



WOLVERHAMPTON JOINT STRATEGIC NEEDS ASSESSMENT 2009

Update January 2010

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1 Executive Summary

The 2009 Joint Strategic Needs Assessment builds upon the comprehensive analysis performed in 2008. This can be accessed from the following link <http://www.wolvespct.nhs.uk/JSNA/rootfolder/index.html>.

The broad thrust of the needs assessment has not changed. The main causes of our poor life expectancy remain the “big six” of Infant Mortality, Coronary Heart Disease, Stroke, Alcohol-related Liver Disease, Suicide and Cancer (particularly lung cancer). Obesity in children and adults remains a significant problem and teenage pregnancy rates are stubbornly high.

Deprivation and inequality feature heavily in our analysis and we confirm the persistent local link between socio-economic disadvantage and survival. We also show variation in access to services by ethnic group. This update examines how the ageing population and increased survival will impact upon one often neglected service area.

The first chapter provides updates to the nationally suggested core dataset wherever new information is available. It draws heavily upon “Window on Wolverhampton” which is led by the City Council in collaboration with partner agencies. It reaffirms that our total population will be relatively stable in the medium term; there will be a significant rise in the over 65 year population and this will lead to an increase in the number of single people. The analysis also shows that our most disadvantaged wards have a higher proportion of children, an important factor in our fight against child poverty. The rapid rise in unemployment in the city consequent upon the international financial crisis is documented.

Learning Disability was a gap noted in our original JSNA and is covered in chapter two. Comparative assessment suggests that there about 4 - 6000 people with learning disability in the city, of whom about 900 will have severe disability. This is in line with the number of people with moderate or severe disability known to live in the city and receive services. It predicts a small (less than 5%) rise in this group of people, mainly in the over 65 age group and due to ageing. Most people with learning disability are cared for by families and increasingly by old or frail carers. Local survey work shows that people with learning disability are three times more likely to be obese and twice as likely to have asthma. Girls with learning disability have a 40% chance of getting pregnant in the 18 months after leaving school. Learning disability accounts for two thirds of special school places, with approximately 60 per year entering adult services.

Chapter three explores Cardiovascular Disease (CVD) in more depth as it remains the single greatest cause of lost life years in Wolverhampton. Although we are improving in this area, mortality from CVD remains considerably higher than the national average. The chapter explores the factors which explain the high burden of CVD in the city. It identifies the non-modifiable and modifiable risk factors for CVD and the impact of these. The potential to reduce the number of CVD events is examined in a model which uses these risk factors and the potential of better risk factor management. The model shows that if new services were focussed on the most disadvantaged groups then this may halve their excess in CVD events compared to the most advantaged in the city.

Mental Health is the last of the detailed analysis undertaken in this JSNA and like learning disability responds to gaps in the initial document. The chapter includes both quantitative and qualitative data relating to the burden of mental health problems and service configuration and productivity. It reviews the determinants of mental health problems especially poverty and unemployment. Encouragingly, suicide rates are falling in the city and the mortality gaps between disadvantaged and advantaged are closing. However the overall burden of mental ill health is high, with at least 14,000 people with depression although these are in line with other benchmarks. Approximately 3,000 people have dementia in the city and this will rise by at least 14% over the next decade. Differences in service use by ethnic group are described with higher rates in certain BME groups, especially the black

population. Considerable information is given on the type of client in contact with services as well as comparative data on service productivity. Important qualitative data is given about the perception of services from stakeholders and service users. Finally financial information is provided which shows that the triangle of spend is opposed to the burden of need with a disproportionate amount spent on a small number of clients.

The last chapter describes how we have evolved the JSNA process in Wolverhampton to firmly support the Local Strategic Partnership in strategically assessing need. It shows the governance arrangements we have put in place which involve the whole partnership. We have identified three priorities for 2010/11:

- 1 Children and Young People: This work will link to and support the new Children and Young People Plan.
- 2 The effects of the recession on the needs of Wolverhampton: This will have a particular emphasis on child poverty.
- 3 The effects of ageing on the needs of Wolverhampton

This JSNA refresh was developed by the Needs Analysis Governance Group of the Local Strategic Partnership. Representatives include:

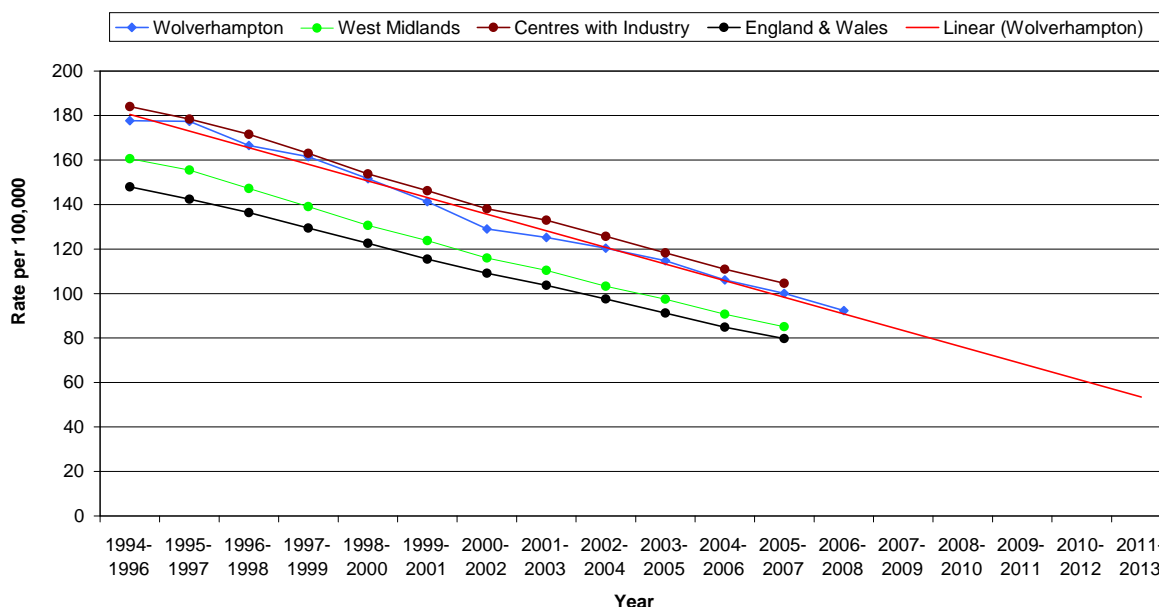
- Local Strategic Partnership
- Voluntary Sector Council
- City Council (Children and Young People Services)
- City Council (Adults and Community Services)
- City Council (Policy)
- City Council (Regeneration)
- PCT
- Police

2 Chapter 3 - Cardiovascular Disease

2.1 Introduction

There were over 2,500 deaths in under 75s in Wolverhampton between 2006-2008. Just over a quarter of these were related to Cardiovascular Disease (CVD) (the majority either Coronary Heart Disease, CHD or Stroke) – leading to over 8,000 lost life years.

Age standardised mortality for circulatory disease in people aged under 75 in Wolverhampton



These trend lines show that age standardised CVD mortality in under 75s is reducing in Wolverhampton. However Wolverhampton rates are still higher than England and Wales, and the West Midlands but lower than comparable areas (i.e. Centres of Industry).

2.2 Risk factors

The non-modifiable risk factors for CVD include age, gender, ethnicity and family history.

Age and Gender

Wolverhampton’s age and gender profile broadly mirrors the age and gender structure of the UK. The older population continues to increase with a rise of 200 people in 2008. It is the older age group that is at greatest risk of CVD.

Ethnicity

The 2007 Mid Year Estimates (MYE) by ethnic group show that approximately 27% of the Wolverhampton population in the city is of Black and Minority Ethnic origin (BME). This compares to national proportions of 16.4%. This shows an increase in the BME population in Wolverhampton of 2.3% since the last census. 14.9% of the Wolverhampton population is Asian, the ethnic group who is at highest risk of CVD.

Family History

Data to describe family history is difficult to access. However, the fact that CVD mortality is higher in Wolverhampton than for England and Wales would suggest that the proportion of people with a family history of CVD will also be higher.

The modifiable risk factors for CVD include smoking, diet, physical activity and alcohol consumption. The modifiable risk factors are all correlated to deprivation.

Smoking

81% of patients aged over 16 years on GP registers in Wolverhampton have their smoking status recorded. Of these 17.1% are smokers.

Modelled estimates from 2003-2005 suggest smoking prevalence in Wolverhampton is 24.7%.

Diet

There is no data about the population's diet either from GP registers or local surveys

Modelled estimates from 2003-2005 suggest that 23.0% of adults in Wolverhampton eat five or more portions of fruit and vegetables daily.

Physical Activity

The annual Sport England "Active People" survey suggests low levels of physical activity undertaken by adults which has not increased recently.

Data from APHO (2005-2006) suggests that 8.8% of adults in Wolverhampton participate in moderate physical activity an average of 5 times per week. This compares to 11.6% nationally.

