - Lived experience consultant

CRAIG DEARDEN-PHILLIPS
Chief Executive and founder of Stepping Out

STEVE SHRUBB
Former NHS mental health Trust Chief Executive and Director of the NHS Confederation Mental Health Network

DR GERALDINE STRATHDEE OBE
Former National Clinical Director for Mental Health at NHS England

PROFESSOR SWARAN SINGH
Head of Mental Health & Wellbeing Division at Warwick Medical School, University of Warwick

KAREN TURNER
Director of Mental Health – NHS England

OTHER ATTENDEES AT COMMISSION MEETINGS

SARAH NORMAN
Chief Executive of Dudley Council and lead officer for the Commission

STEVE APPLETON
Managing Director - Contact Consulting
Secretariat to the Commission

SIMON GILBY
Chief Executive of Coventry & Warwickshire Partnership NHS Foundation Trust
Attending on behalf of local NHS mental health provider trusts

DR PAUL TURNER
Clinical commissioning lead for mental health at Birmingham South Central Clinical Commissioning Group (CCG). Attending on behalf of clinical commissioners

SUPERINTENDENT SEAN RUSSELL
Mental health lead for West Midlands Police. Attended as Chair of the Commission's steering group, before being appointed as Implementation Director

WMCA SPONSORS OF THE MENTAL HEALTH COMMISSION

COUNCILLOR PETE LOWE
Combined Authority Leader Champion, Vice Chair of WMCA, Wellbeing Portfolio Holder and Leader of Dudley Metropolitan Borough Council

The Mental Health Commission would like to take this opportunity to acknowledge the significant contribution that Cllr Darren Cooper, former leader of Sandwell Council, made to the mental health agenda. Darren sadly passed away in 2016.

SECTION FOUR

THE WEST MIDLANDS, A CULTURALLY DIVERSE AND VIBRANT AREA

The Commission's work covers an area of

just over four million people

across an array of vibrant cities, towns and villages.

Our region is incredibly diverse. There are areas of affluence, but also areas with significant social and economic deprivation.

PEOPLE FROM BLACK, ASIAN AND MINORITY ETHNIC (BAME) COMMUNITIES, make up around 1/5 of the total population in our region

NEARLY 2/3 of people in our region are 16-65 years old

OVER HALF OF THE PEOPLE IN OUR REGION live in localities within the 20% most deprived areas in England, including Walsall, Wolverhampton, Sandwell and Birmingham.

SECTION FIVE

THINGS MUST CHANGE

Mental ill health has a massive impact on people in the UK and our region. It affects many aspects of people's lives, and aside from individuals and their families, it impacts on communities, workplaces, public services, our economy, and our society as a whole.

1 IN 4 PEOPLE will experience a mental health problem during their lifetime

1 IN 10 MEN AND 3 IN 10 WOMEN have had a previous psychiatric admission before they entered prison[2]

1 IN 10 CHILDREN between 5 and 16 years has a mental health problem

AMONG PEOPLE UNDER 65 nearly half of all ill health is mental illness

SUICIDE is the biggest killer of men under 49 in the UK

1 IN 6 adults have a mental health problem at any one time

People with severe mental illnesses such as schizophrenia **DIE AROUND 20 YEARS EARLIER**

1 IN 5 MOTHERS suffer from depression, anxiety or psychosis during pregnancy or in the first year after childbirth

SUICIDE is the second leading cause of maternal death

3 OUT OF 4 PEOPLE with mental health problems receive no support

9 OUT OF 10 people in prison have a mental health, drug or alcohol problem[1]

PARTICULAR GROUPS OF PEOPLE ARE AT GREATER RISK OF MENTAL ILLNESS, including Black, Asian and minority ethnic communities

1. Five Year Forward View, NHS England 2014
2. Source - Prison Reform Trust: http://www.prisonreformtrust.org.uk/projectsresearch/mentalhealth

ACROSS OUR REGION, MENTAL ILL HEALTH IS HAVING A HUGE IMPACT

1 IN 4
adults in the West Midlands have a mental health problem

477 PEOPLE
lost their lives through suicide in the West Midlands in 2015

AROUND 1 IN 5
people using mental health services were also using alcohol or substance misuse services

These figures demonstrate the scale of the effect of poor mental health and the challenges faced by those who experience them.

The Health Services Management Centre at the University of Birmingham has also analysed and estimated the economic costs of poor mental health and wellbeing within our region[3]. They found mental health is having a massive impact:

£12.6 BILLION
= estimated cost of mental ill health to the West Midlands

JUST OVER £1 BILLION
= cost of presenteeism per year[4]

6.9 average sick days someone takes in our region – around 40% could relate to a mental health problem[5]

4.159 MILLION
estimated working days lost for mental health reasons

JUST OVER £0.5 BILLION
= cost of mental health related sickness absence per year

70,000 PEOPLE
cannot work due to mental health problems in the region

£1 BILLION
= cost of crime related to mental health problems

NEARLY £1 BILLION
= NHS spending on mental health problems per year.[6]

AROUND £1.7 BILLION
= cost of lost output and productivity by employers in our region

JUST OVER £2 BILLION
= cost of mental health related economic inactivity per year

WE MUST address the causes of poor mental health and wellbeing, do much more to prevent mental ill health, and also ensure access to high quality specialist services, to improve people's lives.

3. Newbigging, K. and Parsonage, M. (2017). Mental Health in the West Midlands Combined Authority. University of Birmingham: Health Services Management Centre.
4. When people who are unwell turn up for work but are less productive
5. Analysis for the Commission
6. Around 1/4 is spent in primary care, and around 3/4 in secondary care

MENTAL HEALTH IN MINORITY GROUPS AND VULNERABLE COMMUNITIES

Mental health problems can affect everyone, regardless of their background. Many factors influence the risk, including social and economic factors, and physical environment.

People from Black, Asian and minority ethnic (BAME) communities, and other minority groups such as lesbian, gay, bisexual and transgender (LGBT), the homeless, those dealing with addictions and those in contact with the criminal justice system, are at higher risk of experiencing mental ill health, and are less likely to seek and access support. Specific issues relating to their mental health needs can be ignored or can be a secondary consideration in the design of mental health services. Given that our region is so diverse, we must consider the needs of these minority groups and ensure that they are met.

The issues relating to mental health in these groups are often ignored and there are acknowledged failures within the system that disadvantage people from these communities.

FOR EXAMPLE, BLACK BRITISH MEN:

- are more likely to be diagnosed and admitted to hospital for schizophrenia[7]
- are more likely to be detained under the Mental Health Act[8] and have more difficulties accessing care[9]

We must act to improve the mental health of all the citizens in our region.

In the actions we have committed to, we have sought to address a number of issues of particular concern to minority groups and vulnerable communities. Our objective is to ensure that everyone affected by mental ill health in this region benefits from the actions we are pursuing.

To ensure we meet the needs of those people and communities who are particularly disadvantaged, the WMCA will appoint a panel of Equality Champions. See page 72.

7. Fearon P, Kirkbride J, Morgan C et al (2006) Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the MRC AESOP Study . Psychological Medicine, 36, 1541-1550
8. Singh SP, Greenwood N, White S, Churchill R (2007) Ethnicity and the Mental Health Act 1983, British Journal of Psychiatry, 191, 99-105
9. Bhui K, Stansfeld S, Hull S et al (2003). Ethnic variations in pathways and use of specialist mental health services in the UK. British Journal of Psychiatry, 182, 105-116

SECTION SIX

WORKING TOGETHER TO MAKE A DIFFERENCE – A CONCORDAT FOR ACTION

We are aware of the risk faced by many commissions - that worthy recommendations fail to get translated into actions, so no one actually benefits. So we have taken a different approach.

To ensure that all key organisations in the WMCA play their part, we decided to seek an agreement whereby organisations commit to action – **a Concordat for Action for the West Midlands**. This is a significant statement of commitment and common purpose that has been shared, agreed and signed by senior representatives in the partner organisations. These organisations have subsequently agreed to implement this Action Plan.

The following Concordat for Action statement demonstrates our commitment to improving mental health and wellbeing in people within our region:

"WE WILL work together to improve mental health and wellbeing, to reduce the burden of mental ill health across the West Midlands. We will work to improve people's lives and to encourage healthy communities.

WE WILL ensure services meet the needs of people with mental ill health and are provided with empathy and compassion. We will involve people who have experienced mental ill health and their carers at the earliest opportunity in decisions about services.

WE WILL work together to develop and deliver the actions in this Action Plan across the West Midlands Combined Authority area."

This approach has resulted in this Action Plan. Key organisations across the West Midlands have worked together to develop and shape it, informed by a set of clear principles. The organisations and leaders have agreed and accepted the actions set out in this plan, and have signed up to demonstrate their commitment to implementing the plan in full.

They have accepted responsibility to work together to improve the mental health and wellbeing of the people within our region. They will work together over the next two years, and on a longer term basis, to make this Action Plan a reality.

PRINCIPLES

GUIDING EVERYTHING WE DO

1. OUR CORE PURPOSE
to promote healthier communities by reducing the impact of mental ill health

2. WE WILL DO THIS THROUGH PREVENTION
and improving access to compassionate and high quality treatments that stop people's health deteriorating

3. WE WILL EMPOWER PEOPLE
to take more control of their lives

4. WE WILL GIVE A STRONG VOICE
and listen to people who have personal experience of, or cared for, loved ones with mental ill health

5. WE WILL PROVIDE A HOLISTIC APPROACH
- services must support both physical and mental health recovery

6. WE WILL ENSURE
services intervene early

7. WE WILL COLLABORATE
with others and work with diverse communities to address inequalities that exist between different groups and ensure equal treatment for all

8. WE WILL USE DATA BETTER
to ensure effective and efficient use of resources

WE HAVE TRANSLATED THESE PRINCIPLES INTO THIS ACTION PLAN, WHICH WILL HAVE A REAL IMPACT ON PEOPLE'S LIVES.

With colleagues in the USA, Scandinavia, Australasia and other parts of the UK, we're building a global network of cities pursuing major initiatives on mental health and wellbeing. We want this to become a growing movement of change. With the help of the International Initiative for Mental Health Leadership (IIMHL), we are building links with key leaders in these cities, and sharing learning, ideas and programmes of work with each other, so we are using the best examples of evidence and innovation to shape our work.

SECTION SEVEN

PEOPLE WITH EXPERIENCE OF MENTAL ILL HEALTH HAVE PLAYED A VITAL ROLE

Too often, people with mental health needs feel let down. They either don't receive adequate care, or it is simply not designed to meet their individual needs.

To help ensure our Action Plan is fit for purpose, we wanted people with experience of using mental health services, either for themselves or for people they care for, to get involved and influence our decision making. We were clear that they wouldn't just endorse decisions that have already been made.

We are very grateful to people from across the West Midlands who joined our Citizens Jury, and who have played a vital role in developing this Action Plan. This diverse group of people have actively participated in this project and helped us to shape this Action Plan.

People with experience of mental ill health will continue to shape our work in the future, and will have a key role in the governance arrangements to ensure that things get done.

You can read the full Citizens Jury report at
www.westmidlandscombinedauthority.org.uk/mhc

SECTION EIGHT

OUR PLAN OF ACTION – WHAT WILL WE DO?

It would have been impossible to consider every factor that influences mental health straight away. So the region has concentrated on areas where we feel we can have the most immediate impact.

This is the start of a journey. In the long run, the region will develop a whole life approach so we achieve the best results for people. But first the Commission is focusing on people of working age. Getting the foundations right in childhood is vital, so that will be a focus of the WMCA's future work. The WMCA will look at this as part of a broader 'Best Start in Life' programme.

As far as possible, our actions are based on evidence of what works, and what will make a difference to people's lives. Where evidence is lacking, we aim to test ideas and to build evidence, which will guide and inform our future actions.

OUR PLAN OF ACTION

Our Action Plan has five themes:

1. SUPPORTING PEOPLE INTO WORK, AND WHILST IN WORK
2. PROVIDING SAFE AND STABLE PLACES TO LIVE
3. MENTAL HEALTH AND CRIMINAL JUSTICE
4. DEVELOPING APPROACHES TO HEALTH AND CARE
5. GETTING THE COMMUNITY INVOLVED

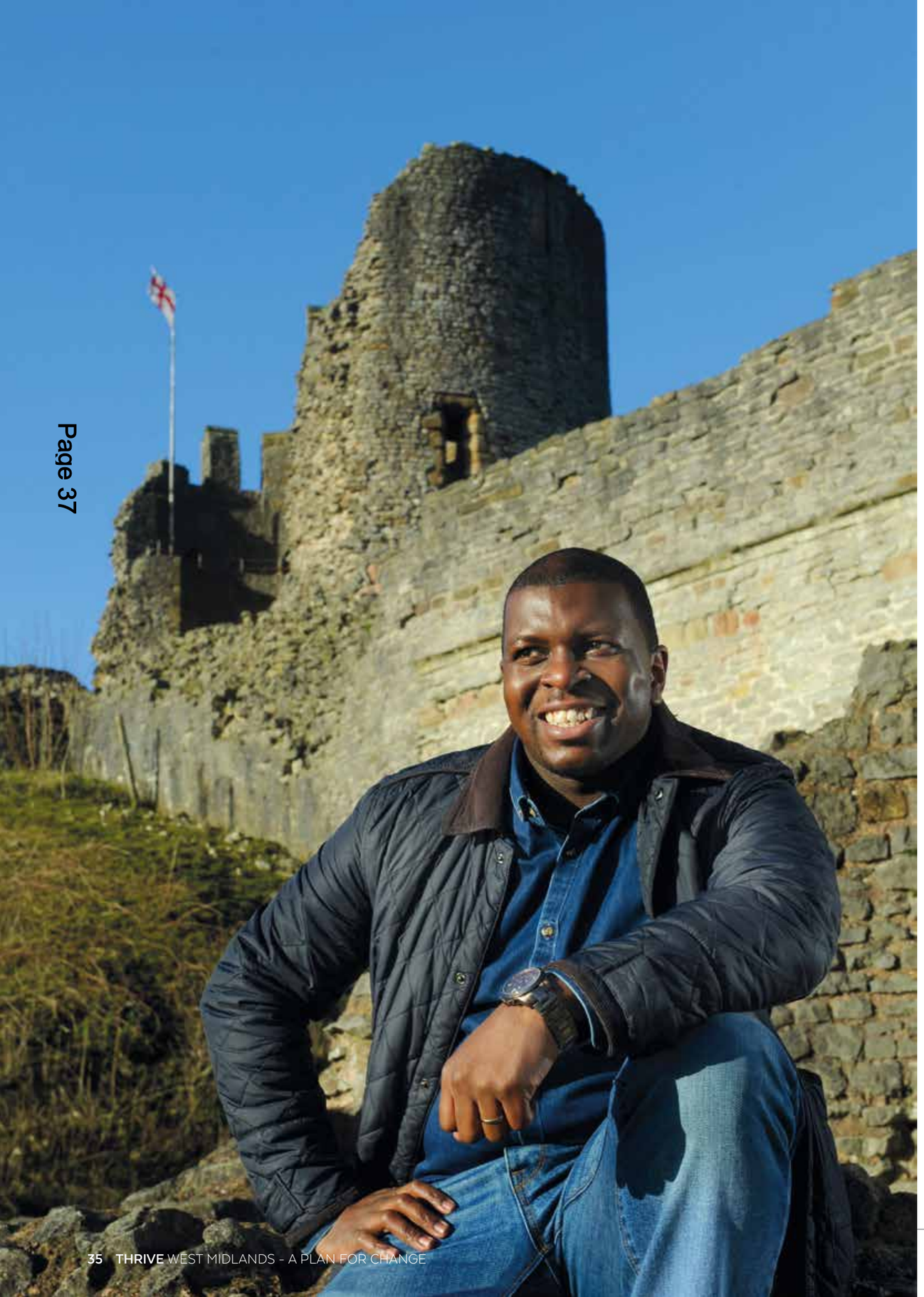
This Action Plan has a whole system approach. We aim to improve mental health and wellbeing in a number of ways, from housing, to criminal justice, to work. The actions are inextricably linked, forming a coherent whole and complementing each other. For example, intervening early features frequently across a number of our actions.

Action Checklist **Every one of our actions**:

- ✓ is consistent with the principles we have set out to follow
- ✓ is informed by the evidence we have received and reviewed
- ✓ has been cross-referenced and influenced by the Citizens Jury recommendations to ensure they have addressed concerns and needs of people with mental ill health
- ✓ will require a coordinated approach to delivery.

Local organisations must actively work together to implement them and to make them a success.

For most of the actions, work has already begun or plans are in the pipeline.



SECTION NINE

OUR PLAN OF ACTION IN DETAIL

In this section of the report, you can find out more about each action, how they'll be delivered and the difference they could make to people with mental health needs.

THEME 1

SUPPORTING PEOPLE INTO WORK AND WHILST IN WORK

Work is good for our mental and physical health and wellbeing, while being unemployed has a negative effect[10]. People in the UK who are unemployed are between 4 and 10 times more likely to develop anxiety and depression[11]. Helping people into work also benefits the local economy. It boosts productivity by reducing unemployment, and therefore reducing welfare benefit spending.

