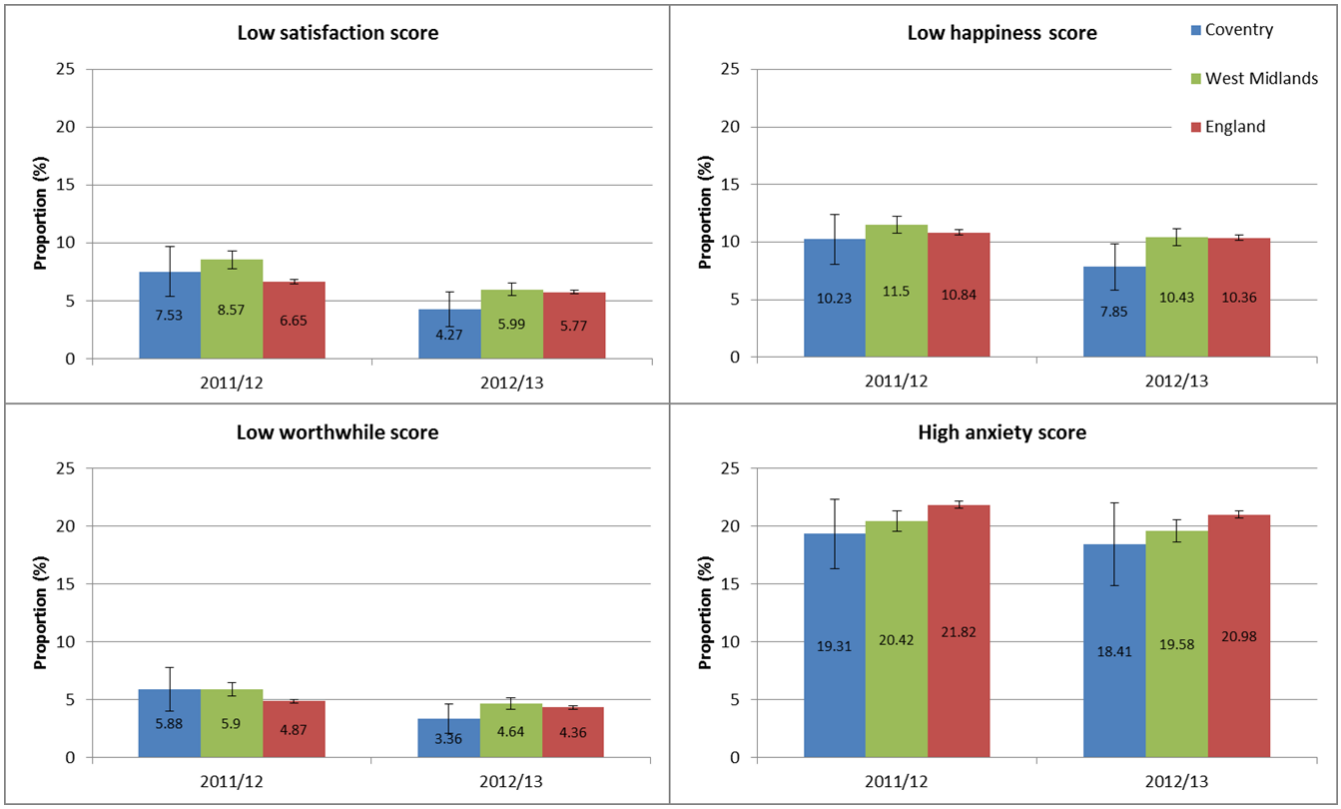
## Appendix 1

## Summary of Wellbeing Indicators

Differences between years and compared to regional and national estimates were not statistically significant due to the relatively wide confidence intervals around the Coventry estimates, with the exception of Coventry having a significantly smaller proportion of people reporting low happiness in 2012/13 than England overall.




**Proportions of residents in Coventry, England and the West Midlands reporting low levels of wellbeing on four indicators,[a] 2011/12-2012/13.**

*Source: Public Health Outcomes Framework*

[a] Responses to the questions are given on a scale of 0-10, where 0 is 'not at all satisfied/happy/anxious/worthwhile' and 10 is 'completely satisfied/happy/anxious/worthwhile'.

| WEMWBS item | *Proportion of respondents (%)* | | | Mean item score |
|---|---|---|---|---|
| | None of the time/ rarely | Some of the time | All of the time/ often | |
| I've been feeling optimistic about the future | 21 | 41 | 38 | 3.2 |
| I've been feeling useful | 12 | 30 | 57 | 3.6 |
| I've been feeling relaxed | 18 | 38 | 44 | 3.3 |
| I've been feeling interested in other people | 16 | 33 | 51 | 3.5 |
| I've had energy to spare | 33 | 38 | 29 | 3.0 |
| I've been dealing with problems well | 8 | 33 | 59 | 3.7 |
| I've been thinking clearly | 5 | 23 | 72 | 3.9 |
| I've been feeling good about myself | 8 | 29 | 63 | 3.8 |
| I've been feeling close to other people | 9 | 27 | 64 | 3.8 |
| I've been feeling confident | 8 | 26 | 67 | 3.8 |
| I've been able to make up my own mind about things | 4 | 19 | 77 | 4.1 |
| I've been feeling loved | 7 | 21 | 72 | 4.0 |
| I've been interested in new things | 13 | 31 | 56 | 3.6 |
| I've been feeling cheerful | 6 | 28 | 66 | 3.8 |
| | | | Average | 51.1 |

## Appendix 2

### Severe Mental Illnesses

Bipolar disorder is sometimes called bipolar affective disorder, and used to be referred to as manic depression. This is a serious, chronic condition with periods where mood is in one extreme or another; one extreme is depression, and the other extreme is mania, which is an abnormally high or irritable mood that may be accompanied by psychotic symptoms such as hallucinations or delusions. Hypomania refers to less severe 'high' periods, where individuals may actually function fairly well but still be at risk of making rash or dangerous decisions. The duration of 'high' and 'low' episodes is usually several weeks or longer, and individuals can experience any number of episodes throughout their lives; in between, there may be gaps of anything from weeks to years where mood is normal. Bipolar disorder affects approximately 2% of people, both male and female, and most commonly develops between the ages of 17 and 29 although it can occur at any age. Around 1 in 6 cases experience the rapidly cycling form of the condition.[101]

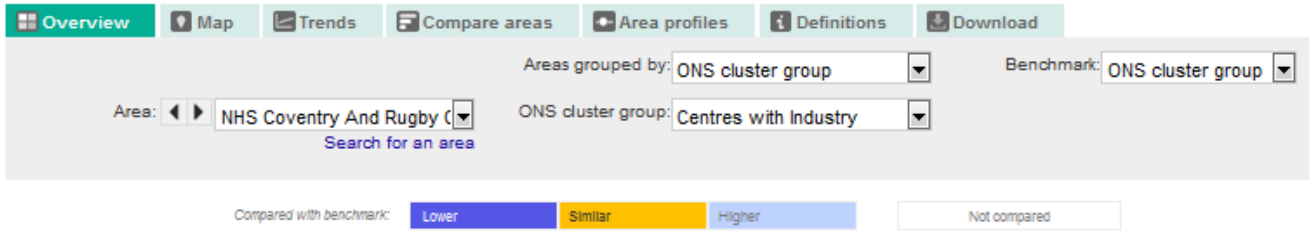
Schizophrenia is the most common form of psychosis and a lifelong condition, which can either be chronic or have relapsing and remitting periods of illness. It starts most commonly in adolescence and the early 20s, with a later peak age in women, but can occur at any age.[102]Men are more likely to experience more severe symptoms,[103] and schizophrenia is more common among migrants,[104] possibly due to environmental and social factors.

## Appendix 3

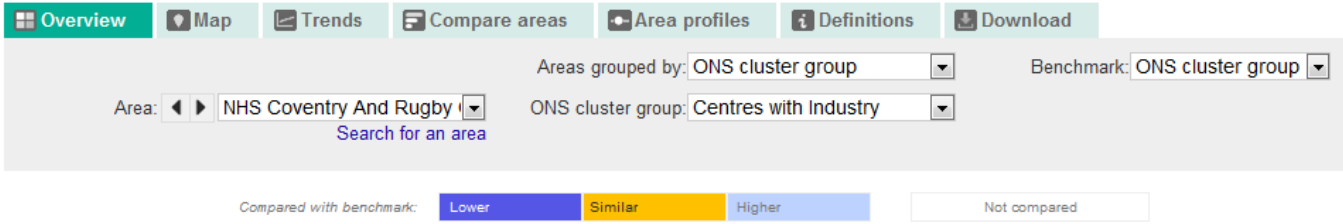
## CCRG Indicators Compared to ONS Cluster Group