Alcohol

There is no data about the population's alcohol consumption either from GP registers or local surveys

Modelled estimates from 2003-2005 suggest that 17.9% of adults in Wolverhampton binge drink.

Wolverhampton has one of the highest rates of deaths arising from alcohol consumption in the country and this number is growing. This increase is more pronounced in areas of deprivation.

Together these risk factors can lead to high blood pressure, high cholesterol, impaired glucose and obesity.

High Blood Pressure

15.7% of patients on GP registers in Wolverhampton are diagnosed with Hypertension. 80% of these have had their BP recorded in the last 9 months. Of these:

63.5% have their BP controlled. 23.8% without drugs and 76.2% with one or more drug.

36.5% do not have their BP controlled. 26.8% of these have not had any drug in the last 7 months

A further 3.9% of patients have raised blood pressure or are on medication which suggest they likely to be hypertensive.

High Cholesterol

39% of patients on GP registers have had their Total Cholesterol measured in the last 5 years.

- 32.3% have a Total Cholesterol of over 5 mmol and are not on a statin
- 27.9% are on a statin and now have a Total Cholesterol of under 5mmol.
- 11.5% are on a statin but still have a Total Cholesterol of over 5mmol.
- 28.3% have a Total Cholesterol of under 5mmol and are not on a statin.

Impaired Glucose

5.5% of patients on the GP register have a diagnosis of Diabetes.

Obesity

40% of patients on GP registers aged over 16 years in Wolverhampton have their BMI recorded. Of these 32% have a BMI of over 30.

Modelled estimates from 2003-2005 suggest that 28.6% of adults in Wolverhampton are obese.

There is a lot of evidence about how individual risk factors affect the population's risk of CVD and in addition there are a number of validated risk calculators that compute an individual's risk from multiple risk factors. However, there is less understanding about how multiple risk factors affect the population's risk of CVD. With the objective of understanding how the prevalence of risk factors in Wolverhampton described above will impact on Wolverhampton's CVD events in the future a model was built to combine the evidence from individual risk factors and the individual risk calculator.

The model predicts risk of cardiovascular events. Local data is used to input population age, sex, ethnicity, deprivation and prevalence of smoking. National data was used to distribute of BMI and systolic blood pressure. The output of expected cardiovascular events over a ten year period is then calculated according to the Qrisk2 algorithm. The initial input into the model use census data for the age, sex and ethnicity. The last census was in 2001 and the QRisk2 algorithm predicts risk of CVD event over the next 10 years. Therefore the output was number of CVD events between 2001 and 2011. For the 2001 Wolverhampton population the model predicted 13443 events compared to 13952 events in the Wolverhampton GP responsible population in the last 5 years times 2. Therefore the model underestimated events by 509.

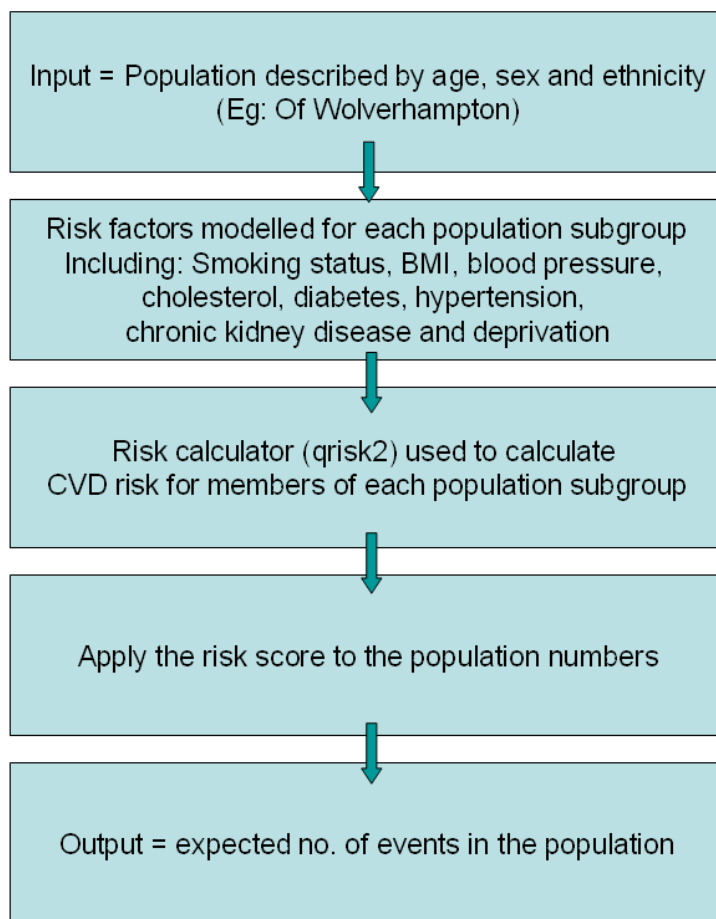


Figure 2

The model can now be used to explore the effect of altering risk factor levels and as a result the impact of introducing new services. This will be discussed further in the services section.

2.3 Burden of ill-health

People who have previously survived a CVD event are at greatest risk of another CVD event.

10.2% of patients on GP registers have a diagnosis of CVD or related Condition (including CHD, Stroke, TIA, PVD, Heart Failure, Diabetes and Chronic Kidney Disease stage 5).

- 3.9% have a diagnosis of CHD
- 1.1% have a diagnosis of Stroke
- 0.9% have a diagnosis of TIA
- 1.1% have a diagnosis of PVD
- 1.0% have a diagnosis of Heart Failure
- 5.5% have a diagnosis of Diabetes
- 0.1% have a diagnosis of CKD stage 5.

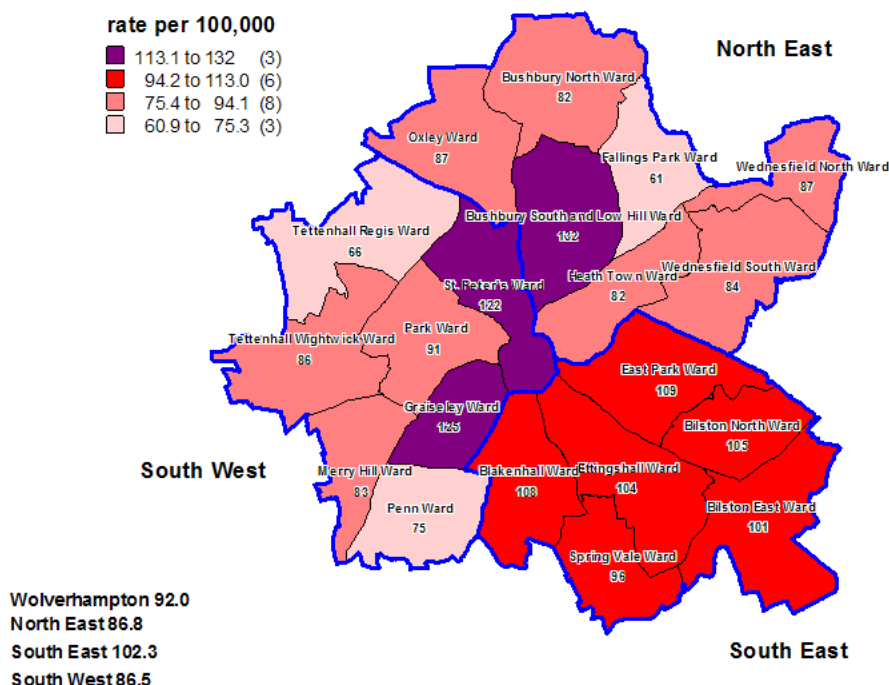
Of patient with a diagnosis of CVD or related condition:

- 14.5% are recorded as smokers and 86.2% of these have been offered smoking cessation advice in the last 15 months.
- 41.9% have a BMI of over 30 and 76.3% have a BMI of over 25. 37.4% of these have been offered diet advice in the last 15 months
- 19.8% had had their physical activity recorded in the last 15 months. 79.2% are not undertaking moderate exercise.
- 78.7% had their BP recorded. 69% had their BP under control.
- 73.3% had their cholesterol recorded. 76.8% had their cholesterol under control.

