

# Mental Health Strategy

2005-2010



Solihull   
Primary Care Trust

Birmingham and Solihull   
Mental Health NHS Trust

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**Solihull**  
METROPOLITAN  
BOROUGH COUNCIL

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# Executive Summary

## 1. The National Context

The Department of Health issued the National Service Framework (NSF) for Mental Health in 1999. It is a 10 year Strategy spanning the full range of mental health care and sets out a vision for reform with the needs of service users, families and carers placed at the centre of future planning and provision, secured on sound evidence with services available 24 hours per day 7 days a week, delivering improved outcomes and quality of life for service users.

It is based on 11 principles and 7 standards and this locally produced Strategy, incorporating significant user and carer participation, responds to the NSF and provides the strategic direction for the development of community orientated mental health services.

## 2. The Local Strategic Context

The key partners of this Strategy are committed to working with users and carers to develop a responsive mental health service which can deliver a quality service and enables people to play a full part in their local and wider community. This requires the mental health strategy to inform and be informed by a range of national and local strategic initiatives, most notably the Community Strategy and the Strategic Framework For Reducing Health Inequalities. This Strategy focuses predominantly upon the needs of adults of working age but also needs to address the needs and of children and young and older people particularly to ease the transition from one service to another.

## 3. Taking Stock - The Position in March 2005

The Solihull Mental Health Strategy is based firmly upon the premise that people can recover from mental health problems and should be afforded care and support to facilitate their participation as citizens in the local and wider community. The capacity of agencies to deliver relevant services to achieve this outcome is underpinned by the closer integration of statutory services between the Birmingham and Solihull Mental Health Trust and Solihull MBC and partnership arrangements including users, carers, Solihull PCT and a range of independent sector agencies.

## 4. Services Currently Commissioned

A wide range of services are commissioned from statutory and independent sector agencies for adults, as well as for older people with mental health needs and children and young people. It is vital to co-ordinate the requirements of the relevant NSFs and the targets set for people of all ages.

## 5. Needs Analysis

A needs analysis has been conducted by the Joint Solihull PCT and MBC Public Health Directorate. It describes the distribution of mental illness in Solihull through the examination of routine activity data. In the main, two sources of data have been used, firstly prescribing and secondly inpatient admissions data. The analysis of activity concentrates on all mental illness, depression, neuroses, psychosis, senile dementia and community activity.

## 6. Strategy and Investment Plan 2005 - 2010

### 6.1 Priorities

This Strategy and its implementation will centre on five important but complementary strands of service improvement; the priorities are:

- Self-Assessment of compliance with NSF Standards

The continuing review and self-assessment of progress towards meeting individual targets as prescribed by the 'Traffic Lights' to ensure compliance with NSF Standards.

- Pre-existing priorities

There are a number of significant pre-existing priorities which are receiving continuing attention. While progress on these will be monitored by the self-assessment, in view of their importance it is useful to highlight them:

- The introduction of a Crisis Resolution Service
- The introduction of an Early Intervention Service
- The introduction of Community Development Workers and the development of culturally sensitive services
- Suicide prevention
- The continuing need to apply Primary Care resources efficiently
- To attain a full complement, and deployment, of Graduate Workers
- To meet the needs of Solihull's prison population
- To commission further dedicated services for women
- Consider options for addressing the need to provide single sex hospital accommodation
- To implement the protocol which fulfils the requirements of the Mental Health Act Code of Practice and reaffirms the hospital as the preferred place of safety, except where a risk assessment indicates otherwise

### Reviews

The outcome of Reviews of the existing range of services currently commissioned and the preparation of proposals for the redesign of service provision, namely:

- Services currently commissioned
- Day Services provided by Birmingham and Solihull Mental Health Trust
- Continuing Care
- Service Redesign
- Reviews of housing related support services funded by Supporting People Grant
- Workforce Strategy

The capacity of all stakeholders to deliver the Strategy and continue to manage high quality services depends on the ability of agencies to recruit and retain a skilled and motivated workforce.

A Workforce Strategy will be required to address a number of key issues, including:

- Agreement to a single set of competencies in order to implement the NSF
- Provision and development of education and training, including pre-qualifying training and continuing professional development
- Assessing for the appropriate skill mix to enable the delivery of each Standard
- Clinical Governance

Clinical guidance to support the implementation of the NSF is provided on behalf of the Department of Health by the National Institute for Clinical Excellence (NICE). Technical appraisals and clinical practice guidelines are issued. A number are due for publication including guidance on anxiety, depression in children, bi-polar disorder, puerperal/perinatal disorder, dementia, drug misuse and attention deficit/hyperactivity disorder.

## 6.2 Key Criteria for the Commissioning of Services

It will be of paramount importance to commission high quality services in line with the stated strategic priorities. In order to achieve positive outcomes for service users and carers services will be commissioned only if evidence can be produced that the following criteria are met.

Services for people with mental health needs must:

- Reduce the need for more intensive forms of long term care and support
- Reduce the incidence of self harm
- Enable choice
- Recognise and address the needs of people from black and minority ethnic communities
- Support carers
- Facilitate the smooth transition of young people to suitable services when s/he becomes an adult
- Facilitate the smooth transition of working age adults to suitable services for older people.

## 6.3 Investment Plan

The implementation of this Strategy in order to comply with the requirements of the NSF necessitates action on a significant number of tasks. Some do not need additional money and are changes of practice or a realignment of priorities which should be absorbed within existing resources. However, a number of tasks will require additional investment in order to achieve the introduction of new services or facilitate the extent of change required.

The priorities of the Strategy are set out above in paragraph 6.3 and have significant revenue consequences. It is these priorities which act as the pivot for the future implementation of the Strategy. A summary of these key issues is provided below in the Investment Plan on page 80. This Plan is prepared @ March 2005 and includes details of the revenue investment in 2005/06 and the timetable for the implementation of each priority. This Plan will need to incorporate details of the longer term revenue requirements and commitments and be subject to regular review by the LIT and the Mental Health Partnership Board.

Significant progress has been made to secure additional revenue to fund important developments for the mental health service. In 2005/06, these additional resources can be summarised as follows:

- PCT - as part of the Local Delivery Plan an additional £650,000 will be invested in 2005/06, resources which will have a full year effect of £750,000 from 2006/07. This investment will fund both the Early Intervention Service to be managed by the BSMHT and other new developments.
- SMBC - The Council has identified a total of 8 Step Change Improvement Projects (SCIPs) which would benefit from additional investment. One of the SCIPs is to achieve a two star rating for adult social care services along with, for example, physical, economic and social regeneration solutions for the Borough. As a consequence additional revenue of £175,000 has been identified to fund the Early Intervention and the Crisis Resolution Services.

## 7. Implementation Plan

An Implementation Plan (Appendix 1) provides full details, for each Standard of the NSF, of each action together with information on the nature of the resources needed, including finance, and an indication of which 'traffic light' is addressed.

# CHAPTER 1

## The National Context

### 1. The National Service Framework

1.1 The Department of Health issued the National Service Framework (NSF) for Mental Health in 1999. It is a 10 year Strategy spanning the full range of mental health care and sets out a vision for reform with the needs of service users, families and carers placed at the centre of future planning and provision, secured on sound evidence with services available 24 hours per day 7 days a week, delivering improved outcomes and quality of life for service users.

1.2 The NSF was based on 11 principles; people with mental health problems should expect services that will:

- Involve service users and their carers in planning and delivery of care
- Deliver high quality treatment and care which is known to be effective and acceptable
- Be well suited to those who use them and non-discriminatory
- Be accessible so that help can be obtained when and where it is needed
- Promote their safety and that of their carers, staff and the wider public
- Offer choices which promote independence
- Be well co-ordinated between all staff and agencies
- Empower and support their staff
- Be properly accountable to the public, service users and carers
- Reduce suicides.

1.3 These principles have been translated into seven standards designed to regulate the development of service provision in key areas. They are:

- Standard 1 - Mental Health Promotion
- Standard 2 - Primary Mental Health Care
- Standard 3 - Access to Services
- Standard 4 - Specialist Care
- Standard 5 - Hospital and Crisis Accommodation
- Standard 6 - Support for Carers
- Standard 7 - Preventing Suicides

These standards were complemented by a series of underpinning strategies which focussed on finance and the workforce.

## 2. The NHS Plan

In 2000 the NHS Plan was published and underlined the Government's commitment to mental health services with investment in new models of service delivery namely:

- Crisis resolution (home treatment)
- Assertive outreach
- Early intervention in psychosis
- Primary care and gateway workers

## 3. Mental Health Policy Implementation Guide

The Department of Health issued further guidance in 2001 and concentrated on the promotion of a detailed understanding of the role and function of these new models of service delivery.

In addition, the guide looked to further enhance the co-ordination of planning and service provision for people who need to make a transition between one service and another. In particular it is crucial to acknowledge that mental health services provide for people of all ages and the importance of co-operative planning and provision for children and young people and older people.

This work will refer to the development of Child and Adolescent Mental Health Service (CAMHS) and to the National Service Framework for Older People.

## 4. Child and Adolescent Mental Health Services (CAMHS)

The importance of child and adolescent mental health services was recognised in 1999 by the 1999 Audit Commission report, 'Children in Mind', the NHS Plan as well as the NHS Modernisation Fund and the Mental Health Grant. The profile of CAMHS services has been further heightened by the publication of the National Service Framework for Children Emerging Findings in 2003 and the Children's National Service Framework in 2004.

The objective is to secure a multi-agency, multi-disciplinary tiered model in order to commission, provide and manage a comprehensive CAMHS. The development of this service will have reference to past work for the local Health Improvement Plan (HIMP) and the local Children's Plan, managed by the Local Authority, complemented by the bidding process for the CAMHS grant.

## 5. National Service Framework For Older People

The Government issued, in September 1999, the National Service Framework for Older People. This guides the delivery of services for older people and the lead responsibility rests with health and social care agencies.

The NSF provides guidance for the care of older people whether that be in residential settings, care in hospital or in their homes. It aims to ensure that:

- older people receive high quality care and treatment, regardless of their age
- are treated as individuals, with respect and dignity
- that there are fair resources for conditions which most affect older people
- and there is an easing of the financial burden of long term residential care.

## 6. The National Service Framework For Mental Health - Five Years On

6.1 A clear direction for the improvement of mental health services was, therefore, given by the foregoing documentation. Service users, carers mental health trusts, primary care trusts, local authorities, voluntary and independent organisations and other stakeholders have forged partnerships to implement the desired changes. This Strategy looks ahead for Solihull to the next five years and will refer to the progress made and to the emerging priorities as they are expressed nationally.

The NSF has promoted many substantial benefits and major change but at this juncture - 5 years into a 10 year programme - much remains to be done to build on the increases in expenditure, staff numbers and use of modern treatments.

6.2 In December 2004 a review was completed of progress, across the country, towards implementing the NSF and each of the seven standards. Louis Appleby reported on the achievements, focusing on the progress as reported by the autumn assessment data of 2003, and judged progress only where evidence could be demonstrated of action and change.

6.3 Importantly, in the light of progress towards implementing the changes demanded by the NHS Plan and National Service Frameworks, while the standards continue to provide the right framework the 'Five Years On' document highlighted a number of areas where the emphasis for further change should concentrate. These are:

### 6.3.1 The mental health of the whole community

This will continue to encourage the shift towards the mental health of the whole community with particular reference to improving mental health care of people from black and minority ethnic communities and to prisoners. A top priority will be to oppose discrimination, provide for a diverse community and highlight the importance of occupational stress.

### **6.3.2 Primary Care**

The accent on primary care will reflect the attention devoted by the NHS on the management of long term conditions and health inequalities, including public health issues such as smoking related diseases which could be prominent in people with mental health problems. Further work will be required to manage the interface between primary and secondary care including the development of further commissioning expertise.

### **6.3.3 Access to psychological therapies**

The National Institute for Mental Health (England) will respond to the long waiting lists which still exist in many places with a programme of work to explore ways to expand the availability of talking therapies. This will include improved psychological therapy skills in front line workers and a broader choice of providers of therapy.

### **6.3.4 Suicide prevention**

The rate of suicide reflects the general state of a community's mental health. There are continuing concerns about the level of suicide by young men because it is the commonest cause of death in men under the age of 35 and the higher rate in unskilled men contributes to health inequalities

### **6.3.5 Specialist mental health services**

The priority areas will include:

- In-patient wards - a new programme will aim to continue the capital investment to improve the physical environment as well as develop new models of in-patient care and improve integration with community mental health services.
- Dual diagnosis - the development of dedicated services for dual diagnosis and improve collaboration between community drug and alcohol and mental health services will receive continuing attention to further improve assessment and management of substance misuse issues.

### **6.3.6 Carers**

There was little to report on progress to improving support for carers. Prompt support, information, practical advice, emotional support and respite continue to be the priorities which need to be addressed.

### **6.3.7 New ways of working**

The New Ways of Working programme will require a review of how the skills of the workforce can be deployed with benefits to service delivery, job satisfaction and work load pressures.

### **6.3.8 Information Systems**

Significant improvements are expected in this area to address the need for the sophisticated collection of information to act as a foundation of change. The outcome from pilot projects of the National Programme for Information Technology will provide further guidance.

# CHAPTER 2

## The Local Strategic Context

### 1. Introduction

In order to respond to the national agenda the mental health strategy must inform and contribute to a variety of inter-connected local strategies. The emphasis placed on the mental health of whole communities only serves to underline the need for co-ordinated series of strategies if appropriate services are to be commissioned and delivered. There are a number of crucial local strategies which form this local context which are discussed below.

### 2. Solihull MBC's One Council One Vision

The Council has successfully introduced a new vision aimed at creating important changes to how the local authority works. All staff are guided in their responsibilities by a Vision which states that Solihull is a place where well being, pride and quality of life is enjoyed by all; the Council promises to deliver quality services which are constantly improving, invest in people and partnerships, and work flexibly and creatively to develop the environment.

This Vision is complemented by a set of Values comprising respect, learning, equality, integrity and caring.

### 3. Solihull Primary Care Trust (PCT)

Solihull Primary Care Trust was formed in 2001 with responsibilities to commission and provide primary health care such as family doctor services, pharmacy services, dental services, opticians services, community nursing and health visiting, and community therapy services, such as speech and language therapy, chiropody, occupational therapy and physiotherapy; and learning disability services which provides a lifelong service for children and adults with a learning disability, that is holistic and designed to meet the needs of the individual;

The PCT also commissions secondary health care and treatment provided in hospitals including Solihull Hospital and Birmingham Heartlands Hospital; promotes health improvement through the health promotion and public health functions which encourage healthier lifestyles through education, information and support; and commission mental health services from a range of providers in the statutory and voluntary sectors including the Birmingham and Solihull NHS Mental Health Trust.

### 4. Birmingham and Solihull NHS Mental Health Trust

Birmingham and Solihull Mental Health NHS Trust provides a comprehensive mental healthcare service for Birmingham and Solihull residents, and to communities in the West Midlands and beyond.

The Trust was created on 1 April 2003 by the merger of the former Northern and South Birmingham Mental Health NHS Trusts which included mental health services for Solihull and has an agreed formal partnership agreement with Birmingham City Council's Social Care and Health Directorate and Solihull MBC Social Services Directorate to provide integrated health and social care services. The core purpose of the Trust is to provide integrated mental health services across Birmingham and Solihull in the most effective and efficient way, ensure the best outcomes for those who use the services and to work in an open, honest and collaborative way with staff, service users, their carers and their families.

## 5. Community Strategy 2003 - 2013

A Place for People is a ten year vision setting out the main aspirations of the Primary Care Trust, the Police, Voluntary Sector, Learning and Skills Council, Business Partnership, Heartlands and Solihull Hospital Trust and Solihull MBC. A set of 9 aims has been agreed for the following 3 years each with a series of objectives.

### 5.1 Making Solihull a place that's good to live for everyone

- Reduce crime and disorder
- Improve the range and quality of housing
- Reduce drug misuse
- Improve access to information, learning, leisure and cultural opportunities through new technologies.

### 5.2 A place that offers opportunities for learning and creativity

- Promote the value of learning and so contribute to individual and community development.

### 5.3 A place where children, young people and family life are valued

- Provide facilities for young people.

### 5.4 A place that is safe from crime and disorder

- Reduce incidents of crime and disorder
- Reduce the demand and supply of illegal drugs

### 5.5 A place that creates jobs and encourages enterprise

- Enable local people to gain local jobs, in particular assisting those people who experience disadvantage or discrimination. To have better prospects of good quality employment and training opportunities.

### 5.6 A place where people enjoy good health

- Address the health inequalities in the Borough, recognising the link between social exclusion, environment, poverty and ill-health
- Ensure health matters are considered in all decision making of public bodies, with effective co-ordination of planning and service delivery
- Promote health lifestyles

- Reduce ill-health in at least one of the four national priority areas, namely mental health
- Develop healthy alliances that enable local people to take greater responsibility for their own health, by working with local communities and a wide range of voluntary and not for profit organisations

### 5.7 A place where people respect difference and diversity

- Develop a strong and positive cultural identity for Solihull
- Celebrate the cultural diversity within the borough
- Respond to the needs of local people and especially minority ethnic groups

### 5.8 A place where people promote caring towards others

- Ensure the provision of an adequate range of supported accommodation, taking into account the needs of carers
- Make sure that people are aware of the assistance that they are entitled to
- Enable more vulnerable and older people to remain living independently in the community.

### 5.9 A place that is inclusive and community focussed

- Build partnerships with community groups
- Take active steps to ensure that local people have access to affordable legal information and advice
- Encourage greater participation in groups and organisations
- Deliver high quality housing support services
- Improve access for disabled people to an increased range of employment opportunities
- Take steps to monitor equalities.

Source: A Place for People, Community Strategy for Solihull 2003 - 2013

## 6 Strategic Framework For Reducing Health Inequalities

### 6.1 Background

Health improvement and the reduction of health inequalities is a top priority locally and nationally. A Strategic Framework has been produced by the Public Health Directorate of Solihull PCT and Council and the latest draft (Number 10 of May 2004) is a vital part of the overall context.

Local health data show that the Borough's population is, on average, very healthy. Looking at averages however, hides any underlying variation, and across Solihull there are large gaps in health expectation and experience, caused by a range of social, environmental and economic factors. These gaps are known as health inequalities.

The Strategic Framework challenges partners agencies to develop ambitious targets and actions to reduce health inequalities overall, in childhood and throughout life. Importantly it makes the connection between multiple deprivation factors and health inequalities, particularly (but not exclusively) in the north of the Borough. It is essential that this strategic framework does not result simply in co-ordinating existing programmes and projects, but stimulates genuinely new approaches and the bending of existing resources on a sufficient scale to have a demonstrable impact on the problem.

Improvements to reducing health inequalities will require a co-ordinated approach, a requirement underlined by the mental needs analysis also conducted by the Public Health Directorate of Solihull PCT and Council. This is discussed in some detail in Chapter 5 and describes the distribution of mental illness in Solihull through the examination of routine activity data. Two sources of data have been used, prescribing and inpatient admissions data and the analysis of activity concentrates on all mental illness, including depression, neuroses, psychosis, senile Dementia and community activity.

In order to clearly set out the overall position of health in equalities within the Borough the pertinent issue are discussed below.

## 6.2 Demography

Solihull is home to approximately 200,000 residents. The Office for National Statistics estimates that the population will remain fairly stable between now and 2011, falling by around 0.3%. However, the age profile is expected to change dramatically, with the proportion of over retirement age rising by over 20%.

The population in the north of the Borough is younger than the south, characterised by a higher percentage in the 0-30 age group and the south has 38% in the 50+ age group compared to 30% in the north. Similarly, the number of people living in the north (45+ residents per hectare), is much greater than the west (from 15 to 44.9), and the rest of the Borough (where it rises from 0 to 14.9 residents per hectare).

The Borough as a whole has a lower proportion of residents from black and minority ethnic communities than the average for England & Wales (94.6% of the borough's population being white) and a significantly lower proportion than the West Midlands average. However, these residents often experience worse health for a number of reasons and their needs will be included the delivery of this Strategic Framework.

## 6.3 Economy

The Borough is an area that is generally robust in economic terms. However, there are pockets of deprivation with the wards (@ 2004) of Kingshurst, Chelmsley Wood, Fordbridge and Smith's Wood featuring in the top 10% of deprived neighbourhoods nationally.

## 6.4 Social

Comparing the social experiences of residents in the four deprived northern wards with Solihull as a whole, it is evident that:

- twice the number of lone parents and up to six times the level of teenage pregnancies than the borough average.

- in terms of education, skills and training, measured predominantly by lack of qualifications amongst adults and children, the four wards suffer from acute difficulties, being in the worst 5% of wards in the country.
- people are more likely to be from manual-skilled, partly-skilled and unskilled occupations and those in the south are more likely to have professional and managerial positions
- people suffer from more crime, particularly in Chelmsley Wood, Fordbridge and Smiths Wood wards, with significantly higher burglary rates and higher levels of drug abuse
- over the three years since 1998/99, the wards that have accounted for the highest rates of criminal damage (offences per 1000 population) include Chelmsley Wood, Fordbridge and Smith's Wood. Criminal damage includes offences such as damage to buildings, arson and vandalism
- the five wards that contribute 57% of all recorded domestic violence incidents in the Borough include Chelmsley Wood, Fordbridge, Smiths Wood, and Kingshurst.
- In 2002/03, only 58% of Council housing (74% of which is in north Solihull) met the Government's Decent Homes standard.

## 6.5 Environment

Solihull borough enjoys a very good living environment overall, with most people enjoying good transport links and access to employment, shopping, public services, leisure and cultural facilities.

Demand to live in the borough is high, which is reflected in high property values. This means however, for some there is a shortage of affordable housing.

## 6.6 Targets

HM Treasury led a cross cutting spending review which examined a range of Government programmes to identify how spending could be applied to greatest effect on health inequalities, using evidence from the earlier 'Independent Inquiry into Inequalities in Health'. The spending review findings have led to the publication in 2003 of the Government's plan for reducing inequalities in health (Tackling Health Inequalities - A Programme for Action, 2003) and identifying the following key health inequalities targets:

National Public Service Agreement Target:

- By 2010 to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.

This is underpinned by two more detailed targets:-

- Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between routine and manual groups and the population as a whole.
- Starting with local authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.

## 6.7 The Way Forward and Monitoring

**6.7.1** The existing ways of working and patterns of service delivery have delivered significant improvements in health and the determinants of health, but have failed to halt the increase in health inequalities. This is not surprising since the primary aim has often been health improvement or general improvement in the determinants of health, rather than health inequality reduction or reductions in differential exposure to the determinants of health. In order to deliver the same level of success in reducing health inequalities as we have in improving health, health inequalities must be given equal status alongside health improvement in everything we do.

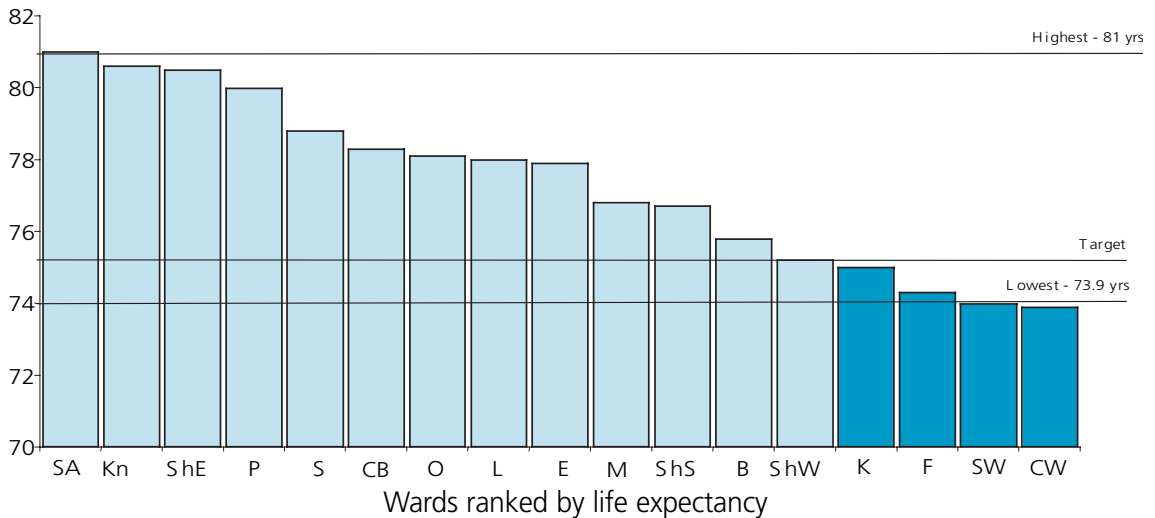
**6.7.2** A key indicator as to the extent of inequality in the Borough is life expectancy and is representative of the inequalities in the Borough.