Compared with benchmark: Lower | Similar | Higher | Not compared

| Indicator | Period | England | Centres with Industry | NHS Airedale, Wharfdale... | NHS Barking And Dagenha... | NHS Birmingham Crosscit... | NHS Birmingham South An... | NHS Blackburn With Darw... | NHS Bolton CCG | NHS Bradford City CCG | NHS Bradford Districts... | NHS Calderdale CCG | NHS Central Manchester... | NHS Coventry And Rugby... | NHS East Lancashire CCG | NHS Greater Huddersfiel... | NHS Greater Preston CCG | NHS Heywood, Middleton... | NHS Leicester City CCG | NHS North Kirklees CCG | NHS North Manchester CC... | NHS Nottingham City CCG | NHS Oldham CCG | NHS Sandwell And West B... | NHS South Manchester CC... | NHS Southern Derbyshire... | NHS Walsall CCG | NHS Wolverhampton CCG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patients with a diagnosis recorded | 2013/14 Q1 | 17.8 | 12.3 | 7.1 | 11.0 | 6.9 | 7.7 | 6.5 | 62.3 | 8.7 | 6.4 | 7.8 | 14.6 | 46.2 | 5.6 | 7.3 | 2.3 | 5.9 | 26.4 | 7.2 | 9.8 | 5.7 | 5.0 | 6.8 | 11.2 | 13.9 | 7.7 | 8.8 |
| Patients assigned to a mental health cluster | 2013/14 Q1 | 69.0 | 73.0 | 79.3 | 88.9 | 83.2 | 81.3 | 70.5 | 85.4 | 80.9 | 79.5 | 78.5 | 58.4 | 77.7 | 59.9 | 81.5 | 59.2 | 46.9 | 75.1 | 81.6 | 65.1 | 85.7 | 47.7 | 79.3 | 63.1 | 74.2 | 76.5 | 77.4 |
| Patients with a comprehensive care plan | 2012/13 | 87.3 | - | 89.3 | 90.8 | 87.2 | 88.2 | 89.9 | 85.5 | 88.9 | 93.7 | 92.0 | 79.9 | 84.1 | 87.3 | 90.4 | 82.8 | 84.8 | 92.1 | 90.8 | 83.2 | 84.8 | 86.7 | 88.4 | 84.4 | 91.3 | 86.6 | 82.8 |
| Patients with severity of depression assessed | 2012/13 | 90.6 | 89.9 | 90.7 | 83.4 | 91.0 | 91.4 | 94.0 | 92.1 | 88.5 | 92.7 | 92.7 | 88.2 | 91.5 | 85.9 | 91.5 | 77.7 | 93.8 | 92.9 | 86.0 | 82.8 | 85.3 | 88.3 | 89.9 | 88.0 | 93.2 | 90.1 | 91.6 |
| Antidepressant prescribing (ADQs/STAR-PU) | 2012/13 | 6.0 | 6.1 | 6.1 | 4.0 | 5.7 | 5.9 | 6.9 | 7.1 | 4.3 | 6.7 | 6.5 | 6.3 | 5.3 | 6.8 | 5.8 | 6.6 | 8.3 | 5.4 | 5.9 | 8.3 | 6.6 | 6.7 | 4.9 | 9.0 | 6.1 | 5.6 | 5.0 |
| People with a mental illness in residential or nursing care per 100,000 population | 2012/13 | 32.7 | 45.3 | 69.8 | 13.0 | 39.0 | 39.0 | 61.6 | 29.5 | 92.0 | 92.0 | 11.9 | 55.5 | 21.5 | 55.5 | 21.1 | 55.5 | 65.9 | 76.7 | 21.1 | 55.5 | 45.3 | 29.7 | 34.4 | 55.5 | 41.8 | 56.2 | 42.4 |
| Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital | 2013/14 Q3 | 2.4 | 2.2 | 1.6 | 2.2 | 2.7 | 3.5 | 3.4 | 2.8 | 3.1 | 1.8 | 2.1 | 2.3 | 2.6 | 2.3 | 1.5 | 2.8 | 1.5 | 2.4 | 2.1 | 2.0 | 1.8 | 1.1 | 2.3 | 1.6 | 2.6 | 1.7 | 3.1 |
| Detentions under the Mental Health Act per 100,000 population | 2013/14 Q1 | 15.5 | 18.9 | 9.7 | 14.1 | 23.8 | 37.2 | 18.3 | 9.4 | 42.3 | 15.8 | 19.4 | 21.9 | 17.9 | 13.2 | 21.3 | 10.6 | 21.1 | 22.5 | 11.4 | 20.7 | 25.6 | 18.9 | 21.7 | 15.6 | 14.6 | 14.5 | 19.5 |
| Attendances at A&E for a psychiatric disorder per 100,000 population | 2012/13 | 243.5 | 332.9 | 414.7 | 351.1 | 158.6 | 387.7 | 552.4 | 772.1 | 43.7 | 59.1 | 665.4 | 832.9 | 333.8 | 449.7 | 432.6 | 446.1 | 590.0 | 10.6 | 354.0 | 925.5 | 330.4 | 556.1 | 54.4 | 783.2 | 41.9 | 319.3 | 21.5 |
| Number of bed days per 100,000 population. | 2013/14 Q1 | 4686 | 5701 | 4122 | 2198 | 5992 | 9946 | 7089 | 3854 | 6823 | 5010 | 5366 | 9366 | 5363 | 4696 | 4643 | 6191 | 4863 | 6788 | 4619 | 6935 | 9008 | 4729 | 5920 | 4937 | 5862 | 3264 | 5398 |
| People in contact with mental health services per 100,000 population | 2013/14 Q1 | 2160 | 2757 | 2274 | 1493 | 2493 | 2849 | 2004 | 1715 | 2941 | 2745 | 2290 | 3881 | 2494 | 2094 | 2586 | 2043 | 4728 | 2912 | 2238 | 4228 | 4580 | 5088 | 2732 | 3662 | 2350 | 2194 | 1998 |
| Carers of mental health clients receiving of assessments | 2012/13 | 68.5 | 70.2 | 46.0 | 44.5 | 107.6 | 107.6 | 32.1 | 46.8 | 51.7 | 51.7 | 0.0 | 217.5 | 36.3 | 71.3 | 7.6 | 71.3 | 18.6 | 96.8 | 7.6 | 217.5 | 4.1 | 88.7 | 141.8 | 217.5 | 50.8 | 0.0 | 23.1 |
| Spend (£s) on mental health in specialist services: rate per 100,000 population | 2012/13 | 26756 | - | 28940 | 25887 | 33686 | 33600 | 34906 | 23508 | 28940 | 28940 | 25972 | 40480 | 34336 | 31496 | 26851 | 26454 | 32337 | 31067 | 26851 | 40480 | 35776 | 29545 | 29907 | 40480 | 40497 | 29311 | 34501 |
| % secondary care funding spent on mental health | 2011/12 | 12.1 | 12.4 | 12.3 | 10.5 | 11.8 | 14.2 | 11.1 | 7.1 | 12.3 | 12.3 | 11.8 | 15.5 | 14.1 | 11.2 | 10.6 | 12.5 | 12.0 | 13.3 | 10.6 | 15.5 | 12.7 | 11.3 | 11.3 | 15.5 | 9.6 | 11.2 | 13.1 |




| Indicator | Period | England | Centres with Industry | NHS Airedale, Wharfdale... | NHS Barking And Dagenha... | NHS Birmingham Crosscit... | NHS Birmingham South An... | NHS Blackburn With Darw... | NHS Bolton CCG | NHS Bradford City CCG | NHS Bradford Districts... | NHS Calderdale CCG | NHS Central Manchester... | NHS Coventry And Rugby... | NHS East Lancashire CCG | NHS Greater Huddersfiel... | NHS Greater Preston CCG | NHS Heywood, Middleton... | NHS Leicester City CCG | NHS North Kirklees CCG | NHS North Manchester CC... | NHS Nottingham City CCG | NHS Oldham CCG | NHS Sandwell And West B... | NHS South Manchester CC... | NHS Southern Derbyshire... | NHS Walsall CCG | NHS Wolverhampton CCG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| People on Care Programme Approach per 100,000 population | 2013/14 Q1 | 531 | 614 | 598 | 549 | 527 | 617 | 876 | 751 | 763 | 591 | 695 | 918 | 434 | 632 | 751 | 653 | 804 | 453 | 607 | 685 | 348 | 842 | 507 | 587 | 713 | 803 | 386 |
| % CPA adults in settled accommodation | 2013/14 Q1 | 61.0 | 58.1 | 67.8 | 92.4 | 68.1 | 66.9 | 5.3 | 89.0 | 68.5 | 65.7 | 62.3 | 65.3 | 76.5 | 5.0 | 61.3 | 5.0 | 62.5 | 35.0 | 65.0 | 56.2 | 19.3 | 48.5 | 68.0 | 59.6 | 88.0 | 43.2 | 76.6 |
| % CPA adults in employment | 2013/14 Q1 | 7.0 | 5.3 | 8.9 | 3.0 | 6.4 | 4.2 | 1.1 | 8.9 | 7.0 | 5.6 | 7.3 | 3.9 | 9.7 | 1.5 | 7.7 | 1.2 | 2.8 | 2.0 | 9.2 | 2.9 | 1.8 | 2.2 | 4.0 | 4.4 | 10.9 | 4.2 | 3.3 |
| Emergency admissions for self harm per 100,000 population | 2012/13 | 191.0 | - | 150.3 | 146.8 | 204.0 | 210.1 | 354.9 | 199.9 | 282.0 | 219.6 | 249.2 | 172.9 | 283.4 | 271.1 | 222.1 | 196.7 | 241.2 | 137.4 | 209.3 | 281.5 | 203.9 | 202.9 | 195.9 | 267.0 | 221.3 | 171.0 | 142.6 |
| Suicide rate | 2010 - 12 | 8.5 | 8.9 | 9.5 | 6.2 | 5.9 | 6.0 | 13.6 | 11.7 | * | 9.2 | 9.2 | 13.7 | 9.6 | 9.3 | 7.2 | 11.4 | 10.1 | 10.3 | 9.4 | 19.6 | 7.6 | 8.1 | 7.1 | 10.6 | 7.7 | 5.8 | 7.7 |
| Hospital admissions for unintentional and deliberate injuries, ages 0-24 per 10,000 population | 2012/13 | 116.0 | 121.2 | 99.4 | 83.2 | 107.9 | 109.0 | 160.9 | 129.8 | 126.7 | 143.7 | 152.9 | 122.3 | 149.9 | 160.6 | 126.9 | 132.9 | 155.6 | 76.3 | 128.9 | 153.6 | 91.2 | 160.2 | 115.7 | 140.0 | 97.1 | 95.0 | 98.6 |
| Rate of recovery for IAPT treatment | 2012/13 | 45.9 | 47.1 | 63.3 | 46.3 | 39.0 | 46.1 | 40.5 | 42.8 | 63.3 | 63.3 | 48.4 | 40.6 | 49.6 | 45.2 | 41.4 | 38.0 | 44.8 | 35.5 | 41.4 | 40.6 | 38.4 | 48.8 | 57.6 | 40.6 | 53.2 | 51.0 | 43.0 |




| Indicator | Period | England | Centres with Industry | NHS Airedale, Wharfdale... | NHS Barking And Dagenha... | NHS Birmingham Crosscit... | NHS Birmingham South An... | NHS Blackburn With Darw... | NHS Bolton CCG | NHS Bradford City CCG | NHS Bradford Districts... | NHS Calderdale CCG | NHS Central Manchester... | NHS Coventry And Rugby... | NHS East Lancashire CCG | NHS Greater Huddersfiel... | NHS Greater Preston CCG | NHS Heywood, Middleton... | NHS Leicester City CCG | NHS North Kirklees CCG | NHS North Manchester CC... | NHS Nottingham City CCG | NHS Oldham CCG | NHS Sandwell And West B... | NHS South Manchester CC... | NHS Southern Derbyshire... | NHS Walsall CCG | NHS Wolverhampton CCG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Depression: QOF prevalence (18+) | 2012/13 | 5.8 | - | 6.4 | 3.3 | 5.7 | 6.3 | 7.0 | 6.8 | 5.6 | 6.1 | 7.3 | 5.7 | 6.0 | 6.2 | 6.0 | 8.0 | 7.8 | 6.1 | 6.1 | 6.9 | 5.2 | 6.7 | 5.1 | 8.1 | 5.8 | 6.0 | 6.6 |
| Depression: QOF incidence (18+) | 2012/13 | 1.0 | 1.2 | 1.2 | 0.6 | 1.0 | 1.2 | 1.3 | 1.4 | 1.9 | 1.1 | 1.4 | 1.1 | 1.0 | 1.1 | 1.1 | 1.4 | 1.6 | 1.6 | 1.6 | 1.4 | 1.2 | 1.0 | 1.0 | 1.5 | 1.1 | 1.1 | 1.2 |
| Depression and anxiety prevalence (GP survey) | 2012/13 | 12.0 | 13.5 | 10.8 | 11.2 | 13.9 | 14.5 | 13.0 | 13.9 | 17.1 | 14.2 | 12.3 | 15.4 | 11.8 | 13.1 | 12.4 | 13.0 | 14.5 | 12.8 | 11.5 | 18.7 | 15.6 | 12.6 | 14.1 | 15.0 | 12.8 | 13.1 | 13.2 |
| Mental health problem: QOF prevalence (all ages) | 2012/13 | 0.84 | 0.93 | 0.87 | 0.74 | 1.00 | 1.17 | 1.11 | 0.86 | 0.89 | 0.90 | 0.89 | 1.14 | 0.86 | 0.98 | 0.87 | 0.88 | 1.05 | 0.98 | 0.82 | 1.14 | 0.92 | 0.87 | 0.98 | 1.13 | 0.74 | 0.80 | 0.94 |
| % reporting a long-term mental health problem | 2012/13 | 4.5 | - | 3.5 | 3.7 | 4.9 | 6.5 | 5.4 | 5.7 | 4.4 | 4.9 | 5.2 | 5.7 | 4.2 | 5.4 | 5.2 | 5.3 | 5.6 | 4.7 | 5.2 | 8.0 | 6.5 | 4.1 | 4.6 | 6.6 | 4.3 | 4.6 | 4.4 |

## Appendix 4

## Social Prescribing and Self-help

- ***Books on Prescription***

  There are numerous self-help books available which individuals can access through bookshops and libraries. Self-help books recommended by NICE or Relate may also be 'prescribed' by health professionals through the *Books on Prescription* initiative,[93] which is a national scheme which is available in all libraries in Coventry. The scheme helps people to understand and manage their health and wellbeing using self-help reading. It is endorsed by health professionals and supported by public libraries.