Deprivation

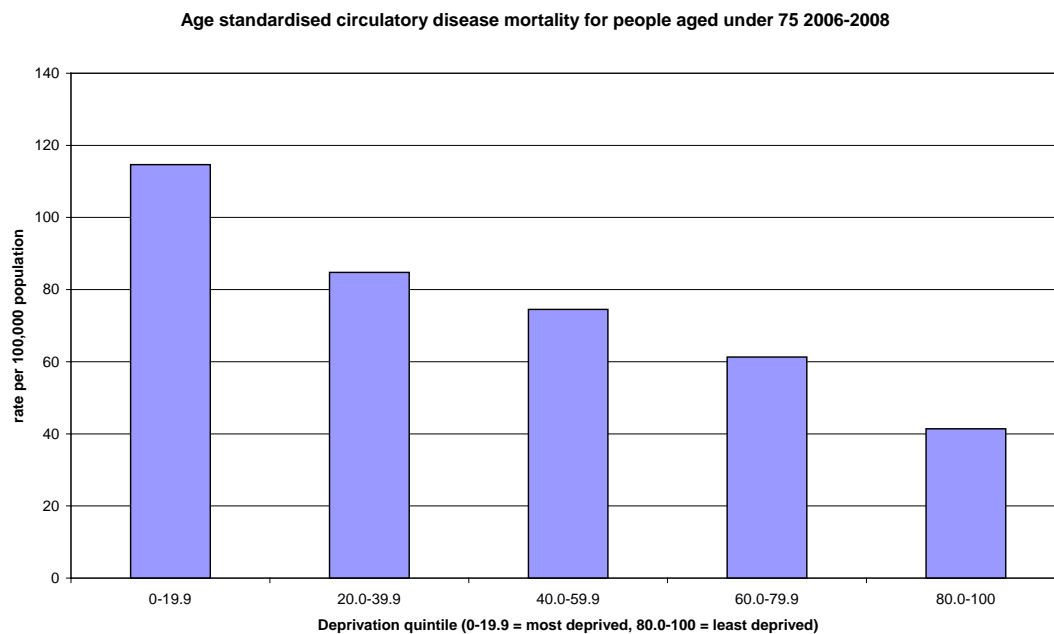
There is variation in CVD mortality across the three localities in Wolverhampton – with the South East having the highest age standardised mortality rates. These differences are not significant.

Age standardised circulatory disease mortality rate for persons aged under 75 in Wolverhampton 2006-2008



However, when mortality is considered at the ward level there are three wards with particularly high rates and none of these are in the South East. They are St. Peters and Graiseley ward in the South West and Bushbury North and Low Hill in the North East. When mortality is considered at the locality level the need in these areas is hidden because of the lower mortality in neighbouring ward.

The figure below shows the difference between age standardised circulatory disease mortality in under 75s between the most people living in area in the most deprived quintile nationally and people living in the other quintiles.'



2.4 Health Services

In 2009-2010 a number of programmes around lifestyle risk management and CVD prevention have been developed

Smoking Cessation

There is an established Stop Smoking Service in Wolverhampton. The service supported 1752 4-week quitters in 2008-2009.

Adult Weight Management

A new adult weight management service started in June 2009. By October 2009, 730 interventions had been completed. At least 88 of these have been referred twice meaning they have lost at least 5% of their body weight.

Physical Activity

There is an established Walking for Health service in Wolverhampton. Over the last year the service has supported 1393 people to have undertaken a led health walk with over 20% doing 25 or more walks. 50% of the walkers were from BME groups and 50% were from deprived areas.

Significant investment has been made in new physical activity equipment across the city including:

- 10 new young peoples gyms;
- 2 older peoples gyms;
- 2 gym upgrades;
- 1 gym in GP practice;
- 12 outdoor gyms;

Portable music systems for schools, children's centres, neighbourhood management teams and community centres; and

BMX track.

Alcohol

This is the second year of the Wolverhampton Keep it Safe campaign. This is a harm reduction campaign which aims to reduce health, social and crime problems caused by excessive alcohol consumption. This is a 10 night campaign over Christmas and New Year.

An Alcohol Service to provide Motivational Enhancement Therapy to people with dependent drinking habits on targeted wards at the Royal Wolverhampton Hospital Trust is due to start early next year.

Plans to develop a community service offering treatment and prevention will be developed in 2010.

Health Trainers

A new Health Trainer Service is due to start early in 2010. They will provide an intermediary service between primary care clinicians and specialist lifestyle risk management services, managing clients who are normally regarded as hard to reach, unmotivated, and/or non-compliant.

Links to mental health services

Referral routes to Wolverhampton Healthy Minds (Talking Therapies) from all parts of the CVD pathway are under development.

Health Checks – Primary Prevention

Health Checks are offered to people with three or more risk factors through General Practice. 660 checks were provided in the first 4 months. This service will continue in 2010.

2250 Health Checks will be provided in 2010 targeting people with mental health problems, people with learning disabilities, people from BME groups and men from disadvantaged areas. Health Checks will identify an individual's risk of coronary heart disease, stroke, diabetes and kidney disease, to communicate this in a way that the individual understands, and for that risk to be managed by appropriate follow-up, including being recalled every five years for reassessment.

Secondary Prevention

A project is underway to improve the management of patients who have had a CVD event. Prescribing pharmacists are supporting practices to improve their patient's management through secondary prevention clinics.

Since this project started in September nearly 20% more patients are being managed optimally in four or more out of six areas.

2.5 Impact of service redesign

The model discussed in the risk factor section has been used to consider the impact of introducing Health Checks.

Research from Sheffield considers the likely impact on risk factors due to Health Checks.¹ It gives a best case scenario, as well as less optimistic targets from the literature.

Risk Factor	Optimistic Target	Realistic Target
Mean BMI	-5%	-2%
Smoking	-13%	-10%
Total cholesterol	-6%	-4%
HDL	+6%	+4%
SBP	-5%	-3%
CKD prevalence	-5%	-3%
Cholesterol/HDL	-7.7%	-1.3%

The changes in risk factors outlined in these two possible scenarios were fed into the model and this provided an outcome in terms of CVD events:

- For the Realistic targets of health checks the model predicted: 11885 CVD events (ie: 1535 events averted).
- For the Optimistic targets of health checks the model predicted: 11235 CVD events (ie: 2186 events averted).

It is also possible to use the model to consider the impact of targeting high risk populations. The table below shows the impact if just the population living in the most deprived quintile were targeted with health checks.

	Most deprived quintile	Other quintiles
Number of people age 35-74	48181	59108
Predicted number (rate) of CVD events without Health Checks	8783 (182 per 1000 population)	6780 (115 per 1000 population)
Predicted number (rate) of CVD events with Health Checks - optimistic	7370 (153 per 1000 population).	

This demonstrates the targeting only the most deprived quintile could nearly halve the gap in CVD events rate from 67 to 38 per 1000 population.

¹ Whitfield M, Gillett M, Holmes N and Ogden E (2006) Predicting the impact of population level risk reduction in Cardio-vascular disease and Stroke on acute hospital admission rates over a 5 year period – a pilot study. Public Health.

3 Chapter 4 - Mental Health

3.1 Determinants of Mental Illness

The association between rates of mental illness and certain population characteristics notably ethnicity, unemployment, poverty and deprivation is well established. In addition people with physical health problems are also shown to be at increased risk of mental health problems.

Ethnicity

Around a quarter of Wolverhampton’s population are of BME origin. The population is projected to grow only slightly, however the composition is projected to change with an increase in BME groups and rise in older people. This will have implications for future configurations of mental health services in order to meet the needs of the changing population.

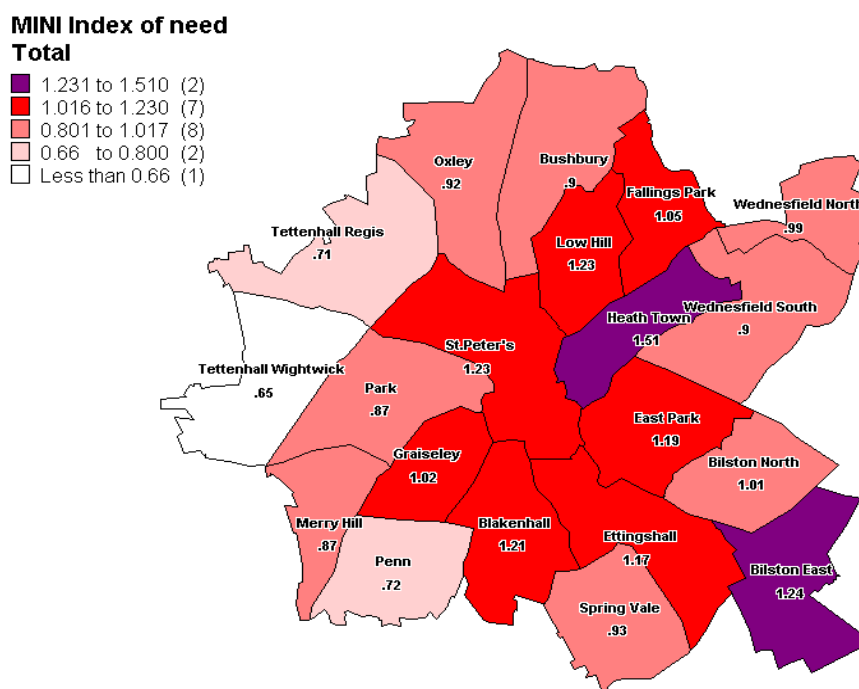
Unemployment

The city has below average employment and wages are below the national average. JSA claimants are above the national average. Further, mental health referrals to social care are high. Generally, disadvantaged people are more likely to suffer mental health disorders, so areas of social deprivation are at increased risk/ need of mental health services. 8 priority wards have been identified in Wolverhampton and these need to be targeted to ensure better outcomes are achieved across the city.