### Life Expectancy

KEY:

B	Bickenhill	O	Olton
CB	Castle Bromwich	P	Packwood
CW	Chelmsley Wood	SA	St Alphege
E	Elmdon	ShE	Shirley East
F	Fordbridge	ShS	Shirley South
K	Kingshurst	ShW	Shirley West
Kn	Knowle	S	Silhill
L	Lyndon	SW	Smiths Wood
M	Meriden		

Life expectancy at birth



## 6.8 National Health Inequalities Indicators and Local Indicators Proposed by the Government

Health indicators that may be helpful to local agencies for measuring health inequalities in their areas have been produced by the Association of Public Health Observatories and the Health Development Agency and is based on data that is currently collected at either national or local levels. There is no obligation to use any of these indicators. Alternative indicators may be more useful, but may require new data collection to be established. The indicators were selected based on the following 5 criteria:

- It is routinely published at local authority or PCT level
- It is updated at least 3-yearly intervals
- It is robust enough to detect changes over time
- It can be interpreted
- If not routinely published, the data to calculate it are routinely collected at local authority or PCT level

In time it will be important to correlate the implementation of the Mental Health Strategy with these indicators and further integrate the contribution of mental health services to reducing health inequalities.

Source: Strategic Framework for Reducing Health Inequalities in Solihull, Draft 10, May 2004

## 7. Solihull MBC : 2001 Census - First Results from Key Statistics

### 7.1 Introduction

Solihull has a population of 199,521 and an area of 17,832 hectares resulting in a density of 11.19 persons per hectare.

There are two main areas of urban development, in the north of the Borough (32% of the population) and in the west (50% of the population), both adjoining neighbouring Birmingham. Nearly 70% of the Borough's area is Green Belt (bordering Stratford on Avon, Bromsgrove, Warwick and Coventry Districts), where there are significant settlements of Knowle, Dorridge, Balsall Common, Meriden, Hampton in Arden and Hockley Heath, accommodating 18% of the population.

The 2001 Census population for Solihull of 199,521 shows a fall since 1991 of 0.17% but is still higher than 1981, when the Census reported a population of 197,933. The position at April 2001 is set out below.

### 7.2 Population

- Sex - The population is evenly split between male (48%) and female (52%) but there are more females in all 5-year age groups above 25 years and twice as many females (5464) as males (2642) over 80 years of age.
- Age - Residents aged over 65 total 33,583 (16.83% of total population), which is nearly 1% higher than the National average. Since 1991 when there were 28,626, there has been a 17.32% increase. In the 85+ age group, the total of 3,578 people shows an increase of 63.4% since 1991. 4.1% of all Solihull residents are aged over 80 years, which is equal to the National average.

- Ethnicity - The District currently has an ethnic minority population of 5.41% (England/Wales: 8.7%). This compares to 2.9% in 1991 - but this increase may reflect a reclassification of ethnic groups in the latest Census. There has been an increase in ethnic groups Indian/Pakistani/Bangladesh (1.20% in 1991 to 2.54% in 2001) and slight increase in ethnic groups Black Caribbean/African (0.78% in 1991 - 0.95% in 2001)
- Employment - There is an economic activity rate of 63.48% of people age 16-74 years.(63.93% of people age 16+ in 1991). Of those in employment 42.64% are working full time compared to 40.95% in 1991. 15.97% of people in employment work in wholesale/retail trades, 12.07% in public administration and education, 15.18% in real estate, renting and business activities and 16.18% in manufacturing. Most people travel to work by car - 68.61%(67.82% in 1991), and working at home has increased during the last 10 years from 4.37% to 9.15% The highest occupation group is 1.Managers & Senior Officials - 18.01%, followed by 4.Administrative & Secretarial - 15.94%

### 7.3 Households

There are 80,930 households in the Solihull - an average of 2.45 persons per household. (2.91 in 1981, and 2.62 in 1991). The average for England/Wales is 2.36

- Household composition - The percentage of Single Person households has increased steadily, from 17.05% in 1981 to 22.04 in 1991 and 26.28% in 2001. Lone parent households with dependent children totalled 1786 in 1981, 2656 in 1991 and 4951 in 2001 and the percentage of households comprising only people of pensionable age has increased from 18.97% in 1981 to 25.41% in 2001. 31.53% of all households include dependent children, compared to 32.14% in 1991.
- Tenancy - In 1981 66.98% of households were owner occupied. This increased to 76.49% in 1991 and to 78.57% in 2001. The % rented from the Local Authority dropped from 25.95% in 1981 to 13.59% in 2001.
- Amenities - Properties lacking basic amenities such as bath/WC constituted only 0.18% of the total in 1991, and this dropped further to 0.11% in 2001. The number lacking central heating decreased from 10.2% to 4.63% during ten years and car ownership/availability increased, with 40.97% of households having 1 car, and 38.44% having access to 2+ cars/vans.
- Deprivation - Solihull had an unemployment rate of 2.96% in 2001 (2.3% in December 2002),and 0.84% are considered to be long-term unemployed (not worked since 1999). 3.97% of all households in Solihull contain children but have no adult in employment- this is a slight decrease since 1991 and compares with 4.90% in England/Wales. 3.93% of households are considered to be overcrowded (1.46% in 1991 - but the specification has changed).

Finally, 4.17% of residents had moved into Solihull between April 2001 and April 2002, 4.39% changed address within the Borough and the equivalent of 4.06% moved out.

Age Range	All people 2001	% Change from 1991	Male 2001	% Male Change from 1991	Female 2001	% Female Change from 1991
0 - 4	11,203	-11.26%	5,855	-8.43%	5,348	-14.17%
5 - 9	13,463	7.85%	6,778	5.66%	6,685	10.17%
10 - 14	14,440	14.68%	7,495	14.53%	6,945	14.83%
15 - 19	12,250	-13.76%	6,334	-12.86%	5,916	-14.69%
20 - 24	8,883	-37.02%	4,473	-38.07%	4,410	-35.91%
25 - 29	10,158	-21.43%	4,859	-22.62%	5,299	-20.30%
30 - 34	13,645	2.52%	6,644	1.54%	7,001	3.47%
35 - 39	15,471	17.61%	7,485	16.83%	7,986	18.36%
40 - 44	14,591	-13.03%	7,178	-11.57%	7,413	-14.40%
45 - 49	12,882	-14.50%	6,319	-15.95%	6,563	-13.05%
50 - 54	15,413	29.77%	7,512	24.70%	7,901	34.99%
55 - 59	13,273	20.26%	6,567	21.12%	6,706	19.43%
60 - 64	10,266	-7.32%	5,077	-5.91%	5,189	-8.66%
65 - 69	9,390	-2.26%	4,392	-2.70%	4,998	-1.87%
70 - 74	8,931	21.71%	4,065	29.46%	4,866	15.91%
75 - 79	7,156	22.16%	3,015	28.85%	4,141	17.71%
80 - 84	4,525	24.55%	1,608	35.35%	2,917	19.30%
85 - 89	2,431	48.50%	775	78.98%	1,656	37.54%
90 +	1,150	107.96%	259	139.81%	891	100.22%
<b>all ages</b>	<b>199,521</b>	<b>-0.17%</b>	<b>96,690</b>	<b>-0.60%</b>	<b>102,831</b>	<b>0.24%</b>

## 8. Race Equality

In 1991 people from black and minority ethnic communities in Solihull formed 2.6% of the total population. The recent 2001 Census has seen a noticeable increase in the number of people from black and minority ethnic communities to 5.41%. This compares with the average for England and Wales of 8.7%.

The Stephen Lawrence Inquiry of 1999 reports warnings of the danger of 'collective failure' and the nature of 'unwitting prejudice' which is akin to institutional racism as defined by the Macpherson Report.

The Race Relations Amendment Act (RRAA) 2000 places a general duty on public authorities to eliminate unlawful racial discrimination, promote equality of opportunity and promote good relations of persons of different racial groups.

In order to meet these responsibilities one of the specific duties of the Act is for each public authority to publish a Race Equality Scheme and the need for Officers to incorporate the promotion of race equality and initiatives to eliminate racial inequality into all relevant policies, plans and strategies and this will include the mental health strategy and the future need for culturally sensitive services.

This is fundamental to the development of mental health services which have been heavily criticised particularly following the report into death of David Bennett which highlighted concerns over clinical practice and previous lack of progress to develop culturally sensitive provision.

## 9. Older People with Mental Health Needs

The NSF for Older People includes standards for people with mental health needs and the aim is to promote good mental health and to treat and support those older people with depression, dementia as well as psychotic illnesses. The standard is for people to have access to integrated mental health services to ensure effective diagnosis, treatment and support for older people and their carers.

Solihull's services work in partnership to fully support and develop a comprehensive mental health service for older people in line with the NSF for Older People. The service is primarily delivered to older people who have severe mental health problems, a long-standing mental illness, or those who require specialist skills.

Further work is required to develop an overarching local strategy for older people in line with the Older People's NSF and this will encompass people with mental health problems.

## 10. All Our Tomorrows, Strategic Commissioning Statement for Extra Care Housing And Care Home Accommodation For Older People, 2005 - 2010

All Our Tomorrows is based on principles which have been thoroughly examined and consequently endorsed by a wide variety of interested parties. These principles are to:

- Enhance care and support for older people in their own homes and their carers; and, where appropriate maximise the use of low intensity support services, assistive technologies and facilitate the adaptation of properties.
- Give relative priority to the development of extra care housing in order to maximise older peoples independence and to reduce the use of care homes by frail ambulant older people.
- Focus public support of places in care homes on more highly dependant older people including people with physical and/or mental health needs.
- Secure change within a mixed economy of care which is able to respond to the diverse needs of older people and to offer accommodation choices consistent with their needs and expectations.

These principles will guide the development of services for older people including residents with mental health problems and further underline a community orientated approach to provision.

## 11. Caring Together, A Strategy for Meeting the Needs of Carers in Solihull, 2004 - 2009

The needs of people who care for users with mental health problems is specifically addressed within the National Service Framework. Solihull has responded by producing a Strategy which raises awareness of carers and carers' issues and aims to respond to their needs including their health, including mental health and well being.

Solihull values the contribution of carers and the commitment to supporting carers is enshrined in the following principles:

- Carers provide the majority of care in the community and this should be recognised.
- Carers have a wealth of knowledge and experience about the care they provide and will be seen as partners in the provision of this care.
- Carers will be empowered to make choices for themselves and have more control over their own lives so that their individual wishes can be respected.
- Carers will be supported to continue to provide care for as long as they are able and wish to do so. Not everyone will be able, or wish to be a carer and this will be acknowledged and respected.
- Services will be equally accessible to people regardless of age, gender, disability, culture or race.
- Carers will be respected and valued as people in their own right, with their own needs as carers separate from the needs of the people for whom they care.

This Strategy will inform and be further influenced by the continuing progress required by Standard 6 of the NSF and the need to support carers providing for people with mental health problems.

## 12. Supporting People Strategy 2004/05 - 2008/09

12.1 In order to set out a clear direction for the future development of housing related support services the Solihull Supporting People Commissioning Body have agreed Key Criteria for the commissioning of new services.

The Commissioning Body will consider commissioning new services if evidence can be produced to demonstrate that the following criteria are met:

- The needs of women are addressed
- Services prevent homelessness
- Services which reduce the need for more intensive forms of care and support e.g. residential care
- Services assist with the reduction of crime or the fear of crime
- The needs of people from black and minority ethnic communities are recognised and addressed
- Proposals are supported with evidence by a multi-agency 'Planning Team' that it will assist the implementation of national client group guidance and the local strategic response and meet consequent targets.

In turn, specific priorities have been agreed for each vulnerable group and for mental health services these are stated as follows:

The emphasis of the Mental Health Strategy is upon the integration of health and social care services with the development of an Assertive Outreach Service, the Community Recovery Team and the proposals to increase day services within each Community Mental Health Team across the Borough. These developments must be compatible with ensuring that all service users are not placed in more restrictive environments than their needs or risk assessment indicates and that service users move to more independent settings potentially freeing up resources and the silting up of existing provision. Among the main priorities within the Strategy is the need to increase the range and availability of community based accommodation with support; and in particular to:

- Assess the numbers of users who may be currently inappropriately placed in residential or nursing homes and where the development of additional housing related support services would enable more individuals to move into independent living freeing up resources.
- Implement the first proposal to meet the above requirement at Lakeside, Kingshurst and support up to 16 people in a supported environment by way of a floating support service.
- Expand floating support services and to increase the range and availability of community based accommodation with support.

**12.2** In August 2002 the ODPM issued The NHS and the Supporting People Strategy - Building the Links - August 2002 and this highlighted the following key points of collaboration between Supporting People and the NSF:

- Standard One - Mental Health Promotion

Health and social services should promote mental health for all, working with individuals and communities and combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

- Standard Five - Hospital and Crisis Accommodation

Aim : To ensure that each person with severe mental illness receives the range of mental health services they need; that crises are anticipated or prevented where possible; to ensure prompt and effective help if a crisis does occur; and timely access to an appropriate and safe mental health place or hospital bed, including a secure bed, as close to home as possible. "

- Standard Seven - Mental health in older people

The aim of this standard is to promote good mental health in older people and to treat and support those older people with dementia and depression.

Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and their carers.

As part of this standard it states that support should be available to older people with mental health problems live safely in the familiarity of their own homes. Social Care and other services should include provision covering, for example, personal care, care of the home, relationships, accommodation, finance, and support to carers.

## **13. Housing Strategy 2004 - 2008**

The Purpose of the Housing Strategy is to enable the Council and partner agencies to develop clear objectives for housing activity in the period to 2008, ensuring that these meet local, regional and national policy priorities.

These objectives and priorities for action are clearly set out in the Strategy including how the Council will work with partner organisations and local people to implement the proposals. These actions will be measurable against set targets that allow them to be evaluated and it is expected that the Strategy will be revised on a regular basis in line with national, regional and local developments. It is intended that they will support the wider social, environmental and economic objectives. There are clear implications and benefits for people with mental health problems bearing in mind the need for users to be able to gain access to accommodation of their choice.

People can be vulnerable for a wide variety of reasons and at different stages in their lives. For some, there is a need for long-term support, but for many, short-term one-off interventions are sufficient. The Council's overall strategy is therefore to make targeted interventions at the lowest effective level in order to enable people to live as independently as possible within the community

The identification of need and services to respond to them are prioritised through the Supporting People programme which now covers all aspects of commissioning, funding and monitoring of housing related support services for vulnerable people. The Supporting People and other related strategies are informed of unmet needs by a network of multi-agency planning teams.

The Housing Strategy recognises that people can be vulnerable for a wide variety of reasons. The focus is on prevention and helping people to live independently in their own homes, although new accommodation is also being provided. The Council's Homelessness Strategy is based on improving prevention and a range of initiatives to promote this have been introduced. The Supporting People programme sets the direction for housing related support services for vulnerable people. The strategy for this, covering the period to 2009 will be published in March 2005.

## 14. Crime and Disorder Strategy 2002 - 2005

The Crime and Disorder Act 1998 gave Local Authorities, the police and other key partners specific responsibilities to tackle crime and disorder. This includes an audit every three years to build a picture of the problems in Solihull including anti-social behaviour and the fear of crime. A Crime and Disorder Reduction Partnership has been established and the Strategy sets out the priorities and actions to bring about crime reduction. The priorities include tackling cross cutting issues such as drug and substance misuse, working with young people and schools, victim support as well as specific crimes and disorders including domestic burglaries, violence, racist and other hate crime and domestic violence.

## 15. Homelessness Strategy 2003 - 2008

The Homelessness Strategy and accompanying Action Plan looks to secure real improvements in homelessness and housing advice in Solihull over the period to 2008.

Among the main priority actions is the provision of supported accommodation for young people, drug misuse and those with dual diagnosis - mental health problems and drug misuse.

The Strategy states that there is a range of supported accommodation and floating support services for people with mental health problems, but supply at various stages of the need spectrum is insufficient. In the north of the borough there is a “grapevine” which facilitates information on where vulnerable people are living. This can lead to vulnerable people suffering harassment from certain members of a local community. Accommodation for people with mental health problems therefore needs to be dispersed, rather than concentrated in one area. Anxiety and depression are very common problems and often the reason for single people having priority under homelessness legislation

In considering the nature of homelessness in Solihull and the need to have more effective prevention, it is clear that there are a number of outstanding and unmet needs. These needs are set out below:

- Better working practices between Housing Services and the Mental Health Team within Solihull.
- The need for specialist supported housing provision for clients with dual diagnosis.
- Some form of direct access accommodation for all age groups.
- A new ‘core and cluster’ scheme to accommodate persons displaced by the closure of Middlewood House.

## 16. Domestic Violence Strategy 2003 - 2005

This Strategy was produced under the auspices of the Solihull Crime & Disorder Partnership and is based on Government guidance that domestic violence services must be fully accessible to all. Agencies must be aware of the needs of women from minority ethnic communities, people with disabilities, elderly people, people with drug or alcohol dependency, people with mental health problems and those in same sex relationships.

There is also an inter- agency framework for “Managing the Suspected Abuse of Vulnerable Adults”. A major contribution to this has been the high level of co-operation between professionals groups, in managing and protecting vulnerable adults from abuse. This abuse takes many forms including physical, sexual, social and emotional abuse and happens within a domestic context and can be violent, and often only coming to light after many years and when people reach old age, or develop dependencies due to ill health or disability.

## 17. Drug and Substance Misuse Strategy 2002

The Strategy renews the emphasis on service delivery and revises targets which are challenging but achievable. These targets include reducing the use of the most dangerous drugs and patterns of drug use by young people, with a particular focus on the most vulnerable; tackling prevalence through a three pronged attack on supply, dealers and traffickers, and assets, and on working with the Afghan government to reduce opium supply; reducing drug related crime; and continuing to expand drug treatment but also improving its quality.

There were 1,562 reported drug-related deaths in 2000 (Health Statistics Quarterly 13, Spring 2002), as well as deaths and substantial ill health arising from blood-borne viruses such as hepatitis and HIV. People can also suffer from illnesses and trauma associated with accidents, poor diet and personal neglect, as well as depression, paranoia and other forms of mental illness.

## 18. Operational Commissioning Statement, Solihull MBC 2005/06 - 2008/09

A coherent approach to the commissioning of all relevant services is set out by the Council in the Operational Commissioning Statement, Community Care and Support Services for Adults, 2005 to 2008. A variety of Strategies, many referred to in this document, guide the strategic direction of service provision - the Operational Commissioning Statement sets out 'the how' - i.e. the best use of resources to procure services of the appropriate quality in order to meet the identified/assessed needs of people for community care and support services consistent with deliverable user and carer choice; and is a document designed to advance the Council's vision and to give life to its values as well as maximising the benefits of Joint Commissioning arrangements with other, but most notably health and housing, agencies and includes the commissioning of mental health problems.

## 19. Enabled Not Disabled a Joint Strategy on Meeting the Needs of People with Physical and Sensory Disabilities 2004-2009

This updated strategy about partnership between agencies and at its heart is a revitalised partnership with people with disabilities and their supporters in understanding and in responding to their needs arising from physical and sensory impairments.

It is worth of note that Clinical Psychologists are involved in both the assessment and treatment of a wide range of psychological problems arising either directly from the physical changes accompanying the physical or sensory disability, or the person's emotional adjustment to that usually permanent change in their abilities.

## 20. Valuing People

In March 2001 Government issued 'Valuing People' A New Strategy for Learning Disability for the 21st Century which sets out the government's wish to see people with learning disabilities integrated into mainstream services including housing and the workplace. The key principles are "legal and civil rights, independence, choice and inclusion". Solihull subscribes to this Strategy when commissioning and delivering services including people with a learning difficulty and a mental health problem.

# CHAPTER 3

## Taking Stock:

### The position in March 2005

#### 1. Recovery

The Solihull Mental Health Strategy is based firmly upon the premise that people with mental health problems should be afforded care and support to facilitate their participation as citizens in the local and wider community.

To enable this a persons health and social needs must be addressed including basic everyday requirements to permit as independent life as possible and not only the medical needs arising from a mental illness.

These needs are integral to self respect and recovery and centre on:

- An acceptable place to live
- Meaningful occupation and engagement in social and community activities
- Further education and training
- An income
- Friendship

These should be promoted within an active campaign to reduce stigma and discrimination surrounding mental health.

#### 2. Integration

A key characteristic of the Solihull mental health service is the agreement, in 2005, between Solihull MBC and Birmingham and Solihull Mental Health NHS Trust for the secondment of local authority staff to the Trust as well as making available some premises.

This would enable a fully integrated service to be delivered to all people resident in the Borough aged between 18 to 64 years of age who are or have experienced severe and enduring mental health problems. This agreement is provided for under Section 31 of the 1999 Health Act.

Agreements between Solihull MBC, Solihull PCT and Birmingham and Solihull Mental Health NHS Trust will confirm the services to be commissioned and delivered and the integration of social care and health staff will assist the provision of all requirements of the local authority including those obligations under the 1948 National Assistance Act, 1970 Chronically Sick and Disabled Persons Act, 1983 Mental Health Act, and the 1990 Community Care Act.

The primary purpose of social care services is the assessment, arrangement and review of services which assist a person to retain or return to their own home and local authority staff will continue to perform these functions within the Trust.

### **3. Solihull PCT - Local Delivery Plan 2005/06**

At the time of preparing this Strategy the PCT was in the final stages of negotiating with the Birmingham and Solihull Mental Health Trust for investment in 2005/06.

### **4. Solihull MBC, Social Services Directorate - 2002 - 2006**

The One Council One Vision (1C1V) process has established 5 objectives for the period 2002 to 2006. These are to ensure a brighter future for children, improve the quality of life, close the gap of inequality, treat people as individuals within a diverse community, and achieve good value services. The Council has identified 8 Step Change Improvement Priorities to focus attention on areas for continued improvement - one of these areas is to 'make a difference through social care'.

The Adult Social Services Directorate will contribute to the corporate performance of the Council and the delivery of an integrated mental health service by endeavouring to successfully achieve a number of targets. The Key Deliverables agreed for 2005/06 are as follows:

- Maintain cash limited discipline and deliver the social care efficiency gains and savings (with reference to the Gershon Report)
- Deliver improved care and support for people within their own homes consistent with promoting independence and choice
- Secure the integration of health and social care systems
- Achieve a further enhanced Commission for Social Care Inspection performance assessment
- Provide evidence of improved user and carer engagement and satisfaction
- Pursue and if possible secure independent sector or Council capital investment in adult social services to deliver social regeneration and meet the needs of older people
- Deliver the Supporting People programme
- Improve performance against the NSF for Older People
- Identify, prioritise and deliver Race Impact Assessments
- Ensure effective recruitment, retention and development of staff, including independent sector staff, through operational commissioning.

### **5. Birmingham and Solihull Mental Health NHS Trust - Business Plan 2005/06**

As referred to above at the time of preparing this Strategy the PCT was in the final stages of negotiating with the Birmingham and Solihull Mental Health Trust for investment in 2005/06.

This agreement will provide the financial investment to enable the Trust to continue to pursue their mission to continually strive for excellence, be realistic about targets and achievements, ensure services are community orientated, while appreciating the need for high quality hospital based services where appropriate, encourage learning within and outside the organisation, listen, hear and explain, create a reflective and open organisation, ensure that it is cost effective and that productive partnerships are developed to achieve these aims.