  Books can be recommended by GPs or other health professionals from the relevant Reading Well Books on Prescription reading list. People can also self-refer to the scheme and use it without a professional recommendation. The books have been recommended by experts, and been tried and tested and found to be useful.

  Reading Well *Books on Prescription* was launched in 2013 with a list for common mental health conditions including anxiety, depression, phobias and some eating disorders. In its first year, the scheme has reached 275,000 people with book-based cognitive behavioural therapy. There has also been a 113% increase in loans of the titles on the list.

  In January 2015 The Reading Agency launched a new *Books on Prescription* scheme to support people with dementia, their friends and families, and the development of Dementia Friendly Communities.[116] All libraries in Coventry have a collection of the books available for people to borrow and there will soon be a collection at UHCW.

- ***Online CBT***

  Online CBT involves completing a number of exercises online to learn self-help techniques for overcoming difficulties. *Beating the Blues*[2] for depression and *FearFighter*[3] for panic and anxiety are both recommended by NICE.[117] Both programmes can be purchased privately, or can be accessed on the NHS for areas where a license has been purchased by the CCG.

- ***Big white wall***

[2] http://www.beatingtheblues.co.uk/
[3] http://www.fearfighter.com/

The *Big White Wall* is a pilot project currently being run across Coventry and Warwickshire. It is an online service which people with mental health illnesses can access anonymously about what is on their mind. It is being used to try and reduce the stigma around mental health illness and is a way of signposting to other services.

- ***Connect WELL***

  It is early days for the Rugby Social Prescribing project (Connect WELL), which started in September 2014, but almost 700 voluntary and community groups have been identified to date to which patients can be referred. The service model requires GP practices to identify patients who would benefit from social interventions and to refer them to either a 'navigator' (for a one off session to signpost patients to activities) or to a 'health buddy' (who will provide up to six sessions of support to enable individuals to access the available activities). Modifications are being made to the programme to simplify access and increase referrals, but there are some signs of success, including positive feedback from patients who have accessed activities through the project. The project will be subject to external evaluation that will inform future opportunities for social prescribing across Coventry and Warwickshire.

**Appendix 5**

**CWPT Services**

- ***Adult inpatients***

  This service cares for adults in an inpatient setting. It should build on patients' strengths, maintaining levels of independence and promoting wellbeing utilising therapeutic interventions which are evidence based and integrated within a full multidisciplinary approach. It provides 24 hour, 7 days a week, inpatient beds for people with mental health problems. The Crisis Resolution/Home Treatment Team are the 'gatekeepers' to all inpatient beds; admission is sought when needs and risks cannot be maintained in the community.

- ***Assertive Outreach***

  The aims of the Assertive Outreach Team are to offer support to people with a primary diagnosis of a severe and enduring psychotic disorder, and those whose lives have become unstable, or have a history of poor engagement with traditional services; to provide appropriate therapeutic engagement in order to reduce hospitalisation and symptoms of illness; to improve clients' social functioning, quality of life and satisfaction with services; and to assist with clients' aspirations and recovery. Assertive Outreach Services should also aim to improve the satisfaction with services of those who support or care for the person.

  The Assertive Outreach team will be involved in engagement, care co-ordination, interventions, referral, assessment, discharge, transfer of CPA and social inclusion. It involves interventions including assertive engagement, frequent contact, basics of daily living, support and intervention for family/carers/significant others, medication and monitoring of side effects, CBT, interventions for co-morbidities, social inclusion, physical health, support with education, training and employment, relapse prevention, crisis intervention, advanced decisions and inpatient and respite care.

- ***CMHT (community mental health team)***

  The CMHT service aims to provide appropriate therapeutic engagement and interventions to complex cases in order to reduce the debilitating effects of long term mental health problems. It does this by reducing hospitalisation and symptoms; improving service users' social functioning (especially their employment and employability), quality of life, and service satisfaction; and assisting with their recovery and aspirations. The service also aims to provide a robust interface working with acute care and

Primary Care Practices (GPs) to ensure that there is a clear commitment in retaining users within Coventry and to be supportive in their return.

This team includes the Primary Care Liaison Service and Perinatal Service in Coventry. The Primary Care Liaison Service aims to provide non-urgent mental health assessment and treatment for people with common mental health problems; screen all referrals that are routine, linking in with Improving Access to Psychological Therapies (IAPT); provide a consulting service to referrers for advice and specialist mental health guidance; be supportive in delivering a primary care stepped model of care; and be involved in the transfer of stable and suitable service users who are on the caseload of the CMHT until they are discharged to their GP practice for on-going monitoring. The Perinatal Service enables women to remain in the community wherever possible, keeping contact with family and friends and retaining their roles within the family. This will reduce hospital admissions, the length of stay in hospitals and out of county placements. A well delivered Perinatal Mental Health Service with support from home treatment will support mothers in their recovery and enable them to return to the lowest level of care provision as quickly as possible.

- ***Crisis Resolution and Home Treatment***

  The Crisis Resolution/Home Treatment Team (CR/HTT) provides a 24 hour, 7 day a week service to people experiencing an acute psychiatric crisis, who require urgent assessment. It provides a flexible, responsive, proactive, co-ordinated and integrated service for individuals with severe mental illness (e.g. schizophrenia, bipolar affective disorder, severe depressive disorder) who are in psychiatric crisis of such severity that, without the involvement of a crisis resolution/home treatment team, hospitalisation would be necessary. This service should be provided in the most appropriate setting (e.g. service users' own homes or a community setting). It will support individuals through their initial crisis and help them on their way to recovery. It aims to achieve the highest level of functioning possible in the least restrictive setting; prevent unnecessary hospitalisation; facilitate more rapid discharge from an acute care setting; offer support to carers from the demands of caring; and provide timely and accessible help to persons experiencing psychiatric crisis. The crisis team is now integrated and centrally located so that the team is able to transfer resources depending on where the need is at a particular time.

- ***AMHAT (Acute Mental Health Team)***

  The AMHAT service is a Consultant led service which provides a mental health assessment service to all inpatients and people presenting to the A&E departments of acute hospitals. The team will seek to improve the identification and understanding of common mental disorders and associated risks in the acute setting, which will improve the patient experience and promote dignity and person-centred care. The service comprises assessment of and advice on the management of patients with mental health problems in A&E, and on inpatient wards; specialist assessment and risk assessment by mental health clinicians to support patients' discharge from acute settings to an appropriate service, or to assist with a management plan in the acute setting where there are care delivery challenges; and providing advice, where appropriate, to acute hospitals with regard to application and clinical intervention under the Mental Health Act.

- ***Early Intervention***

  The Early Intervention Service (EIS) offers a comprehensive service to young adults experiencing an early episode of untreated psychosis throughout the 'critical period' (on average the first 3 years). The service aims to provide appropriate therapeutic engagement and interventions in order to reduce the debilitating effects of psychotic illness by reducing hospitalisation and symptoms; improving client's social functioning (especially their employment and employability), quality of life and service satisfaction; and assisting with their recovery and aspirations.

- ***IAPT (Improving Access to Psychological Therapies)***

  IAPT provides prompt and expert assessment of common mental health problems. More information is provided in section 6.4.4.

- ***Personality disorder***

  The objective of this service is to establish a comprehensive service for people with a personality disorder in Coventry, based on intensive group therapy combined with community based outreach services, and an education and skills facilitation team to train and advise stakeholders and address issues of social inclusion. People with personality disorder should not be excluded from any health or social care service on the basis of their diagnosis, history of antisocial or offending behaviour or self-harm. It is known that there may be higher incidences of co-morbid mental health disorders and other personality disorders and they should have access to a full range of appropriate treatments for these comorbidities.

- ***Place of safety***

  The aim of establishing a Place of Safety for Coventry and Warwickshire is to improve the experience and safety of people detained under section 135/136 of the Mental Health Act 1983. This should provide a rapid access to assessment and appropriate care; least possible use of force or restraint; understanding of illness and situation from all professionals involved; maintenance of confidentiality; and clarity about individual rights.

- ***Rehabilitation and recovery***

  The Rehabilitation and Recovery Team use a recovery based model which aims to provide a multi-disciplinary approach to optimising the mental health and functioning of individuals who experience severe and enduring mental health problems. It targets individuals who have demonstrated high levels of need through multiple admissions, limited responses to treatment, and increased vulnerability or risk due to symptoms of neglect and poor social functioning. The service cares for people with severe and enduring mental health problems that have longer-term needs. It should apply the principle of recovery by developing individuals' strengths, maintaining levels of independence and promoting well-being, and utilising therapeutic interventions which are evidence based and integrated within a full multidisciplinary approach.

- ***Acute day care***

  Acute Day Services are available at Fennel Day Unit in Coventry, Cedarwood in South Warwickshire and in Oakwood in North Warwickshire. Each centre is designed to support people who are experiencing a crisis with their mental health and aims to provide the most appropriate care within a community setting.

- ***Psychiatric Intensive Care Unit (PICU)***

  PICUs are secure, controlled wards providing care and treatment for patients experiencing acute mental illness and distress. Their purpose is to manage and reduce the risks associated with acute episodes of mental illness. Facilities are available at the Cauldon Centre in Coventry and St. Michael's Hospital in Warwick.

**Appendix 6**

**CWPT CQUIN**

**CWPT Mental Health Services**

**Quality Summary**

CQC Reports

CQC inspections were carried out at CWPT in January and July 2014. CQC highlighted that they had found areas of very good practice, however some areas of concern were identified. A number of compliance actions were issued and an enforcement notice was also issued for Quinton Ward which was later removed.

The Trust has responded by developing action plans for implementation across a number of sites including Brooklands hospital, the Caludon Centre, St Michaels Hospital, Community based Mental Health and community services, and Woodloes House. The Trusts action plans have been shared with co-commissioners and monitored via the CRCCG/CWPT Clinical Quality Review Group meeting. A further CQC visit is anticipated in 2015.

Areas for improvement included:

- Impact of the transformation of services
- Sharing learning following serious incidents
- Security systems, safety and suitability of premises
- Risks to patients in seclusion rooms
- Poor governance arrangements around the safe storage and management of medicines.
- Rapid Tranquilisation
- Prescribing issues
- Privacy, dignity and independence of service users
- Staff supervision and support
- Use of agency staff and continuity of care

- Systems for maintaining Health records and Staff records
- Ensuring care plans reflect individual needs
- Mandatory training including access to safeguarding training
- People did not always receive information that ensured they understood their rights as detained patients under the Mental Health Act.
- Inconsistent physical healthcare in mental health settings and poor uptake of physical health training.
- Child and Adolescent Mental Health Services

Community Mental Health Patient Experience Survey 2013

The CQC report stated that the trust is generally performing the same as other providers nationally in all the nine areas assessed by the patient experience survey.