Poverty and Deprivation

Life expectancy in Wolverhampton is not improving. There is high deprivation in the city and many areas are among the most deprived fifth areas of England The figure below illustrates the ward level prevalence of more severe types of mental ill health across Wolverhampton. Areas of higher prevalence are consistent with wards with greater deprivation.

Figure 1 MINI index of need – all mental health causes (ages 16-59)



The Mental Illness Needs Index 2000 (MINI) was developed by the University of Durham as a “ready reckoner” to estimate ward level prevalence of more severe types of mental ill health using national data. It uses 1998 ward level population estimates and considers ward level deprivation.

Physical Health Problems

The percentage of people with a long term limiting illness in Wolverhampton (21%) is slightly high compared to West Midlands (19%) and also above the England average (18%). People with long-term physical conditions are at increased risk of developing depression (Patton, 2001). Depression may be a cause or consequence of physical illness and may exacerbate severity of symptom and increase use and cost of services.²³

Medically unexplained physical symptoms (MUPS)

These are physical symptoms that have no currently known physical pathological cause. MUPS are common, accounting for as many as one in five new consultations in primary care.⁴ It is estimated that this rises to an average of 52% in secondary care⁵. Evidence suggests that as many as 70% of people with MUPS also suffer from depression and anxiety disorders. The estimated costs of medically unexplained symptoms in secondary care for Wolverhampton, across specialties is over £7 million.⁶

3.2 Prevalence of Mental Illness

Severe and Enduring

Stevens and Raftery (2007) estimate the prevalence of psychosis in the population to be (0.4%). The city's QOF data of psychosis registers reports the prevalence to be higher than this at (0.7%). However this is consistent with national QOF registers.

QOF indicators for mental health were slightly below the national achievement levels (See table below).

Mental Health QOF Indicators 2007/08

Indicator	Wolverhampton	England
MH4; Lithium who have had creatinine and TSH checked	95.3%	97.1%
MH5; Lithium with recorded levels in correct range	81%	91.2%
MH6; % of patients with care plan	80%	83.9%
MH7; % or patients with psychoses who are followed up after DNA	85.5%	88.8%
MH8; Register of people with psychoses	0.7%	0.7%
MH9; % of patients with psychoses with a review in 15 months	91%	92.6%

Source: ic.nhs.co.uk

² Katon 2003; Hiller & Fichter 2004; Yates et al 2004

³ Long-term Conditions and Depression: Considerations for Best practice in Practice Based Commissioning, CSIP, 2006

⁴ Bridges, K.W. and Goldberg, D.P. (1985) Somatic Presentation of DSM-III Psychiatric Disorders in Primary Care. *Journal of Psychosomatic Research*, 29: 563–9

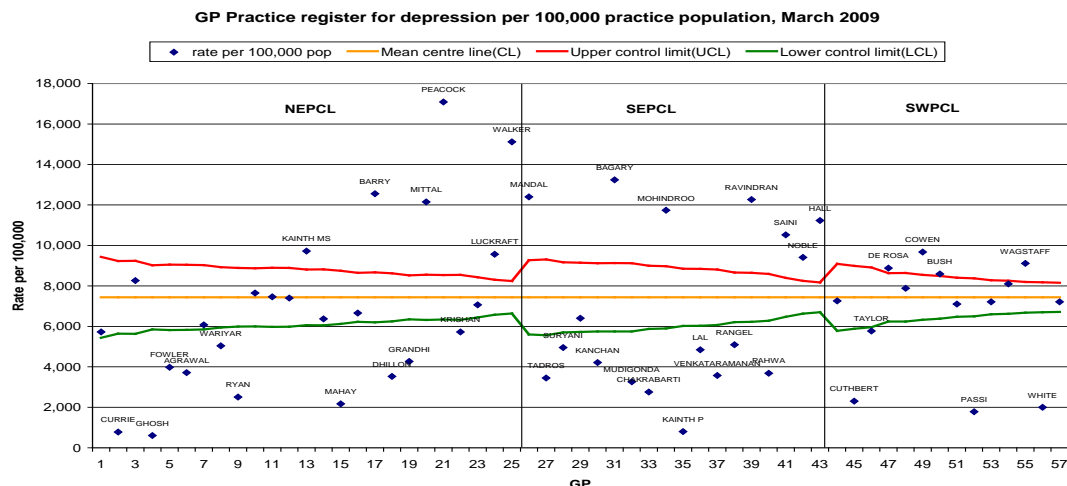
⁵ Nimnuan, C., Hotopf, M. and Wessely, S. (2001) Medically unexplained symptoms: an epidemiological study in seven specialities. *Journal of Psychosomatic Research*, 51: 361–7

⁶ CSIP Primary Care, Nottingham Medical School tool to identify people with medically unexplained symptoms.

The Mental Illness Needs Index 2000 (MINI) predicted Wolverhampton to have 2 % more severe mental illness than the national average. The level of schizophrenia inpatient admissions matched predictions. However, the admission rate for mood affective disorders was 30% lower than the MINI prediction.

Depression

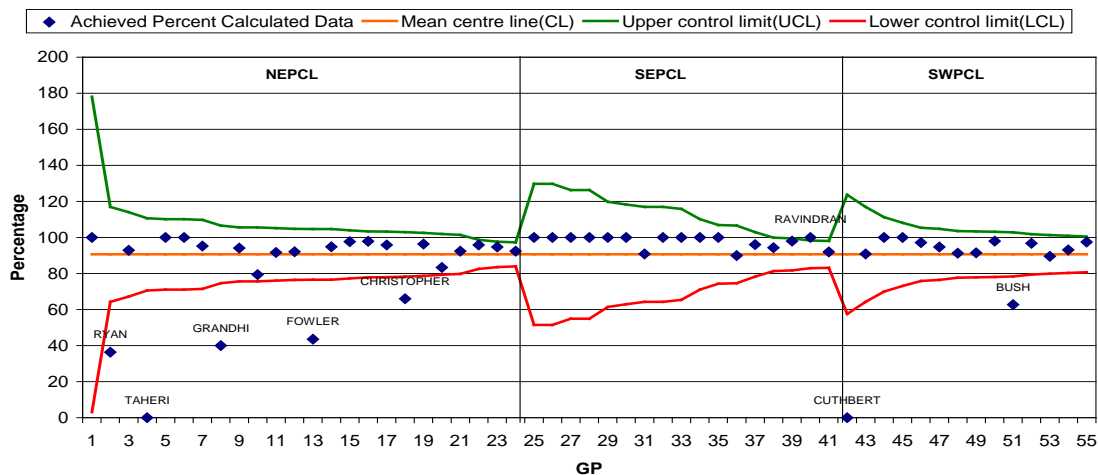
Katon and Schulberg (1992) estimate the prevalence of major depression in people seen in primary care to be between 5-10%. Wolverhampton's QOF depression registers report a comparable prevalence at 5.5%. This approximates to 14,000 people. However, the equity audit report also reviewed GP Practices by practice size in each locality and found there was wide variation in the assembling of GP depression registers with 1 practice having no patients on the register. This is demonstrated in the figure below. Therefore a potential detection issue may indicate that prevalence estimates are too low.



Source: QMAS

Low level depression is thought to be more prevalent among Wolverhampton adults since 2.4% of the population (5,615 people) claim incapacity benefit (IB) on the grounds of mental health, which equates to 42% of those claiming the benefit. This is slightly higher than the regional average (39.5%), and the national average (41%).

Patients with a new diagnosis of depression, recorded between the preceding 1st April to 31st March, the percentage of patients who have had an assessment of severity at the outset of treatment using a tool validated for primary care, March 2009



Source: QMAS

Assessing prescribing of antidepressants as a proportion of the register indicates 4 GP practices were extreme outliers, meaning they prescribed higher than expected for the numbers recorded on their depression register. Patients with a new diagnosis of depression are also required under the new GP contract to have a severity assessment using a validated tool. 17 Practices said 100% of such patients were assessed with a further 9 Practices having lower than required assessments. This is demonstrated in the figure above.

Black ethnic groups were over represented in community services and in patient services. This needs to be examined in more detail.