## 6. Proposals for a Care Trust In Solihull

In February 2005 Solihull PCT and Solihull MBC have completed informal consultation on a proposal to establish a Care Trust.

If a Care Trust is established it would integrate the commissioning and service delivery functions of the PCT and Local Authority and further underpin the existing joint commissioning arrangements for mental health.

## 7. Partnership Arrangements

### 7.1 Mental Health Partnership Board

A Constitution for a Partnership Board has been agreed between Solihull MBC, Solihull PCT and Birmingham and Solihull Mental Health NHS Trust and its membership also includes representatives of users, carers and voluntary bodies.

The key functions of the Board are to act as a liaison point for all bodies, to monitor performance of commissioned mental health services and to agree an annual service plan between Solihull MBC, Solihull PCT and Birmingham and Solihull Mental Health NHS Trust and so make recommendations in respect of the funding of services to the Council and the PCT.

The Board sits at the centre of a network of key bodies and it is increasingly important to ensure clear lines of communication and accountability between the Partnership Board, the Locality Implementation Team, the Board and Professional Executive Committee of the PCT, the Birmingham and Solihull Mental Health NHS Trust Board, the Solihull MBC Cabinet and partner organisations as well as the Locality Implementation Teams in neighbouring authorities.

### 7.2 Locality Implementation Team

Solihull has a well established Locality Implementation Team (LIT) comprising representatives of users, carers, voluntary agencies, Solihull MBC, Solihull PCT, Birmingham and Solihull Mental Health NHS Trust and the Birmingham and Black Country Strategic Health Authority.

It meets regularly and has set up a number of sub groups with a similar representation as for the LIT to focus on key areas. These areas align with the NSF standards and include: a Service User Forum, a Carers Forum, accommodation and support, diversity, training, employment, people with a learning disability and a mental health problem and mentally disordered offenders. The work and reports from these sub groups drive the agenda in Solihull and ensure that progress on the delivering the NSF is maintained.

## 8. Self Assessment and 'Traffic Lights'

### 8.1 Introduction

Progress towards the achievement of the NSF standards is regularly monitored by a self assessment process known as the 'Traffic Lights' - a series of 44 targets and progress towards meeting their requirements is 'scored': red, amber or green depending upon the position at the time of returns to the Department of Health.

### 8.2 Autumn Assessment 2004

The latest return to the Department of Health prior to the completion of this Strategy was completed in the autumn of 2004. Of the 44 targets 15 were green, 18 amber and 11 red. This represented progress from 2003 when the situation read 5 green, 26 amber and 14 red.

Of the 11 red indicators at Autumn 2004 the position for each was as follows and progress was actively sought:

- Community Development Workers (Target 1a) - to identify funding for 2.0 Community Development Workers.
- Suicide prevention (2) and Health Promotion (37a and 37b) - to finalise progress on the appointment to a new post to focus on these issues.
- Crisis resolution (4) and Early Intervention in Psychosis (5) - The original start dates for both these teams was December 2004 although the Strategic Health Authority have agreed for the latter to commence in 2005/06. In both cases neither team is yet fully funded.
- Graduate Workers (8c) - One further worker requires funding to complete the target of 2.0 workers.
- Prison Mental Health service (14) - Further work is required to meet the needs of Solihull's prison population.
- Women's services (15) - While some dedicated services exist an audit is required to fully identify future needs.
- Single sex accommodation (36) - An audit of in-patient accommodation is due as well as consideration of the options for addressing this issue taking into account the constraints of the current layout of ward accommodation at Solihull Hospital.
- 1983 Mental Health Act, Section 135/136 Place of Safety (39) - A protocol has been developed between Solihull MBC, Birmingham and Solihull Mental Health NHS Trust and Birmingham City Council to fulfil the requirements of the Mental Health Act Code of Practice and reaffirms the hospital as the preferred place of safety except where a risk assessment indicates otherwise.

### 8.3 Comparison Across Birmingham and Black Country Strategic Health Authority

The Birmingham And Black Country Strategic Health Authority covers 9 authorities including the 4 Primary Care Trusts in Birmingham, and Sandwell, Walsall, Wolverhampton, Dudley as well as Solihull. It is instructive to note that at the time of the 2004 Autumn Assessment one authority had fewer green indicators than Solihull while regrettably Solihull had most red indicators.

# CHAPTER 4

## Services Currently Commissioned

### INTRODUCTION

A wide variety of mental health services are jointly commissioned by Solihull Primary Care Trust and Solihull MBC. The majority are provided by the Birmingham and Solihull NHS Mental Health Trust but a number are delivered by a voluntary, charitable and private organisations. This chapter sets out details of the services commissioned and other valuable contributions to the portfolio of provision available to local residents @ April 2005.

### Services for Adults of Working Age

#### 1. Community Mental Health Teams

##### 1.1 Community Mental Health Team South, Lyndon Resource Centre

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Lyndon Resource Centre Hobs Meadow Solihull B92 8PW

**Telephone Number** 0121 678 4800

**How Accessed**

- GP/local doctor referral
- Specialist mental health service
- Care co-ordinator

**Opening Hours** Weekdays 9-5

**Description** Community Mental Health Team providing assessment, care coordination, social care and therapeutic interventions from a range of professionals.

##### 1.2 Community Mental Health Team North, Newington Resource Centre

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Newington Resource Centre Newington Road Off Hamar Way Marston Green, Birmingham B37 7RW

**Telephone Number** 0121 678 4950

**How Accessed**

- GP/local doctor referral

**Opening Hours** 9-5 weekdays

**Description** Community Mental Health Team for the North of the Borough which offers out-patient services and CPN base.

## 1.3 Primary Care Liaison Team

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Lyndon Resource Centre Hobs Meadow Solihull B92 8PW

**Telephone Number** 0121 678 4800

**How Accessed**

- GP/local doctor referral

**Opening Hours** contact in Office hours. Some sessions outside office hours

**Description** A team of CPNs providing support to GPs and their colleagues, assessing individuals who present to primary care with mental health problems and delivering some short term interventions

## 2. Assertive Outreach

### 2.1 Assertive Outreach Team

**Provider** Birmingham and Solihull Mental Health Trust

**Postcode** B37 5RZ

**Address** Middlewood House, 15 Larch Croft, Chelmsley Wood, Solihull, B37 7UR

**Telephone Number** 0121 678 4700 Fax Number 0121 678 4704

**How Accessed**

- Care co-ordinator

**Opening Hours** 9-5 Mon-Fri

### 2.2 North Birmingham Assertive Outreach Team (Kingstanding & Sutton)

**Provider** Birmingham and Solihull Mental Health Trust

**Postcode** B24 9AA

**Telephone Number** 0121 685 6788

## 3. Access and Crisis Services

### 3.1 ASW Duty Rota

**Provider** Solihull MBC

**Postcode** B37 5RZ

**How Accessed**

- GP/local doctor referral
- Self referral
- Specialist mental health service
- Care co-ordinator

**Opening Hours** Available 24/7

### 3.2 Emergency Duty Team

**Postcode** B92 7H

### 3.3 North Birmingham Home Treatment Team (Kingstanding & Sutton)

**Provider** Birmingham and Solihull Mental Health Trust

**Postcode** B23 7JA

**Telephone Number** 0121-685 7408

### 3.4 Small Heath Home Treatment Team

**Provider** Birmingham and Solihull Mental Health Trust

**Postcode** B10 0PG

**Telephone Number** 0121 685 7236

### 3.5 Yardley/Hodge Hill Home Treatment Team

**Provider** Birmingham and Solihull Mental Health Trust

**Postcode** B10 9JH

**Telephone Number** 0121 685 6524

## 4 Clinical Services

### 4.1 Out patient clinic

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Lyndon Resource Centre, Hobs Meadow, Solihull, Birmingham B92 8PW

**Telephone Number** 0121 678 4800

**How Accessed**

- GP/local doctor referral
- Specialist mental health service

**Opening Hours** 9-5 Weekdays

**Description** Community Mental Health Team for south of the Borough. Offers out-patient services and is a base for CPN's and Social Workers.

### 4.2 Out patient clinic

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Newington Resource Centre Newington Road Off Hamar Way Marston Green, Birmingham. B37 7RW

**Telephone Number** 0121 678 4950

**How Accessed**

- GP/local doctor referral
- Specialist mental health service

**Opening Hours** 9-5 Weekdays

**Description** Community Mental Health Team Base which offers out-patient service and is a base for CPNS and Social Workers.

### 4.3 Liaison Service (Self-harm)

**Postcode** B91 2JL

## 4.4 Lyndon Day Hospital

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Lyndon Day Hospital Hobbs Meadow Solihull B92 8PW

**Telephone Number** 0121 678 4800

**How Accessed**

- Specialist mental health service

**Opening Hours** 9-5 weekdays

**Description** Day Hospital for people with mental health problems.

## 4.5 Newington Day Hospital

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Newington Day Hospital Newington Road, off Hamar Way Marston Green B37 7RW

**Telephone Number** 0121 678 4952

**How Accessed**

- Specialist mental health service

**Opening Hours** 9-5 Weekdays

**Description** Day Hospital for people with mental health problems.

## 4.6 Bruce Burns Unit

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Bruce Burns Unit Solihull Hospital Lode Lane Solihull B91 2JL

**Telephone Number** 0121 424 5244

**How Accessed**

- GP/local doctor referral
- Specialist mental health service
- Care co-ordinator

**Opening Hours** 24 Hours Staffed in-patient unit

**Description** Mental Health Acute admissions ward

## 4.7 Ward 21

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Ward 21 Solihull Hospital Lode Lane Solihull B91 2JL

**Telephone Number** 0121 424 5221

**How Accessed**

- GP/local doctor referral
- Specialist mental health service
- Care co-ordinator

**Opening Hours** 24 hour staffed in-patient facility

**Description** Mental Health Acute admission unit for the North of the Borough

## 4.8 Intensive Care

**Provider** Birmingham and Solihull Mental Health Trust

**Address** ICA off Bruce Burns Unit Solihull Hospital Lode Lane Solihull B91 2JL

**Telephone Number** 0121 424 5245

**How Accessed**

- Specialist mental health service
- Care co-ordinator

**Opening Hours** 24 Hour staffed in-patient unit

**Description** Mental Health Intensive care Unit

## 4.9 Reed Unit - Eating Disorders (Queen Elizabeth Psychiatric Hospital)

**Provider** Birmingham and Solihull Mental Health Trust

**Postcode** B15 2QZ

**How Accessed**

## 5 Secure Services

### Dan Mooney House

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Dan Mooney House 1 Woodside Crescent off Downing Close, Knowle Solihull, B91 0QA

**Telephone Number** 01210678 4929

**How Accessed**

- Specialist mental health service

**Opening Hours** 24 Hour staffed in-patient unit

**Description** In patient challenging behaviour unit

## 6 Continuing Care Services

### 6.1 Hertford House

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Hertford House 29 Old Warwick Road Olton Solihull B92 7JQ

**Telephone Number** 0121 678 4860

**How Accessed**

- Specialist mental health service

**Opening Hours** 24 Hour staffed in-patient unit

**Description** Unit offers mental health acute rehabilitation.

### 6.2 David Bromley House

**Provider** Birmingham and Solihull Mental Health Trust

**Address** David Bromley House 2-4 Woodside Crescent Off Downing Close Knowle B91 0QA

**Telephone Number** 0121 678 4935

**How Accessed**

- Specialist mental health service

**Opening Hours** 24 hour staffed in-patient unit

**Description** Mental Health Rehabilitation unit offering continuing care.

## 7. Services for Mentally Ill Offenders

### **Solihull Court Diversion Scheme**

**Postcode** B37 5RZ

**How Accessed**

## 8. Therapy Services

### 8.1 Primary Care Alcohol Counselling Service

**Provider** Aquarius

**Address** Aquarius 21 Homer Road Solihull B91 3QG

**Telephone Number** 711 3732

**How Accessed**

- GP/local doctor referral

**Opening Hours** 9-5 Mon-Fri

**Description** Individual counselling, advice and information for people with alcohol related problems and their families. This service takes place in surgeries and is by GP referral only.

### 8.2 Community Alcohol Counselling Service

**Provider** Aquarius

**Address** 21 Homer Rd Solihull B91 3QG

**Telephone Number** 0121 7113732

**How Accessed**

- Self referral

**Opening Hours** 9-5 m-f

**Description** Individual counselling, advice and information for people with alcohol related problems and their families.

### 8.3 Relationship Counselling

**Provider** Relate

**Address** Malvern Park Lodge 22a Park Road B91 3SU

**Telephone Number** 0121 6431638

**How Accessed**

- GP/local doctor referral
- Self referral
- Anyone

**Opening Hours** Mon 9.30-12.30, Tues 1-3 & 6-9, Wed 10-2.30

**Description** Relationship counselling for couples or individuals. Sex-therapy also available

### 8.4 Bereavement Counselling

**Provider** Solihull Bereavement Counselling Service

**Address** Ullswater House Solihull Hospital Lode Lane Solihull B91 2JL

**Telephone Number** 0121 424 5103

**How Accessed**

- GP/local doctor referral
- Self referral

**Opening Hours** 9.30-4.30 Mon-Fri

**Description** Counselling service for adults and children suffering bereavement

## 8.5 Counselling Service

**Provider** Solihull MIND

**Address** Solihull MIND 14-16 Faulkner Rd Solihull B92 8SY

**Telephone Number** 0121 742 4941

**How Accessed**

- Self referral

**Opening Hours** Mon-Thur 9-5 Tues 7pm-8pm Sat (2 hours)

**Description** Counselling service to help you look at ways of dealing with worries. Free service.

## 8.6 Victims of Crime

**Provider** Victim Support

**Address** 145 Stratford Road Shirley Solihull B90 3AY

**Telephone Number** 0121 745 7400

**How Accessed**

- Self referral
- Mainly police referrals

**Opening Hours** 9.30am -12.30 pm Mon-Fri

**Description** Emotional support and practical advice to victims of crime.

## 8.7 Newington Resource Centre, Community Mental Health Team North

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Newington Resource Centre Newington Road Off Hamar Way B37 7RW

**Telephone Number** 0121 678 4950

**How Accessed**

- GP/local doctor referral

**Opening Hours** 9-5 Weekdays

**Description** Community Mental Health Team Base offering out-patients service. Team base for CPNS and Social Workers and Psychologists.

## 8.8 Lyndon Resource Centre, Community Mental Health Team South

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Lyndon Resource Centre Hobbs Meadow Solihull B92 8PW

**Telephone Number** 0121 678 4800

**How Accessed**

- GP/local doctor referral
- Specialist mental health service

**Opening Hours** 9-5 Weekdays

**Description** Community Mental Health Team Base offering out-patient service.

## 8.9 North and South Community Psychotherapy service

**Provider** Birmingham and Solihull Mental Health Trust

**Postcode** B92 8PW

## 9. HOME CARE SERVICES

### 9.1 Community Support

**Provider** Family Care Trust

**Address** 11-13 Land Lane Marston Green B37 7DE

**Telephone Number** 0121 770 6130

**How Accessed**

- Specialist mental health service
- Care co-ordinator

**Opening Hours** 7.30am - 11pm every day, office 8-5 Mon-Th, 8-4.30 Fri

**Description** Service supporting people with mental health issues to live as independently as possible

### 9.2 Hospital Discharge Service

**Provider** Family Care Trust

**Address** 11-13 Land Lane Marston Green B37 7DE

**Telephone Number** 0121 770 6130

**How Accessed**

- Specialist mental health service
- Care co-ordinator

**Opening Hours** 7.30am-11.00pm 365 days office 8-5 Mon-Th 8-4.30 Fri

**Description** Intensive support for people at point of discharge from hospital to prevent readmission. Maximum 15 hours per service user

### 9.3 Day Services North

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Day Services Newington Centre Newington Rd Marston Green B37 7RW

**Telephone Number** 0121 678 4950

**How Accessed**

- Specialist mental health service
- Care co-ordinator

**Opening Hours** Contactable during office hours, 9-5 M-TH, 9-4.30 Fr

**Description** A service providing one to one support for people with mental health problems establishing themselves in the community

### 9.4 Day Services South

**Provider** Birmingham and Solihull Mental Health Trust

**Postcode** B92 8PW

**Telephone Number** 0121 6784800

**How Accessed**

- Specialist mental health service
- Care co-ordinator

**Opening Hours** Contactable during office hours, 9-5 Mon-Th, 9-4.30 Fri

**Description** A service providing one to one support for people with mental health problems establishing themselves in the community

## 10. Housing Related Support

### 10.1 Floating Support

**Provider** Family Care Trust

**Address** 11-13 Land Lane Marston Green B37 7DE

**Telephone Number** 0121 770 6130

**How Accessed**

- Self referral
- Specialist mental health service
- Care co-ordinator
- Landlords

**Opening Hours** 7.30am-11pm 7 days per week

**Description** Providing 20 places of support in people's own homes

### 10.2 Supported Accommodation - Cranmore Court and Brighton House

**Provider** Solihull Care Housing Association

**Address** Cranmore Court and Brighton House

**Telephone Number** 0121

**How Accessed**

- Self referral
- Specialist mental health service
- Care co-ordinator
- Landlords

**Opening Hours** 7 days per week

**Description** 19 places of supported accommodation

### 10.3 Supported Accommodation - Warwick Road

**Provider** Solihull Mind

**Address** Warwick Road

**Telephone Number** 0121 742 4941

**How Accessed**

- Self referral
- Specialist mental health service
- Landlords
- Care co-ordinator

**Opening Hours** 7 days per week

**Description** 8 places of supported accommodation

## 10.4 Supported Accommodation - St.John's

**Provider** Stonham and Sanctuary Housing Association

**Address** St.John's

**Telephone Number** 0121 770 9360

**How Accessed**

- Self referral
- Specialist mental health service
- Landlords
- Care co-ordinator

**Opening Hours** 7 days per week

**Description** 10 places of supported accommodation

## 10.5 Supported Accommodation - Lakeside

**Provider** Family Care Trust

**Address** Lakeside

**Telephone Number** 0121 770 6130

**How Accessed**

- Self referral
- Specialist mental health service
- Landlords
- Care co-ordinator

**Opening Hours** 7 days per week

**Description** 17 places of Supported Accommodation

## 11. Day Services

### 11.1 Drop in

**Provider** Solihull MIND

**Address** 14-16 Faulkner Rd Solihull B92 8SY

**Telephone Number** 0121 742 4941

**How Accessed**

- Self referral

**Opening Hours** Mon, Wed, Thur 12-4.40 Tues 7pm-10pm Sat, Sun 12-6pm Fri 1pm-3pm  
(Women Only)

**Description** Drop in for general support and social contact

### 11.2 Leisure and Education

**Provider** Solihull MIND

**Address** 14 Faulkner Rd Solihull B92 8SY

**Telephone Number** 0121 742 4941

**How Accessed**

- Self referral

**Opening Hours** Occasional

**Description** On-going sporting activities, music, art & craft and drama. One-off short leisure courses, eg creative writing painting etc

## 11.3 Sheltered employment

**Provider** Express Signs

**Address** Express Signs 1 Vulcan House Vulcan Road Solihull B91 2JY

**Telephone Number** 0121 709 0749

**How Accessed**

**Opening Hours** 9-5 weekdays

**Description** sheltered employment for acute and rehabilitation clients with mental health problems

## 11.4 Organic Gardening Scheme

**Provider** Solihull Mind

**Address** c/o Mind 14-16 Faulkner Rd Solihull B92 8SY

**Telephone Number** 0121 742 4941

**How Accessed**

- Self referral

**Opening Hours** Mon, Tue, Thur, Fri, Sat 11-2

**Description** Work experience and leisure activities

## 12. Employment

**Provider** Solihull MIND

**Address** 14-16 Faulkner Rd Solihull B92 8SY

**Telephone Number** 0121 742 4941

**How Accessed**

- Self referral

**Opening Hours** 9-4.30 Mon-Fri

**Description** Labour market informed advice and guidance, job seeking assistance, in-house simulated work experiences, training courses and other confidence raising opportunities. Negotiation and advocacy with employers to retain employment within the legal framework.

## 13. Support Services

### 13.1 Alzheimer's

**Provider** Alzheimer's Society

**Address** The Lodge Resource Centre 210 High Street Solihull Lodge B90 1JP

**Telephone Number** 0121 711 1199

**How Accessed**

- GP/local doctor referral
- Self referral
- Specialist mental health service
- Care co-ordinator
- Anyone

**Opening Hours** 9-4 m-f

**Description** Network of support information and practical help for people with dementia and their carers

## 13.2 Bereavement by suicide

**Provider** S.O.B.S. (Survivors of Bereavement by Suicide)

**Address** c/o Samaritans Station Approach Solihull B91 3QQ

**Telephone Number** 01827 830679

**How Accessed**

- GP/local doctor referral
- Self referral
- Specialist mental health service
- Care co-ordinator
- Will send info out at the request of a range of professionals

**Opening Hours** Group 7.30- 9.30 Last Wednesday of each month Telephone Contact at all reasonable times

**Description** Self-support voluntary organisation supporting any who have been bereaved by suicide, monthly meetings and provide support.

## 13.3 Bereaved parents

**Provider** SANDS

**Postcode** B92 8SY

**Telephone Number** 07890 780433

**How Accessed**

- GP/local doctor referral
- Self referral
- Details given out by hospital and midwives

**Opening Hours** Can be contacted any time. Messages taken Monthly meeting on 2nd Wednesday of the month. 8pm

**Description** Group support for bereaved parents at a monthly meeting Befriending support Annual remembrance service

## 13.4 Gay and Bi-sexual men with mental health problems

**Provider** Outminds

**Address** Solihull MIND 14 Faulkner Rd Solihull B92 8SY

**Telephone Number** 0121 742 4941

**How Accessed**

- Self referral

**Opening Hours** Group meets one evening per week Contact via office in office hours

**Description** Facilitated self-help group for gay and bi-sexual men

## 13.5 Mental Health User Perspective Training

**Provider** Solihull Mind

**Address** 14-16 Faulkner Road Solihull B92 8SY

**Telephone Number** 0121 742 4941

**How Accessed**

- By request from agencies or other groups or organisations

**Opening Hours** 9-4.30 Mon-Fri

**Description** Training in mental health issues delivered from a service user perspective

## 13.6 User Involvement Co-ordination

**Provider**

**Address**

**Telephone Number**

**How Accessed**

- Self referral

**Opening Hours** Office open 9-4.30

**Description** For service users in Solihull, User involvement has many forms from challenging stigma and prejudice to increasing the confidence of service users to influence the services offered. To enable more service user-centric services. Encourage employment of service users. Involvement in planning, delivery and audit.