West Midlands Quality Review Service Review of CAMHS

CRCCG commissioned WMQRS to undertake a review of Coventry and Warwickshire services for children and young people's emotional health and well-being in July 2014. Risks were identified around waiting times and self harm. The report has been followed up with CWPT at the Clinical Quality Review Group meeting and assurance sought regarding immediate actions to address delays in assessment and the Trust has submitted proposals to the CCG.

Staff Friends and Family Test

The Staff Friends and Family Test (FFT) data for Quarter 2 of 2014/15 shows that CWPT is currently achieving a low response rate of 20%. The percentage of CWPT staff recommending the Trust as a place of work was 42%. The percentage of CWPT staff recommending the Trust to receive care and treatment was 57%.

Staff Survey 2013

The staff survey results 2013 indicated the following areas for improvement which have been discussed at CQRG:

- Percentage witnessing potentially harmful errors, near misses or incidents in the last month – the Trust are in the worst 20% of responses for this indicator and the Trust is completing a piece of work to improve performance.
- Percentage experiencing harassment, bulling or abuse from staff in the last 12 months – those staff reporting harassment, bulling or abuse has risen from 2012 results.
- Percentage feeling pressure in the last 12 months to attend work when feeling unwell – the Trust have reduced their sickness rates and as a result staff could be feeling pressure to attend work.

- Percentage able to contribute towards improvements at work - The Trust scored in the bottom 20%. The Trust is doing a lot of work around staff engagement and a communications campaign; 'the big conversation.'

Unexpected Deaths Themed Review

The CCG has undertaken 2 themed reviews around unexpected deaths at CWPT and actions have been agreed as follows:

- review the Root Cause Analysis template to ensure that it captures the information required
- Recording of patient deaths from natural causes
- Involvement of other agencies in the RCA process such as GP's.
- To discuss with LA commissioners how to ensure robust process for recovery partnership to report unexpected deaths and participate in RCA's
- Wider review of suicides to inform system wide strategy

**Appendix 7**

**Summary of Social Care Services**

**Mental Health Services Provided by CCC**

Axholme services consist of 2 areas. Clifton House is for short term assisted living and step down flats. This service caters for adults from Coventry with severe and enduring mental illness who are FACS eligible and ready for enablement. Clients are referred from the single point of entry but many come from medium secure facilities. This is an interim placement and clients are in this service for a maximum of 2 years. This service looks to rehabilitate patients and enable social skills such as daily living skills and budgeting. It works closely with the Community Mental Health Teams and Recovery Partnership.

Clifton House currently has 5 bedrooms providing intense rehabilitation and then there are 4 step-down flats offering opportunities for 5 people. These are never left empty. Clifton House also does outreach support to 25 people who have moved on from the core unit to live in independent tenancies within the community. This support is less intensive and promotes peoples independence by providing advice and support around housing related issues and monitoring people's mental health.

The POD

The Pod is a referral based service for clients with severe and enduring mental illness. All people referred to the Pod must meet FACS eligibility criteria of critical or substantial. The Pod uses a model of care that is personalised and recovery focused, and advocates that people with severe and enduring mental ill health have capacity to direct and control their recovery journey.

This service currently has 113 clients in contact and last year 220 people received direct support from this service. The service is appointment based and actively engages with clients who are medically stable to build life skills and stay well. It is a service which helps clients with direct payments and signposts to other services. The POD has worked to make links with community opportunities. The service is recovery focused and looks to move clients out of the service within 2 years. It supports community mental health services by reducing the number of outpatient appointments and increasing medication compliance.

TESS

This employment service has fidelity with the Individual Placement and Support (IPS) model recommended by the Centre for Mental Health. IPS services are underpinned by the following principles:

Competitive employment is the primary goal

No eligibility criteria

Job search based on individual preferences

Job search rapid, within one month

Employment specialists co-located with clinical team

Support time un-limited and individualised

Benefits advice supports transition to work

Job development is undertaken with local employers

## Appendix 8

## CCG Finance

| CRCCG MH ADULT EXPENDITURE | | | | | | | |
|---|---|---|---|---|---|---|---|
| SUMMARY AS PER NEEDS ASSESSMENT CATEGORY | | | | | | | |
| | | | | | | | |
| MH | MH NA Category Description | Sum of Coventry 13/14 | Sum of Rugby 13/14 | Sum of CRCCG 13/14 | Sum of Coventry 14/15 | Sum of Rugby 14/15 | Sum of CRCCG 14/15 |
| 1 | Secure Services & PICU | 2,535,605 | 287,498 | 2,823,103 | 2,535,605 | 287,498 | 2,823,103 |
| 2 | Clinical Services | 14,747,185 | 3,334,558 | 18,081,743 | 14,745,853 | 3,334,558 | 18,080,411 |
| 3 | Community Mental Health Teams | 7,866,200 | 1,435,876 | 9,302,076 | 7,866,200 | 1,435,876 | 9,302,076 |
| 4 | Continuing Care | 7,034,024 | 992,034 | 8,026,058 | 7,257,687 | 938,045 | 8,195,732 |
| 5 | Access & Crisis Services | 3,476,408 | 1,099,969 | 4,576,377 | 3,476,408 | 1,099,969 | 4,576,377 |
| 7 | Psychological Therapy Services (IAPT) | 1,710,055 | 441,915 | 2,151,970 | 1,710,055 | 441,915 | 2,151,970 |
| 11 | Other Community & Hospital Professional Teams | 513,429 | 135,184 | 648,613 | 301,681 | 66,267 | 367,948 |
| 13 | Support Services | 761,994 | 2,624 | 764,618 | 761,994 | 2,624 | 764,618 |
| 14 | Personality Disorder Services | 0 | 0 | 0 | 208,041 | 54,777 | 262,818 |
| 18 | Primary Care | 28,020 | 0 | 28,020 | 28,020 | 0 | 28,020 |
| **Grand Total** | | **38,672,921** | **7,729,658** | **46,402,579** | **38,891,545** | **7,661,528** | **46,553,073** |

## Council Finance

**Summary of Adult Mental Health Services 2011/12 to 2014/15**

| | |
|---|---|
| I/E | Expenditure |
| Provision | (All) |
| Area | (All) |

| Outturn / Forecast Outturn | Financial Ye | | | |
|---|---|---|---|---|
| Service Group | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
| Day Services | 264,039 | 272,037 | 195,150 | 104,200 |
| Direct Payments | 312,064 | 292,487 | 296,784 | 286,842 |
| Equipment & Adaptions | 1,234 | 2,085 | 1,590 | 0 |
| Nursing | 594,411 | 678,853 | 624,319 | 555,507 |
| Residential | 1,235,507 | 1,435,464 | 1,750,319 | 1,717,722 |
| Supported & Other Accommodation | 743,571 | 662,589 | 516,217 | 378,319 |
| Community Mental Health Team | 2,090,568 | 2,093,779 | 2,085,872 | 2,106,426 |
| Home Support Services | 467,914 | 625,237 | 580,280 | 529,776 |
| Senior Management | 102,676 | 102,800 | 89,599 | 103,750 |
| Deprivation of Liberty Safeguarding | 31,733 | 13,721 | 13,596 | 55,201 |
| **Grand Total** | **5,843,717** | **6,179,053** | **6,153,725** | **5,837,744** |

## Appendix 9

## Details of MHA

Under a section 2, a patient may be detained in hospital for up to 28 days for assessment of their mental health and any treatment they might need. A section 2 will be applied if the patient is being assessed for the first time in hospital, or if their last hospital assessment was a long time ago. After 28 days has passed they may be transferred onto a section 3, which allows detention for up to 6 months and may be renewed. A Community Treatment Order (CTO) may be issued to place a person under supervised community treatment upon discharge from a section 3, or following diversion to hospital from the criminal justice system under certain sections of the Mental Health Act.

A section 4 is used in emergency situations, and allows a patient to be detained for up to 72 hours for assessment. Although the patient may refuse treatment on a section 4, it may be changed to a section 2. Section 5 refers to the holding power of either a doctor (section 5(2)), which allows the patient to be detained for up to 72 hours, or a nurse (section 5(4)), which applies for up to 6 hours. Section 5 orders are not renewable, and the patient may refuse treatment. Sections 135 and 136 allow the police to take someone to a place of safety, i.e. a hospital or police station. A section 135 allows removal to a place of safety from a private place, e.g. home, and a section 136 allows removal from a public place.

## Appendix 10

## QOF Tables

**QOF achievement, exception reporting and patients receiving interventions for Mental Health indicators - Coventry practices, 2013/14.**

| **MH002:** The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate. | | | | |
|---|---|---|---|---|
| | **Achievement score (max. 6)** | **Underlying achievement net of exceptions (%)** | **Exceptions (%)** | **Patients receiving intervention (%)** |
| Minimum | 0.00 | 27.27 | 0.00 | 27.27 |
| 25th percentile | 5.07 | 82.24 | 2.56 | 70.59 |
| Median | 6.00 | 91.67 | 5.41 | 81.40 |
| 75th percentile | 6.00 | 94.44 | 12.50 | 89.29 |
| Maximum | 6.00 | 100.00 | 49.57 | 100.00 |
| **MH003:** The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months. | | | | |
| | **Achievement score (max. 4)** | **Underlying achievement net of exceptions (%)** | **Exceptions (%)** | **Patients receiving intervention (%)** |
| Minimum | 0.63 | 56.25 | 0.00 | 56.25 |
| 25th percentile | 3.78 | 87.76 | 0.00 | 82.89 |
| Median | 4.00 | 91.30 | 3.23 | 86.30 |
| 75th percentile | 4.00 | 95.65 | 6.38 | 90.91 |
| Maximum | 4.00 | 100.00 | 23.93 | 100.00 |
| **MH004:** The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 12 months. | | | | |
| | **Achievement score (max. 5)** | **Underlying achievement net of exceptions (%)** | **Exceptions (%)** | **Patients receiving intervention (%)** |
| Minimum | 0.00 | 25.00 | 0.00 | 25.00 |
| 25th percentile | 4.10 | 73.68 | 0.00 | 66.67 |
| Median | 5.00 | 81.82 | 5.00 | 73.68 |
| 75th percentile | 5.00 | 89.47 | 10.00 | 82.35 |
| Maximum | 5.00 | 100.00 | 42.86 | 100.00 |
| **MH005:** The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months. | | | | |
| | **Achievement score (max. 5)** | **Underlying achievement net of exceptions (%)** | **Exceptions (%)** | **Patients receiving intervention (%)** |
| Minimum | 0.96 | 51.72 | 0.00 | 50.00 |
| 25th percentile | 5.00 | 80.00 | 0.00 | 71.88 |
| Median | 5.00 | 86.44 | 4.17 | 79.41 |
| 75th percentile | 5.00 | 93.33 | 9.80 | 86.96 |
| Maximum | 5.00 | 100.00 | 35.82 | 100.00 |