But challenges remain for people with mental ill health in gaining and maintaining employment, sometimes because of negative attitudes and stigma, and concerns from employers who are less knowledgeable about mental health. Those with mental ill health are more likely to stop working than the general population and other disadvantaged groups. In 2014, we estimate that around 69,800 people in our region were economically inactive for mental health reasons - they were not working, but may not necessarily be registered as unemployed.

In our region the number of people working while being on the Care Programme Approach (CPA) varies widely between the Clinical Commissioning Group (CCG) areas[12] . The CPA is the way that health and social care services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or related complex needs, who need specialist care and support.

Making a difference

These actions can make a real impact by helping people with mental health needs back into work.

10. Is Work Good for Your Health & Wellbeing? Waddell, G. & Burton, K. 2006 London TSO
11. Ref - Lelliott, P., Tulloch,S ., Boardman, J ., Harvey, S., Henderson, H. 2008. Mental Health and Work. Royal College of Psychiatrists.
12. Newbigging, K. and Parsonage, M. (2017). Mental Health in the West Midlands Combined Authority. University of Birmingham: Health Services Management Centre.

Action 1

HELPING PEOPLE WITH MENTAL HEALTH NEEDS BACK TO WORK

We will launch a three year programme, starting in 2017, to expand evidence-based supported employment provision in line with the principles of the Individual Placement and Support (IPS) model. The programme will work with people with severe and enduring mental health issues, common mental health issues and potentially people with chronic physical health issues, who are being treated in a primary care setting. This programme, which is subject to ministerial approval, would be internationally significant in its scale and scope.

What is IPS?

IPS is a 'place then train' supported employment model, in which trained employment specialists work intensively with clients to quickly help them find paid, competitive work and then continue to support them and their employer for as long as necessary. The central principle of IPS is that paid employment (full or part-time) is a realistic goal for everyone who wants a job[13]. It also aims to get people into competitive employment, is open to everyone who wants to work, tries to find jobs that people want to do, and brings employment specialists into clinical teams so that health treatment and employment support are tightly linked. Employment specialists also develop relationships with employers to identify jobs that meet their client's work preferences.

Why IPS?

Supported employment, including Individual Placement and Support (IPS), is a proven way to support people to gain work. Several international studies have shown that people find jobs quicker and stay in employment for longer. Using IPS with young people who present with a first episode of psychosis can increase employment success by as much as 85%[14,15] . The Five Year Forward View for Mental Health recommended that access to IPS across England should be doubled by 2020/21.

There is evidence that IPS services saves around £3,000 a year because of reduced use of mental health care. These savings may be sustained for a number of years and compare with a one-off cost of IPS support of around £2,700 per client.[16]

Who will we work with on this?

Subject to final ministerial approval, we will be working with the Government's Work and Health Unit and NHS England, alongside the local NHS, Academic Health Sciences Network (AHSN) and employers to deliver this project. It will supplement existing resources currently invested by the West Midlands in employment services, such as existing IPS services in Coventry, Dudley and Walsall and the BITA Pathways service in Birmingham.

Our progress and vision

The Government funding will boost the investments already being made to expand IPS for people with mental ill health across our region.
We have received the go-ahead to design the large scale trial. Once we receive final ministerial approval for the agreed design, we will establish a team to make this a reality. They will establish the services we will use and set up contracts, monitor performance, work with local and national stakeholders, and evaluate the programme on an ongoing basis.

The difference this could make

IIPS represents the best-evidenced model of support to enable people with mental health problems to get into work in the world. This programme is ambitious, and could help a significant number of people in the West Midlands with mental health needs over the next five years to secure employment, speeding up their recovery and giving them more independence. It will reduce the welfare bill and demand on mental health services funded by public money.

13. Doing what works: IPS into employment Sainsbury Centre for Mental Health 2009
14. Vocational intervention in first-episode psychosis: individual placement and support v. treatment as usual. Killackey, E., Jackson, H.J. and McGorry, P.D., The British Journal of Psychiatry, 193(w2), pp.114-120. 2008
15. Making the case for IPS supported employment. Bond, G.R. and Drake, R.E., Administration and Policy in Mental Health and Mental Health Services Research, 41(1), pp.69-73. 2014.
16. Priorities for Mental Health, Centre for Mental Health, January 2016

Mental health in the workplace

Two thirds of UK staff feel scared, embarrassed or unable to talk about mental health concerns with their employer. Staff worry about being demoted, missing out on promotions, being seen as less capable or judged negatively, or even losing their jobs[17]. Fearing possible stigma or discrimination, staff turn up for work even if feeling unwell, but they cannot function as normal. Otherwise they may take lengthy periods of sickness absence.

Mental ill health has a significant impact on employers. At any one time nearly one in six of their workforce is affected by a mental health condition such as depression or anxiety[18]. If people leave due to mental ill health, they must recruit new staff, which costs the employer money, and sickness absences pile on further costs. Mental health related absences cost UK employers an estimated £26 billion per year[19]. In our region alone, employers experience around £1.72 billion per year lost output and productivity because of mental health problems in working people.

Public and voluntary sector organisations are far more likely to support employees who experience mental health problems compared to the private sector[18].

But overall, many people are not clear about how their employer supported people with mental ill health, if at all[18].

A healthy workplace leads to happier, more engaged and loyal staff, and a more productive business. A business that commits to wellbeing will retain staff and attract new employees. Costs related to sickness absence will fall and work performance and productivity will rise.

Better managing mental health in the workplace, including preventing and spotting problems early, could save employers 30% or more of the costs outlined in the previous section[20].

A 'whole workplace approach' is needed to improve mental health and wellbeing and create a positive and mentally healthy working environment for all[21]. Effective action includes ensuring that there are supportive managers who help support people's development, and creating a working environment that fosters a sense of ownership and commitment amongst staff.

Making a difference

These actions can make an impact on mental health and wellbeing in the workplace. They can improve lives, boost productivity, cut costs for business, reduce the number of people who end up out of work and claiming benefits, and reduce costs for the NHS.

"Back into work schemes are really important - being in work is good for mental wellbeing, building confidence and combating isolation"

Member of the Citizens Jury

17. How to be mentally healthy at work Mind 2013
18. Employee Outlook CIPD July 2016
19. Mental health at work Centre for Mental Health 2007 http://www.centreformentalhealth.org.uk/employment-the-economic-case
20. Employment: the economic case Centre for Mental Health 2007
21. Written evidence paper to Commission Mental Health Foundation 2016
22. Public Health England paper for the Commission 2016

Action 2

ENCOURAGING EMPLOYERS TO LOOK AFTER THE MENTAL HEALTH AND WELLBEING OF THEIR STAFF

We will launch a 'West Midlands Workplace Wellbeing Commitment' in Spring 2017, where public and private sector employers sign up to demonstrate their commitment to the mental health and wellbeing of their staff.

What is a Wellbeing Commitment?

This local, voluntary commitment is based on the Public Health England Workplace Wellbeing Charter national standard that provides employers with a structured approach to workplace health and wellbeing. Employers will also be given a toolkit to help them improve mental wellbeing in particular. They can implement a range of measures that could help keep their staff well, such as mindfulness, cognitive behavioural therapy (CBT), or line manager training.

Why do this?

We believe this will enable employers in both the public and private sector to take a new approach to the wellbeing of their employees, helping them be more productive and creating more attractive places to work.

Who will we work with?

We will do this in association with Public Health England (PHE) West Midlands and the Chartered Institute of Personnel and Development (CIPD). We'll also collaborate with local employers, Business in the Community and local Chambers of Commerce. We will look to develop a local approach, based on the PHE mental health toolkit for employers.

Our progress and vision

We have worked with our partners to shape plans for this Wellbeing Commitment across our region, building on the excellent work already underway in Coventry. We want the number of employers who are signed up to the Charter in our region to grow, so that we build a growing movement of change.
We want all public sector employers in our area to lead by example. In our first year, our ambition is to recruit 200 organisations from a whole range of sectors to this initiative, and for this to move towards 500 by the end of year two. This will create a cultural shift in the way we provide wellbeing approaches to our staff. A baseline assessment will be conducted across the region with a number of key initiatives being developed which will focus on retaining people in the workplace and enabling organisations to develop improved services for staff who are off sick.

The difference this could make

This initiative could improve employers' perception of mental health and wellbeing so they provide more effective support for their staff to help them to keep well. As well as making a difference to people's lives, employers will also benefit economically. The National Institute of Clinical Excellence (NICE) estimates that implementing interventions to promote staff wellbeing could save employers between £130 and £5,020 per participating employee, by reducing absence or illness at work[22]. We want employees in the 500 organisations to see a difference by 2020.

Action 3

ENSURING THE WELLBEING COMMITMENT HAS A WIDER REACH

We will encourage companies bidding for public sector contracts to sign up to the West Midlands Wellbeing Commitment, or demonstrate an equivalent commitment to the wellbeing of their staff. We will also encourage large companies in the region to have an expectation that companies in their supply chain also commit to such standards.

Why do this?

We want to ensure that our regional Wellbeing Commitment has as wide a reach as possible – and the biggest impact on employers' attitude to their staff's mental health and wellbeing. We believe that it is reasonable to expect any company tendering for a contract funded by public money to demonstrate they have a clear commitment to the wellbeing of their staff.

Our progress and vision

A group of employment experts including the Chartered Institute for Personnel and Development (CIPD) together with business leaders, councils, police and healthcare employers from the West Midlands, are working together to develop and implement the Wellbeing Commitment. One exciting initiative is already being led by the local authority in Coventry - a number of businesses have already signed up to it, and although it is early days, evidence suggests it is making a difference.

Our vision is that when companies tender for public sector contracts, those signed up to the West Midlands Wellbeing Commitment or who demonstrate similar commitments to the wellbeing of their staff will be considered positively by the public body concerned.

The difference this could make

This action will ensure that the impact the wellbeing commitment makes spreads as far as possible in our region, making a difference to many people with mental ill health and helping to prevent their health deteriorating. We believe we can have a positive impact on productivity, reduce costs to business, reduce costs to the NHS and reduce the costs of benefits in our region.

Action 4

EVALUATING A FINANCIAL INCENTIVE TO ENCOURAGE EMPLOYERS

We will work with the Government to trial an innovative 'Wellbeing Premium', a tax incentive that rewards employers demonstrating their commitment to mental health and wellbeing. This trial will reveal if such a financial incentive, accompanied by an employer action plan, reduces staff sickness absence, improves productivity and prevents people leaving work due to mental ill health.

What is the Wellbeing Premium?

The Wellbeing Premium is a financial incentive for employers who demonstrate their commitment to the wellbeing of their workforce by implementing measures that we know can help people's mental health and wellbeing.

Why do this?

We believe we must get employers more engaged in the wellbeing of their staff. Improving staff mental health and wellbeing could have a massive impact, reducing sickness absence, improving productivity, preventing people losing their jobs and reducing NHS costs. In its Five Year Forward View, NHS England highlighted the potential value of developing new workplace incentives to promote employee health and cut sickness-related unemployment[23]. It stressed the importance of engaging employers more effectively in the wellbeing of their workforce and suggested there would be merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees.

Who will we work with?

We will work with Public Health England, the Department for Work and Pensions (DWP) and the Treasury in the Government, and NHS England, together with the local Chambers of Commerce to do this.

Our progress and plans

We will continue to work with the Government's Health and Work Unit, the Treasury and Public Health England to design this Wellbeing Premium – essentially it would give companies a financial incentive, which might include a discount on their business rates, in return for action to improve the wellbeing of their workforce. If we can secure funding for a trial, we will initially look for 100 employers of all sizes, from small businesses to large companies, to trial and evaluate this Wellbeing Premium. In return for a financial incentive, companies would commit to implementing key actions which we know work, such as a line manager training programme, a mental health first aid programme, and giving a board member direct responsibility for wellbeing and for implementing the interventions. This is the first time such a scheme has been pursued in this country – it would be ground-breaking and internationally significant.

The difference this could make

This trial will last two years and will reveal if a financial incentive such as this Wellbeing Premium works. If it is successful, the trial will pave the way for a Wellbeing Premium to be rolled out to employers across our region, and potentially, nationally. We envisage that, if rolled out, it would entitle companies to receive the Wellbeing Premium for two to three years. In that time, we believe companies will see improvements in productivity, reduced sickness absence and greater profitability. As those benefits accrue, public subsidy would no longer be required.

23. Five Year Forward View NHS England 2014

THEME 2

PROVIDING SAFE AND STABLE PLACES TO LIVE

A settled home is vital for good mental health. People with mental health problems are less likely to be homeowners and more likely to live in unstable environments. Housing support can improve people's health and help reduce overall demand for health and social care services.

The national Commission on Acute Inpatient Psychiatric Care for Adults (CAAPC) and NHS England's Five Year Forward View for Mental Health both recognise that housing is important in preventing mental health problems and promoting recovery[24].

In 2014, just under two thirds of people aged 18-69 being treated by secondary mental health services were living in settled accommodation. Even when in accommodation, the risk of common mental health problems is almost double for people living in fuel poverty – and this costs the NHS in England around £859 million each year.[25] Stress caused by housing insecurity or sub-standard housing may exacerbate people's vulnerabilities, worsening their condition, increasing the likelihood of relapse and/or the need for an inpatient admission.[26, 27]

Many people who are homeless also suffer mental ill health. Some people experience a period of sustained housing, followed by a crisis, they lose the tenancy, then are homeless before stable housing is secured again. Mental ill health and drug and alcohol misuse is one of the factors that fuel this cycle.

Making a difference

We must take action to provide safe and stable places to live for people with mental ill health.

24. Five Year Forward View for Mental Health February 2016
25. No health without mental health Supporting document: The economic case for improving efficiency and quality in mental health 2011
26. Mental Health and Social Exclusion, Social Exclusion Unit 2004, Office of the Deputy Prime Minister
27. A basic need: housing policy and mental health Bradshaw, I. Centre for Mental Health 2016
28. Housing First in England An evaluation of nine services Bretherton J & Pleace N University of York February 2015

Action 5

HELPING PEOPLE TO GAIN HOUSING AND WORK

We will build on great work already happening on our region by trialling an innovative scheme to offer a Housing First service with intensive mental health support in the West Midlands. This scheme will support those with complex needs or who are homeless to move into good quality housing and, where possible, into work.

What could this scheme look like?

A number of housing initiatives exist that could help us achieve this. One of these is called 'Housing First' - a form of supported housing which works on the principle that getting someone into a secure home immediately with the right level of support, without needing to go through a series of stages to attain 'housing readiness', helps them address mental ill health, substance misuse and alcohol issues more effectively. It regards housing as a basic right, and emphasises self-determination, choice and a recovery-orientated approach. The housing provided is permanent with a secure tenure, and the offer of housing is not conditional on receiving treatment although support can be offered on a long term basis if required.

Why do this?

Housing initiatives could complement and enhance current housing provision in our region, and could improve mental health and wellbeing, reduce crime, and tackle homelessness. The Housing First approach has already been adopted in Camden, London and in nine other centres in England on a small scale. A recent study found Housing First successfully engaged with long-term homeless people with often very high support needs, delivered housing sustainment and showed progress in improving health, well-being and social integration. It could also save the public purse between £3,048 and £4,794 per person by creating a more holistic approach where organisations are collaborating to work directly with individuals, and their families and carers.[28]

Our progress and plans

A regional pilot of the Housing First model is already taking place in the West Midlands, providing accommodation and support for vulnerable adults with complex needs. We will build on this great work by trialling an innovative scheme to offer a Housing First service with intensive mental health support in the West Midlands. We are now developing these plans.

Who will we work with?

We have been working closely with local authorities, housing associations, and national voluntary sector agencies including Housing First England, a charity which runs social enterprises called BITA Pathways, St Basil's, Changing Futures, Birmingham Voluntary Service Council (BVSC) and Crisis.

The difference this could make

We believe that housing initiatives, including Housing First, provide an opportunity to deliver housing and support that can promote independence and recovery for people with mental health needs. They will ensure that access to housing becomes the central component of the wider package of the support they receive, laying the foundations for successful treatment and recovery, and the potential for employment.

THEME 3

MENTAL HEALTH AND CRIMINAL JUSTICE

People who have been through the criminal justice system are more likely to experience poorer health than the general population. Mental health problems, including conditions such as depression and anxiety as well as more severe mental health problems such as psychosis and personality disorders, have been found to be more prevalent among offenders than the general population[29].

The Bradley Report[30] identified that there are more people with mental ill health in prison than ever before and that being in custody can increase the risk of suicide and self-harm. According to the Ministry of Justice, 107 people in prison took their own lives in the year up until September 2016 - that's almost double the number in 2011-12[31]. The number of self-harm injuries in prisons rose by 26% in the year until June 2016 – around 100 per day. In men this statistic has more than doubled in six years.