## 13.7 Patient Ideas Forum

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Ward 21 Solihull Hospital Lode Lane Solihull B91 2JL

**Telephone Number** 0121 4242000

**How Accessed**

- Self referral

**Opening Hours** Meets every week.

**Description** Service users meet to discuss issues around hospital provision and bring these to the management's attention

## 13.8 Samaritans

**Postcode** B91 1LE

**Address** Station Approach Solihull B91 1LE

**Telephone Number** 0121 704 2255

**How Accessed**

- Self referral

**Opening Hours** Phone 24 hours 365 days per year Callers 8am-10pm

**Description** Emotional Support for people in distress. Aim to reduce death by suicide

## 13.9 Information and Advice Service

**Provider** Solihull Mind

**Address** 14 Faulkner Road Solihull B92 8SY

**Telephone Number** 0121 742 4941

**How Accessed**

- Self referral

**Opening Hours** 9.30-5 Mon-Fri

**Description** Advice and information on all aspects of Mental Health

## 14. Carers' Services

### 14.1 Respite care provision

**Provider** Birmingham and Solihull Mental Health Trust

**Address** The Duty Officer Newington Resource Centre Newington Rd Marston Green Solihull B37 5RZ

**Telephone Number** 0121 678 4950

**How Accessed**

- Specialist mental health service
- Care co-ordinator

**Opening Hours** Contact in office hours

**Description** A range of individual focused respite options provided through CMHT

### 14.2 Support Group

**Provider** Rethink

**Address** Brookvale Day Centre 111 Warwick Rd Olton Solihull B92 7QB

**Telephone Number** 0121 743 0713

**How Accessed**

- Self referral

**Opening Hours** 7.30pm 4th Monday of each Month

**Description** Opportunity for carers and service users to meet professional speakers to exchange ideas and discuss services and new developments elsewhere which could help improve our service. A chance for carers to meet and socialise and share concerns

### 14.3 Solihull Hospital Carers Group

**Provider** Birmingham and Solihull Mental Health Trust

**Address** Contact: Lucy Broughton Bruce Burns Unit Solihull Hospital Lode Lane Solihull B91 2JL

**Telephone Number** 0121 4242000

**How Accessed**

- Self referral

**Opening Hours** Meets every Monday evening.

**Description** Staff facilitated group for carers of people with mental health problems

### 14.4 Carers Drop In and Telephone Helpline

**Provider** The New Door

**Address** The New Door Oliver Bird Hall Church Hill Rd Solihull B91 3QQ

**Telephone Number** 0121 743 0713

**How Accessed**

- Self referral

**Opening Hours** Drop-in: 2-5.15 Tuesday pm in term time

**Description** A drop-in for carers with information available. Information also available on the phone day time and evenings.

## 15. Befriending

### **Take Two Befriending Scheme**

**Provider** Solihull Mind

**Address** 14-16 Faulkner Road Solihull B92 8SY

**Telephone Number** 0121 742 4941

#### **How Accessed**

- Self referral

**Opening Hours** Operates out of hours, but contact in office hours.

**Description** One to one support and friendship to encourage community involvement and accessing facilities.

## 16. Advocacy

**Provider** Solihull Mind

**Address** 14-16 Faulkner Rd Solihull b92 8SY

**Telephone Number** 0121 742 4941

#### **How Accessed**

- Self referral

**Opening Hours** Contact during office hours 9.30-5 m-f

**Description** Individual advocacy on range of issues including, health services, housing, legal, personal, debt etc

## 17. Welfare Benefits Advice

**Provider** Citizens Advice Bureau

**Address** Shirley Centre 274 Stratford Rd Shirley Solihull B90 3AD

**Telephone Number** Enquiries 0870 751 0955 (covers all of Solihull) Fax 0121 745 6863

#### **How Accessed**

- Self referral
- Specialist mental health service
- Open door. Various agencies.

**Opening Hours** 10-4 M-F except Wed 10-1

**Description** Full CAB service plus specific sessions in acute wards and MH resource centres, some home visits. Referral only sessions at Solihull Hospital (non-mental health). Debt counselling and tribunal and county court representation.

## 18. Registered Accommodation Services

**Provider** Stonham

**Address** 2 Ipswich Walk Chelmsley Wood Solihull B37 5QX

**Telephone Number** 0121 770 7620

#### **How Accessed**

- Specialist mental health service
- Care co-ordinator

**Opening Hours** 9-5 m-f

**Description** 15 bedded registered residential home for enduring mental health issues

## Services for Children and Young People

The importance of child and adolescent mental health (CAMHS) services was recognised in 1999 by the NHS Modernisation Fund and the Mental Health Grant and in the NHS Plan. The profile of CAMHS services has been further heightened by the publication of the National Service Framework for Children Emerging Findings in 2003 and the Children's National Service Framework in 2004.

### 1. National Service Framework for Children, Young People and Maternity Services

The Children's NSF is a 10-year programme intended to stimulate long-term and sustained improvement in children's health. Setting standards for health and social services for children, young people and pregnant women, the NSF aims to ensure fair, high quality and integrated health and social care from pregnancy, right through to adulthood. At the heart of the Children's NSF is a fundamental change in thinking about health and social care services. It is intended to lead to a cultural shift, resulting in services being designed and delivered around the needs of children and families. The Children's NSF is aimed at everyone who comes into contact with, or delivers services to children, young people or pregnant women and includes 11 Standards of which the ninth focuses on the mental health and psychological wellbeing of children and young people.

### 3. The mental health and psychological wellbeing of children and young people.

This is the standard on child and adolescent mental health and addresses a number of key issues:

- **Vision**

This is looks to ensure:

- An improvement in the mental health of all children and young people.
- That multi-agency services, working in partnership, promote the mental health of all children and young people, provide early intervention and also meet the needs of children and young people with established or complex problems.
- That all children, young people and their families have access to mental health care based upon the best available evidence and provided by staff with an appropriate range of skills and competencies.
- Rationale

The importance of psychological well-being in children and young people, for their healthy emotional, social, physical, cognitive and educational development, is well-recognised. There is now increasing evidence of the effectiveness of interventions to improve children's and young people's resilience, promote mental health and treat mental health problems and disorders, including children and young people with severe disorders who may need admission.

- **Early Years**

Lack of appropriate stimulation in the early years may result in language delay and together with inappropriate child-rearing practices, especially if characterised by neglect or inconsistency, may lead to emotional or behavioural disorders. Appropriate parenting styles are fundamental to caring for children's mental health and particular support may be required for parents who are ill (including those with mental illness) or who have a disability and this necessitates CAMHS working closely with primary care services, services for adults and early years support services such as Sure Start.

- **Mental Health Promotion and Early Intervention**

All children and young people and their parents or carers require access to information and supportive environments to ensure that the child or young person's mental health is promoted. Specific activities such as tackling bullying, the provision of education to increase awareness of mental health issues and to improve the recognition of children's emerging needs, and the provision of support for those children with particular needs, have a vital role to play in improving the chances for children and young people

- **Partnerships with Children, Young People and their Families**

It has been challenging for CAMHS to ensure the participation of children and young people and their families at all levels of service provision. It is clear that a variety of creative approaches are needed to improve participation and user involvement.

- **Access and Location of Services**

Children and young people and their carers want to be able to access services easily. The location should be easy to get to and well-publicised. The views of children, young people and their parents will vary regarding the most appropriate location for receiving help and services need to be sensitive to these differing views..

- **Improving Service Equity**

While there are many groups of children and young people who require a range of specialised services, there are particular groups whose needs have not been met well by recent service provision. Young people aged sixteen and seventeen years and children with both a learning disability or pervasive developmental disorder and mental health problems have not received sufficient input from CAMHS.

- **Partnership working**

Every Child Matters highlights the Government's commitment to improving partnerships between all agencies. The complexity and variety of children's service provision in any one locality also creates a logistical challenge for services attempting to achieve good partnerships. This needs to be taken into account in the planning and commissioning of services.

- **Developing High Quality Multi-disciplinary CAMHS Teams**

A critical mass of staffing is required for services to be safe, timely and effective and able to respond to a wide range of demands which include the provision of: specialist and multi-disciplinary assessment and treatment services; teaching, specialist consultation and liaison services; research and audit; and support, training, consultation and face-to-face work within primary care settings.

- **Planning and Commissioning Services**

Effective commissioning is a multi-agency activity that requires that the commissioners have the requisite skills, knowledge, time and executive responsibility to undertake the task. The development of a multi-agency CAMHS strategy is essential for effective commissioning and service delivery and is a collaborative process between commissioners and providers. The only services currently commissioned at a national level are those for forensic secure inpatient provision and highly specialist inpatient provision for deaf children and young people with mental health disorders. It will be important to address the issues of Eating Disorders particularly for young people aged 17/18 years of age in order to commission appropriate services.

- **Training and Development**

Providing high quality CAMHS is dependent on having sufficient numbers of appropriately trained staff to deliver high quality services in all four tiers, with a balanced skill mix to ensure the necessary range of skills.

## Services for Older Adults

The key characteristics of the range of services commissioned for older adults with mental health needs can be summarised as follows:

### 1. National Service Framework for Older People

The NSF for Older People includes standards for people with mental health needs and the aim is to promote good mental health and to treat and support those older people with depression, dementia as well as psychotic illnesses. The standard is for people to have access to integrated mental health services to ensure effective diagnosis, treatment and support for older people and their carers.

During 2005/06 Solihull will embark upon the process of developing and consulting upon an Older Persons Strategy. This will respond to the requirements of the NSF and build on existing strategic intentions such as All Our Tomorrows, the Strategic Commissioning Statement for Extra Care Housing and Care Home Accommodation for Older People, 2005-2010. This will provide a clear local strategy for the development of services and address the mental health needs of older people.

## 2. All Our Tomorrows

The strategic direction and principles for the future development of care homes and extra care provision was summarised in All Our Tomorrows and referred to in Chapter 2, The Local Strategic Context. The principles are to:

- Enhance care and support for older people in their own homes and their carers; and, where appropriate maximise the use of low intensity support services, assistive technologies and facilitate the adaptation of properties.
- Give relative priority to the development of extra care housing in order to maximise older peoples independence and to reduce the use of care homes by frail ambulant older people.
- Focus public support of places in care homes on more highly dependant older people including people with physical and/or mental health needs.
- Secure change within a mixed economy of care which is able to respond to the diverse needs of older people and to offer accommodation choices consistent with their needs and expectations.

## 3. Older People's Mental Health Team

A team of Social Services and Mental Health Trust staff are co-located with a remit to provide care management and health intervention for older people with mental health needs. The establishment of this service is a major step forward in achieving Standard 7 of the NSF for Older People and introduce an integrated service for older people with mental health needs.

There will be a team serving the north of the Borough based at the John Black Unit and a team for the south and central areas located at Poplar Road in the town centre.

## 4. Registered Residential and Nursing Homes

There are 3 homes contracted to provide care for people with dementia in the Borough. In summary these services are:

- Lyndon Croft managed by Prime Life who provide 52 residential beds at a newly built home,
- Jubilee Gardens managed by Craegmoor who provide a total of 50 beds, of which 25 are nursing and 13 are residential beds for people with dementia,
- Silver Birches managed by Accord Housing who provide 15 residential beds for people with dementia.

## 5. Re-enablement Service

This is a new service directly managed by Solihull MBC. It is a specialist domiciliary care service which aims to develop independent living skills and so assist people to live in community.

## 6. Assistive technology

Social Services are introducing a new package of assistive technology to enable users to live safely and securely in their own homes. There will also be benefits for family members and friends who share the responsibility for caring and provide peace of mind about the user's security.

The package will include a smoke alarm, fire detector, flood detector, natural gas detector, door sensors, falls detectors, and a cold temperature detector. There are close working relationships between Social Services and Solihull Community Housing who provide a peripatetic floating support service, predominantly to older people, funded by Supporting People Grant. Referrals will be made to Social Services and, based on an individual assessment of need, older people with mental health needs will be supplied with this package of assistive technology.

## 7. Reviews: The Rowans Report and Avonside Report

These two major reports on older people's mental health services were published in 2004. The Birmingham and Black Country Strategic Health Authority (BBCSHA) has commenced a review of inpatient care for older people with mental health problems across all the PCT areas within its catchment and the Older Adult Directorate of Birmingham and Solihull Mental Health Trust (BSMHT) have responded with a programme of action.

### 7.1 The Rowans Report

This relates to an inpatient unit in Manchester and has highlighted a number of issues requiring review from which local lessons can be learnt. These include the number of, and process for managing, complaints; sickness rates which have been exacerbated by the numbers on long-term sick leave and subsequently addressed by such measures as supervision, staff appraisals and preparation of personal development plans; and the recruitment of nursing staff has helped reduce the use of bank/agency workers.

It is local policy that patients should have a care plan and that it is discussed with them by the care co-ordinator, with particular care given with patients whose capacity is impaired; and for the CPA to include a carer's assessment and consideration of carer's ability to provide care.

Policy covering the use of restraint with older people currently being reviewed and staff trained in the use of restraint with older people.

The Trust's management arrangements are being revised to provide a Modern Matron who will be clinically responsible for Maple Leaf Drive, John Black and Ward 10

### 7.2 The Avonside Report

This was written by an independent Inquiry Team following a number of serious incidents in the Avonside Unit during the period 1999 to 2001. This unit provides in-patient assessment and treatment of older people with mental illness in East Birmingham and was transferred into BSMHT following Trust merger in April 2003.

The report highlighted four key problem areas, namely the lack of consistent leadership, a lack of embedded clinical governance, ineffective operational management and a loss of perspective of the core purpose. The report made 10 major recommendations which addressed these areas in detail.

# CHAPTER 5

## Needs Analysis

### 1. Introduction

1.1 A needs analysis has been conducted by the Joint Solihull PCT and MBC Public Health directorate. It describes the distribution of mental illness in Solihull through the examination of routine activity data. In the main, two sources of data have been used: (i) prescribing and (ii) inpatient admissions data. In some cases, however, figures have also been extrapolated from national datasets to provide a benchmark for comparing local figures.

To provide an analysis at a sub-borough level, the 'cluster' configurations proposed by the PCT at October 2003 have been used. Although the configurations may change, they have been chosen because they make a more localised examination of the issues possible than that allowed by the use of the North, South and Central localities. Clusters also overcome some of the data reliability issues encountered when working at an individual practice level.

1.2 The analysis of activity concentrates on the following :

- All mental illness;
- Depression;
- Neuroses;
- Psychosis;
- Senile Dementia;
- Community activity.

### 2. Methodology

The majority of this analysis is based on an interpretation of the following routine sources of activity data :

- Inpatient admissions
- Prescribing in primary care
- Psychiatric outpatient attendances
- Community psychiatric nurse (CPN) consultations
- Patients treated under the care programme approach

**2.1** In most instances, the data has been drawn from the three year period 2000/01 to 2002/03. Using data recorded over this period means that analysis can take place at a much more local level than single year data would allow. It also ensures that any findings are still based on relatively current activity patterns.

**2.2** Figures derived from certain national sources of data have also been used in this report. It is useful to include these figures as they provide a benchmark or reference against which local activity can be compared. The national sources used in this report are :

Psychiatric Morbidity Among Adults Living in Private Households, 20001 : A survey of 8,800 16 - 74 year olds using a questionnaire and interview approach. A subset had a follow-up interview from psychologists for validation.

Key Health Statistics from General Practice, 19982 : Based on data covering 1.4 million patients of all ages from general practices involved in the long term monitoring of morbidity.

Hospital Episode Statistics, 20013 : Department of Health collated returns for all hospital NHS trust activity.

**2.3** Other than a commentary about the incidence of suicide, mortality figures have not been included in this report. Thankfully, premature death where mental illness is the primary cause, is a comparatively rare occurrence. However, from an analytical standpoint, having a low number of events can present problems. The rarity of deaths means that to present statistically robust findings it is necessary to collate data over longer time periods. This in turn raises doubts about how accurately any findings represent the current situation. Further difficulties in interpretation also arise where datasets drawn over differing time periods are used to draw conclusions about the same issue. For these reasons death data is otherwise omitted from this report.

**2.4** The comparators used throughout this report are the draft practice 'clusters' proposed at October 2003. It is important to note that the comparison is based on the number of people registered (with GPs) as opposed to the total resident populations. A map of the clusters is illustrated below and, to assist clarity, throughout the text reference is made to the geographical area which is predominantly served by each of the clusters.

**2.5** The majority of the figures included in this report are presented as standardised rates. As a result, any differences between the clusters will not be due either to the age profile or the relative size of different populations.

<sup>1</sup> Office for National Statistics, 2001, available from The Stationery Office.

<sup>2</sup> Office for National Statistics, 2000, available from ONS.

<sup>3</sup> [www.doh.gov.uk/hospitalactivity/index](http://www.doh.gov.uk/hospitalactivity/index)

2.6 To enhance the rigour with which any findings are reached, the examination of specific issues has been based on the technique of triangulating data sources. This means that wherever possible, at least three sources have been used to examine the same issue. Where they all agree, greater confidence is given to the strength of the finding. Where there is no consistent picture, the actual situation is more uncertain.

2.7 In this report the following conditions are included within the term psychotic disorders :

- Alcoholic psychoses;
- Drug psychoses;
- Confusional states;
- Schizophrenic psychoses;
- Affective psychoses (e.g. manic-depressive psychosis);
- Paranoid states.

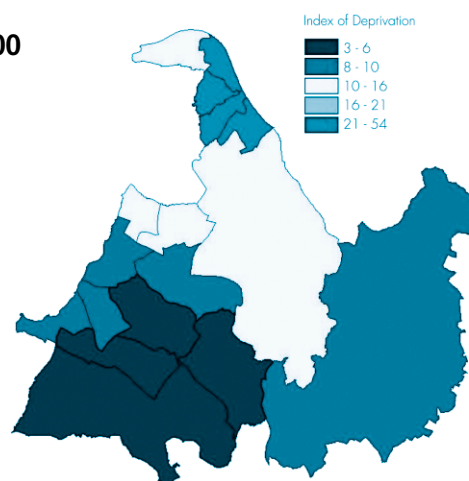
2.8 Neurotic disorders include the following:

- Anxiety states;
- Hysteria;
- Phobic states;
- Obsessive-compulsive disorder;
- Neurotic depression;
- Neurasthenia;
- Depersonalisation syndrome;
- Hypochondriasis.

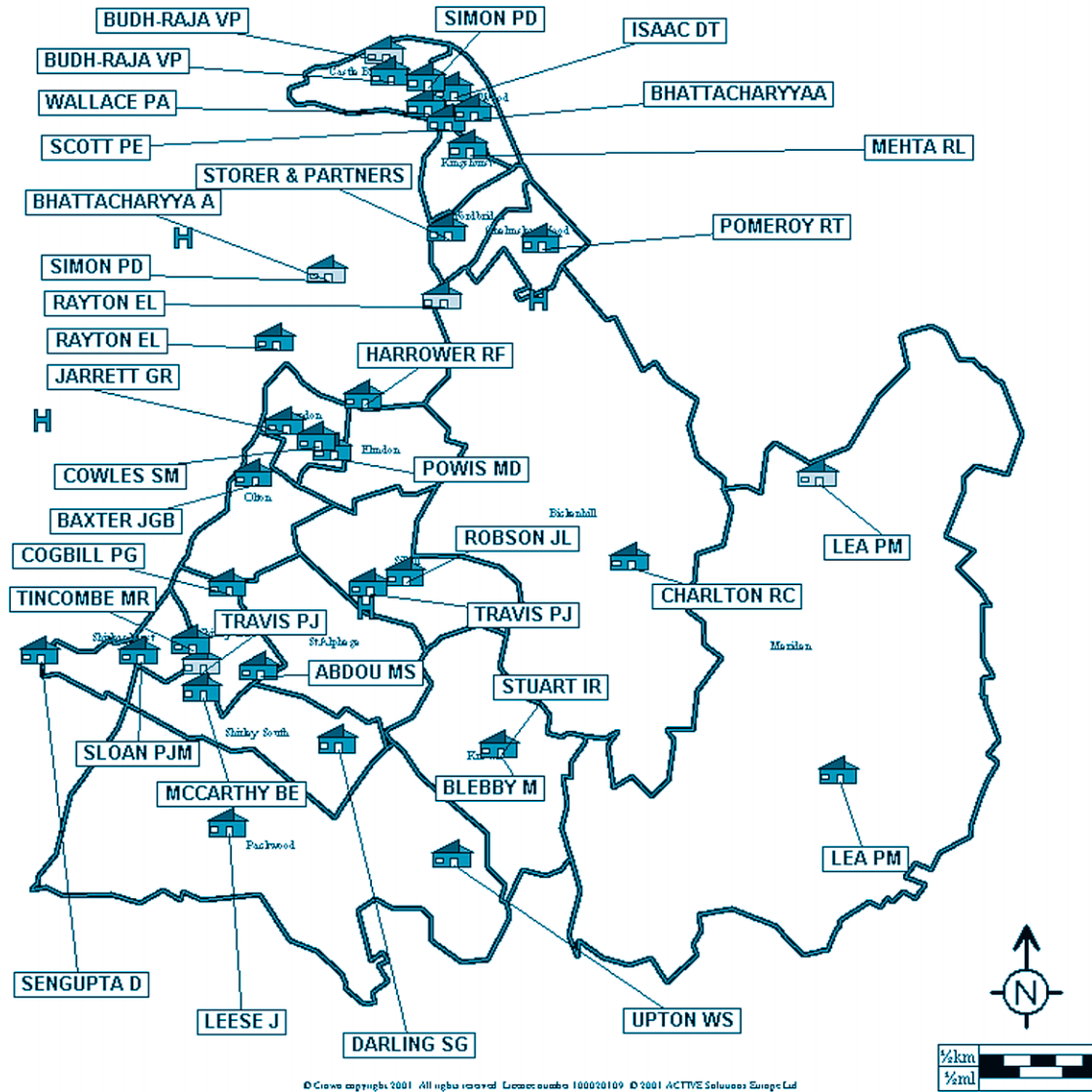
2.9 The categorisation of these specific conditions as either neurotic or psychotic disorders is based on the 9th revision of the International Classification of Diseases.

2.10 A map depicting the levels of deprivation present in the Borough in 2000 is set out below

**Indices of Deprivation 2000**



## Cluster Configurations @ October 2003



**Cluster 1**  
(Castle Brom.  
Smiths Wood)

Bhattacharyya  
Budh-Raja  
Isaac  
Wallace

**Cluster 2**  
(Kingshurst)

Mehta  
Scott  
Rayton

**Cluster 3**  
(Fordbridge  
Chelmsley Wd)

Pomeroy  
Storer  
Melrose

**Cluster 4**  
(Shirley East)

Cogbill  
Lawley  
Simon

**Cluster 5**  
(Lyndon, Elmdon  
Olton)

Cowles  
Harrower  
Jarrett  
Powis

**Cluster 6**  
(Shirley West  
Shirley South)

McCarthy  
Sengupta  
Sloan  
Tincombe

**Cluster 7**  
(Shirley East)

Abdou  
Robson  
Travis

**Cluster 8**  
(Shirley South  
Packwood)

Darling  
Leese  
Upton

**Cluster 9**  
(Knowle, Meriden,  
Bickenhill)

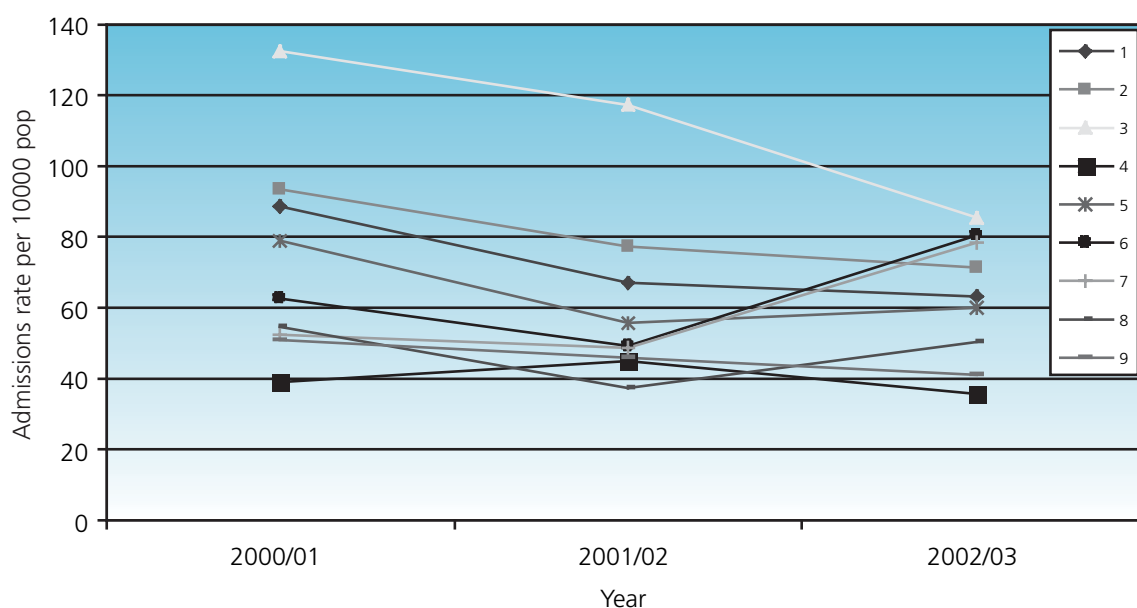
Stuart  
Bleby  
Charlton  
Lea

### 3. Total Mental Illness

#### Standardised Admission Rates

3.0 In Figure 1, the standardised admission rate for all nine clusters is shown for each of the three years 2000/01 to 2002/03. In Table 1, this same information is presented in terms of the number of admissions instead of rates.