**(cont.): QOF achievement, exception reporting and patients receiving interventions for Mental Health indicators - Coventry practices, 2013/14.**

| **MH006:** The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months. | | | | |
|---|---|---|---|---|
| | **Achievement score (max. 4)** | **Underlying achievement net of exceptions (%)** | **Exceptions (%)** | **Patients receiving intervention (%)** |
| Minimum | 0.63 | 56.25 | 0.00 | 56.25 |
| 25th percentile | 3.52 | 85.19 | 0.00 | 80.00 |
| Median | 4.00 | 91.25 | 3.45 | 85.00 |
| 75th percentile | 4.00 | 96.67 | 8.62 | 91.80 |
| Maximum | 4.00 | 100.00 | 31.62 | 100.00 |
| **MH007:** The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months. | | | | |
| | **Achievement score (max. 4)** | **Underlying achievement net of exceptions (%)** | **Exceptions (%)** | **Patients receiving intervention (%)** |
| Minimum | 0.00 | 50.00 | 0.00 | 50.00 |
| 25th percentile | 3.55 | 85.48 | 0.00 | 80.00 |
| Median | 4.00 | 92.86 | 3.33 | 87.93 |
| 75th percentile | 4.00 | 97.62 | 6.90 | 92.86 |
| Maximum | 4.00 | 100.00 | 35.90 | 100.00 |
| **MH008**: The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years. | | | | |
| | **Achievement score (max. 5)** | **Underlying achievement net of exceptions (%)** | **Exceptions (%)** | **Patients receiving intervention (%)** |
| Minimum | 0.00 | 40.00 | 0.00 | 0.00 |
| 25th percentile | 5.00 | 81.68 | 0.00 | 66.67 |
| Median | 5.00 | 87.87 | 12.50 | 76.92 |
| 75th percentile | 5.00 | 100.00 | 22.22 | 83.33 |
| Maximum | 5.00 | 100.00 | 100.00 | 100.00 |
| **MH009:** The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months. | | | | |
| | **Achievement score (max. 1)** | **Underlying achievement net of exceptions (%)** | **Exceptions (%)** | **Patients receiving intervention (%)** |
| Minimum | 0.00 | 0.00 | 0.00 | 0.00 |
| 25th percentile | 0.54 | 100.00 | 0.00 | 91.10 |
| Median | 1.00 | 100.00 | 0.00 | 100.00 |
| 75th percentile | 1.00 | 100.00 | 0.00 | 100.00 |
| Maximum | 1.00 | 100.00 | 100.00 | 100.00 |
| **MH010:** The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months. | | | | |
| | **Achievement score (max. 2)** | **Underlying achievement net of exceptions (%)** | **Exceptions (%)** | **Patients receiving intervention (%)** |
| Minimum | 0.00 | 0.00 | 0.00 | 0.00 |
| 25th percentile | 0.00 | 87.50 | 0.00 | 66.67 |
| Median | 2.00 | 100.00 | 0.00 | 89.58 |
| 75th percentile | 2.00 | 100.00 | 16.67 | 100.00 |
| Maximum | 2.00 | 100.00 | 100.00 | 100.00 |

**QOF achievement, exception reporting and patients receiving interventions for Mental Health indicators - Rugby practices, 2013/14**

**MH002:** The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate.

| | Achievement score (max. 6) | Underlying achievement net of exceptions (%) | Exceptions (%) | Patients receiving intervention (%) |
|---|---|---|---|---|
| Minimum | 0.00 | 37.50 | 0.00 | 33.33 |
| 25th percentile | 5.94 | 89.97 | 4.42 | 76.82 |
| Median | 6.00 | 92.32 | 10.16 | 82.62 |
| 75th percentile | 6.00 | 94.55 | 13.57 | 85.78 |
| Maximum | 6.00 | 98.28 | 19.23 | 94.44 |

**MH003:** The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months.

| | Achievement score (max. 4) | Underlying achievement net of exceptions (%) | Exceptions (%) | Patients receiving intervention (%) |
|---|---|---|---|---|
| Minimum | 1.72 | 67.21 | 0.00 | 66.13 |
| 25th percentile | 3.91 | 91.15 | 1.21 | 86.00 |
| Median | 4.00 | 94.72 | 3.44 | 92.05 |
| 75th percentile | 4.00 | 96.31 | 5.98 | 93.04 |
| Maximum | 4.00 | 100.00 | 9.09 | 96.97 |

**MH004:** The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 12 months.

| | Achievement score (max. 5) | Underlying achievement net of exceptions (%) | Exceptions (%) | Patients receiving intervention (%) |
|---|---|---|---|---|
| Minimum | 1.05 | 52.38 | 0.00 | 50.00 |
| 25th percentile | 4.78 | 79.42 | 5.55 | 54.61 |
| Median | 5.00 | 83.85 | 7.57 | 73.71 |
| 75th percentile | 5.00 | 88.41 | 16.18 | 81.25 |
| Maximum | 5.00 | 100.00 | 41.07 | 100.00 |

**MH005:** The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months.

| | Achievement score (max. 5) | Underlying achievement net of exceptions (%) | Exceptions (%) | Patients receiving intervention (%) |
|---|---|---|---|---|
| Minimum | 2.01 | 59.09 | 0.00 | 56.52 |
| 25th percentile | 4.98 | 81.48 | 2.97 | 70.02 |
| Median | 5.00 | 88.56 | 5.76 | 80.65 |
| 75th percentile | 5.00 | 94.61 | 7.85 | 87.78 |
| Maximum | 5.00 | 100.00 | 27.63 | 100.00 |

**(cont.): QOF achievement, exception reporting and patients receiving interventions for Mental Health indicators - Rugby practices, 2013/14.**

| **MH006:** The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months. | | | | |
|---|---|---|---|---|
| | **Achievement score (max. 4)** | **Underlying achievement net of exceptions (%)** | **Exceptions (%)** | **Patients receiving intervention (%)** |
| Minimum | 2.88 | 78.79 | 0.00 | 72.22 |
| 25th percentile | 4.00 | 91.64 | 1.21 | 83.96 |
| Median | 4.00 | 93.65 | 6.12 | 86.83 |
| 75th percentile | 4.00 | 96.62 | 8.86 | 94.20 |
| Maximum | 4.00 | 100.00 | 12.00 | 100.00 |
| **MH007:** The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months. | | | | |
| | **Achievement score (max. 4)** | **Underlying achievement net of exceptions (%)** | **Exceptions (%)** | **Patients receiving intervention (%)** |
| Minimum | 1.07 | 60.66 | 0.00 | 59.68 |
| 25th percentile | 3.95 | 90.42 | 2.23 | 81.04 |
| Median | 4.00 | 94.10 | 7.50 | 86.08 |
| 75th percentile | 4.00 | 95.52 | 8.08 | 90.82 |
| Maximum | 4.00 | 100.00 | 15.38 | 96.97 |
| **MH008**: The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years. | | | | |
| | **Achievement score (max. 5)** | **Underlying achievement net of exceptions (%)** | **Exceptions (%)** | **Patients receiving intervention (%)** |
| Minimum | 5.00 | 80.00 | 0.00 | 22.22 |
| 25th percentile | 5.00 | 85.12 | 5.82 | 68.97 |
| Median | 5.00 | 96.67 | 16.67 | 80.91 |
| 75th percentile | 5.00 | 100.00 | 24.06 | 83.33 |
| Maximum | 5.00 | 100.00 | 77.78 | 87.50 |
| **MH009:** The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months. | | | | |
| | **Achievement score (max. 1)** | **Underlying achievement net of exceptions (%)** | **Exceptions (%)** | **Patients receiving intervention (%)** |
| Minimum | 0.83 | 83.33 | 0.00 | 83.33 |
| 25th percentile | 1.00 | 100.00 | 0.00 | 88.10 |
| Median | 1.00 | 100.00 | 0.00 | 100.00 |
| 75th percentile | 1.00 | 100.00 | 2.78 | 100.00 |
| Maximum | 1.00 | 100.00 | 16.67 | 100.00 |
| **MH010:** The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months. | | | | |
| | **Achievement score (max. 2)** | **Underlying achievement net of exceptions (%)** | **Exceptions (%)** | **Patients receiving intervention (%)** |
| Minimum | 0.83 | 66.67 | 0.00 | 66.67 |
| 25th percentile | 2.00 | 97.73 | 0.00 | 77.86 |
| Median | 2.00 | 100.00 | 5.56 | 86.11 |
| 75th percentile | 2.00 | 100.00 | 16.67 | 100.00 |
| Maximum | 2.00 | 100.00 | 33.33 | 100.00 |

**Appendix 11**

**User Survey**

## MH User Survey

Introduction and background

This survey is being undertaken to help Coventry City Council and Coventry and Rugby Clinical Commissioning Group to assess the quality of the Mental Health services that are currently provided.

Please complete this survey if you live in Coventry or if you are a patient of a GP with a practice in either Coventry or Rugby.

The survey is based on the questions used by the Care Quality Commission when they inspect services. This questionnaire can be used to provide your views on any of the services that you use.

If you wish to give views on more than one service please complete a separate questionnaire for each service so we can clearly identify views relevant to each service.

THANK YOU in advance for taking the time to complete this survey.

*The data controller is Coventry City Council. The information from this survey will be used to improve our services, the information may be shared with partners to improve service delivery across the city. Your response will be temporarily stored on SurveyMonkey's secure servers based in the USA. SurveyMonkey undertakes not to disclose the responses to others without lawful grounds.*

**1. Please tell us which service you wish to comment on?**

**2. How did you first find out about this service?**

**3. Do you know which organisation provides this service?**

Coventry and Warwickshire Partnership Trust

Coventry City Council

Rugby Borough Council

MIND

Re-think

Other provider

Don't know

Other (please specify)

**4. How are you responding to this survey?**

As a service user

As a carer

Other

Other (please specify)

**5. Is the service safe?**

Yes No Don't know

**How does the service support you in way that helps you stay safe? (by safe we mean free from risk of harm).**

**6. Is the service effective?**

Yes No Don't know

**How well does the service meet your treatment needs? For example, are you seen and supported as often as you need to be?**

**7. Is the service caring?**

Yes No Don't know

**Are you treated with kindness and respect by all staff you come in to contact with? Can you say how?**

**8. Is the service responsive to your needs?**

Yes No Don't know

**How does the service involve you in your treatment planning? For example, are your views/views of people supporting you, such as carers, taken into account?**

**9. Is the service well led?**

Yes No Don't know

**10. Would you know how to make a complaint about the service?**

Yes No

**If you have made a complaint in the last 12 months can you comment on whether your views were listened to and if your complaint was fully investigated?**

**11. Finally, is there any help or support that could be provided which would mean you could reduce your need to access Mental Health Services?**

Please provide some information about yourself so that we can monitor which groups of people have taken part in the consultation. Your response will be temporarily stored on Survey Monkey's secure servers based in the USA; Survey Monkey undertakes not to disclose the responses to others without lawful grounds. All data will be held securely. You are under no obligation to complete any question in this section of the survey if you do not wish to.