For many people, leaving prison is a time of crisis[32]. Commissioned mental health care in prisons is limited except for those with the severest problems and care after leaving prison is particularly lacking for those with short sentences.

Access to mental health support is essential for people throughout the criminal justice system and when they return to the community. The Bradley Report recognised that the majority of offenders with lower-level mental health disorders are not dangerous and could be better treated outside the prison system without any risk to the public. Support when people leave prison must be holistic, starting with basic needs such as accommodation, money and safety.

29. Transforming Rehabilitation: a summary of evidence on reducing reoffending. Ministry of Justice 2013
30. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/562897/safety-in-custody-bulletin.pdf
31. www.gov.uk/government/uploads/system/uploads/attachment_data/file/562897/safety-in-custody-bulletin.pdf
32. Mental Health and Criminal Justice Durcan, G. Centre for Mental Health 2016
33. Offender HNA and Consultancy projects West Midlands Prison Health Needs Assessment 2014-15 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449652/HMP_Birmingham_HNA_West_Mids_2015.pdf
34. COCOA: Care for Offenders Continuity of Access Byng, Prof. R. et al HMSO 2012

The Government's Transforming Rehabilitation policy outlines the strategy for reducing reoffending rates and, in doing so, is reducing the number of victims and the costs to the taxpayer. The policy acknowledges that, whilst there is a need to punish people when they break the law, there is also a need to support people so that they do not commit crime in the future. It suggested that local partnerships that bring together the full range of support, be it in housing, employment advice, drug treatment or mental health services would be central to success.

Our region is already leading the way

Health and criminal justice agencies have already made a concerted effort to improve the way the system supports those with mental ill health who enter the criminal justice system. They have implemented the national agreement to improve crisis care (the Crisis Care Concordat), developed street triage (notably in the West Midlands), and have provided mental health in-reach services in prisons.

The West Midlands is leading the way in a number of areas. Mental health nurses operate within all of the custody facilities across the West Midlands Police Force area under the Liaison and Diversion from custody programme. Liaison and Diversion services link directly into the local Crown and Magistrates courts to identify offenders of any age who have mental health, learning disability or substance misuse vulnerabilities and refer them to appropriate services for support and treatment. The West Midlands is the only police force with 100% coverage of Liaison and Diversion services ahead of the national roll-out deadline of 2019. Our region has developed robust approaches to reduce the use of police cells for people detained under Section 136 of the Mental Health Act.

There are 12 prisons in our region. Around 3,700 adult male prisoners are referred to primary mental health care in prison every year[33]. But there are gaps in provision relating to primary care mental health and counselling. Addressing offenders' mental health problems would have a number of benefits - improving their health, improving the wellbeing of their families and communities, and having wider economic and social benefits by reducing reoffending[34].

Making a difference

Despite big improvements, the issues remain as challenging as ever. We have therefore focused our actions on two areas of work, where we think we can make the biggest impact in relation to criminal justice and mental health.

Action 6

DIVERTING PEOPLE FROM THE CRIMINAL JUSTICE SYSTEM

We will help to implement a programme to make more regular and widespread use of the Mental Health Treatment Requirement (MHTR) in the Magistrates and Crown Courts.

What is the MHTR?

The MHTR is a sentencing option which offers offenders with mental health problems the option of a treatment plan that addresses the underlying causes of offending. It is intended for the sentencing of offenders convicted of (an) offence(s) and who have a mental health problem which does not require secure in-patient treatment[35].

Nationally, the MHTR is rarely used. Aside from the fact that many people may not meet the threshold for a service from specialist mental health services, other barriers to use include a lack of suitable mental health community services in many places, poor processes at the court stage to ensure assessments are readily available to magistrates, unwillingness on the part both of offenders and of psychiatric services, and poor liaison between probation and community mental health treatment providers[36].

Why use the MHTR?

Where MHTRs have been used, people value the stability it can help to bring[37]. There is also emerging evidence from a site trialling MHTR in Milton Keynes that uptake can be increased significantly (and successfully) by having a more proactive approach and having clear arrangements between the courts, health providers and probation services, and Community Rehabilitation Companies (CRCs).[38] The Milton Keynes trial is beginning to show evidence of improved mental health and wellbeing, better coping skills and improved criminal justice outcomes.[39]

Our progress and plans

Although the evidence is still building, we believe more MHTRs should be used. We have already started to examine how to extend the use of MHTRs in our region and have had positive discussions with the Ministry of Justice, CRCs, local court officials and magistrates. We will now work together to establish a programme to ensure much more regular and widespread use of the Mental Health Treatment Requirement as a sentencing option. We have started work in three pilot areas - funding from the Office of the Police and Crime Commissioner (OPCC) will support projects in Coventry and Wolverhampton, and funding from NHS England will support a project in Birmingham.

Who will we work with?

We will work with the Police and Crime Commissioner's Office, the local Community Rehabilitation Company, National Offender Management Service (NOMS), community health commissioners and providers, and the prison service on this programme.

The difference it could make

This programme should help recovery, reduce reoffending, and reduce the cost and impact of crime on the local community. By linking to IPS (see action 1), it could help people back into employment. MHTR offers offenders a choice and an opportunity to regain some control over their lives, giving them the chance to stay in the community and in touch with existing support systems and networks. It shows they are valued as members of society, as opposed to a problem to be dealt with.

35. MHTRs – A guide to integrated delivery National Offender Management Service
36. A Missed Opportunity: Community Sentences and the Mental Health Treatment Requirement' Khamon, Samele & Rutherford Sainsbury Centre for Mental Health 2009
37. The Mental Health Treatment Requirement. Scott G and Moffatt S Criminal Justice Alliance and Centre for Mental Health 2012
38. Mental health and criminal justice Durcan G. Centre for Mental Health 2016
39. http://www.academyforjusticecommissioning.org.uk/wp-content/uploads/2015/01/MHTR-seminar-pres-140115.pdf

Action 7

SUPPORTING PEOPLE WITH MENTAL HEALTH NEEDS WHEN THEY LEAVE PRISON

We will develop a programme that more effectively supports people with mental ill health as they prepare to leave prison and settle back in the community.

Why do this?

When people with mental ill health leave prison there is generally little coordinated support to help them manage their condition. Too often they reoffend and the cycle starts over again.

What initiatives are happening across the country?

There are a number of initiatives taking place across the country that could help us develop this programme.

The Engager project is a five year project taking place in the North West and the South West to develop and evaluate a collaborative care intervention that engages with offenders with common mental health problems, who are close to release, and to set up a pathway of care in preparation for discharge and for up to 16 weeks out in the community. The intervention aims to overcome a number of challenges this group face, including the transition between prison and community, fragmented services based on diagnosis (e.g. substance misuse, depression) and social problems (homelessness, unemployment).

Another national initiative is 'Through the Gate' - a National Offender Management Service/ Community Rehabilitation Company (CRC) led programme to identify opportunities to resettle people as they leave prison. Working with providers, plans are put in place to ensure housing, health and social needs are addressed prior to release, and they work with people for a fixed period after release.

Who will we work with?

We will work with the Police and Crime Commissioner's Office, the local Community Rehabilitation Company, National Offender Management Service (NOMS), community health commissioners and providers, and the prison service on this programme.

Our progress and plans

We believe the Through the Gate and Engager projects are emerging as effective ways to help offenders with mental health needs when they leave prison. As a result, we will develop a programme of work based on these projects within the prisons in our region. We aim to build on the Engager project involving a trial in two prisons in Manchester and Plymouth. We will develop our first programme based on the Engager project in a prison in our region. This programme will support people with mental ill health more effectively from before they leave prison through to release, and while they re-establish themselves back in the community.

The difference it could make

We need to address the challenges faced by people with mental ill health as they leave prison and return to the community. Preparing them for the transition will help them maintain good mental health, and gain access to accommodation, training or work. Having access to services and support will also help to reduce the chances of reoffending.

THEME 4

DEVELOPING APPROACHES TO HEALTH AND CARE

Mental ill health can affect anyone of any age, or from any community. It is vital that people with mental health needs get the right support to treat their condition, as quickly as possible. Neglecting mental ill health can have dreadful consequences for those affected and for their loved ones. Sometimes the consequences are fatal.

In 2015, 477 people lost their lives in the West Midlands through suicide. This has a profound impact on loved ones, friends, work colleagues, and communities. Suicide and self-harm can affect anyone, but is the biggest killer of men under 49.[40] People from minority and ethnic groups are also affected - for example, a study in three cities found that Asian women aged between 15 and 35 are more vulnerable to suicide and self-harm. Self-harm is common among young African-Caribbean women.[41]

There is a growing interest in how we can support people experiencing mental ill health more effectively in primary care. Getting the support right at this point can help prevent people's health deteriorating and can aid recovery. One in four of a GP's patients will need treatment for a mental health problem at some point in their lives. But currently, our health and social care system is not set up well enough to deal with this. Although there have been some great initiatives across the country, we are not meeting patients' needs in many areas.

In the West Midlands, we are not meeting the new national access standards for early intervention in psychosis (EIP) and for psychological therapies. When people are admitted as inpatients in secondary care hospitals, they do not always get the most therapeutic care, with too many cases of people being moved around the country in search of a bed, and too much use of restraint in inpatient wards.

Making a difference

We have identified a number of actions which apply the guiding principles we set out to follow. They address the priorities of improving access to support, intervening more quickly, providing compassionate evidence-based care to meet individual needs, and giving power to people to have a say over their care.

40. Office for National Statistics 2014 (http://visual.ons.gov.uk/what-are-the-top-causes-of-death-by-age-and-gender/)
41. Ethnic differences in self-harm, rates, characteristics and service provision: three-city cohort study Cooper, J., Murphy, E., Webb, R., Hawton, K., Bergen, H., Waters, K. and Kapur, N. The British Journal of Psychiatry,197(3), pp.212-218. 2010

Action 8

A COMMITMENT TO THE CONCEPT OF ZERO SUICIDE

We will launch a 'Zero Suicide Ambition' for the West Midlands - which together with the recently updated National Suicide Prevention Strategy, aims to prevent and reduce suicides across the region.

What is the Zero Suicide approach?

Professor Ed Coffey developed the concept of 'zero suicide' at the Henry Ford Hospital system in Detroit, Michigan. It is based on the concept of suicide not being inevitable and of having ambitious goals rather than planning for incremental progress. The cornerstone of the programme is Perfect Depression Care[42], which has one objective – do everything that can help address depression and avoid doing things that stand in the way of that. Patients are actively engaged and supported to talk about suicide and despair. They are also supported to rediscover hope and find ways to survive, with a continuous eye to re-engaging with and contributing to the communities in which they may live, work, and play for a lifetime. It particularly aims to reach people who have not been reached through previous initiatives and to address gaps in existing provision[43].

Why do this?

The zero suicide approach is showing promising results in the US. The Henry Ford Health System delivered a 75% drop in suicides in the first four years. For two years, there was not a single suicide amongst the patient population[44]. Suicides in the US Airforce fell by one third over six years. At Magellan Health in Arizona there was a 38% reduction in the first two years.

England's Mental Health Trusts have achieved some of the most successful reductions of suicide rates in the world, but the lack of focus on primary care and alcohol services now needs to be addressed. A small number of zero suicide ambition pilot projects in Merseyside, the East of England and the South West are evaluating the improvements they have made using creative and effective local approaches to suicide reduction[44].

The moral imperative of saving lives is what drives this approach but it also saves resources which can then be used to support others. It is hard to place a monetary value on suicide reduction, but other forms of fatality do have such measures attributed to them. Recent work by the Centre for Mental Health suggested that each case of suicide costs around £1.5 million.[45] The human cost is incalculable.

Our progress and plans

We think developing a similar approach in our region could help us significantly reduce the number of suicides. By 2020, NHS England wants to reduce suicides by 10% and for all areas to have multi-agency prevention plans in place by 2017. Inspired by the Detroit programme, but recognising that the Detroit cohort was a more affluent employed group, we will apply and adopt their methods to all our communities and develop and launch a Zero Suicide Ambition across the West Midlands. We want to build on work already being done locally, such as 'Balls to Talk', a campaign in Coventry which uses sporting themes and key messages to direct people to help and support, when they need it. The idea is to encourage people, particularly men, to talk about how they feel. We will ensure that there is an open learning culture so that, when a tragedy occurs, lessons are learnt. We will apply the lessons from Detroit and the East of England where they are adapting the concept of 'perfect depression care', ensuring, for example, that people with chronic physical health conditions who have psychological needs are identified early and get access to support without delay. We have established links with Professor Coffey and those leading the approach in Mersey Care NHS Trust in Merseyside, to learn from their experiences.

Who will we work with?

This action will involve NHS organisations, local authorities, the police, Public Health England, community organisations and the wider community.

The difference it could make

We believe that together with the multi-agency National Suicide Prevention Strategy,[46] a commitment to 'zero suicide' is an important step in reducing the incidence of suicide. We aspire to save lives. This approach challenges the assumption that for some people, suicide is inevitable.

Action 9

WORKING TOWARDS EMBEDDING MENTAL HEALTH IN PRIMARY CARE

We will establish a group of local and national experts to recommend a primary mental health care model for the region that ensures people's mental health needs are more effectively supported. We want to promote and support a new era in mental health promotion, prevention and use of best practice treatments within primary care by the end of 2018.

What happens now?

The concept of primary mental health care is still relatively new in some parts of the world. It is defined by the World Health Organisation as 'mental health care that is provided by primary care workers who are skilled, able and supported to provide mental health services.'[47] Currently, most people with poor mental health and wellbeing will have contact with primary care services through their GP practice.

Why do this?

Primary care is the main source of help for many people with mental ill health. It offers many opportunities to address mental ill health, related physical health issues and medically unexplained symptoms. But currently effective mental health support is lacking in many areas of primary care.

NHS England's Five Year Forward View for General Practice published in April 2016 set out plans to invest in an additional 3,000 mental health workers to work in primary care by 2020.[48] But it is not clear how this will happen.

In Swindon, commissioners responded to pressure on services by developing a primary care triage unit. Patients are referred there by their GP and triaged on the same day. Most people are then referred to an organisation which offers a wide range of support to anyone with common emotional and mental health difficulties, particularly anxiety and depression. This initiative has relieved pressure on the local mental health trust and has significantly reduced inpatient occupancy in adults of working age.[49]

Our progress and plans

Our region is already taking action in this area. Sandwell introduced the Sandwell Wellbeing Hub,[50] offering a range of support[51]. Other CCGs in our region are redesigning primary care mental health services to strengthen provision in primary care and the community. Birmingham South and Central CCG introduced the Edgbaston Wellbeing Hub in 2014, and Birmingham Cross City CCG has commissioned Birmingham Mind to deliver a Wellbeing Hub. Dudley CCG is introducing a new model of care[52] called a 'Multispecialty Community Provider' (MCP), which includes a network of integrated multidisciplinary teams to provide mental health and wellbeing support at a primary care level. These services have developed independently, but show that things are changing in primary care mental health.

We must embrace these developments so we better respond to the range of mental health needs in primary care settings. It must also be joined up and reflect the diversity of the local population and need, avoiding inequalities of access across the region. Resolving primary care in mental health is a huge task, and we must get it right.

We will establish a working group of local and national experts to examine evidence and recommend the best primary care model(s) for the West Midlands. This group will propose practical actions to help GPs, such as drop-down menus to help assess the physical health needs of those with severe and enduring mental ill health. It will consider the case for trialling screening in primary care to identify people with psychological needs.

In particular the group will consider issues such as:

- Social prescribing - a way of linking patients in primary care with sources of support within the community, that work alongside existing treatments to improve health and wellbeing.
- Co-ordinated triage for talking and listening therapies
- Support and training to enhance knowledge and skills of practice nurses
- Pathways for areas such as medically unexplained symptoms, perinatal mental health and psychological trauma
- Effective interventions to support physical health improvements for people with severe and enduring mental health problems

They will make their recommendations in summer 2017, with a view to implementing recommendations by the end of 2018.

Who will be in this working group?

NHS England will coordinate this group, which will be comprised of representatives from local CCGs, provider trusts, and those with national expertise. The full membership of this working group will be agreed by the Implementation Director and NHS England, but will also include:

- Dr Ian McPherson (psychologist and senior mental health leader)
- Dr Paul Turner (GP Clinical Commissioner)
- Dr Geraldine Strathdee (Commission member)
- Dr David Smart (GP Clinical Commissioner)
- Dr Rhiannon England (GP and mental health lead)
- Dr Carrie Ladd (Royal College of GPs Perinatal clinical champion)
- Dr Elizabeth England (Royal College of GPs mental health lead)

We will also seek input from the Centre for Mental Health and the Care Quality Commission.

The difference it could make

Embedding mental health in primary care will make a huge difference to people within our region. This is not just about getting people access to treatment quickly. We want people to receive the right treatment earlier before it gets more serious, increasing the chances of success.