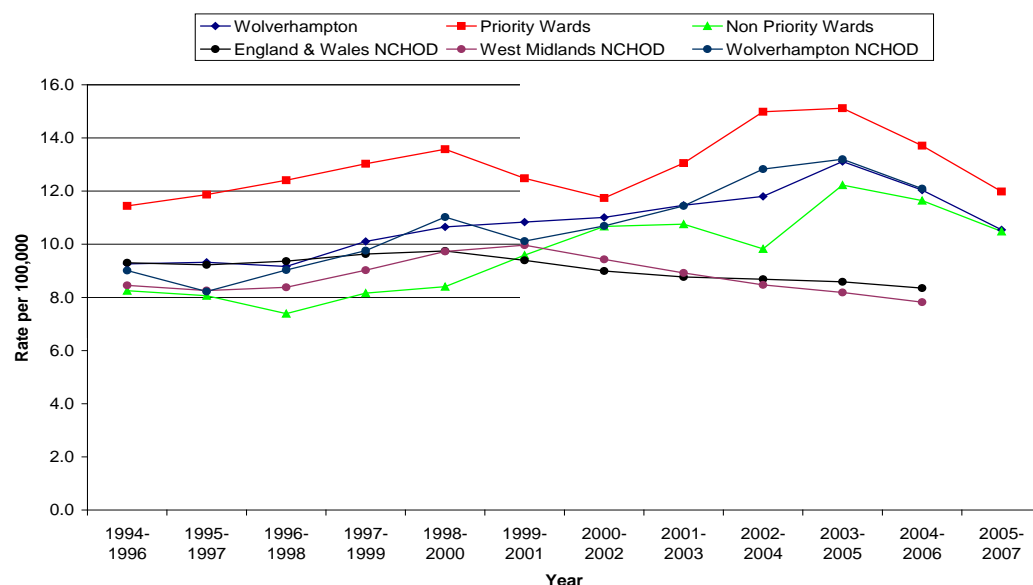
Dementia

Prevalence estimates indicate that there were 2,774 people over 65 with dementia in Wolverhampton in 2001. Population projections for 2011 indicate that the number of people with dementia will have risen over the 10 year period by a further 14% to 3,152.

Suicide

In 2006, the average suicide rate in Wolverhampton was 11.6, compared with the national average of 8.3. There is a large discrepancy between different wards in Wolverhampton, which highlights the health inequality present when dealing with Suicide rates (see figure). These are areas of generally higher social deprivation and unemployment which highlights the strong social context of suicide, which cannot be divorced from other determinants like mental health.

Figure 2 Age Standardised Mortality Rates Due To Suicide



An audit of suicides in Wolverhampton between 2004 – 2008 found that 77% were male, the most common age of suicide is 35-44. This is consistent with national trends. Men are more than six times more likely to commit suicide in the younger age group (25-44). 58% of female suicides occur over the age of 55. Men are nearly twice as likely as women to commit suicide in this age group. Ethnicity was poorly recorded (not known in 20% of cases). Of the cases where ethnicity was recorded, suicide falls evenly across the ethnic makeup of the population, i.e. 9% white: 14% Asian: 4% Black and 2% Mixed. However, the 40-44 age group was disproportionately high for non white patients (50%), with most of these being Asian men. Suicide for Asian females in any age category is very low

The report also found that 30% of suicides were not known to be in contact with any primary or secondary services at the time of death: 30% were being managed in primary care,

usually for depression which was not assessed with a validated tool; 40% had had some contact with specialist mental health services in the last 12 months of their life.

In order to address Wolverhampton's suicide rate there is a need for better early identification, assessment and treatment of depression in primary care, using more robust risk assessment tools.

3.3 Mental Health Services – Access and Productivity

Community Mental Health Services (CMHS⁷)

Black ethnic groups have the greatest representation in CMHS, followed by Asian groups, and then people with a White ethnic background, demonstrated in the table below. Interestingly, the Count me in Census 2008 indicates that referrals from GPs and community mental health teams were lower than average among some Black and White/Black groups.

Access rates to CMHS by Ethnic groups

Ethnic Group	Rate per 100,000	CI-	CI+
White	518.4	485.5	551.2
Asian	714.5	624.8	804.2
Black	1011.6	823.5	1199.7
Mixed	310.5	174.6	446.4
Other	443.5	89.4	797.5
Total	933.7	895.0	972.5

The health equity audit also looked at where people using the CMHS's lived and who their GP was. Use of CMHS by patient postcode was in keeping with the socio-demographic picture in Wolverhampton. Analysis of use by GP showed relatively higher use in the North East locality than the South East and lower in the South West.

In-patient

The local mental health equity audit reported that black men had a four-fold over use of inpatient services compared to their Asian and White counterparts. The starkest difference was seen in the use of forensic services with a 20 times over-use compared to Asian men and 10 fold greater than White men. A similar pattern was also seen for Black women, with an increased use of all services compared to the other ethnic groups. However the "intensity" was not as great as that for men.

The overrepresentation of Black people in inpatient admissions is consistent with national data, however the 'Count-me-in' data suggested an admission rate of 15%, nearly double the 8% rate indicated by the routine audit collection. This would suggest further investigation is necessary to determine the accuracy of Black inpatient admissions, i.e. the locally reported numbers are high, but not as high as the national census would suggest.

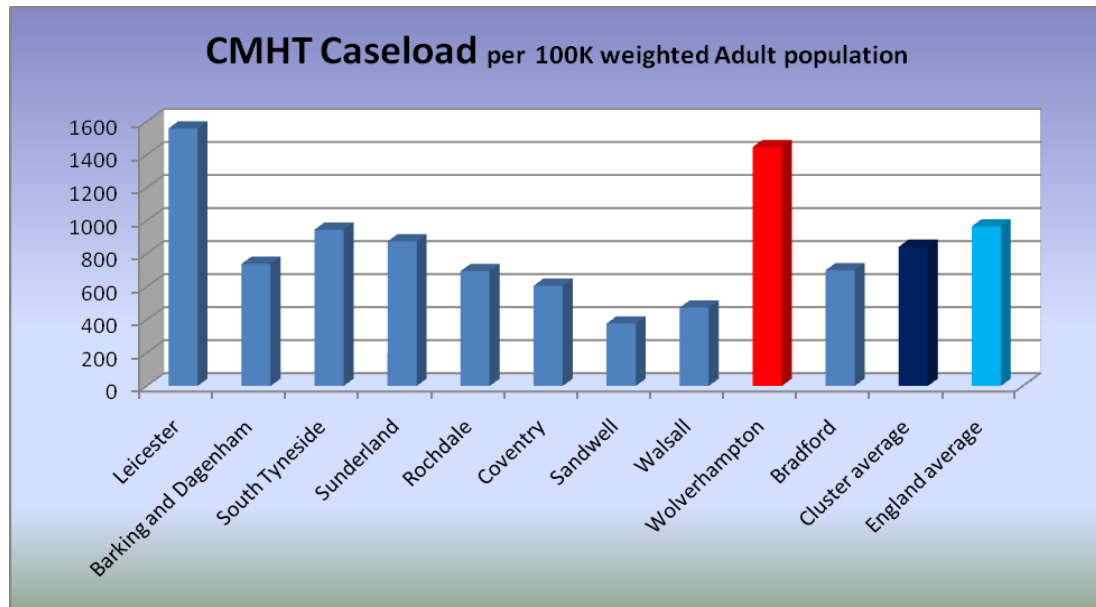
Acute bed provision is in line with comparator norms. Overall admission levels and utilisation are in line with that bed provision and comparator norms. Bed utilisation against high priority acute psychotic illness is above comparator norms. There is pressure on length of stay for psychosis related admissions with length of stay outside of comparator norms which is not accounted for by the skewing affect of a few very long lengths of stay. There are an over

⁷ CMHS comprises the following adult service teams: 2 Crisis Resolution teams, 3 CMHTs, 3 forensic teams, 1 eating disorder team, 1 depot clinic, 1 assertive outreach team, 1 early intervention team; 1 Asian Link Adult

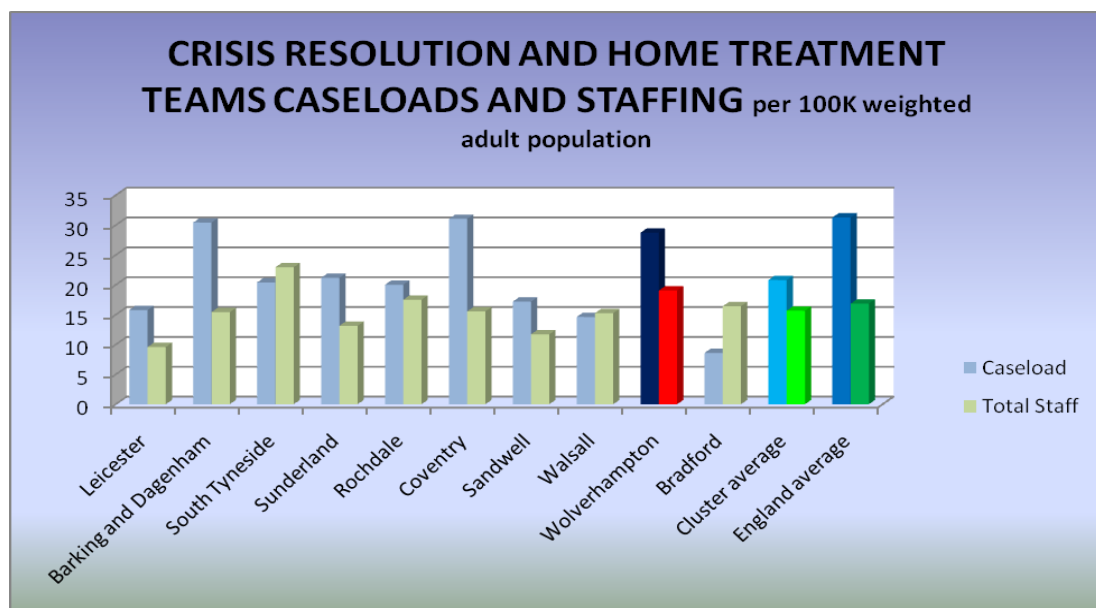
representation of admissions from the BME community. Acute bed staffing is in line with comparator norms. PICU bed provision is higher than comparator norms