**Figure 1: Directly standardised admission rate, all mental illness, by cluster, 2000/01 to 2002/03.**



**Table 1: Number of admissions, all mental illness, by cluster, 2000/01 to 2002/03.**

Cluster	2000/01	2001/02	2002/03	Total
1	189	144	132	465
2	172	142	133	447
3	219	179	138	536
4	97	117	103	317
5	219	158	174	551
6	135	105	170	410
7	163	150	229	542
8	132	90	115	337
9	126	116	102	344
<b>Total</b>	<b>1452</b>	<b>1201</b>	<b>1296</b>	<b>3949</b>

**3.1** If it is accepted that admissions data is an accurate indicator of the level of morbidity in a population, then it is apparent from Figure 1 that Cluster 3/ Fordbridge/Chelmsley Wood experiences higher levels of mental illness than elsewhere. This was clearly the case during 2000/01 and 2001/02, but also to a lesser extent during 2002/03. It is also worth noting that the rate of admission increased markedly in Clusters 6/Shirley West and South) and 7 (Shirley East) during 2002/03, and that this went some way towards masking the continuing high admission rate in Cluster 3/ Fordbridge/Chelmsley Wood.

**3.2** There was quite wide variation in the admission rate across the clusters. The average admission rate per year varied from 39.88 per 10,000 population in Cluster 4, to 111.71 per 10,000 population in Cluster 3/ Fordbridge/Chelmsley Wood. Cluster 4/Shirely East also had the lowest number of admissions, with just 317 patients admitted over the three years, compared to an average of 439 admissions per cluster.

## Hospital Episode Statistics

**3.3** It is possible to use Department of Health hospital episode statistics as a baseline with which to compare activity locally. This provides a national comparator, or benchmark against which local patterns can be analysed. In this case, hospital episode statistics provide an indication of the expected number of inpatient admissions in each cluster. These figures are based on applying the age-specific admission rates for England as a whole to each cluster population. The resulting figures are shown in Table 2, together the actual number of admissions on average per year.

**Table 2: Expected and actual number of admissions per year by cluster.**

Cluster	Expected no. admissions per year	Actual no. admissions per year*	Difference (actual - expected)
1	83	155	72
2	69	149	80
3	64	179	115
4	92	106	14
5	103	184	81
6	81	137	56
7	112	181	69
8	94	112	18
9	90	115	25
<b>Total</b>	<b>788</b>	<b>1316</b>	<b>528</b>

\* The actual number of admissions are based on an annual average of the three years 2000/01 to 2002/03.

**3.4** It is apparent that all nine clusters have a greater number of admissions than expected based on hospital episode statistic data. There is a mean excess of around 59 admissions per year, for each cluster. The most marked difference between actual and expected admissions can be found in Cluster 3/Fordbridge and Chlemsley Wood, while for Cluster 4/Shirley East the difference amounts to just 14 admissions.

**3.5** Looking beyond the actual figures, the way the clusters rank against each other also produces some interesting findings. Clusters 5/Lyndon, Elmdon and Olton and 7/Shirley East are clearly shown to have the highest number of admissions whether expected or actual figures are used. This is especially interesting in relation to Cluster 7/Shirely East as it has only the fourth largest total population among the cluster groupings. Conversely, Clusters 8/Shirley South and Packwood and 4/Shirley East both have lower rankings in terms of actual admissions, than that suggested based on their positions in the expected column.

## Prescribing Data

**3.6** Alongside admissions data, information about the prescribing of psychiatric medication in primary care is also available. Table 3 shows the average daily quantity (ADQ) prescribed by cluster during the period 2000/01 to 2002/03. Prescribing of the following drugs are represented in this table : hypnotics, anxiolytics, benzodiazepines, antidepressants and anti-dementia drugs.

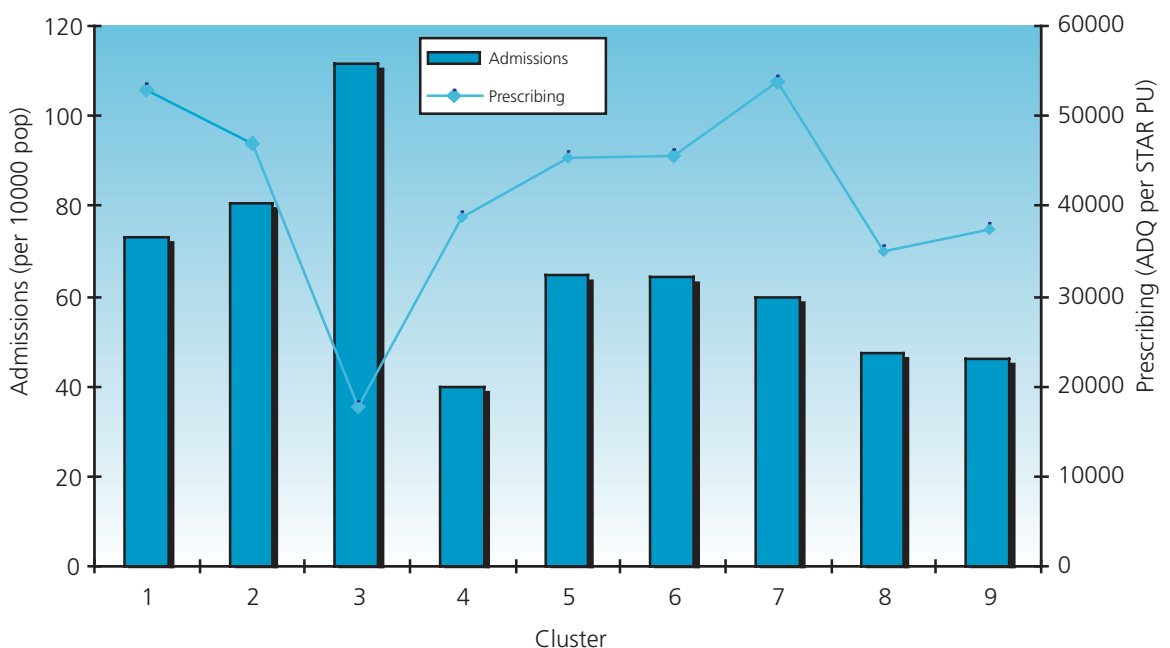
**Table 3: Average daily quantities prescribed by cluster, 2000/01 to 2002/03.**

Cluster	ADQ per STAR PU
1	17,635.38
2	15,627.52
3	5,890.68
4	12,922.25
5	15,155.37
6	15,188.25
7	17,931.36
8	11,656.52
9	12,456.94

3.7 At least one caveat should be attached when interpreting these figures. It is important to recognise that medications are often prescribed in primary care to treat a wider range of mental illnesses than that encompassed by admissions data. As such, prescribing data might be seen as a broader indicator of the level of overall morbidity due to mental illness in a population. However, it might also be a slightly poorer measure of the specific prevalence of any single type of mental illness because the same drug might be used to treat patients with differing diagnoses.

3.8 Figure 2 compares both prescribing and admission rates for each cluster, and shows that the relationship is not necessarily linear (i.e. a high prescribing rate equals a high admission rate).

**Figure 2: Prescribing and admission rates by cluster, all admissions, 2000/01 to 2002/03**



3.9 It has already been noted that prescribing and admissions data do not necessarily relate directly to the same populations, however, evidence of an 'iceberg effect' might be expected. It could be assumed that populations which exhibit higher levels of severe mental illness (i.e. admission rates) also probably have greater levels of mental illness more generally (i.e. prescribing rates). Where this does not occur and the two variables are not positively associated, then it raises questions about why a positive association may not be present.

3.10 In Figure 2 it is apparent that, in general, the iceberg effect does operate. However, for differing reasons, it is not as strongly evident in Clusters 3/Fordbridge and Chelmsley Wood and 7/Shirley East. Cluster 3/ Fordbridge and Chelmsley Wood has the lowest prescribing rate of all the clusters, and yet has the highest admission rate. Conversely, Cluster 7/Shirley East has the highest prescribing rate, but ranks only sixth in terms of admissions.

**3.11** Assuming that the data is accurate, there are three potential scenarios that might explain the situation in Cluster 3/ Fordbridge and Chelmsley Wood. Firstly, there may simply be a greater proportion of more severely mentally ill patients in this cluster population. Secondly, the availability of services may be such that there are fewer alternatives to hospital admission than elsewhere. Thirdly, patients who would be prescribed medication in other clusters are being managed without the recourse to medication seen elsewhere.

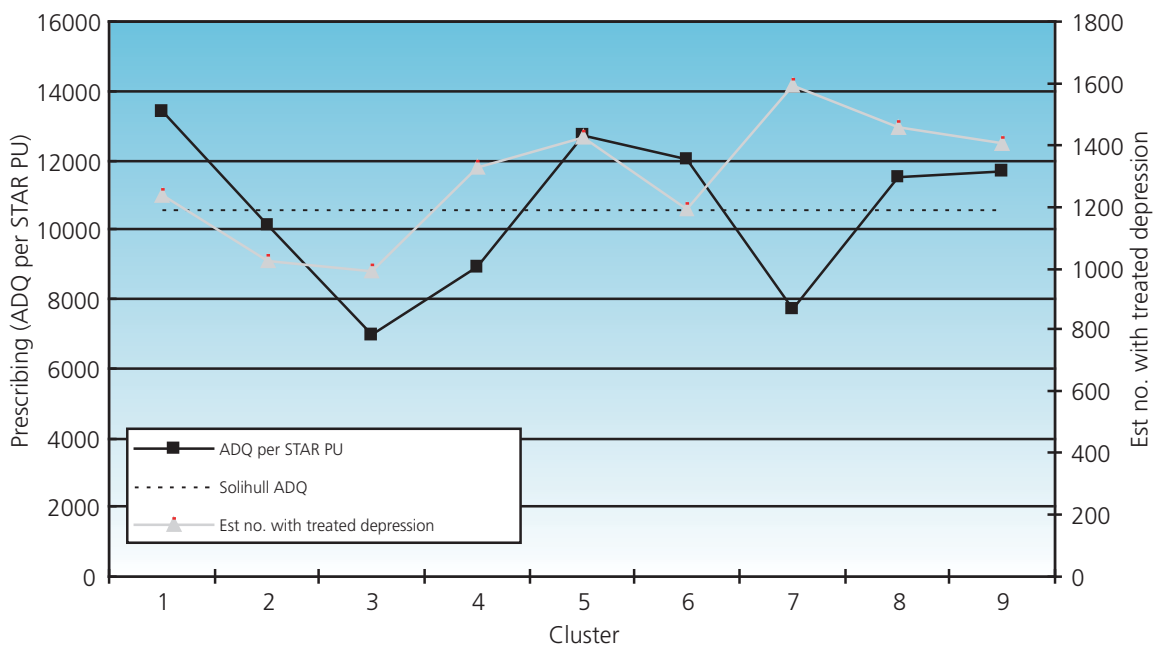
**3.12** In the case of Cluster 7/Shirley East, two potential scenarios could be operating. Firstly, the availability of alternatives to hospital admission may be such that patients with mental illness are able to be managed away from the inpatient setting. This would explain the relatively low admission rate. Secondly, the high prescribing rate might be because a greater proportion of patients have low levels of illness which require treatment but not necessarily admission.

## Depression

### Prescribing Data

**3.13** Depression is one of the most common mental illnesses encountered in primary care. Using figures derived from Key Health Statistics for General Practice it is possible to produce an estimate of the expected number of adults treated for depression in primary care each year for each cluster. These estimates are shown below, together with actual rates of antidepressant prescribing in each case.

**Figure 3: Expected number of adults treated per year and actual prescribing for depression, by cluster.**



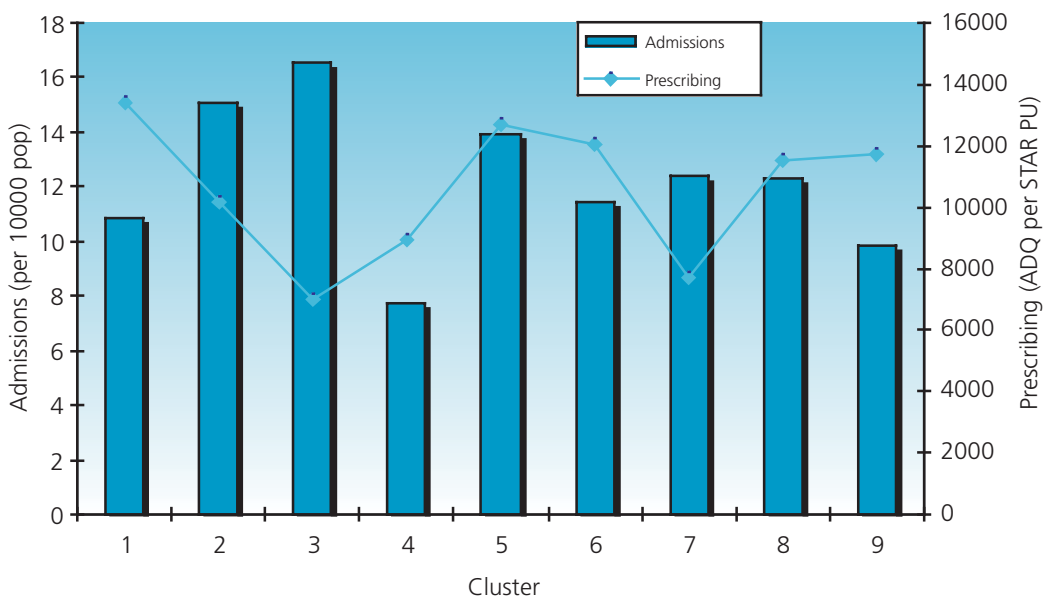
3.14 With the exception of Cluster 7/Shirley East, the pattern of prescribing across the clusters broadly matches that produced by the national estimates. This suggests that the relative levels of prescribing shown here are a good indicator of the distribution of depressive illness among the clusters. However, it does not provide any endorsement in relation to absolute levels of prescribing, i.e. whether the amount is too much or too little.

3.15 The low level of prescribing in Cluster 7/Shirley East is to some extent an unexpected finding. The results in Figure 1 showed that this cluster had the highest prescribing rate when looking across a broad range of psychiatric medications. As depression is one of the commonest mental illnesses encountered in primary care, prescribing to treat this specific condition might be expected to be higher. The prevalence rate extrapolated from Key Household Statistics also supports this view.

### Admissions Data

3.16 Admission rates due to depression present a different picture to that seen for prescribing, as illustrated in Figure 4. This is not altogether surprising if one indicator represents more severe depressive illness and the other the more general, low level illness.

**Figure 4: Prescribing and admission rates by cluster, depressive illness, 2000/01-2002/03.**



3.17 With the exception of Cluster 4/Shirley East, the admissions data suggests that severe depressive illness is fairly evenly distributed among the clusters. The reason why Cluster 4/Shirley East in particular has a relatively low admission rate is uncertain. As Table 4 shows, the low admission rate also corresponds to an equally low number of admissions in this cluster.

**Table 4: Admissions due to depressive illness by practice cluster, 2000/01 - 2002/03.**

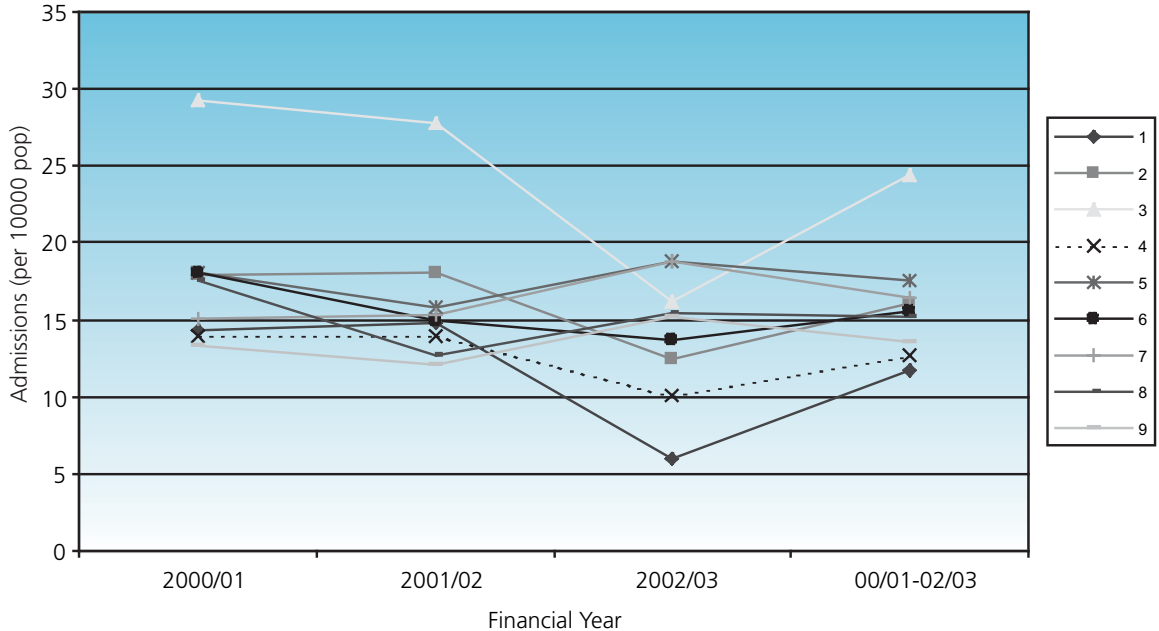
Cluster	2000/01	2001/02	2002/03	Grand Total	% Total
1	29	18	21	68	9%
2	28	28	27	83	11%
3	27	35	17	79	10%
4	16	22	26	64	8%
5	39	36	50	125	16%
6	30	24	19	73	9%
7	36	33	52	121	16%
8	36	20	29	85	11%
9	25	21	29	75	10%
<b>Total</b>	<b>241</b>	<b>237</b>	<b>270</b>	<b>773</b>	<b>100%</b>

## Neurotic disorders

### Admissions Data

3.18 Figure 5 shows the standardised admission rate due to neuroses for each financial year and overall for each cluster. The most obvious finding is the relatively high admission rate in Cluster 3/Fordbridge and Chelmsley Wood, especially during the period 2000/01 to 2001/02.

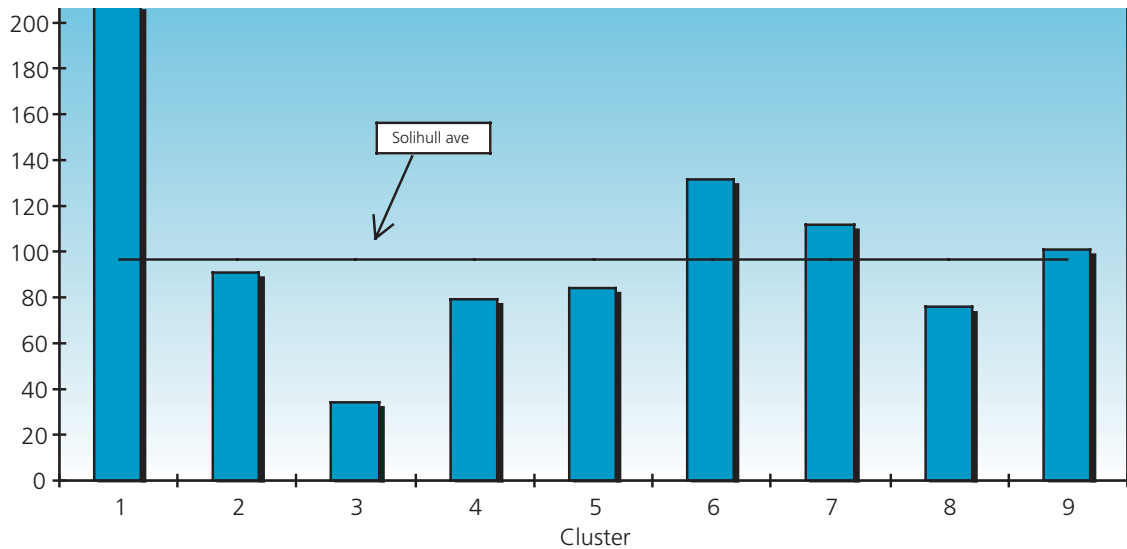
**Figure 5: Neuroses admissions 2000/01 to 2002/03 by practice cluster.**



## Prescribing Data

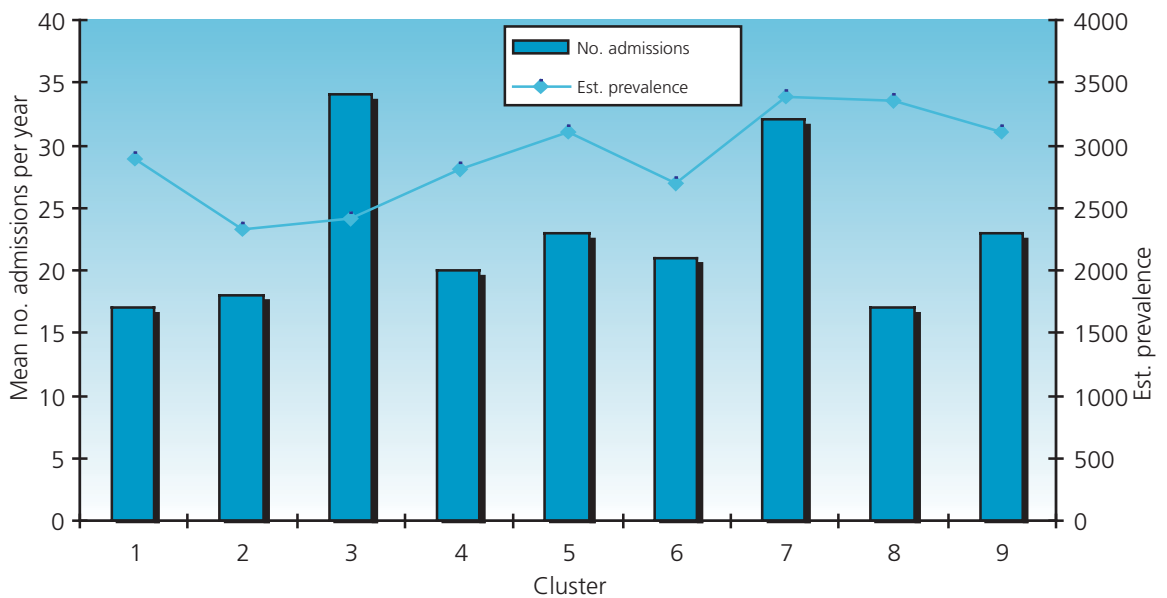
**3.19** The amount of prescribing in Cluster 3/Fordbridge and Chelmsley Wood, is again low relative to the rate of admission. This is illustrated in Figure 5 below which shows combined hypnotic and anxiolytic prescribing rates per admission. Conversely, Cluster 1/Castle Bromwich and Smiths Wood has a relatively high rate of prescribing per admission.

**Figure 5: Hypnotic and anxiolytic prescribing rates per admission, by cluster.**  
**3.20**



Using figures derived from the Adults in Private Households Survey 2000, it is possible to compare the mean number of admissions per year with an estimate of the expected prevalence of neuroses in each cluster. The results of this comparison is shown in Figure 6.