"There were so many opportunities for early intervention and services to help but because of the disjointed approach and lack of communication, I just fell through the cracks"

Member of the Citizens Jury

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45. Zero suicides Moulin, L. Centre for Mental Health 2015
46. http://16878-presscdn-0-18.pagely.netdna-cdn.com/wp-content/uploads/2015/02/Annual_Report_acc.pdf
47. Integrating mental health into primary care: a global perspective. Funk, M., Ivbijaro, G. Geneva: World Health Organisation/WONCA 2008
48. Five Year Forward View for General Practice NHS England April 2016
49. Evidence to the Commission from Thomas Kearney, Swindon CCG
50. http://www.sandwell.gov.uk/info/200222/healthy_sandwell_healthy_you/762/mental_health_and_wellbeing
51. The Esteem Team: Co-ordinated care in the Sandwell Integrated Primary Care Mental Health and Wellbeing Service. Thiel, V., Sonola, L., Goodwin, N. and Kodner, D. King's Fund. 2013
52. Dudley is one of 29 areas selected to test a new model of care following the publication of the Five Year Forward View (5YFV) in October 2014. http://www.dudleyccg.nhs.uk/about-commissioning/integration/

Action 10

ENSURING OUR REGION TREATS PSYCHOSIS EARLY AND EFFECTIVELY

We will help to ensure the region meets national access and waiting time standards for early intervention in psychosis (EIP) services[53].

What is Early Intervention in Psychosis (EIP)?

Psychosis is a mental health problem that causes someone to perceive or interpret things differently from those around them. EIP is a safe and effective programme that identifies and treats people with psychosis, so they can receive effective treatment early and can get on with their lives.

Why do this?

Intervening early in psychosis is critical to maximise the chances of successful treatment. Disability plateaus quickly in psychosis and the early phase of the condition is a critical period to intervene to have the maximum impact in the longer term. A recent economic evaluation based on the OPUS study in Denmark shows that EIP has a 97% chance of being cost effective over five years[54]. It shows that EIP is very effective and represents good value for money - for every £1 invested in EIP a return of £15 could be expected over a ten-year period. It has shown that EIP generates costs savings of £2,234 per person over three years from improved employment and education outcomes.

Room for improvement

The evidence is clear - EIP works. But provision across the country and in the West Midlands is concerning. Half of EIP services in England have experienced budget cuts in the past four years, some by as much as 20%[55]. Current Department of Health and NHS England referral and treatment guidelines say that over half of people across the country experiencing a first episode of psychosis should be treated with a NICE approved care package within two weeks of referral. But many patients face unacceptable delays in accessing EIP services, greatly reducing their chances of recovery[55].

Our region is not immune to these issues. We are failing, nationally and in the West Midlands, to meet the access standard, with most areas failing to invest sufficient funds necessary to provide the full, evidence-based treatment programme.

Our progress and plans

Our region led the way in this area by developing EIP during the early 1990s. Now, we agree that the organisations in our region must work together to address the issues of funding and provision of EIP. NHS England will lead a programme to ensure the national standard for treatment and maximum waiting time standard are met.

Who will be involved?

This action will be led by NHS England in the region working with CCG commissioners and mental health providers, with the support of the Strategic Clinical Networks (SCNs) and Academic Health Sciences Networks (AHSNs). They will implement plans to ensure the national standard is achieved by the end of 2017.

The difference it could make

Getting EIP funding and provision right in our region could mean everyone with psychosis in our region gets access to the right treatment, quickly. NICE found that EIP services reduce the likelihood that individuals with psychosis will relapse or be detained under the Mental Health Act, potentially saving the NHS £44 million each year through reduced hospital admissions[56].

Action 11

EXAMINING THE PRINCIPLE OF EARLY INTERVENTION

We will establish a group of local and national experts to examine how the principle of early intervention should be applied to other areas of mental health care, so we could support people much earlier, whatever their age.

What does early intervention mean?

As with psychosis, intervening early with a range of mental health problems is critical to prevent it escalating and causing a range of further problems and even disability. Emerging evidence suggests that applying the principle of early intervention could benefit other disease areas alongside psychosis. There is also a powerful case for taking a whole life approach, by intervening in the early years of a child's life.

Why do this?

We believe that there are potentially large improvements that could be achieved for people by intervening earlier and intervening with effective healthcare. We want to assess the evidence for this.

Our progress and plans

We will establish a working group to examine whether applying early intervention approaches could benefit people who experience other mental health conditions. For example, it could include evaluating the impact of early interventions during a child's early years and through school. They will examine schemes such as that in Philadelphia where children are screened for multiple 'adverse child events (ACE)', such as violence, sexual abuse, and drug and alcohol addiction. Those children identified are given early support before significant mental health issues set in. The working group will report their findings by summer 2017.

Who will we work with?

Members of this group include Professor Swaran Singh (University of Warwick), Max Birchwood (University of Warwick), Karen Edwards (NHS England West Midlands), Tom Fox (Dudley Early Intervention Service), and Dr David Shiers (former GP and EIP national lead).

The difference it could make

By examining the evidence for early intervention, this action will reveal if having a clear early intervention treatment approach could enable doctors to provide the best care and improve the lives of people with mental health needs in our region.

> *" [In hospital] I was assessed to see if I was a risk to myself, but I wasn't referred to anyone, and no one checked to see if I had a support network when I got home"*
>
> **Member of the Citizens Jury**

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60. Evidence to the Commission from Prof. Tim Kendall, NHS England National Clinical Director for Mental Health
61. http://www.ardengemcsu.nhs.uk/files/7114/3265/7953/Case_Study_-_Mental_Health_Repatriation.pdf
62. http://www.covwarkpt.nhs.uk/aboutus/news-events/press-releases/Pages/September%202015/NHS-services-land-national-award.aspx

Action 12

Ending out of area placements

We will end out of area mental health hospital placements – where mental health patients are placed in an in-patient bed at a hospital outside the area of the five mental health NHS Trusts in our region – for acute mental health care by the end of 2017.

Why do out of area placements happen?

Out of area placements usually happen when the local provider NHS Trust does not have bed capacity. Out of area placements in mental health has been an issue for some time. The Commission to review acute inpatient psychiatric care provision for adults (CAAPC), chaired by Lord Crisp, highlighted out of area placements as an issue of particular concern.

In September 2015, 499 adults in England had to travel more than 30 miles, for admission to a service which should be provided locally, such as acute care, psychiatric intensive care or rehabilitation services[57]. A more recent report following a Freedom of Information Act request showed that 5,411 patients were sent to out of area hospitals in 2015-16[58]. Although some out of area placements are provided by other NHS Trusts, often these beds are purchased from independent sector mental health care providers.

Why should we stop it?

We acknowledge that occasionally, patients do need specialist inpatient care that is not available in our region. But if care is available, we should use it. We know that when people are sent out of area, there is an increased risk of suicide[59]. The distances often make it harder for family and friends to visit and this can cause additional distress for them and patients. Out of area placements are also expensive – although we have no national figures, one English NHS Trust spent £4.8 million on such placements.

New initiatives are emerging to deal with this. For example, Sheffield Health & Social Care NHS Foundation Trust has undertaken a radical programme of repatriating patients from out of area placements whilst reducing bed numbers, in part by reducing length of stay, at the same time. They have reinvested the resources saved into local provision - in a crisis house and in improved community and crisis support - which resulted in reduced admissions. The number of out of area placements fell from almost 40 to under five[60].

Our progress and plans

Great work is already happening in our region to reduce out of area placements. Over the past four years, NHS provider trusts, CCGs and a Commissioning Support Unit have worked together to repatriate 100 people, saving £12 million[61,62]. This programme has been award winning. The MERIT Vanguard, an alliance of NHS trusts in the West Midlands working to transform the way acute mental health services are provided, is leading work to reduce out of area placements.

Nationally, NHS England wants to end out of area placements for all adult acute mental health care by 2020. But we are more ambitious. We will end out of area placements for routine admissions in all mental health services, for all age groups, by the end of 2017. No one will be sent out of the area of the four Trusts making up the MERIT Vanguard. The MERIT Vanguard will establish a small working group to work out how to achieve this.

Who will we work with?

Organisations across the MERIT Vanguard, including local authorities, will be involved in delivering this action.

The difference it could make

We believe that out of area placements are bad for patients, too expensive and have a negative effect on recovery. Ending this practice will ensure people in our region receive the best care, closer to home. This is an exciting opportunity to develop pathways into and out of hospital care, acute care and supported housing, and will be an important initiative for the whole country.

Action 13

REDUCING INAPPROPRIATE INPATIENT ADMISSIONS

We will help to explore effective alternatives to inpatient care that meet the individual needs of people with mental ill health, including those in crisis, and test which work best before implementing them. We will look at successful schemes such as crisis houses, and explore the case for establishing a network of host families in the region. We will learn from others across the country, such as Hertfordshire, Cambridge and South London, where digital systems to manage bed capacity are now in place.

What are the options?

When an individual is in a distressed state and in need of support, there is often no alternative but to admit them into inpatient care. A recent study found that over half of inpatients could have been treated effectively in community settings if appropriate services had been available[63]. Alternative options are being developed across the country. We are working to understand bed capacity, and how effectively these alternative options reduce unnecessary admissions.

Crisis houses - accommodation that provides for people who find themselves in significant mental distress and crisis - are one such alternative for some people with acute mental health problems[63]. Crisis houses are community-based alternatives to hospital admission, providing support and temporary respite from the person's usual place of residence. In Leeds, there is an alternative non-residential model to crisis houses, Dial House, which operates without overnight beds. The Richmond Fellowship service, Box Tree Farm, in Ratby near Leicester is also another great example of crisis house provision.

Emerging evidence suggests people prefer residential crisis houses to inpatient wards, they carry less stigma, and are a good alternative for people not needing close supervision and observation[64,65]. Crisis houses may be more cost-effective than psychiatric care[66,67], and can help people meet others that can help them cope in the event of future difficulties. A bed in a crisis house in Tower Hamlets costs half that of an inpatient bed in the local mental health trust.
In Sheffield, a crisis house has helped to reduce out of area placements, reduce pressure on inpatient services and has provided positive support to people in crisis. Research found that patients had better alliances with staff in community crisis houses because they were given more freedom than in standard acute psychiatric wards[68].

Another approach is to develop a network of host families - where a patient stays with a family that supports them. Host families provide an alternative to hospital for people experiencing a period of mental ill health. This approach has been pioneered by Hertfordshire Partnership NHS Foundation Trust. The scheme, the first of its kind in the UK, is based on evidence that people with mental ill health recover better if they are out in the community, in a supportive family setting, and taking part in a daily routine.

Our progress and plans

We want to explore different models that are alternatives to inpatient care. We believe crisis houses, and other alternatives such as host families, could help to provide a range of options so that we can better tailor support to an individual person's needs, including needs of people from diverse communities. Despite an increase in the number of crisis houses across England in the last two years, crisis house provision in the West Midlands is limited, although there are emerging plans within Birmingham and Walsall.

We will build on this encouraging work and develop plans to establish or expand crisis houses and other alternatives in the West Midlands that are effective alternatives to inpatient care.

Who will we work with?

We will work with housing associations, other third sector organisations, the NHS and local authorities to make this action a reality.

The difference it could make

Crisis houses and other services could offer a more accessible alternative and reduce demand to inpatient care that improves outcomes for people. It could provide good value for money.

Action 14

REDUCING RESTRAINT IN INPATIENT CARE

Building on existing progress, we will apply for a grant from the National Institute for Health Research (NIHR) for a major project to substantially reduce the use of restraint in inpatient settings.

Why use restraint at all?

Physical restraint has always been used in mental health settings to manage patients. Incidences of violence towards staff and other patients, or where a person poses a significant risk to themselves, can result in the use of restraint and/or seclusion[68]. Between 2011 and 2012 there were 60,000 assaults reported against NHS staff in England, and just over two thirds of these were in mental health or learning disability settings[70].

Why reduce restraint?

Physical restraint can cause injuries to patients and staff, and can be highly distressing for patients, who often associate it with psychological trauma and loss of dignity. It can destroy trust between staff and patients. Restraint incidents are often followed by additional containment measures, such as medication or restrictions, which patients may see as controlling and coercive[71].

Physical restraint is still common in UK mental health settings. In England during 2015/16, 66,681 physical restraints, and 12,347 face-down restraints were reported across 49 mental health trusts. In 2014, new national guidance called Positive and Proactive Care was published to address this and encourage a culture where restrictive interventions are only ever used as a last resort.

There are examples of promising practice in various parts of the country. For example, the concept of No Force First was introduced by Mersey Care NHS Foundation Trust, to change ward cultures from containment to recovery and coercion-free environments. No Force First is reducing restrictive practices in in-patient environments, with restraint halving on pilot inpatient sites in the first year and significantly lowering staff absence rates[72].

Who will we work with?

We will work with Professor Joy Duxbury at the University of Central Lancashire, a leading academic voice pursuing restraint reduction. We will also ensure the involvement of representatives of the four local mental health trusts in the region.

Our progress and plans

We believe that it is not possible to provide good therapeutic care and deliver on the principles of recovery when force or coercion is heavily used in inpatient care. We therefore want to significantly reduce the use of restraint and seclusion. We will learn from others who are doing this now and build on existing progress.. With Professor Duxbury and the local mental health trusts, we will apply for funding from the National Institute for Health Research (NIHR) to complete a major programme across the North West and the West Midlands aimed at substantially reducing the use of force, and to evaluate the impact such a programme could have. We aim to substantially reduce force across the West Midlands by December 2017 and in the longer term.

The difference it could make

This programme will inform ways to avoid restraint except in exceptional circumstances, restoring dignity and improving care for patients in our region and beyond.

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71. Should nurses restrain violent & aggressive patients Duxbury, Prof. J & Wright, K. Nursing Times; 107: 9,early on-line publication 2011
72. http://www.merseycare.nhs.uk/about-us/striving-for-perfect-care/no-force-first/

Action 15

GIVING CHOICE TO PEOPLE

Integrated Personal Commissioning (IPC) is a new approach to joining up health, social care and other services. We will help to trial IPC in the region for those with mental ill health. This approach gives power and control to people over the funds available for their care.

Why do this?

The principle of giving control of the budget for care to people has been developed in social care in local government. The right to a personal budget in social care is now enshrined in the Care Act, 2014. The principle gives people choice over their own care. Now, the principle is developing within the NHS in the form of personal health budgets.

IPC helps people manage their own health by giving them more choice and control about the personal care they receive. It enables people, carers and families to combine and control the resources available to them across the system, to 'commission' their own care through personalised care planning and personal budgets. IPC also supports people to develop their knowledge, skills and confidence to self-manage through partnerships with the voluntary and community sector, and peer support. IPC also accords strongly with the Commission's guiding principles.

Who will we work with?

We'll work with NHS England, local councils and the IPC programme nationally.

Our progress and plans

NHS England wants to trial pooling social care and NHS funds for individual people so they have control over their whole budget.

Birmingham has been selected by NHS England as a pilot site to trial the development of IPC for people with mental ill health.

The difference it could make

IPC aims to help people take control, have a better quality of life, achieve the outcomes that are important to them, have greater involvement in their care and design the support they need.

Action 16

IMPROVING PERINATAL MENTAL HEALTH

We will establish a group to ensure access to specialist 'perinatal' mental health services across the region for women during pregnancy and after they give birth to their babies, in line with the national priority for perinatal mental health.

Why do this?

One in five mothers suffer from depression, anxiety or psychosis during pregnancy or in the first year after childbirth, and suicide is the second leading cause of maternal death in the UK behind heart and circulatory disease. This can have devastating effects on the family and affect children for their whole lives. Perinatal mental illnesses cost the NHS significant amounts of money. The total long-term cost of perinatal depression and anxiety is estimated at around £550 million for each one-year cohort of births in our region.[73] Giving early, effective help to people affected by postnatal depression and psychosis is vital to prevent symptoms worsening, to reduce these awful statistics and to prevent the devastating effects on families.

What is happening?

NHS England's Five Year Forward View for Mental Health has proposed a major national programme aimed at ensuring that every part of the country has access to specialist perinatal mental health services. In November 2016, NHS England set out plans to fund new specialist community mental health services that provide evidence-based specialist perinatal mental health care for mums before and after birth in 20 areas of the country – including Birmingham South Central CCG in our region - so they reach 30,000 more women a year by 2021. A further £20 million will be allocated in 2017.

Our progress and plans

We will establish a working group to develop a plan to ensure access to specialist perinatal mental health services across the region. We will build on the local expertise available and ensure that an effective specialist perinatal mental health service is developed in our region as a high priority.

Who will we work with?

We will work in partnership with the Associate National Clinical Director for Perinatal Mental Health, Dr Giles Berrisford, who is also a Consultant Psychiatrist based in the region. We will also work with local commissioners and providers.

The difference it could make

Improving perinatal mental health could improve the quality of life for many women and families, and save the NHS money in the long term.

73. Newbigging, K. and Parsonage, M. (2017). Mental Health in the West Midlands Combined Authority. University of Birmingham: Health Services Management Centre.

Action 17

INVESTIGATING WHY MENTAL HEALTH ACT DETENTIONS ARE RISING

We will examine why detentions under the Mental Health Act are rising in the region, particularly numbers of repeat detentions, and if there are inequalities which need addressing.