**12. Are you?**

Female Male

**13. How old are you? (general use)**

Under 16 16 – 24 25 – 34 35 – 44 45 - 54
55 – 64 65 – 74 75 – 84 85+

**14. What is your ethnic background?**

White - British (includes English / Welsh / Scottish / Northern Irish)

White – Irish

White - Gypsy/Irish Traveller

White – Other

Mixed - White and Black Caribbean

Mixed - White and Black African

Mixed - White and Asian

Mixed – Other

Asian/ Asian British - Indian Asian/ Asian British – Pakistani

Asian/ Asian British – Bangladeshi

Chinese

Asian/ Asian British – Other

Black/ Black British – African

Black/ Black British – Caribbean

Black/Black British – Other

Arab

Any other ethnic group

**If you selected other for any of the above ethnic groups, please provide details below:**

Thank you for taking the time to complete this survey.

**Appendix 12**

**User Focus Group Feedback**

**Key Points From Service Users and Carers Focus Group February 2015**

**Discussion Group One:**

**Thinking about Mental Health Services, what is working well?**
**What helps in making you feel good and function well?**
General points:

Coventry AIMHS was highly complimented, for the following reasons:

- It is a user-led service that treats people as friends and equals rather than patients/clients
- Service users are encouraged to lead discussions, and there is flexibility in the sessions
- Staff are positive, approachable, supportive and patient
- Focuses on shared experiences, lifelong learning and social connections

Social interaction – Making friends and providing "Peer Support" is also important.

Bipolar UK - Monthly meetings are helpful.

Services for people psychosis/bipolar or schizophrenia are generally good, however neuroses tend to be poorly supported.

The IKEA café is often used as an informal drop-in centre.

Key Points:

- Services that provide peer support and a sense of belonging are valued
- Services such as the Pod that connect service users to mainstream opportunities in the community are valued
- Opportunities for education & involvement, e.g. more PPI events – confidence building and feeling valued – more consultation with service users in a 'real' sense (rather than just tokenistically)
- 136 suite at Caludon – works well (place of safety instead of police cells)
- Mental health matters helpline – this works well
- Samaritans telephone helpline – this also works well
- Foodbanks provide essential support for some
- Contact with GP's and IAPT
- GP services seem to be improving – GPs seem to have more knowledge about mental health, and are asking the right questions (though it was acknowledged that practices vary)

- Referral pathways seem to be better
  Services that provide peer support
- Connection – to mainstream
- 136 suite at Caludon – works well (Place of safety in place of police cells)
- Mental health matters and the Samaritans - both work well
- Services that emphasise peer support and connect people to each other and services in the community are valued.
- Contact with GP's and I.A.P.T are helpful

**Discussion Group Two:**

**What needs to improve, focussing on information about services, access to services and adequacy of community support?**

General points:

Provision for over 65s was a major issue, as services for older people tend to focus on dementia – older people with mental health issues fall through the gaps

- Services that focus on getting people together socially can be difficult to access for someone with mental health issues, e.g. social phobias
- Some services have closed down, e.g. Coopers Lodge

There is also a lack of mental health provision for people with long-term health conditions and cancer (the latter is prioritised in Warwickshire).

It was felt that while there was much improvement among GP services overall, there is still a lack of understanding around the physical health needs of people with mental health problems – people felt that their physical health problems were often dismissed as psychosomatic, or attributed to their mental health problems.

There were also issues around reception staff at surgeries, and getting GP appointments:

- Being asked about the reason for needing an appointment by the receptionist feels intrusive, particularly when at the surgery (not much privacy at the desk)
- Agitation or distress can be mistaken for aggression, so people presenting in a state of mental distress may be refused appointments due to 'no aggression' policies
- For surgeries that require people to call first thing in the morning for an appointment, this can be problematic for people who have difficulty sleeping (e.g. those with anxiety and depression)

Some of the larger services were considered to be quite impersonal, and there was a sense of being treated like cattle ('cash cows') rather than individuals – a 'them/us'

attitude, and too much emphasis on targets. This related more to the perceived ethos of the organisation, rather than the 'shop floor' staff, who were generally very good.

Key Points:

- More information in mainstream settings e.g. Libraries, newspapers etc would be helpful
- More information at GP surgeries – GPs also need to be more aware of community resources/support that is available
- Earlier intervention and support (helping people maintain their independence – pre-appointee (ie before MH advocacy service)
- More self-help provision and less medicalisation where possible (not all mental health problems will be mental illness)
- Inadequacy of community support is fuelled by lack of information/early intervention – needs to start with education in schools
- Do more 'out of hours' – e.g. MIND should be delivered out of hours; GP home visits would be helpful
- Improvement to information relating to what is available (information hubs?)
- Transition between services CAMHS/services for adults/older adults
- More services for over 65s – services should not have an upper age limit unless there is a need for specialised care, e.g. dementia – need to focus on individuals and not their age
- More information in mainstream settings
- Earlier intervention and support (helping people maintain their independence – pre-appointee)
- Inadequacy of community support is fuelled by lack of information/early intervention
- Do more 'out of hours' – e.g. MIND should be delivered out of hours
- Improvement to information relating to what is available (information hubs?)
- Transition between services camhs and wider services that support people.
- More services for over 65's are required.

**Discussion Group Three:**

**What needs to improve, focussing on involvement of users and carers in care planning and the relationships/links between services?**

General points:

The role of carers and the need to increase their involvement was emphasised. It was felt that there needs to be more flexibility in the triangle of care, as carers are often left out. For example, current confidentiality policies can prevent necessary exchange of information between carers and healthcare providers, particularly when the patient

themselves is too unwell to articulate their own needs.

- A lot depends on ‘how vocal’ family/friend are
- Care plans – should provide information on social interaction not just Mental Health disorder. It should reflect an individual’s behaviour, their ability to access communication, transport, employment opportunities (what is persons vocational opportunities) ALSO should look at physical problems.
- Services don’t know what each other are doing – generally.
- People not listened to generally – but depends on the professional (e.g. depends who GP is)
- Problem for parents with MH problems scared to share problems in case children taken into care.
- Avon mental health measure – designed for service user to have maximum input (advocates use it a lot)
  Feedback to carers/ service users doesn’t happen.
- Services sometimes do not check to see if referral has been acted upon
- GP appointments – issues with accessing/requesting appointments
- No privacy at GP reception
- Inpatients are not always aware of or have any input into Care Plan
- All care plans must be signed by the patient
- Carers are left out of discussions and care planning
- Need better pathways – transitions are far from seamless
- No involvement in discharge planning
- Some IPU patients are unaware that they have a care plan (Caludon unit)
- Access to home visits is required

Key Points:

- Care plans need to more inclusive/holistic reflecting the wider range of factors that impact on mental health. They should address social needs, interests and exercise/hobbies, and have input from service users and carers
- Patients and carers need to be listened to more. Better involvement for carers (triangle of care: users/carers/providers); more patient-centred care and concordance in decisions about care – people should not be pushed into doing things they don’t feel comfortable with
- Do more to promote experts by experience
- More PPI  and opportunities for feedback at each service (it should be easy to give compliments as well as make complaints)
- Do more to promote experts by experience
- Need advocacy in ‘strategic places’ – currently in POD/part of MIND drop in service/as part of ‘single point of access’ to Council Services and NHS 111
- Need advocacy in ‘strategic places’ – currently in Pod/part of MIND drop in service/as part of ‘single point of access’ to Council Services and NHS

- Greater focus on wellbeing – this is a priority with early intervention needed
  Care plans need to be more holistic and not focus on medical/clinical need. They should address social needs, interests and exercise/hobbies.
- Better involvement for carers required.
- Greater focus on wellbeing – this is a priority for early intervention.

**Discussion Group Four:**

**What needs to improve?**

**How could you be better supported in relation to crisis?**
**What support would help prevent crisis?**
**What would help at a time of crisis?**

General points:

- There is a gap in support for those who may be experiencing what they feel is a crisis, but without imminent danger of suicide or self-harm.
- Prevention of crisis is helped through group support, sharing issues and problems.
- Doing voluntary work helps – having a purpose – helping people socialise.
- e.g. litter picking carer in contact with opportunity.
- At time of crisis- Crisis team not responsive.
- Crisis team misnamed – they are gate keepers to hospital beds the true crisis service are police and A&E.
- A&E service need to be better able to handle crisis.
- Walk-in-centres and NHS 111 need support with MH professionals.
- Benefits sanction – is a crisis for people. No money or food – turns into a MH crisis.
- Crisis team out of hours access (not good)
- Crisis/halfway house is required as an alternative to a hospital admission.
- Having a support service available out of hours (third sector) would be beneficial.
- Crisis team needs to be renamed. You cannot access it by 'self-referral'
- Not being fobbed off when I call for help – would help a lot. Need to be treated as a person.
- A befriending support service out of hours would help.
- At the moment there appears to be no support on public holidays (all services)

Key Points:

- Prevention – peer support/group support and opportunities to socialise would reduce crises
- More MH input in mainstream services/A&E/walk in etc. to recognise crises and provide the support necessary

- Caludon centre – meant to do activities, not enough for patients to do. Rely on medication
- Listen more to ‘next of kin’/carers – they often know when a service user is in danger of a crisis
- Advocacy around benefits/housing etc. needed +++. If individuals were supported with wider problems earlier many crises could be avoided.
- There is no current crisis service out of hours (current provision needs renaming) – needs to be some provision 24/7, 365 days
- The scope of the service needs to be more clearly defined
- Need alternative support services out of hours – (? Provided by voluntary sector)
- Need a physical location i.e. crisis house – central provision
- Prevention – peer support/group support opportunities to socialise are required.
- More MH input in mainstream services/A&E/walk in etc are required.
- Staff need to listen more to ‘next of kin’/carers.
- Advocacy around benefits/housing and other welfare benefits needs to be provided at much higher levels and much earlier. The consequences of not doing this is that health is picking up the costs.
- No crisis service out of hours (current provision needs renaming)

## Appendix 13

## Recovery Forum Feedback

### Discussion with Coventry Recovery Forum

Coventry Recovery Forum is a community group whose members are all in the process of recovering from addiction. There were approximately 15 members of the group present for the discussion on 09.12.2014.

Following a general introduction to the Mental Well Being / Mental Health Needs and Assets assessment the group discussed the factors that promote Health and Wellbeing and the factors that undermine or reduce Wellbeing. This was followed by a discussion about Mental Health services. The following summarises the key points raised.

Mental Well Being:

**Factors that promote Wellbeing**

- Valuing community, promoting relationships enabling people to find purpose.
- 5 ways/10 ways to wellbeing – should continue to be promoted/integrated into front-line services.

There needs to be continued recognition of the benefits of Assets Based Working. Community groups need to be recognised as the solution and invested in. There needs to be a different attitude from front-line services, recognising the legitimacy of 'lived experience' and relying less on professional judgement alone (sharing power).

The winter month's shelter initiative provided by the coalition of 7 churches was identified as a valuable asset in the City.

**Factors That Undermine / Threaten Wellbeing**

Not recognising the inter-related challenges that individuals face eg – poor housing and debt/poverty issues (re-enforced by a rigid benefits system).

Failure to recognise community as a resource in addressing problems.

**General Observations about Mental Health Services**

More services need to be 24/7, 365 days (people's needs cannot be met through 9-5, Monday to Friday services – as many services currently operate).

There needs to be more integration between services – and more generally an integration of services into the communities they serve (more 'outreach'). There was a general feeling that there are too many cracks between services – people are falling through.

Commissioners should seek evidence from providers that they are connected to each other and connected to communities.