**Figure 6: Average number of admissions per year, and estimated prevalence of neuroses among 15-74 year olds, by cluster.**



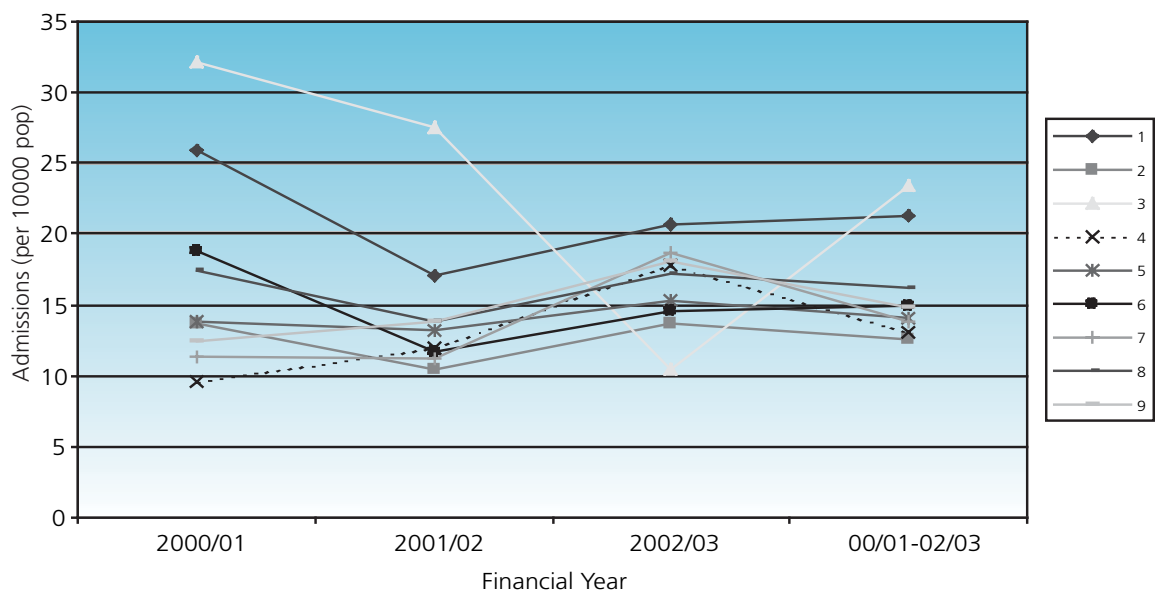
3.21 Overall, there is very little association between the number of admissions each year and the figures showing the estimated prevalence of neuroses. This may reflect the fact that admissions are pretty rare, typically around 23 patients per year per cluster, or the fact that estimates derived from national sources tend to be less sensitive to local circumstances. Nevertheless, it is worth noting the high number of admissions relative to the estimated prevalence in Cluster 3/Fordbridge and Chelmsley Wood and, conversely, the low level of admissions in Cluster 1/Castle Bromwich and Smiths Wood compared to the prevalence estimate.

## Psychotic disorders

### Admissions Data

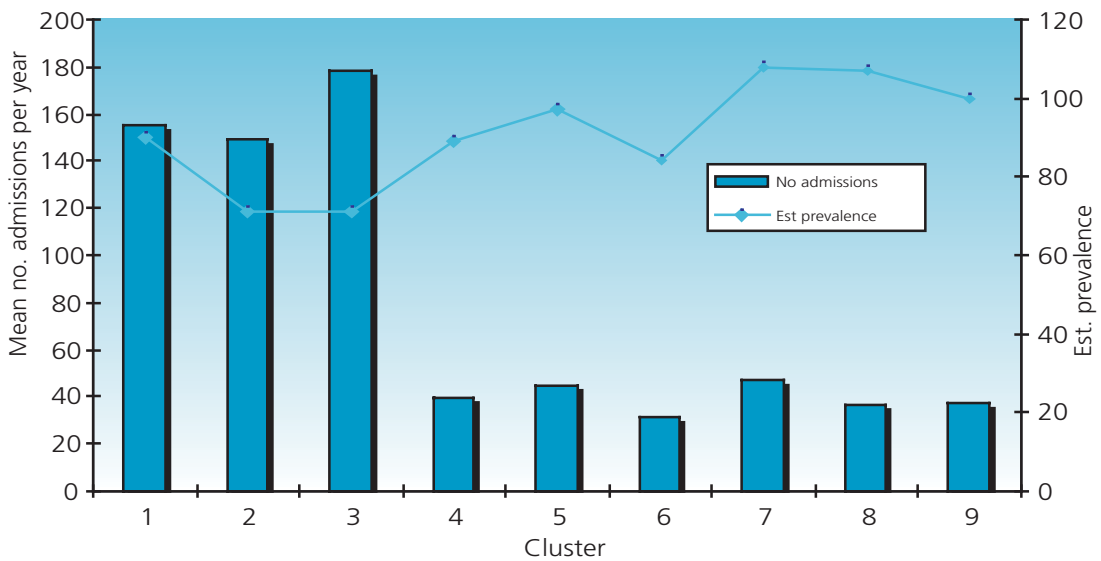
3.22 Figure 7 presents a similar picture for psychoses admissions to that seen previously in relation to neuroses. Cluster 3/Fordbridge and Chelmsley Wood clearly has a relatively high admission rate over the first two years, and, as a result, this cluster has the highest admission rate over the three years as a whole. In numerical terms, there are around 179 admissions per year in Cluster 3/Fordbridge and Chelmsley Wood, which compares with an average across all clusters of 80 admissions.

**Figure 7: Psychoses admissions 2000/01 to 2002/03 by practice cluster.**



3.23 Figure 8 uses further data taken from the Adults in Private Households Survey 2000 to provide an estimate of the number of adults with a diagnosis of psychoses by cluster. It is clearly evident that Clusters 1/Castle Bromwich and Smiths Wood and 3/Fordbridge and Chelmsley Wood have higher numbers of patients admitted each year on average. In addition, the number of admissions in these clusters bears little resemblance to the estimated prevalence derived from national sources.

**Figure 8: Average number of admissions and estimated prevalence of psychoses among 15-74 year olds, by cluster.**

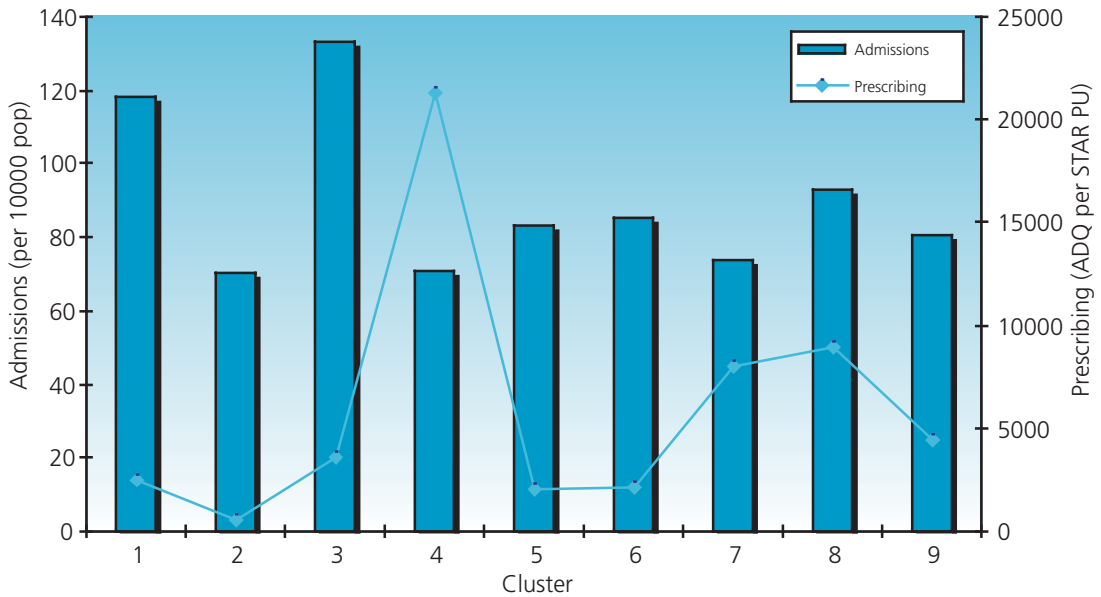


3.24 The national figures suggest that the populations of clusters 7/Shirely East, 8/Shirley South and Packwood and 9/Knowle, Meriden and Bickenhill are likely to experience the greatest levels of morbidity from psychoses. This finding differs from the local data markedly in relation to 8/Shirley South and Packwood and 9/Knowle, Meriden and Bickenhill where, both in terms of numbers and standardised rates, the prevalence of psychoses is less than elsewhere.

### Senile Dementia

3.25 Figure 9 compares the rate of admission with prescribing for dementia among those aged 65 years and over. It is important to note that, in this instance, the two variables are not drawn from identical time periods. The admission rates are based on data gathered over the three years 2000/01 to 2002/03, while the prescribing data is taken from single year figures for 2002/03. This was necessary because the widespread use of drug treatments for dementia is a relatively new development. Pre-2002/03 prescribing was inconsistent across practices, raising doubts about the reliability of using data drawn from the two earlier years.

**Figure 9: Prescribing and admission rates due to senile dementia, by cluster.**



### Prescribing Data

**3.26** Figure 9 indicates that there is a relatively high rate of prescribing in Cluster 4/Shirley East. There were 21,327 daily doses of medication prescribed in Cluster 4/Shirley East to treat dementia, which compares with an average of 5,943 daily doses across Solihull as a whole. It is worth re-emphasising at this point that these figures are age-standardised, therefore, the high rate of prescribing cannot simply be due to a greater proportion of older people in Cluster 4/Shirley East. These figures suggest that either the amount of dementia or its severity could be greater in Cluster 4/Shirely East than elsewhere, or, alternatively, that prescribing practices might be different. It must also be acknowledged, however, that the fact that only single year figures were used might also have an effect on the reliability of the findings in relation to prescribing.

**3.27** Cluster 4/Shirely East does have a relatively low admission rate, which might suggest that patients are being managed without recourse to hospital admission. This would to some extent explain the high prescribing rate. However, Cluster 4/Shirley East does not have the lowest admission rate, and both clusters 2/Kinghurst and 3/Fordbridge and Chelmsley Wood exhibit similar admission rates, but without the high pattern of prescribing.

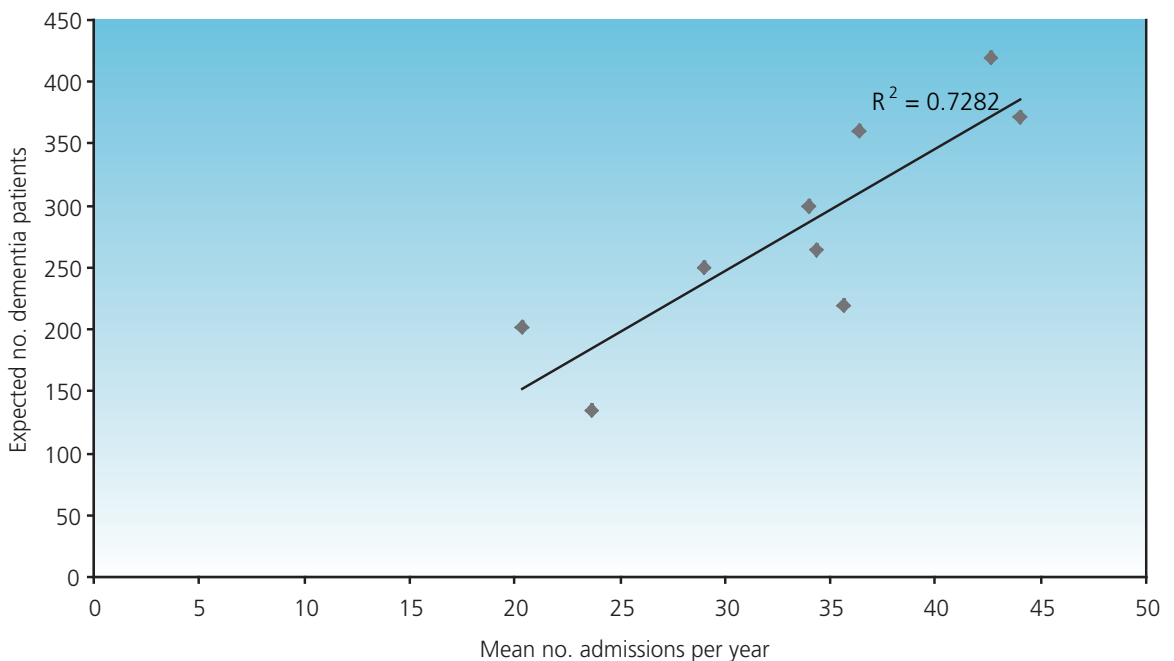
## Admissions Data

**3.28** Across all the clusters, prescribing and admission rates are poorly associated. In terms of admissions, clusters 1/Castle Bromwich and Smiths wood and 3/Fordbridge and Chelmsley Wood clearly exhibit the highest rates. In the case of Cluster 1/Castle Bromwich and Smiths Wood, this corresponds to around 118 admissions per 10,000 65+ year olds, or 36 admissions per year. In Cluster 3/Fordbridge and Chelmsley Wood, there are around 133 admissions per 10,000 65+ year olds, or 24 admissions per year.

**3.29** To some extent the relatively high admission rates in these two clusters suggests a greater prevalence of more severe dementia in the two populations. However, the actual number of admissions in each case is small, and any findings should be interpreted with caution. Indeed, instead of a greater prevalence of more severe dementia, these findings could equally point to a lack of alternatives to hospital admission compared with elsewhere.

**3.30** To pursue this issue further, it is possible to assess the accuracy with which admissions figures represent relative levels of dementia using data from external sources. The Cognitive Function and Ageing Study provides national estimates of the incidence of diagnosed dementia among older people. These national estimates have been extrapolated to each of the cluster populations to produce estimates of the number of older people likely to have a diagnosis of dementia. The degree to which these estimates correlate to the actual number of admissions for each cluster is shown in Figure 10.

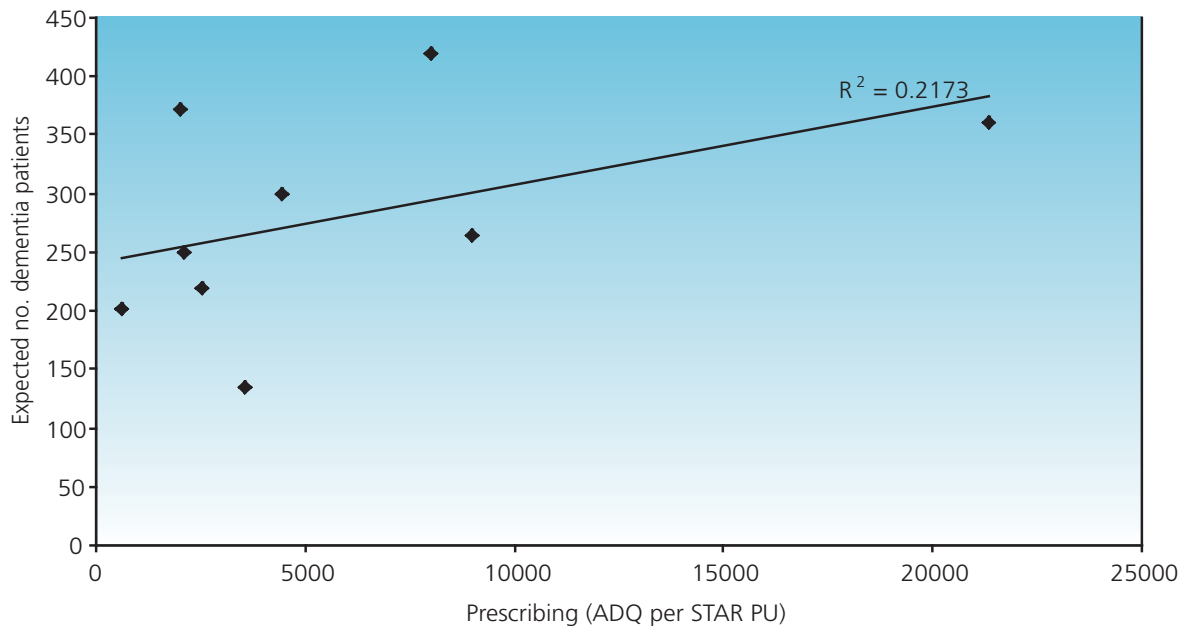
**Figure 10: Estimated number of patients with dementia and actual number of admissions, by cluster.**



3.31 Figure 10 indicates that there is a strong positive association between the actual number of admissions and the estimated number of patients with dementia across the nine clusters. This finding gives greater confidence in the reliability of standardised admission rates as an indicator of respective levels of dementia within the clusters.

3.32 Conversely, the association between national estimates and prescribing rates is apparently much weaker. This is illustrated in Figure 11.

**Figure 11: Estimated number of patients with dementia and actual prescribing rates by cluster.**



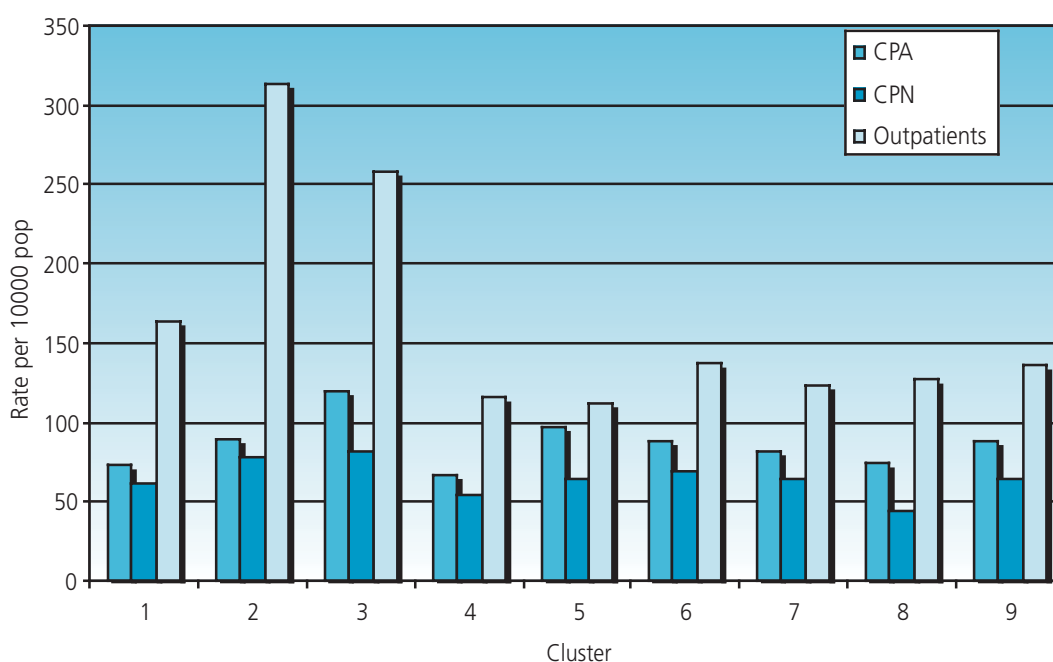
3.33 As Figure 11 shows, there is still a positive association between prescribing and the expected number of patients with dementia, but it is much weaker than that seen in relation to admission rates.

3.34 There are two reasons which might explain why the national estimates do not correlate more closely with the local prescribing rates. Firstly, the national estimates may be a poor indicator of the actual levels of dementia in the clusters. If this is the case, then it also raises doubts about the reliability of using admission rates to assess levels dementia. Secondly, the prescribing rates might themselves be an inaccurate indicator. To some extent the latter reason appears unlikely as, unlike some of the other psychiatric medications, anti-dementia drugs are used to treat a single, specific condition. However, using only single year data may have had an effect on the accuracy of the figures. This could be tested in the future with prescribing data drawn from a three year period.

## Community Activity

**3.35** Alongside the admissions and prescribing data described above, more general information, unrelated to any specific type of mental illness, is also available. This relates specifically to information about patients who are treated under the care programme approach, the workload of community psychiatric nurses and outpatient attendances at psychiatric clinics. The rates of activity for these three variables are shown in Figure 12 for each of the nine clusters. In each case, the figures shown are standardised rates per 10,000 population.

**Figure 12: CPN, CPA and psychiatric outpatients activity by cluster, 2000/01 to 2002/03.**



## Care Programme Approach (CPA)

**3.36** Across Solihull, the average number of patients subject to CPA each year is around 490. The average annual number within each cluster ranged from 41 patients in Cluster 4/Shirley East, to 68 patients in Cluster 5/Lyndon, Elmdon and Olton.

**3.37** Following standardisation, the highest rate of CPA was exhibited in Cluster 3/Fordbridge and Chelmsley Wood. This equates to 119 patients on CPA per 10,000 population, or around 63 patients each year. Across all nine clusters the average rate of CPA was 86.46 per 10,000 population.

**3.38** Together with the highest rate of CPA, Cluster 3/Fordbridge and Chelmsley Wood also had the highest proportion of CPA patients on enhanced CPA. More than a third (36%) of patients were likely to be on enhanced CPA at any one time. In comparison, the average proportion of CPA patients on enhanced CPA in the remaining eight clusters was 14%.

## Community Psychiatric Nursing (CPN)

**3.39** Overall, around 365 patients are being seen by CPNs each year. Again, the most activity is taking place in Cluster 3/Fordbridge and Chelmsley. Around 43 patients were found to be under the care of CPNs in this cluster each year. This equates to a standardised rate 81.64 per 10,000 population. In comparison the standardised rate overall was 64.44 per 10,000 population.

## Outpatients

**3.40** There are around 1,618 psychiatric outpatient appointments each year across the whole of Solihull. This figure equates to around 906 patients, or an average of 1.78 appointments per patient.

**3.41** Figure 12 clearly shows a high rate of referral in clusters 2/Kinghurst and 3/Fordbridge and Chelmsley relative to elsewhere in Solihull. In fact, a third of all the patients seen each year in outpatient clinics came from these two clusters. This figure equates to 40% of all psychiatric outpatient appointments.

## 4. Discussion

**4.0** The first point to note is that the comments included in this report are based mainly on data relating to service activity. As such, there are certain limitations that should be borne in mind when interpreting the results. Activity is largely a measure of the level of demand for a service, and this is not necessarily the same as the level of need. The type of services used and the frequency with which they are utilised can be influenced by a range of factors not always linked to the nature or severity of an illness. For example the decision to admit a patient can depend on various non-clinical factors such as where they live, their social circumstances or the local availability of alternative provision. Similarly prescribing can be affected by factors such as the willingness of patients to consult with their GP, or whether a particular practice is able to dispense medicines on-site.

**4.1** In most needs assessment work, it is the norm to use mortality data as the most objective measure when comparing different levels of health need. However, for illnesses which may be both chronic and severe, but not necessarily life threatening, deaths tend to be a less reliable measure. It is for this reason that mortality data does not feature significantly in this report where information in relation to suicide is included. Although not part of the main body of the report, an account of suicides in Solihull is included as it is one of the key outcome indicators in relation to mental health services.

4.2 Because activity is only a rough indicator of underlying need, it is difficult to draw any concrete conclusions from a report of this type. In addition, the triangulation of admissions, prescribing and national data has introduced ambiguity as opposed to any clear, reliable findings. Contradictions have been found which require further exploration using data sources other than that included in this report.

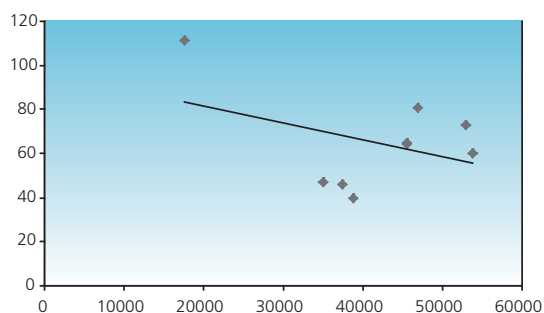
4.3 Accepting these caveats, this report has raised some interesting findings. Perhaps the most important discovery is the high standardised admission rate in Cluster 3/Fordbridge and Chelmsley. This was a consistent trend, regardless of whether looking at specific diagnoses or mental illness in its totality. In addition, measures of the usage of community services also tended to be higher in this cluster than elsewhere.