What is the Mental Health Act?

The Mental Health Act 1983 includes powers which enable people to be admitted, detained and treated in hospital against their wishes. This power can be used if you are putting your own safety or someone else's at risk and you have a mental disorder. It is commonly known as being 'sectioned.' The Mental Health Act applies in England and Wales, and covers what rights you have, how you can leave hospital and what aftercare you can expect to get.

Why investigate why detentions are rising?

Detentions under Section 136 of the Mental Health Act have been increasing nationally for the past twenty years and this is reflected in the figures for the WMCA region. In 2015-2016, people from specific Black and Asian Minority Ethnic (BAME) communities constituted nearly 40% of people detained under the Mental Health Act (MHA) in the region.[74]

The recent Care Quality Commission annual report[75] of the use of the MHA in England and Wales also showed a continuing rise in detentions under Sections 2 and 3 of the MHA. This is a trend that has been continuing for the past five years. Understanding why this is happening could reveal new ways to reduce these levels and deal with detentions better.

Our progress and plans

We want to examine why detentions are rising with the aim of finding ways to deal with this better. We want to find out why particular diverse communities are also affected more than other people. We want to know how many are repeat detentions within three months of release and what factors contribute to this. We will establish a working group to do this.

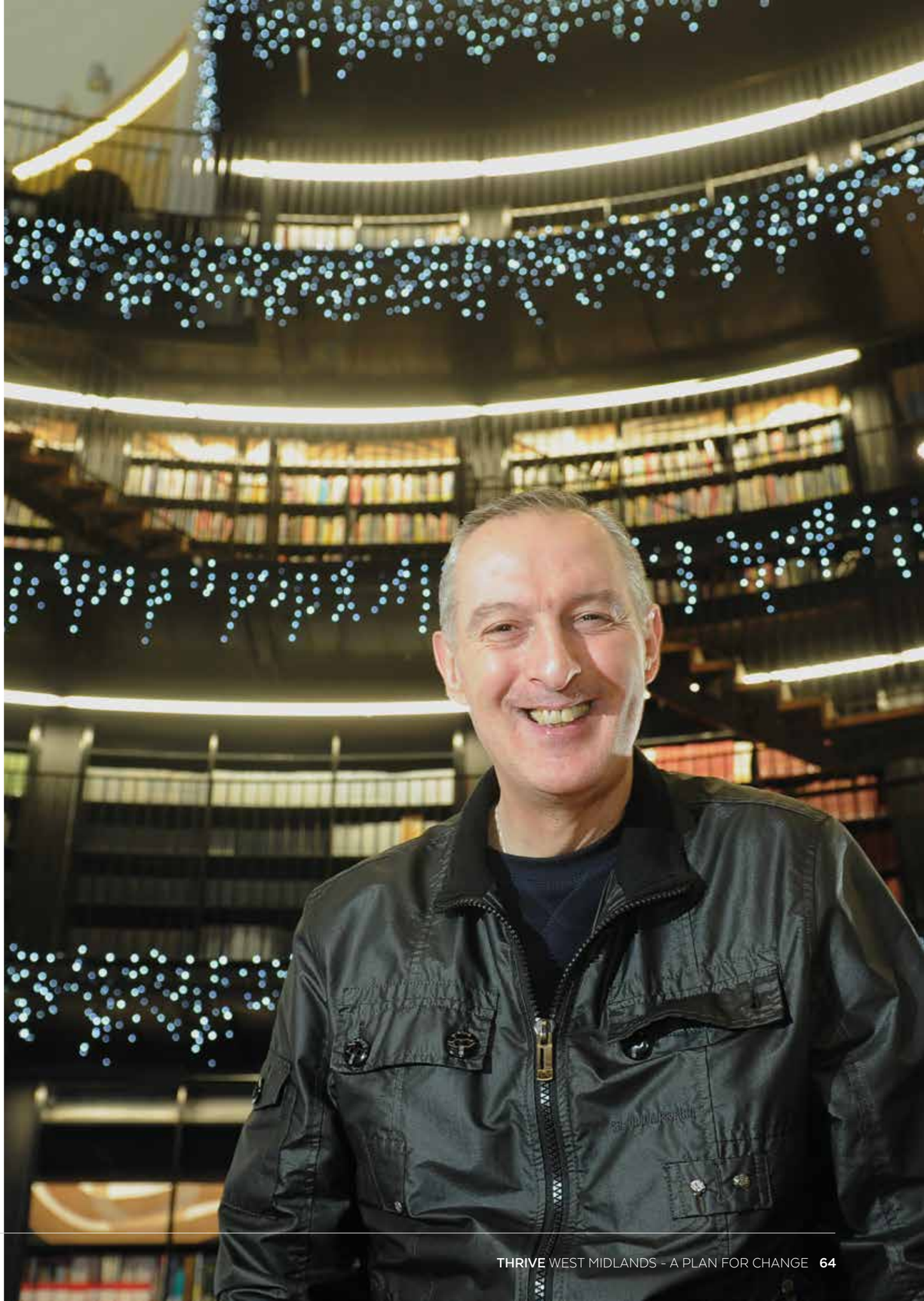
Who will we work with?

We will work with mental health trusts, criminal justice agencies, the ambulance service, NHS England and our local Crisis Care Concordat groups. We particularly want to ensure that we develop approaches which prevent repeat crisis episodes within a three month period of initial detention.

The difference it could make

The approach will establish the evidence so that we understand current trends better and apply what we learn. We will identify the best way to improve the way people are treated.

74. Newbigging, K. and Parsonage, M. (2017). Mental Health in the West Midlands Combined Authority. University of Birmingham: Health Services Management Centre.
75. Care Quality Commission Mental Health Act Review 2016



THEME 5

GETTING THE COMMUNITY INVOLVED

A recent survey found most people had high levels of awareness of 'mental wellbeing' as a concept, and most had positive attitudes towards improving their own mental wellbeing[76]. Campaigns such as Time to Change have helped to change public attitudes to mental health. People also have greater access to information about mental health, including through the NHS Choices website, which is now the world's most popular mental health information site.

But still people with mental health problems continue to experience stigma and discrimination, and negative attitudes towards them. A person with schizophrenia is less likely to be accepted into society compared with a person with depression, and people are not very willing to interact with people with either condition in more personal settings. In the workplace, only a few people think that depression or schizophrenia would not be detrimental to an employee's promotion prospects[76].

Many people cannot recognise symptoms of mental ill health and don't know which interventions or treatments could help[77]. Training people in mental health first aid is one way to improve their knowledge. People who have completed this training say they are more knowledgeable and understand how to help people with mental health problems[78]. Over half of UK employers would like to do more to raise levels of mental health awareness and knowledge within the workplace and improve staff wellbeing, but don't feel they have the right training or guidance[79]. Initiatives that do this would help to reduce stigma and help people experiencing mental ill health to get the help they need, faster. A good example of this in the West Midlands is the charity St Basil's, who alongside local health trusts, developed a programme to make the charity a 'psychologically informed environment'. This involved providing core training in psychological skills for their staff so they can better support their young clients.

Making a difference

Raising awareness and knowledge of mental health and how to support people in our communities will go some way to reducing this stigma and help people to be more understanding. These actions will help to do this in our region. Our ambition is for the West Midlands to lead the way in eradicating stigma and in raising awareness and understanding of mental ill health and wellbeing.

Action 18

RAISING AWARENESS OF MENTAL HEALTH AND WELLBEING IN THE COMMUNITY

We will launch a programme of community initiatives to raise awareness of mental health and wellbeing, guided by people with experience of mental ill health and driven by the community.

Why do this?

Encouraging the wider community to talk about mental health, and participate in events and initiatives that raise awareness of it, help to break down stigma and discrimination. Campaigns such as Time to Change are having a positive effect on public attitudes to mental health. Across the country, many community based organisations and sports clubs, including professional football, rugby and cricket teams, are also raising awareness of mental health in the community.

Our progress and plans

We are launching some specific initiatives in Mental Health Awareness Week in May 2017, and hope others in our region develop them with WMCA support. These initiatives will include:

- launching an annual 'Walk out of Darkness' in May 2017 - a 10 mile sponsored walk through the region to raise funds for organisations supporting people with mental ill health and raising awareness of mental health
- an annual awards ceremony to recognise people in local communities who do amazing work supporting others - health and care workers, volunteers, loved ones, other public and private sector workers, those involved in vital research, managers who lead and achieve change
- exploring whether a community art initiative such as that developed in Philadelphia could help to improve public mental health and wellness in our region
- developing a network of 'Mental Health Champions' - organisations and individuals who commit to promoting positive mental health and wellbeing, such as football and rugby teams, and cricket clubs.

Who will we work with?

Partners could include community and voluntary organisations, Public Health England, local sports teams and businesses to develop a programme of community involvement events. We will work with the charity Clasp on the Walk out of Darkness. We hope members of our Citizens Jury, who have helped us to shape this action plan, will play a key role in this initiative. We hope that the first Mayor of the West Midlands Combined Authority launches a Mayoral fund to support community initiatives.

The difference it could make

This initiative will build momentum in the region around mental health and will raise awareness and improve understanding in our communities.

76. Attitudes to mental health problems and mental wellbeing British Social Attitudes NatCEn Social Research July 2016
77. The public's ability to recognize mental disorders and their beliefs about treatment: Changes in Australia over 8 years Jorm, A. F., Christensen, H., & Griffiths, K. M. (2006). Australian and New Zealand Journal of Psychiatry, 40, 36-41.
78 Mental Health First Aid England: is improving the mental health literacy of the population contributing to a public health priority? Jaman, P., Paterson, P. and Pearson, L. 2014
79. How to be mentally healthy at work Mind 2013

Action 19

A LARGE PUBLIC HEALTH PROGRAMME IN MENTAL HEALTH FIRST AID

We will launch a large public health programme to train up to 500,000 people across the region in Mental Health First Aid (MHFA) or other equivalent programmes over the next ten years. We will explore public and private partnerships to fund such a programme. We'll also campaign for Government to amend First Aid legislation for employers, to include mental health.

Why do this?

Those with mental ill health still experience stigma. Although it has an impact on many people, families and workplaces, there is a significant lack of awareness and understanding of how best to support people with mental ill health. Giving people information about mental health conditions and what to do if someone is affected will give people the skills to support someone in crisis and will help people understand what help is available. It will help people spot symptoms earlier and seek help earlier.

The concept of MHFA is gathering support across the world and is showing promising results in Australia. The Thrive programme in New York will train 250,000 New Yorkers in MHFA to help change the culture around mental health[80].

Emerging evidence suggests that with a good workplace mental health strategy (where MHFA is a component), staff are more willing to report mental ill health as the reason for absence. It can facilitate a return to work and people return more quickly. Generic mental health literacy initiatives to help people spot mental health problems could also be cost effective - Public Health England has estimated that for every £1 spent on training people to spot depression in workplaces, society will save £5.03, and for every £1 spent on workplace health promotion programmes, society will save £9.69.

What will mental health first aid consist of?

Mental Health First Aid (MHFA) training is an accredited educational course designed for the public which aims to improve knowledge of mental health in the general population and reduce stigma around mental illness and suicide. It was first introduced in England in 2007 as part of a national approach to improving public mental health.

Since then, it has been delivered to young people, in schools, in workplaces and with health care workers, and the general public. Some organisations choose to deliver other, equivalent programmes, such as the one developed by the charity St Basil's to make the charity a 'psychologically informed environment.'

Our progress and plans

MHFA is already being commissioned in the WMCA by some local authorities and provided through local Mind associations. MHFA courses are also offered by local NHS trusts and many West Midlands employers, as well as through independent training providers.
We will build on this great work by training up to 500,000 people across the West Midlands over the next ten years. There will be two levels of training - one for front line workers across the public, private and voluntary sectors and another for the wider community. We want to substantially raise awareness and understanding of mental health and wellbeing in our region to help people support those with mental health problems more effectively.

We'll also campaign for Government to amend First Aid legislation for employers, to include mental health first aid.

Who will we work with?

We will work with Public Health England, Mental Health First Aid England and other providers of training.

The difference it could make

We believe this large mental health first aid programme across our region could bring significant benefits to our community and to employers. Educating people how to support people with mental ill health will improve people's knowledge of mental health and how they can support each other, helping to bring our communities together. It would improve mental health literacy and understanding across the region, reducing stigma and discrimination.

80. https://thrivenyc.cityofnewyork.us/

SECTION TEN

PAVING THE WAY FOR SUCCESS - ENSURING OUR ACTIONS BECOME A REALITY

Key organisations across the West Midlands have worked together to agree to this action plan and are committed to fully implementing it.

We are also committed to doing this work in a way that complements and is integrated with other initiatives and programmes of development and various NHS plans, including those requirements set out in the Five Year Forward View for Mental Health and its implementation plan. The Commission's work has been reflected in in the Sustainability and Transformation Plans (STPs) covering the WMCA area and relevant actions are reflected in the plans for the Merit Vanguard.

To ensure our actions become a reality, we have put the following leadership and governance structures in place:

DIRECTOR LEVEL LEADERSHIP

Superintendent Sean Russell has been appointed as the new Implementation Director within the WMCA. He is responsible for implementing these actions, and driving and co-ordinating the work needed to make them happen.

Sean has already been working closely with us to ensure this Action Plan is supported by concrete plans which are owned and endorsed by the organisations that will implement them.

His role will also involve establishing robust governance, programme and project management arrangements that support implementation.

A NEW WELLBEING BOARD

This new Board will support Sean and will oversee the implementation of the actions and ensure this Action Plan is delivered. It will be responsible for monitoring progress, including keeping the WMCA Board updated. It will hold organisations to account to ensure they do what they have said they will.

It will align this Action Plan with other existing areas of work including Sustainability and Transformation Plans (STPs), Health and Wellbeing Boards, and the national Five Year Forward View for Mental Health, to ensure we do not duplicate effort and provide real value to the public through our work.

A steering group will support the Wellbeing Board. It will be responsible for guiding the local work needed to develop and deliver the Action Plan.

Working groups that focus on each of the actions will report to the steering group. They will be responsible for getting the day-to-day work done to implement the actions.

"I am delighted to be appointed as the WMCA's Implementation Director. I welcome the opportunity to build a stronger collaboration between our partners to improve the mental health of people in our region. Ultimately, I am determined to improve the way we use the resources available to us to reduce the impact of mental ill health, to improve the service the public receive and reduce the stigma that mental ill health has in our communities."

Superintendent Sean Russell

AN ONGOING ROLE FOR THE CITIZENS JURY

We have worked with people with experience of mental ill health to develop and shape this action plan. Members of our Citizens Jury will continue to have a key role in the implementation phase.

Now known as the West Midlands Cooperative, Citizens Jury members will be supported by the WMCA to continue their valuable engagement and challenge role. Their experience will give us invaluable insight from experts by experience and carers, and play a key part in shaping and doing the work to implement our actions.

WE WILL APPOINT A PANEL OF EQUALITY CHAMPIONS

The report of the independent taskforce report on mental health, the Five Year Forward View for Mental Health, recommended that the Department of Health appoint an equalities champion to address the disadvantages experienced by certain groups of people with mental health needs.

We believe we must address discrimination and inequality in mental health services in the West Midlands. Our work provides an opportunity to both acknowledge and tackle these inequalities.

We know that particular individuals and communities experience multiple disadvantage, including those from black and minority ethnic backgrounds, lesbian, gay, bisexual and transgender people, those who face inequality as a consequence of age and those with physical disability. We must champion the principle of equal treatment for all with mental ill health.

To ensure we address inequalities, the WMCA will appoint a panel of Equality Champions to work with the Implementation Director and others across the region to ensure that people get equal access and equal treatment regardless of their ethnicity, age, gender, and sexual orientation. Having a panel will ensure that every strand of the Action Plan accurately reflects our regional diversity and demographics.

MENTAL HEALTH CHAMPIONS WITH THE SEVEN COUNCILS

When we started this work, the WMCA had plans to recruit mental health champions within the seven councils. The Champions initiative is part of a national mental health challenge set up through a collaboration between the Centre for Mental Health, the Mental Health Foundation, Mind, Rethink Mental Illness, the Royal College of Psychiatrists and Young Minds[81].

The seven constituent member councils of the WMCA have an elected member who is a mental health champion. We have worked with the champions to encourage them to work together and be part of the implementation process, ensuring the priority of this work and of mental health more generally is reflected in the work of their councils and the WMCA as a whole. We'll encourage the non-constituent member councils and other organisations in the public and private sectors to follow suit. Warwickshire, one of the non-constituent member councils, already has one in post.

The council champions are all personal signatories to this Action Plan. They will champion mental health and wellbeing across the local authorities and ensure guidance is being followed.

81. www.mentalhealthchallenge.org.uk

SECTION ELEVEN

THIS IS THE BEGINNING OF A JOURNEY

Our ambition is clear – we want the West Midlands to lead the way on reducing the burden of mental ill health, promoting mental wellbeing and using public and private resources more effectively.