Community resourcing

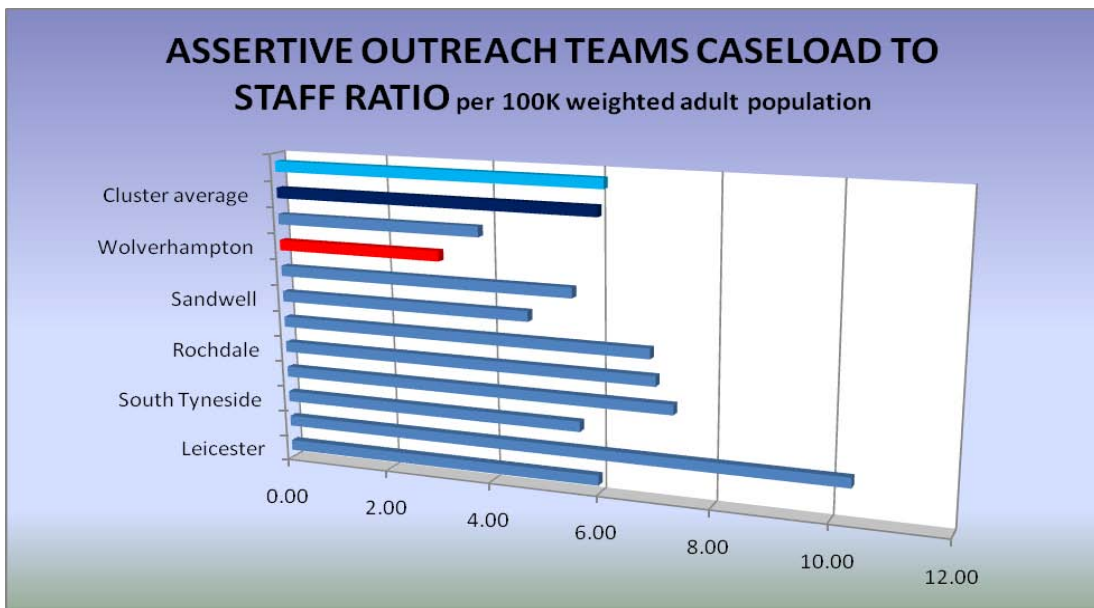
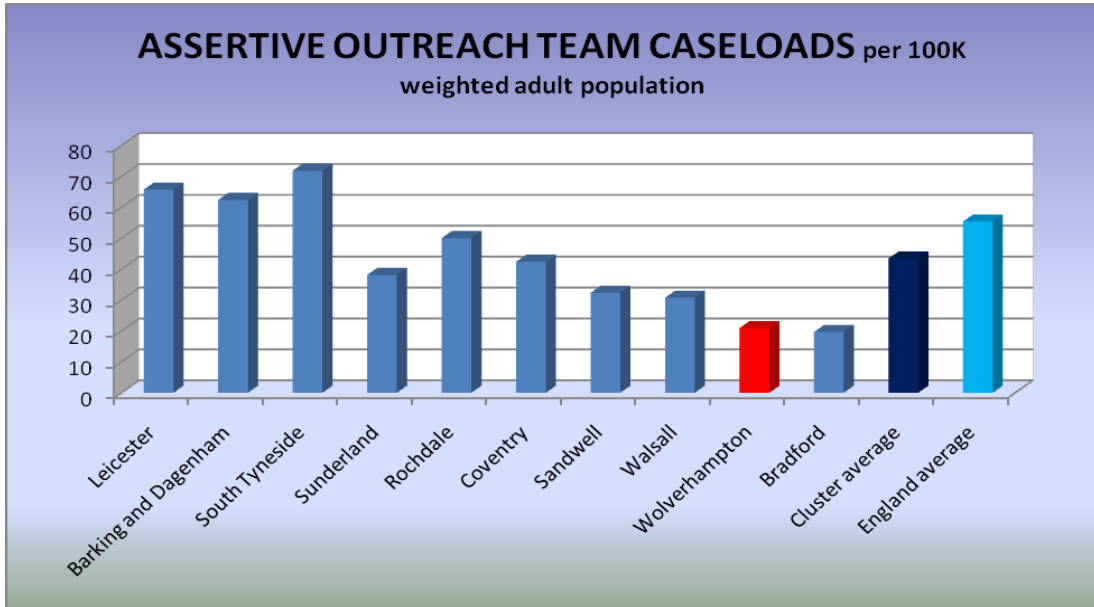
Community Mental Health Team (CMHT) staffing was above cluster average, below national average. CMHT caseloads very high; 75% above cluster average, 50% above national average.



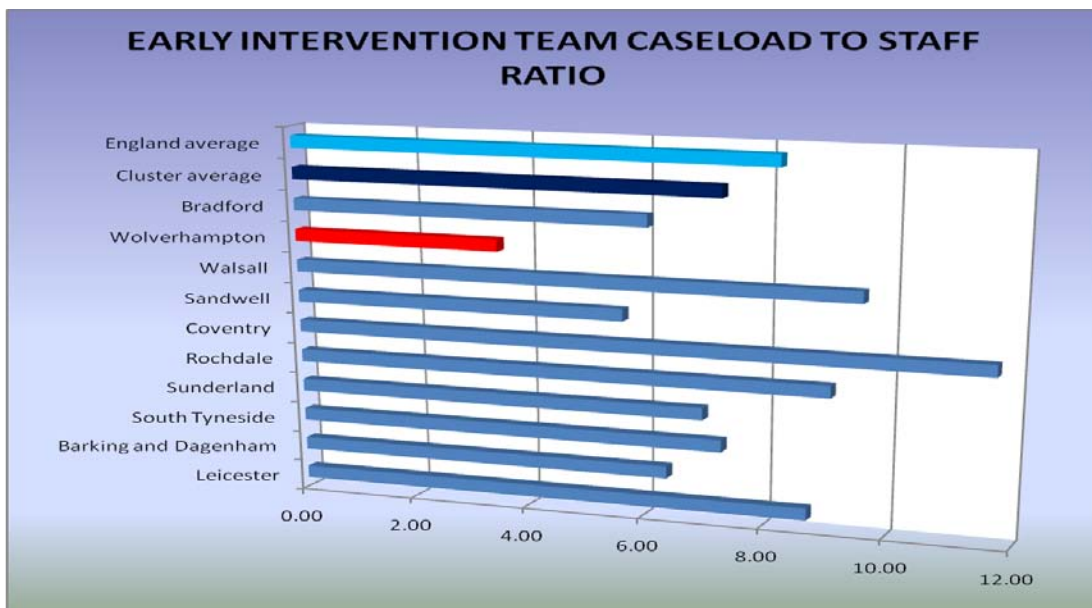
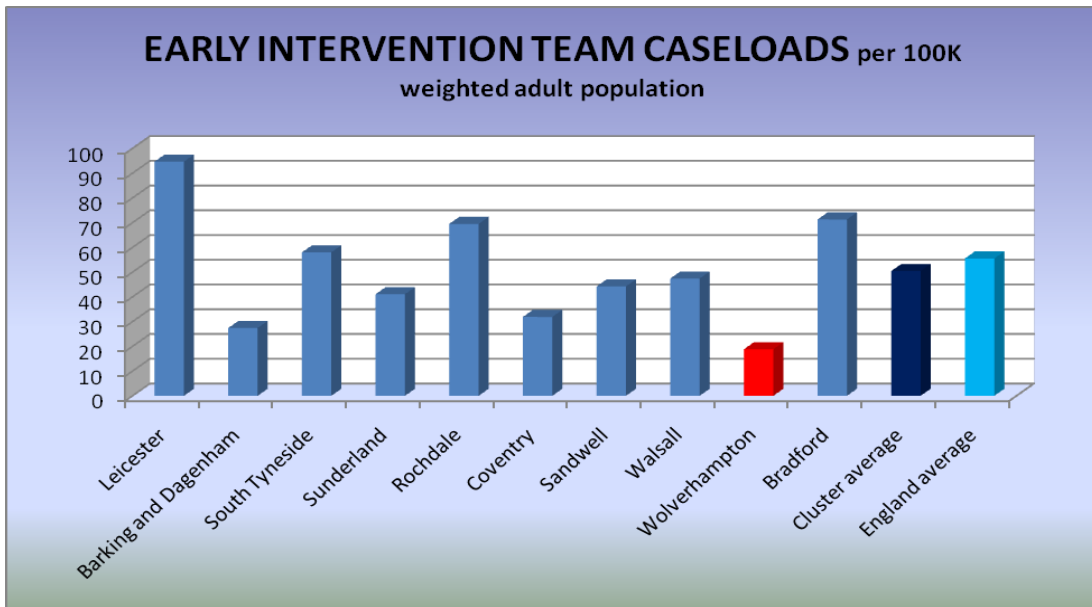
Crisis Resolution and Home Treatment caseload was 38% above cluster average, although below national average, and staffing 22% above the cluster average



Assertive outreach team staffing 25% below national average and caseload 63% below national average. Caseload to staff ratio lowest in cluster and only 50% of national average



Early intervention team caseload is 22% below cluster average and 66% below national average. Early intervention team caseload to staffing ratio lowest in cluster.