4.4 These findings do clearly suggest a greater prevalence of mental illness in this cluster. However, some uncertainty about the reliability of this finding is raised by the fact that Cluster 3/Fordbridge and Chelmsley was found to have the lowest overall prescribing rate of all the clusters. If both prescribing and admissions data are seen to be indicators of the same issue, i.e. the level of mental illness, then they should be more positively associated than was found to be the case.

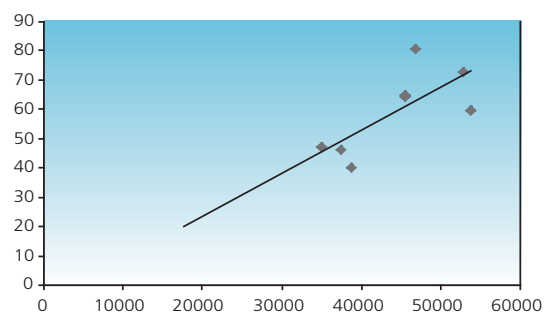
4.5 The effect that Cluster 3/Fordbridge and Chelmsley has on the association between prescribing and admissions across all nine clusters is shown in the two scatterplots below.

**Figure 13: Association between prescribing and admissions.**

**13a) Including Cluster 3**



**13b) Excluding Cluster 3**



4.6 Ignoring the actual figures, what these two graphs show is the extent to which the prescribing rates in Cluster 3/Fordbridge and Chelmsley skew the overall results. If Cluster 3/Fordbridge and Chelmsley is removed from the analysis (13b) then there is actually a strong positive association between prescribing and admission rates, i.e. greater prescribing equals greater admissions. This is intuitively what might be expected if both indicators are measures of the incidence of mental illness.

4.7 The relationship between admissions and prescribing in Cluster 3/Fordbridge and Chelmsley might be partly explained by the fact that the prescribing data relates only to prescribing in primary care. If, as the admissions and community activity suggests, severe mental illness is more evident in Cluster 3/Fordbridge and Chelmsley, then additional prescribing might be taking place in the secondary care sector. This potential omission could be explored through the use of prescribing data from Birmingham and Solihull Mental Health Trust.

4.8 Excluding Cluster 3/Fordbridge and Chelmsley, broadly there appears to be a two tier distribution of mental illness. This is shown most clearly in Figure 13b above. Based on a correlation of prescribing and admission rates, the following four clusters all have similarly high indicated levels of mental illness :

Cluster 1/Castle Bromwich and Smiths Wood  
Cluster 2/Kinghurst  
Cluster 6/Shirley West and Shirley South  
Cluster 7/Shirley East

4.9 In the second tier, the following four clusters all seem to have lower levels of overall illness :

Cluster 4/Shirley East  
Cluster 5/Lyndon, Elmdon and Olton  
Cluster 8/Shirely South and Packwood  
Cluster 9/Knowle, Meriden and Bickenhill

4.10 Looking at the map in Appendix 1 it is apparent that those clusters in the first tier are situated either in the north of the Borough (Clusters 1/Castle Bromwich and Smiths Wood, 2/Kinghurst and 3/Fordbridge and Chelmsley), or towards the east (Clusters 6/Shirley West and Shirley South and 7/Shirley East). Furthermore, the wards situated in these localities are known to be among the more deprived parts of the Borough (see Appendix 3) . As the incidence of mental illness is inversely associated with indicators of deprivation such as unemployment and child poverty, a higher prevalence among the populations in these clusters might be expected.<sup>4</sup> This finding in relation to the location of these practices also provides greater confidence that admissions and prescribing data may be accurate proxy indicators of need.

4.11 Ethnicity is also associated with mental illness, and black and minority ethnic groups are known to have higher rates of mental disorder than the general population.<sup>5</sup> In Solihull, the greatest prevalence of ethnic minority groups is to be found in the east of the Borough, as well as in Chelmsley Wood and Smith's Wood (see Appendix 4). This again increases the expectation that mental illness is more likely to present among populations in these parts of Solihull.

4.12 Other more specific points include the following :

### Depression

4.13 The rate of antidepressant prescribing in Cluster 7/Shirley East is lower than that suggested either by the extrapolation of national estimates or the admission rate.

4.14 Based on admissions and prescribing data, the prevalence of depression in Cluster 4 is lower than expected.

### Neuroses

4.15 Potentially fewer patients than expected are being admitted in Cluster 1/Castle Bromwich and Smiths Wood. This finding is largely due to the relatively low admission rate during 2002/03, together with a relatively high prescribing rate for hypnotic and anxiolytic drugs.

### Psychoses

4.16 The average number of admissions each year in Clusters 1 /Castle Bromwich and Smiths Wood, 2/Kinghurst and 3/Fordbridge and Chelmsley are markedly higher than elsewhere in the Borough. These three clusters account for 67% of all admissions each year. National estimates suggest that the greatest prevalence should be found in Clusters 7/Shirley East, 8/Shirley South and Packwood and 9/Knowle, Meriden and Bickenhill.

### Senile Dementia

4.17 The prescribing of anti-dementia drugs is much greater in Cluster 4/Shirley East than in any of the other clusters. Admissions are more common in Clusters 1/Castle Bromwich and Smiths Wood and 3/Fordbridge and Chelmsley.

<sup>4</sup> Department of Health (1999) Saving Lives : Our Healthier Nation. London, The Stationery Office.

<sup>5</sup> Department of Health (1999) National Service Framework for Mental Health. London, Department of Health.

## Community Activity

4.18 More than half of all the patients attending outpatient appointments are registered with practices in either Clusters 1/Castle Bromwich and Smiths Wood, 2/Kinghurst or 3/Fordbridge and Chelmsley.

## Suicide

4.19 The suicide rate in Solihull tends to be below the national rate. Those who do take their own life tend to be older than expected, and they are more likely to have been in contact with mental health services in the year prior to death.

## 5. Conclusion

5.0 Using routine NHS data to assess the prevalence and distribution of mental illness is a difficult process. Most sources of data are designed to count activity of one type or another, and levels of service activity do not necessarily equate to levels of need. In practice, there are very few sources of data available which identify health needs accurately. This is especially so in relation to mental illness, where conditions can be difficult to diagnose and outcomes are poorly recorded.

5.1 Acknowledging the limitations of the available data, this report suggests that the prevalence of mental illness is greatest in Clusters 1/Castle Bromwich and Smiths Wood, 2/Kinghurst and 3/Fordbridge and Chelmsley, which serve those populations situated in the north of the Borough. In the case of Clusters 1/Castle Bromwich and Smiths Wood and 2/Kinghurst, this assertion is based on the degree to which overall prescribing and admission rates were found to be associated. In the case of Cluster 3/Fordbridge and Chelmsley, where the association between prescribing and admissions was weak, data in relation to community activity has also been taken into account.

5.2 In some instances, the extent to which mental illness appears to be a phenomenon of the north of the Borough is marked. In the case of psychoses, Figure 8 clearly shows the high number of admissions in Clusters 1/Castle Bromwich and Smiths Wood, 2/Kinghurst and 3/Fordbridge and Chelmsley relative both to elsewhere in the Borough, but also to what might be expected based on the size and age profile of the cluster populations. A similar situation was found in relation to community activity. Despite the fact that only around 30% of the Solihull population are registered with a GP from Cluster 1/Castle Bromwich and Smiths Wood, 2/Kinghurst or 3/Fordbridge and Chelmsley, more than half of all persons attending psychiatric outpatients were referred from one of these three clusters.

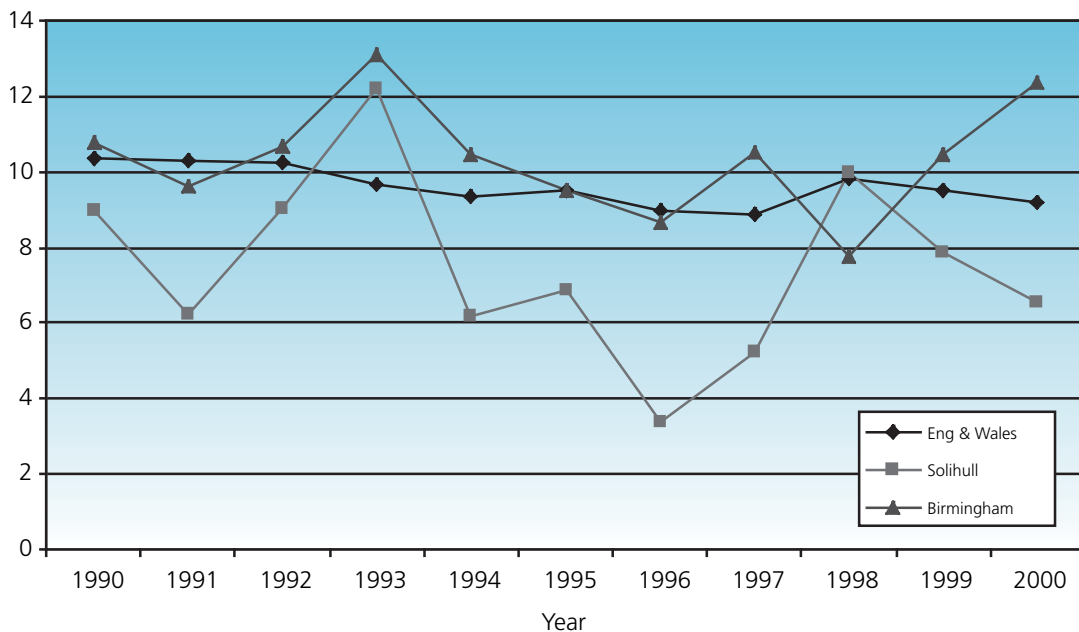
5.3 However, it should again be stressed that activity does not necessarily equate to need, and further examination of this issue could usefully be undertaken if other data were available. For example, prescribing data from specialist mental health services could be combined with primary care data to give a more complete picture of medication usage. Length of stay and readmission rates per patient might also tell us more about the severity of mental illness. Information about access to other services such as counselling would also help to present a fuller picture of differing levels of mental illness, and how this was distributed across the Borough.

## 6. Suicide in Solihull

### 6.1 Annual Trends

Figure 1 shows the annual trend in suicide in Solihull during the years 1990 to 2000. The mortality rates for both England and Wales and Birmingham are also included for the purposes of comparison.

**Figure 1: Directly standardised mortality rate from suicide, England & Wales, Solihull and Birmingham, 1990 to 2000.**



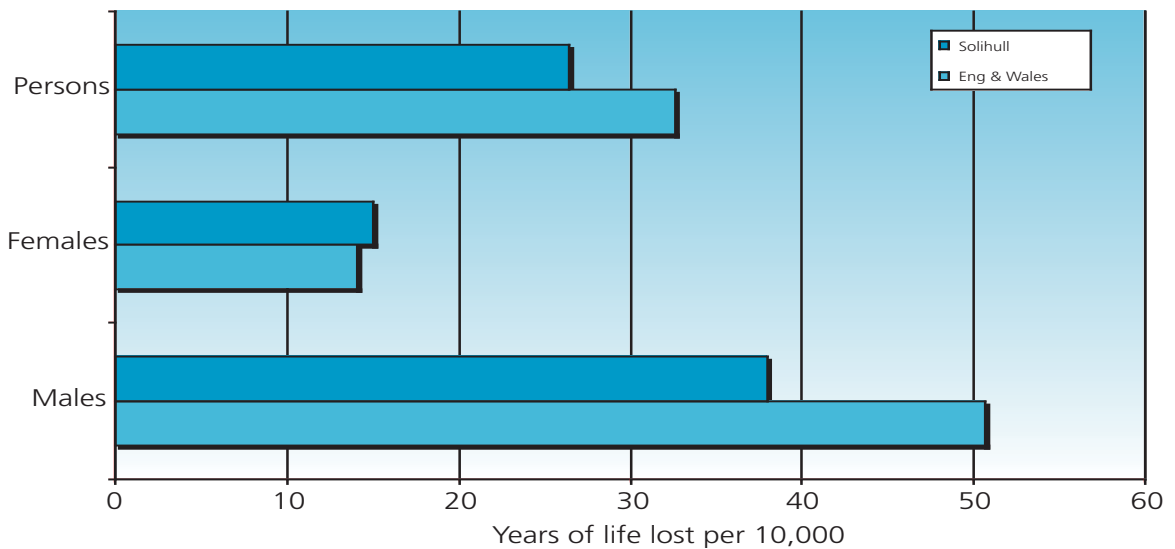
The marked fluctuations year on year in Solihull are an indication that there are very few deaths occurring given the size of the population. Over the time period shown, there were in fact just 16 deaths each year in Solihull on average. Figure 1 also shows that, with the exception of years 1993 and 1998, mortality in Solihull tended to be lower than in the neighbouring Borough of Birmingham, and also lower than in England and Wales as a whole.

### 6.2 Years of Life Lost

Because suicides tend to occur among the relatively young, it is interesting to look at the years of life lost, or the premature death rate from this cause. Figure 2 compares the number of years of life lost per 10,000 population in Solihull with that for England and Wales as a whole.

**Figure 2: Average number of years of life lost annually per 10,000 population,**

## Solihull and England and Wales, 1998 to 2000 pooled.



Years of life lost is based on deaths that occur before 75 years of age. Figure 2 indicates that there are approximately 27 years of life lost per 10,000 population each year in Solihull. This is slightly lower than the 33 years of life lost per 10,000 population in England and Wales. This suggests that suicides may be occurring among a slightly older age range in Solihull. In addition, according to Figure 2, this is more likely to be the case among males rather than females.

### 6.3 Suicide Surveillance

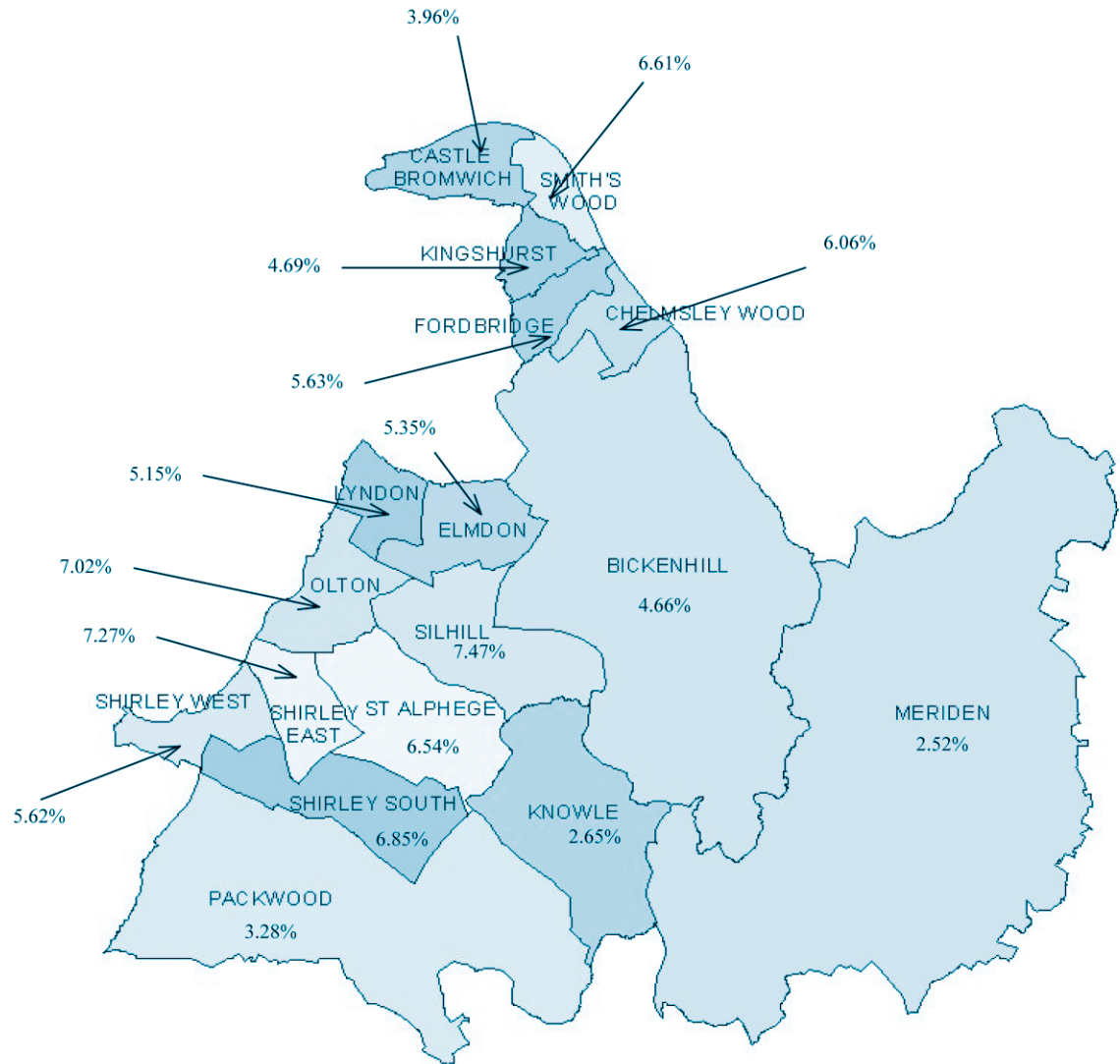
In line with good practice and the audit requirements of the Commission for Health Improvement, Solihull PCT maintains a record of all suicides that occur in the Borough. Although this is largely a prospective audit system, details are available about all suicides in Solihull dating back to September 2001. To further aid the process of audit, similar details are being recorded as those contained within the National Confidential Inquiry (NCI).<sup>6</sup> Summary findings to date are listed below :

Since September 2001, there has been a total of 22 deaths listed as either suicide or open verdict. In the calendar year 2002, 15 deaths were recorded. The average age at death is 49 years. This is slightly older than the 25-34 year old age band within which the majority of suicides occurred in the NCI.

To date, 73% of suicides have been among males. This is very similar to the findings reported by the NCI, where three-quarters of suicides occurred among men. Hanging is the most common method of suicide, followed closely by overdose. This matches the findings of the NCI. So far, 18 out of the 22 cases have had their medical records reviewed. Of these, 11(61%) cases were found to be in contact with mental health services. This compares with around a quarter of cases in the NCI.

<sup>6</sup> Appleby, L et al (2001) Safety First : 5-year report of the National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness. London, Department of Health.

## Solihull - % of population from black and minority ethnic communities



# CHAPTER 6

## Strategy and Investment Plan 2005 – 2010

### 1. Investment In Commissioned Services @ March 2005

#### 1.1 Commissioning Arrangements

In Chapter 4 - Services Currently Commissioned - details were set out of all mental health services commissioned as well as other available provision for Solihull. It is worth reiterating that mental health services are commissioned jointly by Solihull PCT and Solihull MBC. A key post is the Joint Commissioning Manager who is responsible for, and accountable to, both agencies to commission a full range of services. The post holder reports to and is a member of both the Primary Care Trust and Social Services Commissioning Teams. If a decision is taken to form a Care Trust then these commissioning responsibilities will be taken forward into any revised arrangements that obtain within a Trust.

In Chapter 3 - Taking Stock in March 2005 - the governance arrangements of the mental health service were explained, a network of communication and accountability for totality of commissioning and delivery of mental health provision. The social care approach to commissioning is set out in the Operational Commissioning Statement 2005/06 - 2008/09 and this is summarised in Chapter 2 - The Local Strategic Context. The approach of the PCT will be governed by Department of Health guidance on Commissioning a Patient-led NHS and the development of practice based commissioning.

#### 1.2 Investment @ 2004/05

##### 1.2.1 Total resources available

In the 2004/05 financial year the available information identified that a total of £13,347,000 was invested by Solihull PCT and MBC to commission mental health services. This investment can be summarised as follows:

Commissioning Agency	£	%
Solihull PCT	11,117,000	83.3
Solihull MBC	2,230,000	16.7
<b>Total</b>	<b>13,347,000</b>	<b>100.0</b>

In addition, the PCT also invest approximately £1m to address eating disorders, usually by way of placements elsewhere in the region.

### 1.2.2 Deployment of available resources

An analysis of the deployment of these resources would reveal that the vast majority is invested in the Birmingham and Solihull Mental Health NHS Trust, with significant sums with Solihull Social Services together with some services contracted for with external voluntary and charitable organisations. In summary, the current investment with provider organisations is:

Organisation	£	%
Solihull MBC - Assessment and Care Management	370,000	2.8
Birmingham and Solihull Mental Health Trust	11,117,000	83.3
Solihull MBC - Directly Managed Provision	1,600,000	12.0
Voluntary and Charitable Providers	260,000	1.9
<b>Total</b>	<b>13,347,000</b>	<b>100.0</b>

### 1.2.3 Voluntary and Charitable Providers

In addition to the services commissioned from statutory agencies there is an albeit low level of investment in commissioning voluntary and charitable organisations to deliver mental health provision. The most significant partners are (in alphabetical order):

- Family Care Trust
- Solihull Care Housing Association
- Solihull Mind
- Stonham

These agencies provide a range of provision including advocacy, employment, drop-in, befriending, housing related support and residential care; full details are available in Chapter 4 - Services Currently Commissioned.

## 2. Review of Investment

A key question facing Solihull is whether the £13.3m is invested appropriately and whether the right services are being commissioned from the relevant provider agencies.

### 2.1 Services currently commissioned

In turn, central to this issue is the need to confirm that the summary of current investment fully accounts for all resources which funds and commissions services. A Review of the supply map of services and funding sources would enable this task.

## 2.2 Day Services provided by Birmingham and Solihull Mental Health Trust

A Review of the Day Services provided by the Birmingham and Solihull Mental Health Trust is underway. This Review is likely to focus on:

- The need for an Acute Day Hospital to work in conjunction with the Crisis Resolution and in-patient services.
- A programme of specific therapeutic interventions delivered from a variety of community settings.
- Strengthening links with services commissioned from voluntary and charitable providers as well as other community initiatives. This would ensure that the concept of social inclusion is underlined and access is facilitated to education, training, work, leisure, housing related support, accommodation and other community activities.

## 2.3 Continuing Care

There has also been constructive debate about the current range of continuing care provision in the Borough. This provision focuses on the residential facilities at Hertford House and David Bromley House.

The role and function of these services should be seen in the context of other provision on the same continuum, namely: (i) existing residential care where individual places are funded by Social Services; (ii) housing related support services funded by the Supporting People Grant and accountable to the Commissioning Body comprising Solihull PCT, Solihull MBC and the National Probation Service; and (iii) domiciliary care services.

A Review of the services currently commissioned including the nature and extent of the funding and provider arrangements and service specifications may lead to an improved application of resources.

## 2.4 Service Redesign

The preparation of this Strategy affords the opportunity to review all components of the totality of provision to ensure that the NSF and the priorities as set out in Five Years On are addressed. The NSF Standards and the continuing self assessment will demand that commissioners rigorously review arrangements to ascertain the most appropriate means by which to deliver high quality services which enable positive outcomes for service users and carers.

## 3. Strategy 2005 - 2010: Priorities

This Strategy and its implementation will centre on five important but complementary strands of service improvement; the priorities are:

### 3.1 Self-Assessment of compliance with NSF Standards

The continuing review and self-assessment of progress towards meeting individual targets as prescribed by the 'Traffic Lights' to ensure compliance with NSF Standards.

## 3.2 Pre-existing priorities

There are a number of significant pre-existing priorities which are receiving continuing attention. While progress on these will be monitored by the self-assessment, in view of their importance it is useful to highlight them:

- The introduction of a Crisis Resolution Service
- The introduction of an Early Intervention Service
- The introduction of Community Development Workers and the development of culturally sensitive services
- Suicide prevention
- The continuing need to apply Primary Care resources efficiently
- To attain a full complement, and deployment, of Graduate Workers
- To meet the needs of Solihull's prison population
- To commission further dedicated services for women
- Consider options for addressing the need to provide single sex hospital accommodation
- To implement the protocol which fulfils the requirements of the Mental Health Act Code of Practice and reaffirms the hospital as the preferred place of safety, except where a risk assessment indicates otherwise.