Great work is already taking place in the West Midlands. But we can and must do more. We will build on great practice wherever it exists.

This Action Plan is the start of a programme of work involving many people and organisations, who have worked together to agree these actions and are now actively working together to deliver them.

As we build momentum we aim to address further issues over the whole life cycle and develop a comprehensive public health approach aimed at reducing the burden and impact of mental ill health.

For the majority of the actions we know there is an evidence base. For some actions, it may not be as well developed as for others. Therefore a programme of evaluation will be commissioned to assess and report on how effectively each action is implemented, and how they strengthen pathways and equalities in these challenging economic times.

This evaluation will need to be undertaken thoroughly and over a reasonable period. We expect the WMCA to commission an evaluation programme, working with organisations with expertise in evaluation work.

We will share our learning with other city regions participating in the global network.

And people with experience of mental health issues will continue to shape our work, ensuring we meet the mental health needs of people in our region.

SECTION TWELVE

THANK YOU TO:

- All who have contributed to and supported the Commission's work
- Those who joined our **Citizens Jury**, and who have played a vital role in developing this Action Plan. This diverse group of people have actively participated in and influenced our decision making, and will continue to play a central role
- **Stakeholders and members of the public** who took part in our listening events
- Individuals and organisations who submitted evidence
- **Karen Newbigging** (Health Services Management Centre at the University of Birmingham), **Michael Parsonage** and **Andy Bell** (Centre for Mental Health) for their work on the baseline assessment report and scrutiny of evidence
- **Kerry Jones** and **Ajaib Paul** at Dudley Borough Council
- **Will Woodward** and **Meliz Ahmet**, from Norman Lamb's office for their work in supporting the Commission.

Read this Action Plan and follow our progress on the WMCA website

www.westmidlandscombinedauthority.org.uk/mhc

APPENDIX

WORK UNDERPINNING THIS REPORT

Since it began, we have completed a range of work, supported by a Steering Group of representatives from local organisations in the public and third sector. We have also sought advice and input from other organisations on particular areas of work.

STEERING GROUP

We established a steering group to ensure we remained in touch with the views of the community and of local public services, and to give advice about how best to provide additional support to people living with mental ill health.

The steering group consists of representatives of the local NHS, both provider and commissioning sectors, adult social care, housing associations, third sector groups, a local representative of the Department for Work and Pensions and the police.

BASELINE ASSESSMENT

Through the WMCA, we engaged the Health Services Management Centre (HSMC) of the University of Birmingham, working with the national Centre for Mental Health (CfMH) to conduct a baseline assessment of current mental health and wellbeing in the area covered by the WMCA.

We asked them to:

- **establish and understand the costs of poor mental health to the West Midlands**
- **provide an audit of current public sector (NHS/ local authority) and voluntary sector mental health service provision in the WMCA area**
- **provide an audit of all current or planned initiatives relating to mental health whether public, private or voluntary sector**

Read this baseline report at **www.birmingham.ac.uk/ hsmc/mh-wm-combined-authority**

PUBLIC ENGAGEMENT

We wanted to enable people not involved with the Commission to deliberate, have their voices heard and to influence the outcomes of the process. We felt this was central to our success.

To do this, we engaged Social Future, a community interest company to lead the development and delivery of three listening events held in Birmingham, Coventry and Dudley during April and May 2016. Participants discussed subjects of their choice.

Social Future also helped to create, and supported, our Citizens Jury. Read more on page 31.

SCRUTINY OF EVIDENCE

We invited a range of individuals and organisations to submit evidence relating to our key areas of work. Thirty sources submitted written evidence.

We engaged the Centre for Mental Health to independently scrutinise this evidence. This process involved:

- reading, summarising and providing a critique of the submissions received
- exploring how far the submissions concur with existing published evidence in relation to the Commission's key areas of work
- highlighting any gaps in the written evidence or relevant counter-evidence
- producing a synopsis of the evidence available in relation to each key area of work

This evidence has helped to shape this Action Plan.

NOTES

WEST MIDLANDS COMBINED AUTHORITY

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Shropshire Council	Committee and Date Health and Social Care Scrutiny Committee 27th March 2017 10.00 am	Item **3** Public

Update on Accommodation for Adults with Learning Disabilities – Community Living Service and Shared Lives Service

Responsible Officer Michelle Davies Service Manager Commissioning and governance
e-mail: Michelle.Davies@shropshire.go.uk Tel: 01743 253093

1. Summary

This report provides an update on two accommodation services for adults with learning disabilities that transferred from the Council to independent providers during the summer 2014

2. Background

In March 2014 Shropshire Council's Cabinet approved the transfer of two accommodation services for adults with learning disabilities from the Council to an Independent Provider.

The Community Living Service transferred to Midland Heart. However, since the Update provided to Cabinet in July 2015, Midland Heart have given their notice on the contract. This has now been retendered using our supported living framework and the successful provider, Perthyn, will take over the running of the service on 1st April 2017

The Shared Lives service continues to be provided by Positive Steps and this contract has recently be extended for a further 12 months to provide us with an opportunity to fully review how the service can be developed going forward and necessary amendments to the contract can be made

3. Recommendations

A That members note the transfer of the community living contract to new providers Perthyn, on 1st April 2017

B That Members review the service developments achieved by Positive Steps since the last update in July 2015

C That Members consider how the services are meeting the demand across Shropshire both geographically and in relation to care needs, i.e., have they expanded to cover mental health and older people

D That Members consider areas for improvement.

REPORT

4. This report is in two parts. Part 1 relates to the Community Living Service and Part 2 the Shared Lives Service.

Part 1 Community Living Service

The Community Living Service was an in-house CQC registered domiciliary care service provided by Shropshire Council until June 2014 when it was transferred to Midland Heart following a competitive procurement process.

There are currently 18 geographic locations, supporting 37 customers; 3 x 24 house Services in Oswestry, 1 x 24 hour service in Much Wenlock, 5 x 24 hours service in Shrewsbury and a further 9 locations within these areas where the support is not Provided on a 24 hour basis.

Service Ethos and Developments

Due to the transfer of the community living service from Midland Heart to Perthyn, a summary of the service delivery model applied by Perthyn has been provided highlighted examples of service users living in Shropshire who are already supported by Perthyn

As a part of their person centred approach, Perthyn supports individuals in maximising the opportunities to access activities and local amenities whilst supporting them to present a positive image of themselves in their local community. They facilitate Person Centred Planning and Reviews with a focus on Positive Risk Taking and use of the Active Support Model to identify opportunities, plan and take action to meet individual's needs and wishes, to achieve positive outcomes and a good quality of life.

Teaching staff about the impact of their behaviour on how others see the people they are supporting and how this affects their integration, paying attention to how they engage with the individual in public; promoting skills and abilities, not doing things for them because it is quicker or automatically speaking on their behalf.

Supporting people with their appearance and developing social skills and patterns of behaviour that encourage others to respond positively and want to engage with them is essential in building sustainable and supportive relationships. Helping people to be actively involved within the community; seen as a valued customer and good neighbour as well as thinking about how they can use their skills to help the community and meet their own cultural and religious beliefs. Perthyn support people into education and employment by working with local colleges and businesses, providing additional support needed initially to help people engage, reducing gradually over time.

As part of Perthyn's management development programme they are providing dedicated resources to support managers to look more widely at what the community has to offer. This includes setting up of opportunities in very small groups for people to make the links with identified volunteer groups, local colleges, religious communities etc. Their approach to volunteering in particular is to look for opportunities for people to volunteer, making sustainable links, as well as potential opportunities to receive some support.

Staff recruitment

Perthyn adopts a range of recruitment activities to attract local people to work for them, many of whom have not previously worked within the care sector.
They advertise using Shropshire free radio, Shropshire Star, Express and Star, Oswestry Chronicle as well as digital platforms
They work in partnership with the Job Centre attending local job fairs to attract local people. They attend regular jobs fairs they organise in Shrewsbury College, and the army barracks.
They also attend commercial jobs fairs e.g. Theatre 7 in Shrewsbury.

Perthyn works with other providers via SPIC to consider the wider issues facing the sector, look at problem solving, sharing creative ideas and solutions.
They work with local volunteering agencies, drawing on their skills and experience in management of volunteering. This provides opportunities for people they support to work alongside volunteers with specific skills while contributing to the ongoing delivery of those voluntary services.

Following a pilot in Nottinghamshire, Perthyn will be introducing an apprenticeship scheme within Shropshire from May 17 which will provide people with a pathway to secure, permanent and sustainable employment within Perthyn.
.

Individual highlights for service users currently receiving support from Perthyn

a) J lives in Shrewsbury with two other ladies who Perthyn support. She has lived in a variety of locations in the past, with different support set ups, some of which have broken down, and as a result J can get very attached to people around her. She asked for a review meeting in February and told staff a number of things she would like to work towards in the coming months. As a result, J has got herself cat - which she now looks after herself and helps meet her need to care and look after something. She has also started to use some of her 1:1 support to learn to use the bus independently. J said at the meeting that she would like to get involved in interviewing new staff and has recently helped take part in two rounds of interviews for new support workers. Finally, she told staff at her meeting that she would like to work, either as a waitress or a shop assistance, and though she has not quite achieved this yet, she is currently waiting to hear back for a number of enquires she has made at local charity shops.

b) B is 74 years old with a learning disability who has lived most her life in institutional care. Having lived in a long stay hospital when young, she moved into a care home for the elderly in Shrewsbury 3 years ago. In recent months, challenging behaviours - which had been occasionally exhibited - escalated to the point where she was in crisis. The LA considered an emergency admission into a secure hospital, whilst at the same time asking Perthyn to investigate the possibility of her moving into Hillsview in Church Stretton. When B first visited Hillsview she was clearly extremely agitated and had a large bruise on her forehead where she had banged her head repeatedly against a wall at her current care home that morning.
The care home had decided to serve notice on her residency there because she was regularly upsetting other residents and going in and out of their bedrooms.

Some very speedy work was done with B's social worker, community nurse and, most importantly, L, another service user who has lived at Hillsview for many years with support from Perthyn. L was initially reluctant to consider B as a fellow tenant, but agreed with the help of his advocate to try living with her as long as regular reviews were built into the first few weeks of her stay. B moved into Hillsview in May with a 1:1 support package for 12 hours each day. By the time of her second review in mid-June, she was acknowledged by all present to be like a different person. After a disrupted first week, B had settled fantastically well. She had discovered that, for the first time in her life, she had her own space and access to her own kitchen. She was able to wash up, potter around her home or go out into her local community whenever she wanted to. The support workers she was with would respond to her requests about what was coming next, what she wanted to do and who was going to be supporting her. They had supported her to manage the pressure sores which (unknown to Perthyn), she had developed at the care home, so that she was now no longer in pain when she sat on her newly adapted chair. She was eating better, sleeping better and had put on a little weight.

B was even able to tell the review meeting how happy she was now she had moved, using a complexity of language that other professionals had never known she had. Even L now tells staff how much he enjoys spending time with B and having some new company around!

c) C who lives in Gobowen has been supported to get the internet in her bungalow and purchase an iPad for the first time. She was supported to gain some funding towards this from a local charity 'The Sequal Trust'. Staff are supporting her to learn how to use some of the games and 'apps' on the pad, and also building up pictures and symbols as part of her ongoing communication support. One unexpected benefit of the technology has been the impact it has had on C and her family. Relations have not always been smooth over the years, but staff are now regularly supporting C to e-mail her parents and brother, and also send over photos of what she has been doing. C struggles to communicate over the telephone, so for the first time her family is able to keep with what C is doing on a day to day basis, and feel more involved in her life and support as a result. C is also now taking part in her own food shopping for the first time in a number of years.

d) C lives at Blackfriars in Oswestry. She started to be supported by Perthyn in the summer following a transfer of services, and a lot has changed for her since. In particular, she is now able to move around her home in comfort as joint working has taken place with OTs and her staff team to assess her mobility needs, and ensure that she is supported using all the equipment she needs. She has been supported to move into a brighter and more spacious room. Changes to the management and support have provided the springboard to look at what C is doing with her time both in her home and out in the community. Her staff are starting to support her with a regular pattern of community activities, including Zumba, bowling and aromatherapy sessions. She is also in the process of choosing her own mobility car for the first time as her service changes from registered care to supported living. Just before Christmas, her support team helped her get in touch with an old friend who she hasn't seen for years who lives in a service now also provided by Perthyn in Welshpool. Regular visits have been set up and C is very much looking forward to renewing this relationship.

e) Volunteering opportunities:

Following on from a Person Centred Review L was supported to find a voluntary position with a local charity shop. L will be completing jigsaws (something she likes to do at home) that have been donated to the shop, to ensure that all the pieces are there before they are sold.

J who lives at Gains Avenue in Shropshire has got a job at a local hospital one day a week and is waiting on a DBS check to start a second voluntary job

JG who lives at the Elms has secured a new day service working at Ditton Priors farm and has started a voluntary gardening job at the Derwen College

M who lives in Shrewsbury has started to go mountain biking with his support worker on a regular basis in the Shropshire Hills

Handover of Midland Heart contract to date:

Perthyn have been working closely with Midland heart since the beginning of February 2017. They have a Regional manager assigned to the transfer as well as office and frontline staff.

Midland Heart have been relying on agency staff to support a number of their schemes, therefore Perthyn now act as an agency for Midland Heart, supplying their staff to individuals who require support. This proactive approach has enabled Perthyn's staff to get to know both the individuals they will be supporting in the community prior to the transfer and to work closely with the Midland Heart staff who will TUPE over. Once the service does transfer to Perthyn, they will have continuity of staff working with individuals and less reliance on agency staff going forward.

The regional manager of Perthyn has been visiting the properties and talking to service users, carers and staff to find out what has been working well and what can be improved, so that measures can be put in place to implement news ways of working at point of transfer. Perthyn have also been having 1:1 meetings with Midland Heart staff who are transferring and discussing working patterns and how improvements can be made in this area and Midland Heart staff have elected a staff representative group who can relay staff views to Perthyn.

It is clear that Perthyn have been working extremely hard to make the impending transfer of services as seamless as possible, dedicating additional resources to ensure all are aware and involved in the processes and any changes that they plan to make are done so jointly with both service users, staff and carers.

Part 2 Shared Lives Service

The Shared Lives service transferred in June 2014 to Positive Steps a newly formed local organisation.

The new provider continues to develop the service through recruiting new Shared Lives Carers. The table below indicates the improvements made in increasing the number of shared lives carers since the last report

There are currently 6 long term vacancies are 4 respite vacancies. Positive Steps are working closely with Social Work teams to fill these vacancies, and sending weekly reports. They hold 3 monthly meetings with team managers from North, Central and South Shropshire and this has really helped to complete the matching process and place individuals.

Table 1 Recruitment of new Shared Lives Carers

	July 2015	**March 2017**
Number of Shared Lives carers	45 Long term 25* Short term 20 *11 of these carers also provide Short Term replacement care	55 Long term 33* Short term 22 *7 of these carers also provide Short Term replacement care * 28 carers recruited by Positive Steps Shropshire since June 16th 2014.
Number of people supported	69 Long term 34 (includes LD 22, MH 1, ABI 1,MH/LD 10) Short term (replacement care) 35 (includes LD 33 and PD 2)	85 Long term 50 (includes LD 35, LD & dementia 2, MH 3, OP 2, MH/LD 8) Short term (replacement care) 35 (includes LD 34 & MH 1)

As you can see from the able above, the number of cares has increased by 10 since the last report (28 new carers have been identified whilst others have deregistered) The variety of placements offered has also changed during this time and Positive steps are now able to offer more Shared Lives placements to individuals with mental health needs, dementia care and support for older people.

The development of the Shared Lives service supports people to live in their local communities including for periods of respite . The tables below indicates the number

of long and short term Shared Lives carers in each geographic location of the county and the location of carers by town and village

Table 2: Geographic location of Long and Short Term Carers

Location of Shared Lives Carers				
	July 2015		March 2017	
	Long Term	Short Term	Long Term	Short Term
North	10	9	15	12
South	12	6	14	3
Central	3	5	7	4

Table 3: Location of Shared Lives Carers by Town and Village

March 2016

South	Central	North
Bishops Castle	Shrewsbury	Whittington
Pontesbury	Sutton Farm	Market Drayton
Craven Arms	Monkmoor	Llanrhaedyr
Little Stretton	Castle Fields	Wem
Priest Weston	Town Centre	Oswestry
Morville	Berrick Grange	Nesscliffe
Highley	Radbrook Green	Bomere Heath
Ditton Priors	Springfield	Whitchurch
Broseley	Harlescott	West Felton
Leintwardine		Hadnall
Bridgnorth		Clive
Cressage		

The process for recruiting Shared Lives carers includes approval by a Shared Lives independent panel. There have been 7 panels since June '14 – recruiting 28 new carers. The next panel is April 12th and there are 7 new applicants to be approved. Positive Steps have also held 2 panel review meetings as the documents have changed considerably.

Positive Steps report that in recent experience new carers joining the shared lives scheme are looking to provide permanent placements. New carers seem to have a care and support background so feel confident to offer these types of placements.