Some services need to be better described/understood so they can be accessed most appropriately (eg. IAPT, Crisis service).

Some service users reported positive experience of services (eg. UHCW Alcohol Liaison service utilising peer-led support, the COMPASS and SWISH services and the Coopers lodge service).

Some people's experience of services led them to recommend that providers should be encouraged to adopt a 'strengths based' approach to service user assessment (rather than a focus on deficits). Service users need to feel valued, listened to and treated as individuals – these are all pre-requisites to recovery.

**Appendix 14**

**Feedback from 3rd Sector**

Third sector event- notes

*Mental Wellbeing- assets*

- Grass roots organisations- experts by experience
- Numerous specialist groups which cover different communities
    - Sahara have cancer support group to tackle belief of negative karma
- Services available at different levels i.e. advice, intervention, recovery, access to counselling (more than just IAPT- improved access to psychological therapy)
- VAC (Voluntary Action Coventry) book (service directory) – now online only
- MECC (Make every contact count) training for organisations Basic needs being met e.g. homeless support services
- Public services in communities not just city centre.
- Social support interventions led by community groups, tackling isolation e.g. Age UK fit as fiddle and get going together programmes, dementia friends
- Organisations encourage meaningful life e.g. independence, giving, healthy eating, activity, day trips
- Organisations can give structure in the day for people who can't work.
- Able to recognise community solutions/ prevention
- Partnership approach between client and agency
- Organisations focus on empowerment- change mind-set that person is of value in society
- Workplace wellbeing charter- important for people working in these organisations
- Improvements to cycle ways and introduction of walking schemes
- 10 ways to wellbeing build community resilience.

*Mental Wellbeing- improvements required*

- Better referral pathways between agencies- Mental health professionals/ police/ job centre/ GP
- Holistic approach to individual, whole person circumstances, people shouldn't be labelled.
- Improved partnership working (mandatory training)
- Commissioners need to engage with community and third sector to understand populations and their role. Currently one sided which is frustrating.
- Improvement in communication and collaboration between third sector organisations so no overlap, link up services
- Currently lack of facilities/ space
- Need more awareness raising
- Lack of funding

- Need peer support groups
- Could have drop in centre in town (unused shop that charities can book for day)
- Currently limited space so have to make appointments, not good for confidentiality
- Tackle stigma- need to get employers to support people in workplace to keep jobs, phased return to work. Job centre good at this??
- Health services not geared to prevention
- Transport issues for people getting to services, especially elderly.
- Lack of time for professionals as trying to support so many people.
- Poor support for refugees- no access to benefits, housing overnight but nowhere to go in day. Not acknowledged group, poor access.
- People in isolated situations become 'invisible'.
- Decreased public services an issue e.g. cuts to libraries closing down or reduced hours

*Mental Health Services- assets*

- Prevention by third sector so individuals don't reach secondary services
- Third sector closer to community so less stigma/ not on official records, don't have to go to 'official' building, improve relationship between healthcare professional and client
- Co-location of services
- Peer support groups
- Advocacy roles
- GPs do well under extreme pressure
- Third sector have lots of experience
- Third sector provide support for people without a diagnosis
- New street triage service

*Mental Health Services- improvements required*

- Need mechanism for communication between third sector and Coventry and Warwickshire clinical commissioning group (CCG)
- Need partnership forum between integrated agencies, council, CCG, MH trust
- Need clear referral routes
- Improvements when transition from child services to adult
- Need to make info on services more available- not just online, variety of languages
- Holistic use of modern media – newspapers, GP screens, social media, radio, DVD about all services
- Record and use power of recovery
- Currently long waiting lists
- Improve healthcare professionals knowledge of what is available in third sector
- Restrictive criteria to access some services- need to be more inclusive
- Method of comparing NHS services with voluntary sector

- IAPT
    - Inaccessible
    - 2 hour phone assessment
    - Not responsive, should be integrated
    - Everyone gets same no. appointments regardless of need
    - People go through IAPT before referral to other agencies e.g. CRASAC/ Relate
    - Vulnerable people need face to face, continuity
- Need mental and physical health partnership
- Recovery partnership not referring to Aquarius
- Professionals have deficit approach to assessment
- Mental health not one of CCG priorities
- GPs need better info about third sector
- Need to engage universities/ colleges
- Need consistency in contact
- Tick box culture not good, emphasis on quick fix
- Poor services for people with complex needs
- Too much reliance on third sector for prevention without funding
- Need better access via drop in services
- Third sector should have training on how to react in certain circumstances, services available.
- Crisis team don't see individuals straight away.
- Sometimes response from safeguarding not timely
- Poor info about new IPUs (integrated practice units) for public, difficult terminology e.g. psychosis/ organic
- Single point of entry only for CWPT, need single point of entry for whole network.
- Named contact for mental health to contact with queries
- Longer term funding for provider so can do long term planning.

**Appendix 15.**

**Feedback from wider stakeholders**

## Wider Stakeholder Event – Summary of Key Points

## Discussion Group 1: Mental Wellbeing

## Feedback Points

### What is going well?

- Enabling individuals through social prescribing but needs to be more widely available and needs to be greater choice.
- Information – sign posting opportunities (e.g. Ability to download resources etc.)
- People more aware of what they need to do to maintain control.
- Opportunities for volunteering/keeping working are there.
- Strong/existing partnerships/collaborations and service providers going above and beyond their care service offer.
- Community mobilisation/self-help seeing more residents engage in community activities.
- Last few years have seen an improvement in the integration of services across sectors and improved strategic commissioning.
- Feeling of community cohesion; good quality of local connections.
- Affordable opportunities.
- Geographically compact area that makes it easy to get about, visit, take part and see others.
- Tile Hill – Physical Activity Community Project.
- Social landlords – VIP Project.
- MECC/10 ways to wellbeing project.
- A shift to promoting recovery.
- Employment services helpful in supporting people to access and sustain work.
- CWPT/CCG's proactive remodelling of services e.g. liaison and diversion, street triage, and 'place of safety'
- Healthy Walks: City Council – Passion for walking, not around dependant on 'need' but has universal scope.
- Orbit – community hub – to bring things together. Matrix management model.
- Accessibility of pharmaceutical services – website. Empowers people to make own choices. 'Healthy living pharmacies!'
- Arts – external investment FARGO/Food/Music – feeling of richness in the city – can this be stretched so more people benefit?
- 'Sense' of community neighbours/asset building – Streetwise/time banks
- Many people are proud of where they live and are hopeful for the future.
- There are a variety of activities/options to suit the diverse population – giving choices.
- Lots of opportunities to be active that don't necessarily include leisure centres.
- Lots of good parks in urban areas. Spon End play parks and green gym. Canal Basin.

## Discussion Group 1: Mental Wellbeing

## Feedback Points

### What needs to improve?

- Access to choices and greater choice for individuals, more openness from professionals promoting individual ownership.
- Direction of funding – do more to support programmes and projects that are working well.
- Better employment support/understanding of managers/training needs so they are better able to support to employees.
- Provide better and more diverse roots into volunteering.
- Physical environment; Coventry has derelict areas, too much concrete, not enough greenery, too many betting shops, junk food shops, payday loan shops, empty shops and buildings.
- Involve 3rd Sector more – use their experience and share learning.
- Improve our dialogue with residents and communities – do we (public sector employees need to work evening to do focus groups/residents groups with people who work during day, let people email their feedback.
- Pedestrian safety across the city – particularly in shared space areas, improve open spaces to include physical activity apparatus for older people.
- Coventry home finder is an unfriendly inaccessible service (only available on the internet)
- Current lack of culture/linguistic sensitivity – there are still labels! Always room for improvements in communication, ensuring everyone knows what everyone else is delivering.
- More investment from local businesses etc. into local community.
- Replicating good practices from some areas e.g. Earlsdon newsletter etc.
- Stronger community networks – free events etc. – making people more aware of what's going on.
- More health promotion to reduce stigma and encourage asking for support earlier.
- Need timely interventions, people wait too long.
- Troubled families need to work better with MH services.
- Offer holistic assessment and services.
- Better partnership to support people to overcome barriers and share resources – particularly between big and much smaller organisations. Health/Social care/Voluntary groups need to be more coordinated.
- More equality for resources across the city – not concentrating on particular areas.
- Improve transport to reduce isolation – community transport being key, more flexibility needed.
- Allow empty shops to be used for positive use.

## Discussion Group 2: Mental Health Services

## Feedback Points

**What support and/or services currently work well?**

- Early intervention/prevention for young people (particularly those already engaged in social care)
- Integrated service between CWPT and Social Care through section 105 agreement.
- Coventry refugee, asylum seeker and migrant centre have successful referrals from specialist GP.
- Positive activities such as books in prescription and mind/rethink events such as the employment event in March.
- Being considered 'expert' in own condition and being treated. Holistically as a person not an illness.
- Advocacy/3rd part support – to speak about what's happening – understanding processes and keep carers supported.
- Services are on our doorstep; easy to find and get to.
- Variety of community groups and community support is available.
- Perception that there may be less of a taboo about mental illness (less stigma in Coventry compared to other areas)
- More availability-
  - IAPT
  - More choice for counselling
  - Quicker interventions
  - Good tools
- Referral and assessment for offenders are now much quicker.
- New pathways much quicker.
- Support for MH users – work is working very well.
- Work and Job shop very good. Staff at Job shop awareness raised around MH – helped them to have discussions at first point of contact.
- POD – users and long term/enduring MH short term holistic support to promote long term wellness and wellbeing. Work/home/social connections/giving etc./OP appointments etc.
- Tailored support for individuals – connecting people to other organisations e.g. housing. Max 2 years – often less – 12 weeks – 2 years.
- Learning from people who have been through journey to see what works well and what hasn't.
- Empowering service users to be in control and take responsibilities for their interventions.
- Good services e.g. POD but internet directory needed (that is regularly updated)
- Good SPE and good 136 suite (place of safety)
- Good work on personalisation and some services are recovery/outcome focussed.
- Reorganisation of services has generally had a positive impact and useful that people can talk to GP's etc. – more equal distribution.
- Changes in funding – less funding – is having a positive impact on organisation of services.
- Social norms about talking about the issues are improved and people who have recovered are more able to talk about it and support other people – less stigma.

**Health watch Feedback**

**Healthwatch Coventry summary report on issues regarding local mental health services**

**Introduction**

Healthwatch Coventry is the consumer champion for health and social care services locally, working for the interest of those who need or use services.
Healthwatch has pulled together this information in order to feed into the current mental health needs assessment being carried out by Public Health in Coventry.
Healthwatch Coventry gathers feedback and information regarding local NHS and care services in a number of ways including: outreach; visits to services; surveys; gathering information from our community connectors in voluntary, community and self help groups; and information from the topics of questions and concerns raised with us.