## 3.3 Reviews

The outcome of Reviews of the existing range of services currently commissioned and the preparation of proposals for the redesign of service provision, namely:

- Services currently commissioned
- Day Services provided by Birmingham and Solihull Mental Health Trust
- Continuing Care
- Service Redesign
- Reviews of housing related support services funded by Supporting People Grant

## 3.4 Workforce Strategy

The capacity of all stakeholders to deliver the Strategy and continue to manage high quality services depends on the ability of agencies to recruit and retain a skilled and motivated workforce.

A Workforce Strategy will be required to address a number of key issues, including:

- Agreement to a single set of competencies in order to implement each NSF Standard
- Provision and development of education and training, including pre-qualifying training and continuing professional development
- Assessing for the appropriate skill mix to enable the delivery of each Standard

## 3.5 Clinical Governance

Clinical guidance to support the implementation of the NSF is provided on behalf of the Department of Health by the National Institute for Clinical Excellence (NICE). Technical appraisals and clinical practice guidelines are issued. A number are due for publication including guidance on anxiety, depression in children, bi-polar disorder, puerperal/perinatal disorder, dementia, drug misuse and attention deficit/hyperactivity disorder.

While there is no statutory requirement for PCTs to fund guideline implementation, as there is for technology appraisals, the recommendations of NICE will be considered locally with a view to assisting the delivery of the Strategy and NSF Standards.

#### 4. Strategy 2005 -2010: Key Criteria for the Commissioning of Services

It will be of paramount importance to commission high quality services in line with the stated strategic priorities and consistent with practice based commissioning and the devolution of budgetary responsibilities to General Practitioners. In order to achieve positive outcomes for service users and carers services will be commissioned only if evidence can be produced that the following criteria are met.

Services for people with mental health needs must:

- Reduce the need for more intensive forms of long term care and support
- Reduce the incidence of self harm
- Enable choice
- Recognise and address the needs of people from black and minority ethnic communities
- Support carers
- Facilitate the smooth transition of young people to suitable services when s/he becomes an adult
- Facilitate the smooth transition of working age adults to suitable services for older people.

#### 5. Strategy 2005 - 2010: Investment Plan

The implementation of this Strategy in order to comply with the requirements of the NSF necessitates action on a significant number of tasks. Some do not need additional money and are changes of practice or a realignment of priorities which should be absorbed within existing resources. However, a number of tasks will require additional investment in order to achieve the introduction of new services or facilitate the extent of change required.

The full schedule of action is set out in the Implementation Plan at Appendix 1. This provides full details, for each Standard of the NSF, of each action together with information on the nature of the resources needed, including finance, and an indication of which 'traffic light' is addressed.

The priorities of the Strategy are set out above in paragraph 3 and have significant revenue consequences. It is these priorities which act as the pivot for the future implementation of the Strategy. A summary of these key issues is provided below in the Investment Plan. This Plan is prepared @ March 2005 and includes details of the revenue investment in 2005/06 and the timetable for the implementation of each priority. This Plan will need to incorporate details of the longer term revenue requirements and commitments, be subject to regular review by the LIT and the Mental Health Partnership Board.

Significant progress has been made to secure additional revenue to fund important developments for the mental health service. In 2005/06, these additional resources can be summarised as follows:

- PCT - as part of the Local Delivery Plan an additional £650,000 will be invested in 2005/06, resources which will have a full year effect of £750,000 from 2006/07. This investment will fund both the Early Intervention Service to be managed by the BSMHT and other new developments.
- SMBC - The Council has identified a total of 8 Step Change Improvement Projects (SCIPs) which would benefit from additional investment. One of the SCIPs is to achieve a two star rating for adult social care services along with, for example, physical, economic and social regeneration solutions for the Borough. As a consequence additional revenue of £175,000 has been identified to fund the Early Intervention and the Crisis Resolution Services.

## Investment Plan 2005 - 2010: Initial Statement 2005/06

Service (Traffic Light @ 2004)	Preferred Provider	PCT Contribution £	SMBC Contribution £	Comment	
Early Intervention (5)	B&SMHT	200,000	175,000	This service is being implemented in a staged fashion in order to ensure that the most appropriate model of delivery is adopted.	
Crisis Resolution (4)	B&SMHT	550,000*		This service is now fully operational.	
Community Development Workers and culturally sensitive services (1a)	To be identified		A total of 2.0 wte workers will be recruited and the service is likely to be commissioned from a non-statutory agency.		
Suicide Prevention (2)	B&SMHT		A Suicide Prevention Strategy will be prepared and complement the Mental Health Promotion Strategy.		
Primary Care (11)	B&SMHT		The Locality Implementation Team (LIT) is continually steering improvements and will benefit from participation in the Collaborative.		
Graduate Workers (8c)	B&SMHT		A total of 3.0 wte workers will be recruited.		
Prison Service (14)	B&SMHT		Through and after care is provided in conjunction with the Mentally Disordered Offenders and Assertive Outreach Teams.		
Women's Services (15)	B&SMHT		The LIT is monitoring improvements of gender specific services.		
Single sex accom. (36)	B&SMHT		Capital investment has realised improvements.		
Place of Safety (39)	B&SMHT		The service is compliant with the Mental Health Act Code of Practice and further Trust wide consideration of this issue is underway.		
Audit of current commissioned services	To be determined		The LIT reviews the current range of services commissioned to ascertain compliance with strategic requirements		
Day Services Review	To be determined		This Trust led Review of its services is complete and the outcome monitored by the LIT.		
Continuing Care Review	To be determined		A Sub Group of the LIT is leading this Review.		
Service Redesign	To be determined		The LIT will monitor redesign to ensure compliance with the Strategy.		
<b>Total</b>			<b>750,000</b>	<b>175,000</b>	

\* A significant proportion of these resources were invested in the Crisis Resolution Service

# APPENDIX 1

## Implementation Plan

### Underpinning

No.	Traffic Light @ 2004	Action	Resource	£ Fye
1	All	All stakeholders to agree a Vision and Values statement for the Strategy. This will assist the promotion of a partnership approach to the development of user led community services.	-	0
2	All	Mental health services to be commissioned and delivered within an integrated structure based on partnership.	-	0
3	All	All services to be reviewed to ensure they are sensitive to the needs of people from black and minority ethnic communities and to assess the need for dedicated provision which may be required.  All residents must be treated fairly and equitably and racial equality is at the core of the service and all procedures should be reviewed to ensure that the workforce is able to deliver a culturally sensitive service.	-	tbi
4	All	All services to be reviewed to ensure they are sensitive to the needs of women.  All residents must be treated fairly and equitably and all procedures should be reviewed to ensure that the workforce is able to deliver a service sensitive to the needs of women.	-	tbi

## Standard 1 Mental Health Promotion

No.	Traffic Light @ 2004	Action	Resource	£ Fye
5	37a, 37b	<p>Prepare and implement a costed strategy for Mental Health Promotion for Solihull.</p> <p>The Mental Health Locality Implementation Team (LIT) will have a clear strategy for provision of mental health promotion based on the present MHP activity and an identification of need in Solihull. 0.5 Health Promotion Worker</p>		18,000
6	33, 37b	<p>Mental Health Promotion Strategy to look at ways of supporting employers to employ and retain people who have mental health problems and address problems of poverty and stigma due to lack of employment.</p>	-	0
7	27	<p>To secure user representation on the LIT and other bodies responsible for commissioning services.</p>	4 user representatives	800
8	27	<p>Involve service users in audits of the service.</p> <p>BSMHT Clinical Governance Committee will report to LIT that all audits involve service users; and all providers are expected to adopt similar procedures.</p>	-	0
9	27, 29	<p>Involve service users in the recruitment process, including preparation of selection criteria.</p> <p>Providers will confirm to LIT that suitable procedures are in place. considered.</p>	-	0
10	17, 33	<p>All agencies involved assisting service users find employment to improve the co-ordination of services.</p> <p>LIT will set up Employment Sub-group to review all options, identify gaps and disseminate information so that employment and training opportunities can be made available to all service users.</p>	-	0

No.	Traffic Light @ 2004	Action	Resource	£ Fye
11	33	<p>To ensure service users perceive the statutory services as organisations which respect the experience of people who have suffered mental health problems and who do not subscribe to popularly held bias.</p> <p>Action to be taken to make it easier for service users to find employment within mental health services. The expertise derived from lived experience to be recognised. All providers will include personal experience of mental health problems as a desirable attribute in person specifications for posts.</p>	-	0
12	33, 34	<p>Employees of the mental health services who have mental health problems to be supported.</p> <p>To ensure that all services benefit from the experience of staff who have first hand experience of mental distress and that service users will be able to perceive services as safe environments for people with mental health problems.</p>	-	0

## Standards 2 & 3 Primary Care and Access to Services

No.	Traffic Light @ 2004	Action	Resource	£ Fye
13	1b, 8c, 11,	<p>Expansion of the Primary Care Mental Health Team to cover all practices. The Team will comprise a range of skills, including Graduate Workers. Their role will be to assess and, where appropriate, provide short-term support to adults from age 17 upwards within primary care settings, ensure that people approaching their GP receive an improved service, referring and signposting service users to other appropriate services (including secondary services) and to help GPs and staff in primary care to develop their knowledge and skills and be confident in their assessment and treatment of people with MH problems.</p> <p>This will address inequities in health care across Solihull, reduce inappropriate referrals to secondary care and provide a range of interventions for service users in primary care</p> <p>An audit of service users and GPs will indicate satisfaction with the service they receive. 2.0 Graduate Workers</p>	<p>3.0 STaR workers 2.0 CPNs</p> <p>Training Accommodation</p>	160,000
14	16, 40	<p>Members of the Primary Care Mental Health team will have the skills, training and support to deal with a wide range of problems including dual diagnosis (drugs/alcohol and mental health problems) and dementia and can provide a service suited to people from black and minority ethnic communities.</p> <p>Service users with complex problems will receive an improved service from GPs and their teams. GPs will be better supported in their role with service users who bring special challenges.</p>	-	0

No.	Traffic Light @ 2004	Action	Resource	£ Fye
15	11	<p>To enable people needing onward referral from primary care to receive their first, or first 2 appointments, with a psychiatrist in a primary care setting; and ensure that service users referring themselves to primary care will receive the most appropriate service and reduce unnecessary referrals to secondary care.</p> <p>Data gathered by BSMHT will indicate at least 50% take up.</p> <p>This will enhance user choice, improve engagement between service users and mental health services.</p>	-	0
16	24	<p>Protocols to be devised to offer support to Primary Care to continue treatment of people with ADHD older than 17 years old, possibly through the Primary Care Mental Health Team, and so assist to fill the current gap in provision for people with ADHD who graduate from the CAMHS service.</p>	-	0

## Standards 4 & 5: Specialist Care, Hospital and Crisis Accommodation

No.	Traffic Light @ 2004	Action	Resource	£ Fye
<b>Care Programme Approach (CPA)</b>				
17	9, 18	To revise the CPA process and documentation to place the service user's own defined outcomes and the planning of their own care at the centre of the care co-ordination process; include service user-defined outcomes (and actions to move towards these outcomes) within the CPA process; and assist staff to fulfil their roles without duplication.	-	0
18	9, 16	To meet the recommendations of the David Bennett Enquiry and ensure that the cultural needs of people from black and minority ethnic communities ensure are met in a sensitive manner; and to establish within the CPA process and documentation a mandatory requirement to include details of each service user's ethnic origin.	-	0
19	9	To enhance measures within the CPA process and documentation to improve social inclusion and take account of issues relating to accommodation, occupation and relationships.	-	0
20	7, 9	Expand the CPA to include all people receiving secondary mental health services and so ensure that all service users receiving care commissioned by statutory services are in receipt of the same quality of care planning with a care co-ordinator based in the community.  BSMHT will report to LIT that all people receiving secondary care are fully included in CPA.	Expansion of CMHTs by 1.0 CPN	32,000
21	9	Launch of electronic CPA to reduce duplication and make care plans available to the services at all times. This will ensure a safe and consistent service and meet government requirements to allow access to high quality care at whatever point a user may come into contact with the statutory mental health services. Costs related to restructuring of information services following formation	of BSMHT and IT equipment and training. tbi	

No.	Traffic Light @ 2004	Action	Resource	£ Fye
22	9	<p>All staff to receive training and resources to allow them to understand and carry out the CPA.</p> <p>This will ensure that all service users receiving a service from statutory services benefit from high quality care co-ordination, needs assessment, risk assessment and review; to ensure that different levels of support can be targeted and varied as service users' circumstances change; to ensure that service users are at the centre of a responsive service committed to fulfilling their needs and upholding their human rights by ensuring nobody is kept in a more restrictive environment than necessary.</p>	Training	0
23	9, 18	<p>All providers will adhere to the Recovery Model to ensure that service users are encouraged to look at their desired outcomes including employment and occupation and ensure that these aspirations and action plans to move towards them are recorded within the CPA.</p> <p>Recovery Model to be included in training plans and reviewed by BSMHT Clinical Governance Committee and Joint Training Group.</p>	-	0
24	9, 18, 33	Change the culture within specialist mental health services to ensure that the assumption that service users do not work is challenged. Employment issues included in all CPA needs assessments and reviews.	-	0
25	7, 9, 11	To ensure that service users' needs and wishes are always central to all decisions about admission and discharge and progress is not delayed by organisational problems. This will require clear communication between wards and community services is optimised by applying the CPA process rigorously.	-	0

No.	Traffic Light @ 2004	Action	Resource	£ Fye
<b>Assertive Outreach Team</b>				
26	3, 9	<p>Develop the assertive outreach team to increase availability and accessibility and ensure the Assertive Outreach service is faithful to the model required through the Policy Implementation Guide.</p> <p>(i) Service to be available during daytime and evening and 7 days per week. Working hours of team to expanded to seven days per week to have a more flexible service enabling a better fit with service users lifestyles and aspirations.</p> <p>(ii) Further develop the assertive outreach team to enhance skill mix by the recruitment of a 1.0 Occupational Therapist. This will enhance the range of interventions available in order to provide a service which will help more service users achieve their desired outcomes.</p>	tbi  1.0 Occupational Therapist	72,000  36,000
<b>Crisis Resolution</b>				
27	4, 9	Set up a Crisis Resolution/Home Treatment Team. This service will give Solihull residents a swift response in a crisis, enhance the options available to provide meaningful alternatives to hospital admission and allow service users to return home from hospital more quickly.	14.0 wte	600,000
28	4, 9	Set up Crisis Accommodation as alternative to hospital for service users in crisis. This will provider Solihull residents who are in crisis and alternative to hospital when they cannot remain at home.	tbi	tbi
<b>Early Intervention</b>				
29	5, 9	Set up an Early Intervention Service. This will provide for residents of Solihull who experience a first or second episode of psychosis with treatment as soon as possible in an unrestrictive environment. This service will fulfil a PCT Local Delivery Plan target.	10.0 wte	400,000

No.	Traffic Light @ 2004	Action	Resource	£ Fye
<b>Accommodation, In-patient and Rehabilitation services</b>				
30	7, 36	To continue improving in-patient areas to maximise the therapeutic possibilities of wards ensure that in-patient areas are suitable environments to promote mental well-being and promote the best possible service user experience.	tbi	tbi
31	7	In light of a strategic focus on community services, in-patient services continue to be provided safely with sufficient staffing to promote a stimulating service to a population of in-patient service users who will be suffering a greater level of mental distress than the average at present.	-	0
32	9	Re-align day hospital services to ensure that they provide a service for people who are acutely ill. Resources will be targeted effectively on people with most need, provided on the basis of assessed need within the CPA and contribute to a community alternative to hospital admission.	-	0
33	9	Ensure that the in-patient rehabilitation services work more closely with the CMHTs. This will maximise progress for service users and ensure that the CMHTs have access to expertise in rehabilitation. The care management function is carried out within CMHT and rehabilitation staff are to be more actively involved.	-	0
34	7, 19	Carry out assessments the usage of all in-patient beds, rehabilitation, nursing, residential and supported accommodation places (with reference to geographical location).  This will ensure that all service users are receiving care and support at the appropriate level, inform future commissioning intentions (by increasing the range and availability of community-based accommodation) and ensure that Solihull service users can gain access to a range of accommodation options to meet their needs and that no-one is living in a more restrictive or insufficiently supportive environment than they require.	-	0

No.	Traffic Light @ 2004	Action	Resource	£ Fye
35	19	Providers of housing related support financed by the Supporting People programme should be encouraged to help tenants find accommodation suited to their aspirations of independence and achieve maximum autonomy consistent with their ability, safety and aspirations.	-	0
36	9, 19	To establish a Community Recovery Team comprising the former Middlewood Rehabilitation Service and SMBC Day Services.  This service will enable service users to receive a rehabilitation service outside institutional settings consistent with the recovery model; increase the mental health service's capacity to help service users to develop skills needed for independent living as a part of the CPA/care management process; and provide rehabilitative support to service users in their own homes to maximise independence.	-	0
37	9,18, 19, 33	Stakeholders to work together to increase the availability of suitable accommodation. The LIT Sub-group for accommodation will assist the promotion of measures aimed to maximise choice for service users, reduce time spent in hospital awaiting suitable accommodation.	tbi	tbi
38	18, 21	Develop a wider range of drop-in options and increase the sources of support available to service users living in their own tenancies or homes. This will be based on enhancing self help options, user choice and widening the range of providers active in the Borough.	-	tbi
<b>Drop-in Services</b>				
39	9, 17, 18, 33	Stakeholders to work together to increase the availability of suitable employment opportunities. The LIT Sub-group for employment will assist the promotion of measures aimed to maximise choice for service users to maximise their potential.	tbi	tbi

No.	Traffic Light @ 2004	Action	Resource	£ Fye
<b>Mentally disordered offenders</b>				
40	9, 14	To address the needs of mentally disordered offenders and enhance service to provide prison in-reach.  To ensure that people with mental health problems who become involved with the criminal justice system receive appropriate assessment and care throughout the process and that there is clear communication between all agencies.  The mentally disordered offenders Sub-group of the LIT will review these issues.	Prison in-reach worker	32,000
41	9, 14	Ensure all Solihull citizens with mental health problems in prisons are assessed and entered on the CPA so that prisoners can receive services suited to their needs on discharge.	-	0
42	40	It is no longer viable to view service users who use substances as separate from the mainstream mental health service. To ensure that statutory mental health services are equipped to help all service users with mental health problems all staff to have access to training and support in working with people presenting with dual diagnosis (mental health and substance misuse).	-	0
<b>Dual diagnosis</b>				
43	40	To recruit a small proportion of staff with a special interest in dual diagnosis to assess and co-work with service users who present a special challenge. This will enable the statutory services to gain access to specialist help for service users with complex problems relating to drug and alcohol use.	Staff	34,000
<b>Talking Therapies</b>				
44	18	Review the availability, range and need of talking therapies throughout all mental health services. Talking therapies are frequently requested by service users and carers but there are inequities in Solihull's current level and distribution of provision.	-	0

No.	Traffic Light @ 2004	Action	Resource	£ Fye
<b>Mental health of people with learning disabilities</b>				
45	22	<p>Develop clear pathways for people with mental health problems and learning disability in order to ensure safe and co-ordinated services which meet the needs of all vulnerable people.</p> <p>Protocols to agreed by the statutory services; and to include provision for adults on the autistic spectrum after consultation with other relevant agencies.</p>	-	0
<b>Liaison</b>				
46	9	<p>Develop a liaison service throughout the hospital in partnership with Heart of England NHS Trust and other Acute Hospital Trusts.</p> <p>This will ensure that the mental health needs of people within physical health settings are addressed, enhance the patient experience, minimise length of hospital stay and facilitate assistance with waiting times.</p>	0.5 wte Consultant Psychiatrist 0.5 Senior House Officer 2.0 Nurses 1.0 Social Worker 0.2 Therapist 0.5 Admin.	190,000
47	15, 38	<p>Provide an improved and whole systems approach to mothers, and their babies, who are experiencing perinatal mental health problems. To ensure the safety and prompt treatment of mothers and their babies, before and after birth. This will reduce the danger of suicide in this most vulnerable stage of development.</p>	2.0 Community staff	68,000
<b>Specialist Services</b>				
48	38	<p>To develop a model for a Community Eating Disorder Service straddling the transition between both services and implement. This will ensure that service users who have eating disorders can receive treatment at, or close to, home reducing the trauma and cost of hospital treatment, a reliance on unplanned out of area hospital placement and in hospital admissions for eating disorders.</p>		2.0 Community Staff 68,000

No.	Traffic Light @ 2004	Action	Resource	£ Fye
<b>Children and young people</b>				
49	24	<p>To agree clear protocols for transition which focus on the needs of the young person rather than the needs of the services. This will require agreement between adult mental health services and the Child and adolescent mental health service (CAMHS) and the learning disability service and other agencies e.g. Connexions</p> <p>This will ensure that young people with mental health problems reaching the age of 17 continue to receive services they need with as little disruption as possible and ensure a whole systems approach with other programmes for young people.</p>	-	0
	24	<p>To review the CPA and other processes in the light of the Laming Report on the death of Victoria Climbié and assess whether the current arrangements are appropriate to protect children at all stages of the care co-ordination process for adults and that all staff are aware of their responsibilities under child protection. This will require the participation of the PCT Safeguarding Children Group, Area Child Protection Committee and providers.</p>	-	0
<b>Adult Protection</b>				
50	9	<p>To review the CPA and other processes to provide suitable arrangements to protect adults who may be suffering abuse and exploitation.</p>	-	0

## Standard 6: Carers

No.	Traffic Light @ 2004	Action	Resource	£ Fye
51	8b	Commission Carers Worker from the voluntary sector to carry out carers assessments and promote the importance of carers needs.	Carers Support Worker	15,000
52	8b	Increase investment on provision of respite for carers.	Respite services	10,000
53	8b	Provide readily available information for carers on all aspects of mental health including primary care.	Information material	5,000
54	8b	Commission training, involving carers, for staff in provider agencies to raise awareness of the needs and concerns of carers. There needs to be an improvement in the involvement of carers in the provision of services to avoid carers feeling marginalised and not having their needs recognised and	addressed. Training	5,000
55	8b	Ensure Carers are represented on the Locality Implementation Team and other bodies making decisions about commissioning and service delivery. This will allow carers concerns will be considered at all stages.	-	0
56	9	Ensure carers know the identity of the Care Co-ordinator and Responsible Medical Officer. This will permit the appropriate involvement of the carer with arrangements for their family member/friend.	-	0
57	9	To examine with carers, users and staff the implications of Data Protection and Freedom of Information legislation and guidance on Coldicott Guardians.	-	0
58	8b	To develop a strategy for young carers of people with mental health problems. This will be prepared with agencies including Young Carers and Solihull MBC's Education & Children's Services Directorate. It will promote the principal that young carers can have a normal life, optimise their educational possibilities, assist users to receive the level of care needed without reliance on young carers.	-	0

## Standard 7: Suicide Prevention

No.	Traffic Light @ 2004	Action	Resource	£ Fye
59	2	BSMHT Clinical Governance Group to commission an audit based on the suicide prevention toolkit of how current services fulfilling the expectations of guidance and take action to address any deficits identified.  To facilitate the planning process so that residents of Solihull have every assistance to avoid the misery caused by suicide and that Solihull reaches the goal of a 10% reduction in suicide by 2010.	-	0
60	2	To prepare a multi-agency Suicide Prevention Strategy.	-	0
61	2, 9	Review the CPA process and documentation to ensure it takes into account measures which contribute to the prevention of suicide.	-	0
62	2, 9	Establish a service to assess and follow up people who harm themselves.  This will provide support to Accident & Emergency services working with people who self-harm and meet the government requirement that all people who are admitted with self harm are followed up within a week of discharge. It will also contribute to the prevention and avoidance of misery caused by suicide and that Solihull reaches the goal of a 10% reduction in suicide by 2010.	0.2 Consultant Psychiatrist 0.2 Senior House Officer 1.0 Nurse 1.0 Social Worker 0.3 Admin.	100,000