There has been more introduction to the service through word of mouth by those already providing care and the positive experience existing Shared lives carers are communicating is encouraging others to apply.

Positive Steps now receives referrals from all teams supporting adults with care and support needs when previously Shared Lives predominantly was a Learning Disability service.

Summary of support offered:

Shared Lives Services offers support in a family environment to individuals assessed as having a learning disability, a physical disability, a frail older care need or mental health care.

- Individuals using Shared Lives service have the opportunity to share the daily life of the carer and their family and friends and to live an ordinary domestic life in the same kind of home as others in the local community.
- An individual in a Shared Lives arrangement is supported by the carer to live an independent life, as well as being supported in making their own choices and living the kind of life they want to live.

- Fundamental to any Shared Lives arrangement is the promotion of the physical, emotional and spiritual wellbeing of the person placed and their protection from abuse and harm.

- Positive Steps aims to offer high quality and well-matched placements to racially and culturally diverse communities of Shropshire.

- Positive Steps aims to offer a service to individuals who may use the service for both respite and long term living arrangements, with well-matched Shared Lives carers as well as the possibility of day time support only as well.

- Positive Steps aims to continuously evaluate and improve the quality of service it offers and has consulted with carers through the use of questionnaires over the last 12 months. As a CQC registered service it is important that Positive Steps can demonstrate how it delivers a quality service as well as demonstrating how it responds promptly to matters raised by service users and carers.

Individual highlights for the service

a) Supporting a lady SP who requested she wanted to lose weight for her own self-esteem and health. She joined slimming world with her carer, SP has now lost 5 stone she has now stopped taking her diabetic medication and has a whole new wardrobe. She was entered into “Slimming World lady of the year” by her Slimming World consultant and was presented the winning trophy in November 2106 at the annual Slimming World ball held at Albrighton Hall. SP is so happy with this achievement

b) Taken directly from an interview with a service users asking about their experience of their shared lives placement

Interview between T & Matt 14/03/2017

T – Why do you like living with your shared lives carers?
Matt – It's a lot calmer than when I was living at home, I am learning new skills like doing my own laundry and cooking. I am talking a lot more than I did before I moved.
T – What has changed since moving in with your carers?
Matt – My confidence has improved, I can get away from arguments with my family.
T – Is there anything new in your life since being with Positive Steps?
Matt – Yes, I volunteer at Louise House café, this is helping me develop new skills in the kitchen and giving me the experience of working. I also attend A4U autism hub once a week, there I have made new friends and enjoy the different activities they put on.
T – What's the best thing about your carer?
Matt – I can pick my own clothes, they never shout and I can talk to them about anything.
T – What's the worst thing about your carer?
Matt –Nothing.
T– Is there anything else you want to say?
Matt – I enjoy my time there.

C) This statemnt was taken from a student social worker who is currently completing a placement with Shared Lives:

I am currently on my 70 day placement with Positive Steps which started on 16th January 2017, whilst being on placement with Positive Steps they have all made me feel so welcome and the wealth of knowledge within the team is outstanding. Throughout my placement I have had the opportunity to meet many people who benefit from the service Positive Steps provide, they all speak very highly of Diane and her team. Positive Steps have provided me with opportunities to develop and grow within a safe environment. The placement has more than met the professional capabilities framework which I need to be assessed against.

Positive steps had a CQC inspection in October 2016 and the outcome of the service was reported as 'Good' in all 5 areas. See Appendix B

Training for Shared Lives Carers

Positive Steps have commissioned and delivered bespoke training for Shared Lives carers which has been valued by the Cares who have accessed the training. This is a continuing aspect of the service to ensure that shared lives carers are skilled and competent in meeting the needs of the people that they support. Positive Steps have also produced and implemented an Induction Process for new carers again ensuring that the correct skill base is available to support individuals.

A summary of the mandatory training Courses provided which all of the shared lives carers have attended or are down to attend within the next training date are provided below:

- Medication in Care
- Fire training

- Moving and Handling
- Infection Control
- Record Keeping
- MAPA
- Health and Safety
- MCA/Dols
- Safeguarding
- First Aid

Fire training and MCA has been developed for people supported and carers to attend together.

These courses and other courses have been developed in close conjunction with Joint Training and have been tailored so that they are more relevant to the specific requirements of Shared Lives Carers. Joint Training have been very helpful as they have shared Course Evaluation sheets with Positive Steps. A recurring theme is that Shared lives cares are saying that they prefer training to be delivered in groups as when courses are undertaken in this way, it is a good opportunity for cares to meet and share experiences. All of the Positive Steps team have attended the training in order to fully appreciate the issues faced by carers.

Service Developments

- Positive Steps have now employed a Recruitment Manager 3 days per week – their role is the ongoing recruitment of Shared Lives carers and overseeing the assessment process.

- Questionnaires are sent out twice a year to gain feedback on the service, and how it can be improved. See Appendix A, it is noted in the past 12 months they have received 23 compliments and no complaints

- They have expanded their service and now have more carers who can provide support to individuals with mental health needs and older people

- They have arranged social get togethers for the people they support and carers – next is a tea dance on the 18th June 2017 at the Lion Hotel Ball room to tie in with and support Shared Lives Week.

- Promoting the use of “together” training – for the people they support and their carers.

- Developing their domiciliary service and now currently provide 62 hours per week domiciliary care in Shropshire.

- Working in partnership with A4U and Men in Sheds to run Louise House Café.

- Positive steps are registered for Homeshare with Shared Lives Plus – this service is to be developed further, but essentially it involves individuals who do not have assessed social care needs, but would benefit from some support at home, privately advertising a spare room through Positive Steps and in return for the room the individual would offer support hours, shopping, appointments etc., this would not include personal care. Positive steps provide the matching service and complete all necessary checks.

- Positive Steps are working closely with local Advocacy Groups and have commissioned one of the groups to promote an independent steering group for service users to evaluate and look at new ways of working in taking the Shared Lives forward as well evaluating, as peers, the quality of the accommodation, support and care provided.

- Positive Steps have produced the paperwork provided for service users in an easy read format.

- Positive Steps continue to facilitate 6 weekly drop-in sessions at locations around the county where carers have the opportunity to meet the Registered Manager ensuring that they feel part of the shared lives care team as well as providing the opportunity to raise concerns or questions that can be promptly addressed.

- Positive Steps continue their membership of Shared Lives Plus (a national shared lives organisation), Shropshire Partners in Care, Shropshire Chamber of Commerce, Shropshire RCC, and Skills for Care thus ensuring that they have access to the appropriate business support both in relation to care, volunteer support and business development.

- Positive steps are now part of a national pilot scheme from Shared Lives Plus – looking at home from hospital and how they can support the local hospitals discharge teams. Positive Steps will be working closely with our Integrated Care Services team going forward to further develop this service, this is a 12 month pilot.

- Positive Steps have established a shared lives website which includes a 'members only area' which is password protected and exclusively for Shared Lives carers. This gives shared Lives carers access to up to date Handbook, Policies & Procedures and regularly used documents within the service.

- Positive steps now take on Social work students completing their social work degrees

5. Conclusions

- Perthyn have demonstrated their successful approach to person centred planning with service users and have already dedicated a significant amount of time to the community living service prior to transfer to ensure this happens smoothly and they can begin supporting individuals to achieve their goals and aspirations, enabling their independence in their local community to continue to develop

- Positive Steps are continuing to expand their business, they now have a domiciliary care element, the Home From hospital Pilot they have been asked to take part in by Shared Lives Plus will enable to them to continue to further enhance their business going forward, especially as the demand for care in the community following hospital admission is ever increasing. They are seeing an increasing number of applications to become shared lives carers due to the positive experiences shared by existing carers

- Going forward, for both services, in order to continue to support local recruitment and involvement of the local community in these services, it has been suggested that they request to attend the MiR (Making it Real) local advisory groups in the relevant areas. This will give them the opportunity to talk to local people, service users, carers and staff representatives from Shropshire Council about their services developments and to involve those representatives. This platform could also provide an opportunity for members of the Shropshire Association of Locals Councils to attend and contribute service developments including staff recruitment.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Councillor Lee Chapman – Adult Services and Commissioning (South)
Local Member All – this is a countywide matter.
Appendices Appendix A – Respite relatives Survey, Relatives Survey, Customer Questionnaire Appendix B – CQC report

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REPLACEMENT CARE RELATIVES SURVEY

1. Are you consulted about the respite/replacement care and support your relative receives?

☺ Yes	☹ No	😐 Don't know
18	1	1

2. Is your relative supported in a respectful and person centred way?

☺ Yes	☹ No	😐 Don't know
21		

3. Do you think the support your relative receives in respite/ replacement care helps to keep them safe and is appropriate to their needs?

☺ Yes	☹ No	😐 Don't know
20		1

4. Is your relative supported to eat and drink in a way that meets their needs?

☺ Yes	☹ No	😐 Don't know
20	1	

5. Do you think that the house/s where your relative has respite is suitable for their needs and is clean and safe?

☺ Yes	☹ No	😐 Don't know
20		1

6. Is the service well led and has systems in place for you to book respite for your relative?

☺ Yes	☹ No	😐 Don't know
21		

7. Do you think information about your relative is handled sensitively and appropriately?

☺ Yes	☹ No	😐 Don't know
20		1

8. Is your relative listened to and communicated with in a way they understand?

☺ Yes	☹ No	😐 Don't know
20		1

9. Overall are you happy with the service you have received from Shared Lives?

☺ Yes	☹ No	😐 Don't know
21		

Are there any other comments you would like to make?

1. S is very happy in respite.

2. Mr and Mrs Christie and Jane are very happy with respite.

3. N and myself are extremely happy with respite, it works very well for both of us. I've never seen N so happy when he goes and returns.

4. The respite care from all involved is superb, very good communication between us all. You help make our lives much happier as all our needs are met and E and I are happy with all your support. Thank you at positive Steps and carers.

5. Since Shared lives put us in contact with Nigel and Jayne we not only get respite but peace of mind knowing K is happy and they are very caring, Thank You.

6. E respite carers are all wonderful and I am very happy and grateful that you filled a gap very quickly when needed.

7. We are very pleased about the support my daughter receives.

8. The service from social services has deteriorated. As a parent carer we need more time for respite not less and our daughter needs more time away from us to gain useful experiences. Cutting her respite time in half has affected us all badly.

9. S said Ruth is nice.

10.Excellent, caring, so helpful for our family to have a break, and our son loves to go.

10. I find Carol & Roland caring and loving people who look after Ian well.

THANK YOU FOR YOUR HELP.

RELATIVES SURVEY

3. Are you consulted about the care and support your relative receives?

☺ Yes	☹ No	😐 Don't know
11	2	

4. Is your relative supported in a respectful and person centred way?

☺ Yes	☹ No	😐 Don't know
11		2

3. Do you think the support offered your relative helps to keep them safe and is appropriate to their needs?

☺ Yes	☹ No	😐 Don't know
12		1

4. Is your relative supported to eat and drink in a way that meets their needs?

☺ Yes	☹ No	😐 Don't know
12		1

5. Do you think that the house where your relative lives is suitable for their needs and is clean and safe?

☺ Yes	☹ No	😐 Don't know
12		1

6. Is the service well led, has competent workers and managers?

☺ Yes	☹ No	😐 Don't know
11		2

7. Do you think information about your relative is handled sensitively and appropriately?

☺ Yes	☹ No	😐 Don't know
10		3

8. Is your relative listened to and communicated with in a way they understand?

☺ Yes	☹ No	😐 Don't know
12		1

9. Overall are you happy with the service you have received from Shared Lives?

☺ Yes	☹ No	😐 Don't know
12	1	

Are there any other comments you would like to make?

1. My son has got the best place possible to meet all his needs. He is very well cared for and listened to by his placement as well as positive steps staff. They have gone up and beyond helping him to be happy, safe and secure. Thank you.

2. The reason for the negative reply is that we have no contact with G since 2009. She stayed one weekend but we heard from my other sister that via her carer that G was getting very upset after seeing her family. So it was decided that she severed all ties with us. We think it's such a shame as she must miss everybody as there is such a big family.

3. It's difficult for me to answer every question with a simple yes or no because I don't always have a full enough picture of what my relative experience because I live a considerable distance from Shrewsbury and see him infrequently. Although I do speak to my relative once a week, he isn't communicative about such matters as your questionnaire addresses and therefore I can't be sure that silence on his part means no issue, however my clear general impression is that the service is dealing with him very well as are his carers and regular respite carers.

4. Very happy this was a good move.

5. D has settled into her new home really well and is very happy. I am able to see her often and she also comes and stays when we have family events. If Claire and Ian are doing something with their family it works very well and we as a family are very happy with how she is taken care of.

6. Thank you for all your help.

THANK YOU FOR YOUR HELP.

INDIVIDUALS QUESTIONNAIRE

5. Do your carers help you to live in the way you want?

Yes	No	Don't know
18		1

6. Do your carers listen to you and help you to make choices and decisions?

Yes	No	Don't know
19		

3. Is your guest room the way you like it?

Yes	No	Don't know
19		

4. Are you involved in deciding what activities you would like to do or try?

Yes	No	Don't know
18	1	

5. Does your shared lives carer help you to look after your own money?

Yes	No	Don't know
18	1	

6. Do your carers help you to take your medication safely?

Yes	No	Don't know
15	1	

7. If you were unhappy with your support from your carer or your accommodation would you be able to complain to a manager?

Yes	No	Don't know
9	3	6

8. Does your shared lives carer help you to see your Dr, dentist or nurse?

Yes	No	Don't know
5	10	1

9. Overall, are you happy with your replacement carers?

Yes	No	Don't know
18		

Please write any comments, questions or suggestions here?

1. I still live at home with my parents but enjoy my respite care.

2. Some questions E wouldn't understand.

3. D enjoyed his overnight stay and says he will be happy to go again. D can't write but has communicated with us so we can fill it in.

4. I like Jayne and Nigel, I am part of the family. I like staying there.

5. S very happy with the service. Many Thanks

6. N wanted me to write that he's happy with all of his respite especially the home environment.

7. Two ladies, 3 cats and a dog which I like. Her husband is funny and makes me laugh. I can read but can't handle money so will need help.

THANK YOU FOR YOUR HELP

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Positive Steps Shropshire Limited

Louise House

Inspection report

Roman Road
Shrewsbury
Shropshire
SY3 9JN

Tel: 01743251568

Date of inspection visit:
07 September 2016
09 September 2016

Date of publication:
18 October 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 7 and 9 September 2016 and was announced.

Positive steps Shropshire provides personal care for people as part of a shared lives and domiciliary care scheme. A shared lives scheme support a variety of different arrangements where families and individuals in local communities can offer accommodation and/or support for people. At this inspection they were providing care and support for 85 people.

A registered manager was in post and present during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were safe as staff had been trained and understood how to support people in a way that protected them from danger, harm and abuse. Environmental risk assessments on individual properties were completed and actions undertaken to reduce the risks to people. Staff had access to care plans and risk assessments and were aware of how to protect people from harm.

The provider completed appropriate checks on staff before they started work to ensure they were safe to work with people. People received help with their medicines from staff who were trained to safely administer these and who made sure they had their medicine when they needed it.

People received care and support from staff that had the skills and knowledge to meet their needs. Staff attended training that was relevant to the people they supported. Staff received support and guidance from a management team who they found approachable. People had their rights upheld by staff who knew the appropriate legislation which directed their roles.

People's likes and dislikes were known by staff who supported them in a way which was personal to them. People had positive relationships with the staff members who supported them. People had their privacy and dignity respected and information personal to them was treated with confidence. People had access to healthcare when needed and staff responded to any changes in need promptly and consistently. People were supported to maintain a diet which promoted well-being.

People were involved in decisions about their care and had information they needed in a way they understood. When people could not make decisions for themselves staff understood the steps they needed to follow to ensure people's rights were upheld.

People and staff felt able to express their views and felt their opinions mattered. The provider and registered manager undertook regular quality checks in order to drive improvements. The provider engaged

people and their families and encouraged feedback. People felt confident they were listened to and their views were valued.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.
People were protected from the risks of abuse as staff were trained and knew how to recognise and respond to concerns. Risks associated with people's care had been assessed and actions taken to minimise the risk of harm. People received assistance with their medicines by trained and competent staff members.

Is the service effective?

Good

The service was effective.
People were supported by trained staff members who had the skills to meet their needs. People's rights were upheld by staff members who were aware of guidance informing their practice. People had access to healthcare when they needed.

Is the service caring?

Good

The service was caring.
People had positive and caring relationships with those who supported them. People had their privacy and dignity maintained. People's personal information was kept confidential by staff members supporting them. Information was shared with people in a way they understood.

Is the service responsive?

Good

The service was responsive.
People were involved in the planning of their own care and support. The provider responded to people's changing needs. People were able to raise any concerns and were confident any issues would be addressed to their satisfaction.

Is the service well-led?