This data demonstrates a high number of emergency admissions with a significant degree of complexity. Qualitative evidence suggests crisis assessment and intervention is too slow and earlier engagement opportunities are missed. The consequence is increased demand and increased length of stay. Opportunities for supporting earlier discharge is compromised by lack of capacity and skill/confidence within CMHTs. Staffing and caseloads across community teams support perceptions of pressure and concerns in different parts of the system, from high and static caseloads in the CMHTs, high caseloads in the Crisis team, low caseloads and functioning of the Assertive Outreach Team, and low caseloads in the Early Intervention Team.

Community Mental Health Team

A detailed audit reviewed 13% of the caseload of CMHTs, Assertive Outreach Team, Early Intervention Team and Day Services using the Yorkshire Care pathway methodology.

Audit of CMHT Caseload - NAS Sample and number of completed forms

	Caseload on day of census	Per 100k estimated adult pop	Per 100k total pop	NAS Sample	Completed forms
Assertive Outreach Team	47	29	18	11	11 (100%)
CMHT North	883	1559	984	117	23 (20%)
South East CMHT	812	1749	1105	104	30 (29%)
South West CMHT	1008	1641	1036	127	59 (46%)
Early Intervention Service	66	40	25	17	13 (76%)
Brooklands Day Service					2
Not recorded					30
Grand Total	2816			376	168

This audit showed the majority of patients in the sample had a primary diagnosis of Schizophrenia, Psychosis and Bi-polar (75%), with smaller proportions suffering from Anxiety and Depression (13%), Eating Disorder/Personality Disorder /Obsessive Compulsive Disorder /Post Traumatic Stress Disorder (8%). 20% of patients had a marked disability.

The majority of the sample was White (63%), The African and Caribbean population were over-represented (22%). No Asylum Seekers were recorded in sample.

The majority of patients were single (58%) with no children (75%) and either living alone (45%) or with partner, family or friends (51%). Carers needs were only assessed in 17% of sample, Carers refused assessment in 5%.

Only 21% owned a property and 19% were in supported accommodation or a nursing home.

The average patient demonstrated serious impairment in social, occupation or school functioning demonstrated on the SOFAS⁸ with only 10% in paid work, voluntary work or training. However a high percentage had some form of social network/friends.

15% of sample on enhanced CPA (Care Programme Approach), 78% on standard CPA. 65% were not on Section, 22% were on Section 117 (of the Mental Health Act). The majority of the sample cases were seeing more than one professional for their care. Overall there were good levels of co-operation with treatment, with over 70% passive acceptance or active

⁸ SOFAS - The higher the score (maximum 100) the better, the lower the score the greater the impairment from mental and physical problems

participation in attending appointments; accepting contact at home or in the community; and with medication.

70% of patients had between 1 and 6 contacts a month with only 23% at least once a week or more. Telephone contact was lower, with an average of 34% none/not known telephone contact. The DNA rate was 70% overall, but was lower in Assertive Outreach Team, Brooklands Day Service and Early Intervention Service. 8% of patients were perceived as having unmet need.

Assessment of current risk highlighted 30% at moderate or severe risk of suicide, 39% at moderate or severe risk of self-neglect, 28% at moderate or severe risk of being aggressive, 10% at moderate or severe risk of being exploitive, 305 at moderate or severe risk of being vulnerable to exploitation and 3% at severe risk or committing arson.

3.4 Qualitative Data

Complaints

There were 55 complaints made about mental health services between April 2007 and April 2009. The most common complaint referred to the lack of access to mental health services and available support (18%). Other common complaints included: poor treatment and care in the community, the general inpatient environment including food and problems with medication

Complaints about Mental Health Services in Wolverhampton



Voluntary Sector Research

Two projects have also recently been conducted to examine mental health services for both Asian men and women. Overall both studies found that mental health services were not meeting the needs of Asian people. This was because of a lack of understanding of Asian culture on the part of mainstream mental health services and front line workers, lack of support, lack of information about the mental health services available and language barriers. At the same time a significant number of Asian people were simply not aware of the existence of any mental health services in Wolverhampton. The reviews recommended a number of ways to improve mental health services including involving Asian people in developing services; both male and female service users stated that having someone to talk

to who understands what they are going through would help, especially if this was done by Asian workers in their own language. There is also a need to make provide more information about the range of mental health services available to Asian communities in Wolverhampton, how to access them and to ensure that all services are more supportive. Additionally addressing the stigma and negative perceptions surrounding mental health issues is important.

Stakeholder Interviews

Semi-structured interviews were held with a wide range of stakeholder by an independent organisation. This has provided a direct opportunity for people who work in the system or receive care and support from local services to comment in confidence about their experiences. A number of key strengths and issues were identified and described in the table below.

Strengths

Stakeholders identified a skilled and dedicated workforce. However, there was also evidence of poor morale and issues with vacancies. There was evidence of individuals' knowledge, commitment and dedication to try and improve the service and a real understanding of the challenges to be faced and the rich potential that is afforded by the current workforce and developing service model to successfully move forward. If harnessed through effective management and leadership this is one of the greatest assets Wolverhampton has.

Strong engagement and interest in mental health development amongst a number of GPs was highlighted and a well developed locality framework for practice based commissioning

There is an emerging care pathway (work on acute care pathway) and commitment to put in place key and well resourced NSF functional services - specifically assertive outreach, early interventions and crisis resolution home treatment. There are issues with some of the interfaces between services and some of the delivery of certain aspects of the service, but many of the building blocks of a modern and fit for purpose whole systems approach are in place.

There is an acknowledgement that Crisis Resolution Home Treatment service has evolved out of a number of previous teams and this has impacted on its compliance with Policy Implementation Guidance (PIG) standards. This has resulted in a clear strategic plan for imminent implementation that will fully integrate all staff under a single manager, see recruitment to vacant social work and occupational therapy posts, resolve 24 hour medical cover and utilise the full pooled staffing resource.

A number of innovative local approaches and service developments have been described. These include:

- the development of a Single Point of Access;
- a notably diverse, vibrant and forward thinking range of third sector organisations; a 'beacon status' and critically acclaimed local forensic initiative and model of working that has created a dedicated capacity located in community teams and interfaced with regional medium secure resources;
- successful second wave bid for the development of an IAPT service;
- the current review of day services that provides a real opportunity to remodel services in line with current national thinking and policy around personalisation and social inclusion;
- Current thinking on the development of approaches to support dual diagnosis and personality disorder, building upon the forensic services model; and some innovative practice and a generally well respected model of care within older people's mental

health such as home treatment that potentially provides potential shared learning and development.

A vision of a recovery based model of care was often articulated and an associated strategic ambition to develop and enhance primary care services in partnership with social care and the 3rd sector that supports a re-focus of community mental health services to support more complex mental health needs.

Coterminosity between health and social care and fully integrated and multi-disciplinary teams is a strength. Whilst many interviewed felt the full advantage of this had not been realised there was a genuine belief in a strong willingness to work together to realise the full potential of this opportunity.

Issues and Pressure Points

Communications was often highlighted as a difficulty which resulted in people feeling they did not fully understand how the system worked, what the full range of opportunities, how they might contribute and be involved in change and development. What became clear through the process of engagement was that there was varied understanding of what services there were, how they operated and crucially how they could get the system to work properly and be more responsive especially in crisis situations.

Assertive outreach was identified as being too selective in its eligibility criteria leading to an under performance in overall caseload and a reluctance to develop skill and capacity in supporting dual diagnosis and wider definitions of vulnerability and complexity of need.

Single point of access was thought to be a very positive development that has the potential to simplify access into mental health services. However in practice many thought it was not working in a way that improved access. Two specific issues were often cited: no direct referral option with referrals having to come via GPs. Given the demographic and cultural diversity of the city early access to mental health services via a GP and then the SPA team may not promote timely intervention. Many spoke of observing missed opportunities to intervene at an earlier stage leading to crisis admissions to hospital or entry into the criminal justice area or forensic services; and no capacity within CMHTs to respond to assessed need.