**Issues regarding services**

The following information is to highlight issues and potential issues regarding mental health service provision and commissioning:

**1. Mental health and substance misuse – service gaps**

From outreach we are picking up significant feedback regarding a service gap/ catch 22 in the treatment of people who have both mental health issues and substance misuse issues:

- Lack of access to IAPT service for those with substance use issues
- MIND not able to provide support as referrals are considered too high level
- Addaction's delivery model is different in Warwickshire and Coventry. It is understood that the service in Stratford delivers low level CBT but Coventry does not.
- A woman who was encouraged to give her tenancy up by Whitefriars as she was alcohol dependent was admitted into the Caludon Centre as there was no other provision available.
- It would be helpful if GPs gave a dual diagnosis. Often the mental health issues are the primary issue that has led to self medicating with alcohol but the mental health issues won't be treated until a patient is not using alcohol.
- Swanswell (Alcohol and Drug support services) are not receiving referrals from the Caludon Centre, and Swanswell have tried to establish a relationship.
- Crisis team making assessment that issues are alcohol related rather than seeing underlying mental health issue.
- Swanswell (Alcohol and Drugs charity operating in Coventry) are not receiving any referrals from the Caludon Centre

Healthwatch has sought information from Addaction regarding their services and from Coventry and Warwickshire Partnership Trust (CWPT) regarding the interface between mental health and substance misuse services and joint working protocols which were in the process of being agreed. Healthwatch continues to identify individuals whose experiences indicate a lack of a joined up approach to dealing with mental health and substance misuse issues.

**2. Care planning**

Coventry LINk carried out work to review care planning for mental health patients and produced the report *Care planning for mental health service users in Coventry: Recommendations (February 2013).* This found that care planning was patchy and made recommendations including quality checks on the care planning process. Service user frustrations included the need for them to have more than one care plan, with care plans with each agency they were being supported by eg by different CWPT services and MIND, rather than this being joined up. Some service users also felt a great sense of personal responsibility to ensure they met their care plan.
CWPT developed an action plan at the time; however care planning continues to be mentioned as an area of inconsistency of care and it also related to effective discharge for inpatients, where issue have also been picked up.
We have recently identified an issue of a lack of care plans for people with mental health issues who are released from prison back into the community of Coventry.

**3. IAPT**

Use of and access to IAPT service for people from Black, Asian and Minority Ethnic communities has been flagged in previous Equality Delivery plans by the PCT and CCG. We are not aware of any progress towards addressing the lower levels of use by different BAME groups.
We have also heard about referrals to IAPT being bounced on to other agencies; and issues for people with mental health issues who had in addition been referred for memory assessment being told they could not continue their IAPT until this assessment had been made, long waits for assessment and then after a negative dementia diagnosis no route back to IAPT.

**4. Housing**

Agencies report a lack of appropriate housing for people with mental health issues, eg not addressing specific individual needs, or alternatives to hostel living for people who find this kind of shared environment difficult.

**5. Service gaps – which agency is responsible?**

Gaps in services eg of case of someone who had absconded from a secure mental hospital and a local agency which contacted the police and they said they could Page **3** of **3** 8 January 2015

not help as their assessment as more than 72 hours old and to contact the Crisis Team which offered an appointment for the man, even though it was unlikely he would attend an appointment.

**6. Crisis team**

Coventry LINk carried out work looking at access to mental health services, which focused on the the Crisis Resolution Home Treatment Team: *Out of hours mental health services in Coventry recommendations for mental health Commissioners (July 2010).* Healthwatch has continued to take an interest in the operation of the Crisis team and urgent mental health services.
Recent feedback indicates concerns with the capacity/resourcing of the Crisis Team and responsiveness eg in situation where someone threatening suicide. Service users and support agencies feel that the Team are supporting less people.

**7. GPs**

GPs are being expected to play an increasing role in the treatment of people with mental ill health, with more mental health patients being discharged into GP care under new CWPT models of care. Healthwatch is concerned regarding the clinical knowledge, understanding of services and capacity of some GPs to effectively carry out this role. Some GPs are very knowledgeable regarding mental health issues and treatment however others are not. Patients need to feel confident in the knowledge and approach of their GP or they will not seek their help. GPs should be supported to ensure their up to date understanding. Also GP services are under demand pressure locally so appointment availability for people with mental health issues or people who are beginning to become more ill will be an issue.

**8. Impact of service changes**

The impact of service changes is starting to feed through to service users for example: People who have previously had low level support and a quarterly outpatient appointment have been signed off seemingly without their knowledge. When they have enquired they have been told they have been signed off and will need to go back to their GP – see above for concerns regarding GPs' ability to support.

**9. Other**

 Feedback from the community indicates that Black men who experience mental health issues are less likely to seek support.

 Availability of community mental health support – we have received comments that agencies/service users feel this type of support is virtually none existent. This raises questions regarding expectation, delivery and whether services are designed to meet service user needs.

**Carers Centre Feedback**

As requested a brief summary of some of the issues raised by carers who support someone with a mental illness who have been supported at the Carers Centre

**Concerns identified in mental health from carers**

**Accessing support in a crisis** The crisis team are not always available to come out they will suggest that the person call their care coordinator or attend A&E (some care coordinators equally appear to be unable to make a home visit and will also suggest to them to attend A&E, carers state that if they have personally taken there cared for to A&E they have done so with great difficulties leading to a risk to themselves, as the cared for will try and get out of the car, run off, be very unpredictable. Whilst attending A&E they have had to wait for many hours before the person is seen as one can appreciate when someone is very unwell they will have great difficulties whilst attending A&E as they may exhibit agitation, restless, emotional, confused, and erratic behaviour, the stress on the carer is immense, especially if they then have to take the person home as there are no beds. Some carers have informed us that they have had to attend A&E several times in one week before the person has been admitted (I do question has there been a risk assessment undertaken on the family)

We have also been informed that when some carers accompanying their cared for to a G.P appointment some GP were unsure of the correct procedure of how to access services, also they can only refer someone if they are at risk to themselves or others, if some interim intervention was given this could prevent a lot of admissions or crisis situations.

**Carer concerns** We suggest to carers to write to key professionals if it is difficult for them to raise their concerns, as this is not breaking confidentiality only informing, carers report to us that in the majority they receive no response or acknowledgement and feel as though they are not being listened to and yet these carers are often the ones who can identify any deterioration in the person they support, hence this could prevent relapse.

**Complaints** carers who had complained felt that they not been kept informed also that the process was very lengthy one carer made a complaint that took 7 months for a response.

**Central Booking Service** carers have called this service as they are often confused as to who their cared for should be receiving services from, which team or who is the key professional there has been lack of clarity and confusing information and incorrect telephone numbers given

**Discharged from the Caludon** some carers inform us that the person they care for are discharged from the Caludon on a section 2 generally a detainment of 28 days this section has been lifted although they have only been there for a few days (I do question if consideration is being taken of the family situation or have they been involved and included)

Carers Development worker for Mental Health

**Appendix 16**

**Summary of Evidence for Prevention and Recovery**

**Evidence of Economic Impact of Mental Health Promotion**

Summary from:

**Mental Health Promotion and Prevention: The Economic Case. Martin Knapp, David McDaid and Michael Parsonage (editors). Personal Social Service Research Unit, London School of Economics and Political Science, January 2011.**

Key findings include:

Health visiting and reducing post-natal depression gives significant improvement in quality of life, interventions may produce cost savings in medium and long term, but further evaluation required. ICER £4500 QALY.

Parenting intervention for children with persistent conduct disorders, parenting programmes are cost-saving to public purse. When wider costs of crime included savings from intervention by factor of 8 to 1.

School based programmes for conduct disorder in childhood strong case that school based programmes are cost saving, with substantial wider benefits.

School based programmes to reduce bullying limited evidence, but anti-bullying interventions appear to offer good value for money.

Early detection for psychosis – can reduce risk of transition to full psychosis and shorten duration of untreated psychosis. Savings demonstrated in health care services, criminal justice, suicide, homicide and lost employment.

Early intervention in psychosis – aim to reduce relapse and readmission rates, leads to lower costs due to reduced admissions.

Screening for alcohol misuse and brief intervention in Primary Care reports a robust economic case: low cost interventions in Primary Care offer good value for money in reducing alcohol related harm.

Workplace screening for depression and anxiety disorders. Good investment for employer – reducing absenteeism and presenteeism.

Promoting well-being in the workplace. (Flexible working, career progression, stress audits, staff training in management) can give substantial return on investment.

Debt advice and Mental Health. People with unmanageable debt 33% increased risk of depression/anxiety. Potential for debt advice interventions to alleviate debt and improve Mental Health.

Population level suicide awareness training and intervention – good evidence for GP suicide prevention training, appears highly cost effective from a health perspective.

Bridge safety measures for suicide prevention. Construction of safety barrier effective if bridge is 'suicide hotspot'.

Collaborative Care for Depression in Type II Diabetes. Data from USA indicates 13% of new case Type II will also have depression, exacerbating complications part due to poor self-management. Collaborative care includes GP advice and care, use of anti-depressants and CBT for some patients.

Medically Unexplained Symptoms. Physical symptoms caused by mental of emotional factors estimated to cost 11% of total expenditure on health services for work age patients, CBT demonstrated to be effective.

Befriending of Older Adults. Befriending deliver by volunteers, promotes social inclusion and reduces loneliness.

**Investing in recovery. Making the business case for effective interventions for people with schizophrenia and psychosis.**
**Martin Knapp 1, Alison Andrew 1, David McDaid 1, Valentina Iemmi 1, Paul McCrone 2, A-La Park 1, Michael Parsonage 3, Jed Boardman 3, Geoff Shepherd 3**
**1. Personal Social Services Research Unit, London School of Economics and Political Science2. Centre for the Economics of Mental and Physical Health, Institute of Psychiatry, King's College London3. Centre for Mental Health, London**
**April 2014**

Key findings include:
In terms of supporting recovery in those with schizophrenia/psychosis there is particularly clear evidence for early intervention teams, Individual Placement Support for employment, Cognitive Behavioural Therapy and Crisis Resolution Home Treatment Teams.

It is recognised that a recovery focussed culture is required by professionals and organisations. It is noted that evidence is limited in some areas because the application of recovery principles to service design is relatively new. So for example Recovery Colleges represent promising practice for which evidence is developing. The evidence in the report is described for:
Early detection of psychosis, with evidence demonstrating that early detection saves costs in the long term
Early intervention in psychosis – there is growing evidence of effectiveness. In summary over a 10 year period £15 in costs can be avoided for every £1 invested.
Employment support using IPS – research demonstrates improved clinical outcomes and reduced hospitalisation. Some evidence that UK services need further development/awareness raising with users and professionals.
Family therapy – it is estimated that there is a 97% chance this therapy will be cost-saving – reducing relapse and the need for hospitalisation
Criminal Justice Liaison and Diversion – there is a 'slight' evidence base but these services are being trialled nationally
Physical Health interventions – there is a high probability that support for smoking and weight gain would be cost-effective

Supported Housing – evidence of reduced homelessness and reduced hospitalisation exists
CRHT – costs of services can be reduced by up to 30% using this model
Crisis Housing – there are many different models but in summary this housing can be effective and lower cost than hospital
Peer Support – the evidence base is limited and inconclusive but the economic case is promising. They can help reduce costs due to reduced admissions, with an estimated £4.76 return for £1 invested.
Self-management – there is some evidence of increased quality of life, with reduced relapse and readmission but more work is needed to evaluate cost-effectiveness
CBT- there is emerging evidence that CBT is likely to be effective and cost-effective
Anti-stigma/Discrimination- the national 'Time to Change' campaign should continue
Personal budgets – there is evidence that personal budgets generate better outcomes and are more cost-effective than standard care
Welfare advice – There is a case for investing in welfare advice with only a small reduction in the number of relapses required to generate savings.