Good

The service was well led.
The management team was accessible to those they supported. The provider and staff members had shared values regarding the support they provided. The provider had systems in place to monitor the quality of service provided and made changes when needed.

Louise House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 and 9 September 2016 and was announced. The provider was given 48 hours' notice because the location provides a shared lives and domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of one inspector and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service. We looked at our own system to see if we had received any concerns or compliments about the provider. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law.

We asked the local authority and Healthwatch for any information they had which would aid our inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to assist in our planning of the inspection.

We spoke with ten people receiving support, three relatives, six staff members, the registered manager, the nominated individual and one advocate. We looked at the care and support plans for two people. We also looked at records of quality checks, risk assessments, incidents and accidents, client surveys and feedback, medicines and details relating to staff recruitment.

Good

Is the service safe?

Our findings

We looked at how people were kept safe from abuse. People told us they felt safe and protected when assisted by staff members from positive steps. One person told us, "I feel very safe with them (Staff) they have my interests at their heart." Staff we spoke with had an understanding of the different types of abuse and what to do if they suspected something. One staff member told us, "I would report anything immediately and complete an incident form to record what I saw." We saw one staff member raising a concern regarding one person they supported. They informed the registered manager. The registered manager had made notifications to the local authority when abuse or ill treatment was suspected in order to safeguard the individual.

The provider had systems in place to monitor any concerns raised and reviewed these on a regular basis as part of a management team. This was to identify any common themes or issues which could affect others. For example, following one concern the provider had accessed a "staying safe on social media and on-line" training programme for people and staff members. This was to minimise the risk of exploitation when using the internet and social network sites.

People told us they felt safe when receiving support from positive steps. People we spoke with told us they had individual assessments of the risks they encountered. For example people had assessments to minimise the risk of harm for mobility and falls, road safety and risks around the home. One staff member told us they had a full home environment risk assessment completed by positive steps. As a result a recommendation was for an additional fire extinguisher which was provided. Staff understood how to minimise the risks of harm for those they supported whilst still engaging in activities people enjoyed. One person told us how they cooked their own meals but with a little help. A staff member told us, "[Person's name] does struggle around the cooker. We support them to use other kitchen utensils like the microwave so they are still involved but in a way that is safe." The registered manager had systems in place to monitor any incidents or accidents and to investigate when required. For example, following an incident and a concern raised by the fire service the provider accessed training on fire awareness and prevention. This training was aimed at people using services and staff members. One person told us they went on this training and found it really useful as they now know how to prevent fires.

Staff members told us before they were allowed to start working with people they had to go through a safe recruitment and selection process. They told us this was to ensure they were safe to work with people. The registered manager described the appropriate checks that would be undertaken before staff could start working. These included satisfactory Disclosure and Barring Service (DBS) checks and written references. The (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with people. We saw records where these checks had been completed.

People told us they thought there were enough staff available to meet their needs. The provider had systems in place to ensure people received the correct amount of support in order to meet their needs. One relative told us, "We had a bit of an emergency and needed extra support. We contacted positive steps and they did all the arranging for us and got us the extra support we needed." The registered manager told us their initial

assessment was essential to ensuring the correct amount of support is provided from the start of their involvement. If changes in need are later identified they will arrange additional support to ensure they continue to meet the person's needs.

We looked at how people were supported to take their medicines. People told us they were prompted by staff members to take their medicines or assisted when they needed. One person said, "They [registered manager] did a check to make sure I could do my own medicines." We saw assessments for people and their ability to understand and to take their own medicines. When they needed assistance or prompts this was done by staff members trained and assessed as competent to assist. The provider had records of all medicines taken by people which also included side effects. Staff we spoke with knew what to look for if they were concerned about any side effects and what action to take if they suspected an adverse reaction. One staff member said, "We have regular checks to make sure we are following the right processes and to make sure those we support are safe."

Good

Is the service effective?

Our findings

People we spoke with believed the staff supporting them had the right skills and training to assist them. One person said, "[Carer's name] has been on some recent training. They did first aid and health and safety. I know because we always talk about what they have done." Staff members told us when they first started training they were provided with an initial training programme which equipped them with the skills to fulfil their role. Staff members also accessed additional training relevant to those they supported. One staff member said, "I wanted more training on dementia awareness, what to look for and how to seek support. This was provided and I now feel I have a greater understanding of the condition."

People we spoke with and staff members told us they attended training events together. One person said, "I go where [staff member's name] goes and we learn together." One staff member said the benefits of attending training courses with the person being supported is that they can then discuss the course together. One person told us they attended an exercise, health and wellbeing event along with a staff member. They told us they really enjoyed it and were looking at making some lifestyle changes, along with the staff member and felt they could motivate one another."

Staff members told us they felt supported in their role and that they always had the opportunity to seek advice and support. One staff member said, "[Registered manager's name] comes out and sees us at home. We have the opportunity to talk about anything we like and seek any advice. It is informal and relaxed and this helps us to raise anything we want."

People received assistance from staff members who felt supported and motivated in their roles.
Staff members told us they have the opportunity to attend social events as well as training sessions with other staff members. One staff member told us, "It is good to meet up with others and talk with new staff members as well as those who have been around for a while. It is an opportunity to share ideas, experiences and learning and to support each other."

People were supported to make their own decisions and were given choice. One person said, "It's all about me and what I want." One relative told us, "[Person's name] has a full choice of what they want to do, eat, and wear when they go to stay with positive steps. They can take their personal possessions and make their room their own whenever they go." Another relative told us when their family member first stayed with positive steps they went on a couple of trial stays. They were then able to decide if they liked it or not and if there were any changes they wanted to make.

People were supported to make decisions for themselves. When this was not possible staff understood current guidance which was followed in order to protect people's rights. Staff had a clear understanding of the principles of the Mental Capacity Act and the process of best interest decision-making.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Any applications must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA. The registered manager had made appropriate applications to the court of protection to ensure people's rights were upheld. At this inspection the decisions were still pending but the provider had taken action to ensure the least restrictive interventions were in place to maintain people's best interests. The provider had trained and prepared staff in understanding the requirements of the MCA.

People were supported to have enough to eat and drink and to maintain a healthy diet. One person told us, "I love to pick the tomatoes and have them for my tea. I can always ask for more if I want or just get it myself." One staff member told us, "We do have to promote people's healthy choices. Sometimes someone makes a decision which we cannot support as this would potentially damage their health. However we try and educate people and present opportunities for them to make positive changes to their diet." People received assistance to eat and drink enough to maintain well-being.

People had access to healthcare services and were supported to maintain good health. One person told us, "If I am feeling poorly I will just say to [Staff member's name] and they will sort if for me." Staff members we spoke with told us if they had a concern about someone's health they would always seek advice from a medical practitioner. We saw records outlining people's health needs and guidance for staff members informing them what to be aware off and what to do if they had a concern. One person told us about their ongoing medical issues. They said they had assistance from a staff member to help manage it and to keep well.

Good

Is the service caring?

Our findings

People we spoke with described the staff who supported them as fantastic, lovely and great. People regarded those who they lived with or stayed with a great deal of personal regard. Staff we spoke with talked about those they supported with warmth, kindness, and a mutual respect. One person told us, "They (staff) are brilliant, fantastic in fact." A relative said, "At first I was a little apprehensive but then I saw just how well they (person and staff) got on together. It was lovely and gave me a great deal of reassurance."

Staff took the time to reassure people at times they felt worried or scared. One person told us, "I didn't like something and it made me feel a little scared. I told [staff member] and we made it better together." One staff member told us they noticed a change in one person's behaviour and that they were acting differently. They told us they allowed the person the space to physically express how they were feeling and when they were ready the staff member approached them to see if they could help. The staff member said, "I didn't anticipate how they were feeling but once they told me we were able to work through it together. However, what they needed at that point was space and time and when they were ready we could be there for them."

People told us they thought staff members communicated with them appropriately and in a way they understood. Staff members we spoke with told us they would adapt how they spoke with people depending on the person's personal styles and preferences. Some people were able to maintain a conversation when others needed other adaptations to prompt their understanding. We saw information was given to people in pictures when they wanted as a visual guide for what was being said. We saw a talking book provided by positive steps which gave people the information they needed in a way they could understand.

People were involved in making decisions about their own care and support. These decisions were recorded and staff were aware of how people wanted to be supported. One person said, "I met with [Registered manager's name] and I told them what I wanted. They listened and I can change my mind. They told me that was not a problem."

People receiving support were encouraged by positive steps to access advocacy services. One advocate told us, "Our role is to help those receiving support to have a free voice. To be able to be heard and to build relationships with people so that we are able to help them express themselves." The registered manager told us they promoted the use of advocates and regularly arrange coffee mornings and drop in sessions for people to attend. This is so people are able to express themselves in an environment they felt comfortable in. One advocate told us, "If someone feels safe and comfortable they are more likely to talk to you and express what they want. This is supported by positive steps who I believe are eager to get it right for people."

People told us their privacy and dignity was respected by staff providing support. One person said, "I get my own room and my own space." One staff member told us, "We recognised someone would become embarrassed at times they needed assistance. We had to go slowly with them and take personal care at a pace that they decided. Our assistance is now minimal as they have got the skills to help themselves and we are just there in case we are needed."

People were supported to develop their existing skills to maintain their independence. One relative told us, since [relative's name] has been going to positive steps they have really come out of their shell. I have noticed just how independent they are becoming and I believe this is because they are exposed to greater life experiences with the support of the staff members."

Staff members we spoke with understood the need for confidentiality and told us they never discussed anyone's private information with anyone who wasn't entitled to it. If information needed to be disclosed the staff member would seek the permission of the person or encourage them to share the information themselves.

Good

Is the service responsive?

Our findings

People told us they had care plans which were personalised to them. We saw information contained in the care plans detailed what people thought staff members needed to know in order for them to do their job. One person said, "I met with [registered manager's name] at the start. We talked all about what I liked and what I wanted." One relative told us how their family member was very resistant to change and new experiences would cause stress and anxiety. They told us the registered manager came out on three separate occasions and built a relationship with their relative before they even started to discuss a placement. This relative said, "They took to time to get to know us all and this really helped the transition to accepting their help and support. I think if they didn't do this it would have failed."

We saw records of people's likes, dislikes, personal histories and social interests. When people first received support from positive steps they would be matched with a staff member most appropriate to assist them. One family member told us, "After they (positive steps) found out all about [relative's name] they identified the most appropriate match for them. Someone who would not only support them but who would share the same interests in life. They would then have the opportunity to have a trial stay with them before any permanent decision was made." One staff member said, "When first supporting someone we will always meet in a safe natural place and have a chat over a coffee. It is a good starting point to get to know someone."

People, and when needed family members, were involved in regular reviews to ensure they were receiving the right support to meet their needs. One person told us, "They [registered manager's name] comes out once a month. We can have a chat and they ask me all about my support and if I need any changes." Relatives we spoke with told us they felt included in the planning of their family members support and that their opinions mattered to positive steps. One relative told us, "We were a bit anxious that we would be told how they were going to care. The reality is that [relative's name] tells them how they want their support. We were not expecting that."

Staff we spoke with knew the individual needs and preferences of the people they supported. Personal likes and dislikes were recorded and staff could tell us what people's preferences were. For example, one staff member said, "[person's name] has a great love of all things chocolate. We do need to help them make positive choices but this is something they truly love." Another staff member told us, "[Person's name] has limited experiences of different foods. They tell us they want to keep trying different foods and so we do this all the time with them. They still can't handle the spicy foods just yet. But they are working at it."

People felt comfortable about raising any concerns or complaints with staff members or the registered manager. One person said, "If I am worried I will just go straight to [staff member's name] and they will help me." We saw people had access to the complaints policy and information in an easy to read and follow format. No one we spoke with told us that they had ever had the need to raise a concern. All those we spoke with told us should they feel the need to make a comment they felt it would be responded to appropriately. They had confidence it would be addressed sensitively and efficiently by positive steps. The registered manager had processes in place to respond to any concerns raised.

Good

Is the service well-led?

Our findings

People told us they felt involved and informed about the service that was provided. People knew who the management team were and told us they saw them regularly. People told us they met with the registered manager individually once a month or whenever they wanted to see them. People and staff members told us that they can contact the positive steps office at any time and they felt their contact is always welcomed. One staff member told us their preferred method of contact is by email and they always receive an immediate response.

People and staff members told us they are informed about developments within positive steps by regular news letters. We saw newsletters which contained information regarding training and social events as well as general guidance to support people and staff. The registered manager told us they hold regular training events and social occasions as well as drop in advice sessions for people and staff members to attend. It is during these events people can discuss aspects of the support they receive as well as just having a good time.

People and staff told us they believed the provider created a culture that was open and transparent. One staff member told us they received praise and a thank you when it was appropriate but also constructive criticism when direction is needed. They gave us an example when they changed how they approached the advice they had given someone they supported. The staff member told us, "In hindsight I recognised what was said had been inaccurate and this was constructively pointed out by the management team. I learnt from it and correct any mistakes I had made." Staff members used feedback they received constructively in order to make positive changes about how they worked with people. People were supported by staff members who worked transparently and who were open to direction by a supportive management team.

We asked staff members what they believed the values of positive steps were. One staff member told us, "It is always about putting the person first. Making sure they are appropriately placed with the right person so the experience is positive and fulfilling for all those concerned." People we spoke with told us they found their placements had a positive impact on their lives and personal development.

Staff members told us they felt valued by the provider and any ideas or suggestion were appreciated and actioned if necessary. One staff member told us they believed as an organisation they needed different recording methods for those they supported. They said, "These systems have now been introduced and it feels like a breath of fresh air. Information can be easily accessed if needed meaning people receive a more efficient service."

Staff members told us there were appropriate policies in place to guide their practice including a whistleblowing policy. Staff understood the whistleblowing process and felt they would be supported by the provider should they ever need to raise a concern. Staff understood what was expected of them and were supported to complete their role. Staff told us they felt the management team was supportive and approachable for advice and guidance when they needed.

People were regularly asked for their feedback on how their care and support was provided including any recommendations for change. One person said, "We receive questionnaires in the post along with a stamped addressed envelope which encourages us to fill it in and send it back. To be honest everything is great and I have no recommendations for improvement." Other people and relatives told us if they did have a recommendation they would raise it at a social drop-in event or just phone and talk to the registered manager. All those we spoke with told us they felt any comments would be welcomed and actioned by the provider.

At this inspection there was a registered manager in post. The registered manager maintained their personal and professional development by attending regular training and support sessions appropriate to their role. Any learning or changes to practice were cascaded to staff members through regular team meetings or one to one sessions. The management team understood the requirements of their registration with the Care Quality Commission. The provider had appropriately submitted notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale.

The provider and registered manager had systems in place to monitor the quality of service provision. The registered manager told us they assessed information from quality checks, incident and accidents and feedback from people and staff which they used to drive improvements. Following quality checks and feedback the registered manager identified some of their social events and support sessions were not being accessed by people. They identified this was possibly because of the rural location of some of the placements. As a result they rotated the social events so that they took part in people's home towns and villages. At this inspection we saw details of the next social event taking place in a rural village which was more accessible to people in that area.

The registered manager told us they utilised the services of an external organisation to complete a mock inspection to identify any areas they could improve. We saw details of this mock inspection report and the actions completed as per its recommendations. We saw the management team had identified what changes needed to be made and then individualised these to those they supported. The provider and management team had a clear plan for the development of service they provided. This was split into six monthly achievable targets which was reviewed and included the progress made and what was still required. The registered manager told us that in addition to the expansion of the service they were also looking at expanding on people's experiences of work to increase social and vocational skills for people. People were supported by a provider and management team who had quality systems in place and made changes for improvement when required.

HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE
PROPOSED WORK PROGRAMME AS AT 17 March 17

DATE	ITEM	REASON FOR UNDERTAKING
27 March 2017 Deadline for reports: Noon Thurs 16 March 17	**Shared Lives and Community Living** **Mental Health Services** **Young Carers** *(Members of Young Person's Scrutiny Committee to be invited to attend)*	Committee to assess progress following the commissioning out of Shared Lives and Community Living To receive and consider the recommendations of the Regional Commission on Mental Health Report, particularly in relation to delayed discharges from hospital To ascertain what support is currently available for young carers and the plans for future support
5 June 2017		
24 July 2017		
25 Sept 2017		
20 Nov 2017		
29 Jan 2018		
26 March 2018		

Information Requests / Suggested Items for the Work Programme:

- **The Health and Wellbeing Board has asked the Committee to look into measuring the outcomes of the 'Year of Physical Activity' launched in April 2015 – to be added to the Work Programme in 2017**
- **Annual Report of the Director of Public Health**
- **Availability of physiotherapy and occupational health services**
- **Extent of and role of Frail and Elderly co-ordinators in GP surgeries – links with work of Neighbourhoods Group of STP. Joint HOSC?**
- **Return visits to Oak Farm, Innage Lane, and The Meres Day Care approx. Oct 2017 to consider any impacts following change of provider**
- **Sexual Health Services / Alcohol and Substance abuse – possible Joint Scrutiny with C&YP**
- **Mental Health Services**

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