A number of concerns were expressed about the role, function and resourcing of CMHTs. These have potentially significant implications for the overall provision of mental health services. Four specific concerns were regularly identified:

- Loss of identify and purpose following the development of key NSF services, which has affected morale and the effectiveness of the service.
- Issues of service user involvement, choice of treatment and more self determination in the care management and care planning process were consistently raised. These findings are in line with the findings of the 'Heath Care Commission Follow Up Review 2008/9 on Adult Community Mental Health Services'; loss of focus and prioritisation of complex mental health needs.
- Whilst there is a strategic recognition that CMHTs should become more focused on meeting complex care needs, the service appears to many, to be supporting very high and static caseloads that prevents access of higher priority need at an earlier stage. There has been little development around New Ways of Working that might help prioritisation and management of complex need; level of resource within CMHTs being insufficient, having reduced over recent years to support NSF developments.
- This coupled with high sickness levels and vacancies has significantly impacted on the sustainability of a critical mass within the teams; and interface with crisis team and acute inpatient care. This may in part be linked to issues of levels of staffing and morale, however there was concern that CMHTs look for the crisis service to take on

crisis support when perhaps the CMHT is best placed to meet that increased need as well as concerns about longer lengths of stay in acute inpatient settings caused by an inability to support earlier discharge back to community services.

Concerns were expressed about the operation of crisis resolution and home treatment. These included a lack of responsiveness to crisis assessment and gate keeping functions especially out of hours, leading to vulnerable people having to be taken to A&E for assessment; and the disjointedness of the service which for many people appears to operate as four separate elements; home treatment north and south, crisis assessment and single point of access; the crisis service subsuming the A&E liaison function and resource, but finding it difficult to provide consistency in responsiveness.

It was felt that the potential of NSF service developments had not been maximised due to a lack of focus on whole systems working. There was significant concern expressed about the degree of fragmentation across the system, with services being isolated and in some case defensive and overly protectionist in their response to referral and care pathway management. There was a sense that the various bits of the system did not work in the way that other parts of the system expected and therefore access into services and movement through services was compromised resulting in potentially high risk situations.

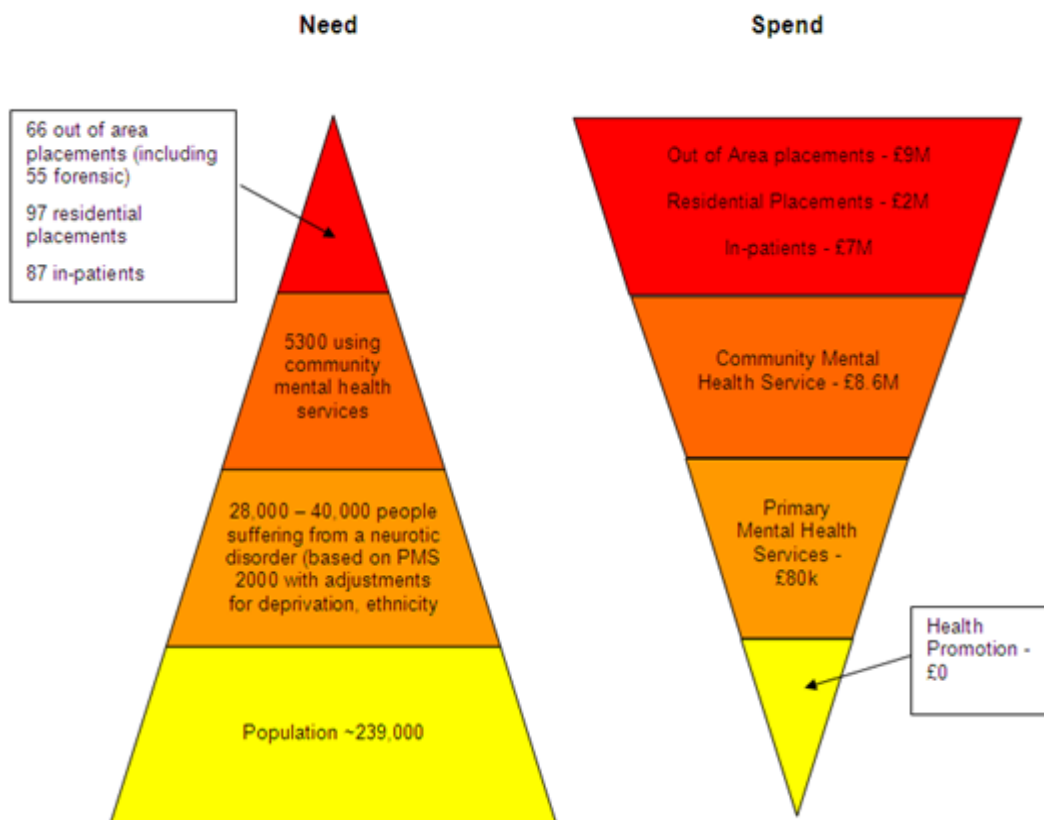
There was a perception of a very traditional and medical treatment orientated approach to providing care that is not in keeping with the diverse culture and need of the local population or a wider social inclusion evidence base. The social and economic determinants of poor mental health that are recognised by many GPs are not well reflected in the corresponding staffing, skill mix and philosophy of statutory provider services. There was reported to be a fear and suspicion of mental health services from the BME community which make up nearly 25% of the population. Issues of under representation of people from bme backgrounds in primary and community based services and over representation in inpatient and tertiary based services were thought to be the norm.

The system's responsiveness to crisis situations and its management of risk was severely questioned on a number of occasions with particular concerns on vulnerable people having to be taken to hospital sometimes on public transport before an assessment could be undertaken.

3.5 Finance

Total spend on adult mental health spend in Wolverhampton is £31,403,000. The total spend is split into direct costs of £27,605,000 and indirect, overhead and capital costs of £3,798,000. Investment weighted for population is less than for the SHA, England or the ONS cluster but only marginally (£173 cf. £178, £177 and £179 respectively).

The estimated need and total mental health direct costs for 2008-2009 is described in the figure below. This demonstrates the need to redress the balance of spend to reduce the emphasis on high cost low volume interventions at the higher steps of care and increase the emphasis on low cost high volume interventions at the lower steps of care.



Within this context, increasing access to mental health services in primary care, especially talking therapies is a key project requiring new investment in the short term that is needed to enable the wider objective to redress the balance of services to be achieved. As a result this has been chosen as strategic goal 4. This will be achieved through strategic initiative 4 – Talking therapies: early intervention mental health services. The budget for this is outlined in the table below.

Planned investment in Psychological Therapies

	2008-09	2009-10	2010-11	2011-12	2012-13
Planned Investment	£300,000	£1,270,000	£1,500,000	£2,000,000	£2,680,000
Planned number of intervention	200	2,352	2,800	3,800	5,000
Proportion of intervention successful	50%	50%	50%	50%	50%

3.6 Conclusion

This needs assessment highlights four key areas that need to be addressed to improve mental health services in Wolverhampton.

A recovery approach needs to be supported through developing a stepped model of care. This can be achieved by building on the Healthy Minds (Improving Access to Psychological Therapies) initiative to develop a primary care or step 3 mental health service that affords

alternatives to referral into secondary care services as well as providing an exit route for those currently in secondary care services.

This would in turn allow for the development of case management for people with stable severe mental illness as well as access into a wide range of mental health and wider community support services that support an alternative to entry into or prolonged presence in secondary care specialist services. This would be a crucial development in achieving a more balanced and effective model of care and care pathways which can more readily respond to the diversity of culture and need within the local population.

Community services for people with more complex and challenging mental health needs need to be strengthened and integrated. This will be achieved through refocusing current specialist secondary care services to develop community capacity and expertise thereby reducing reliance on in area acute care and out of area tertiary and forensic care.

The working hypothesis – based on evidence from phase one – is that a significant proportion of current step 4 activity in CMHTs could be undertaken (according to level of need) either within a primary care mental health service at step 2-3 or within the currently under-performing specialist mental health service functions developed through the NSF – Crisis Resolution and Home Treatment Teams (CRHTs) and Early Intervention Teams (EITs) and Assertive Outreach (AOT).

Support and intensive treatment for people with long term and/or complex needs (including dual diagnosis and moderate personality disorder) could then be provided through a new complex and long term care team drawn from the existing resource in CMHTs and working closely with the AOTs and rehab services.

Access routes across the system need to be improved and clarified. The ability to respond rapidly to crisis situations at an earlier point in time and in a way that is acceptable and relevant to diverse cultures will afford opportunities to provide alternatives to admission or to presentation within criminal justice settings. This in turn will maximise the effectiveness of the whole systems care pathway and the specialist functional services within it.

Through the development of the local recovery house an increased number of individuals will be offered an alternative to hospital admission.

Reliance on forensic and other high cost individual placements needs to be reduced. This would free up significant resources to fund the redesign and refocus of community services in both primary and secondary care over the longer term.

These four elements are interdependent on each other. The current community secondary care services cannot create capacity and develop expertise without reducing its current activity. This current activity cannot be supported in an alternative way without the development of an enhanced primary care service and associated wider community support services. The whole systems working that promotes movement between and increased access and choice to the various service options within the care pathway cannot operate without addressing responsiveness to crisis situations and the deployment of gate keeping and effective single point of access. The investment that will be necessary to develop primary care and wider community support services is currently locked into forensic services and into low productivity within the status quo.