WMCA Wellbeing Board

Date	24 October 2019
Report title	West Midlands Thrive Update
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Accountable Chief Executive	Deborah Cadman -WMCA
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Report has been considered by	Henry Kippin, Public Service Reform Director, WMCA

Recommendation(s) for action or decision:

The Wellbeing Board is recommended to:

1. To note the progress in the delivery of current priorities.

1. Purpose

1.1 This paper provides an update of progress of the key programmes of work within the Thrive West Midlands Mental Health Commission Action Plan.

2. Background

2.1 In January 2017 WMCA Mental Health Commission, led by Sir Norman Lamb and sponsored by Sarah Norman CEX Dudley Metropolitan Borough, published the Thrive Action plan. The approach was to develop a programme that would slowly start to change the dial on poor mental health in the region within the bounds of not working in health or social care devolution space.

2.2 The Action Plan brought together key partners in the region to work collaboratively and the proposal was to ensure that the approach maintained significant investment of experts in the field, time and wider resource commitment to drive the action forward. Throughout the

programme PHE, NHSE including CCGs and Local Authorities have provided strong leadership and support throughout.

2.3 The Action Plan focused on five core themes; supporting people into work and whilst at work, providing safe and stable places to live, improved mental health outcomes and the criminal justice system, developing approaches to health and care, getting the community involved.

2.4 The Wellbeing Board have been updated previously on key programmes; Thrive into work, Thrive at work, Community Sentence Treatment Requirements and Citizen Jury development. This report will seek to update on the progress of the main programmes to date and to outline a few outputs from the programmes. It will also seek to address the issue of scalability and outline the proposals currently being considered.

3. Supporting People into work and whilst at work

3.1 This work stream was set off with three main programmes. Thrive into work was commenced in 2017 having developed in conjunction with the Department of Health (DH) and Department of Work and Pensions (DWP) Work and Health Unit (WHU). A randomised control trial (RCT) was established that would seek to work with people who have poor physical and mental health issues and had been out of employment for in excess of 28 days. The model was seeking to build on evidence that had been obtained for the Individual Placement Support (IPS) programme in secondary mental health care. This model had never been tested in primary care and working with the Government departments the approach was to develop sufficient evidence to build a business case by academic evaluation for the Treasury to consider future spend. WMCA was commissioned and was granted 10.18M for the programme over four years.

3.2 The programme budget is allocated as follows: -

Year	Programme Team	Third Party	Provider Contracts	Total
2017-18	157	538	1,561	2,256
2018-19	294	494	3,093	3,881
2019-20	237	294	2,396	2,927
2020-21	131	128	857	1,116
TOTAL	819k	1,454k	7,908k	10,180k

The Programme Budget breaks down into three key funding domains:

Programme Team

Funding for the Central Programme Team based at the WMCA. This team has considerable responsibility for managing and oversight of the delivery of the Programme. This includes:

- Contract Management,
- Performance,
- Data and analytics,
- Relationship brokerage particularly with the NHS,
- Budget Management,
- Communications and Marketing
- Future Sustainability of the IPS Model driving Health and Work Strategy

Third Party Costs

Wolverhampton CCG costs in relation to, administration of NHS Contracts, administration of Health Led Trial budget, IT and HR functions

- WMCA infrastructure costs (Meeting Rooms, Finance, IT and HR)
- Independent strategy and Policy advice.

Provider Costs

- Responsible for delivery of the Health Led Trial across four CCG localities.

3.3 Programme update

3.4 It must be recognised that this is a trial and assumptions made in the development stage of the design were based on potential access to individuals within Wolverhampton, Dudley, Sandwell and West Birmingham and South Birmingham CCGs. The programme has seen significant challenges including recruitment of participants within the primary care health arena. One challenge has been the disconnect between health and DWP. Primary care do not routinely capture patients work status and although individuals currently receiving fit notes may be work connection there are many people with long term conditions who are out of work and not identifiable though the system. Information on claimants of Employee Support Allowance is available from DWP but this information is not shared with Health and as such identification of individuals in this space has been challenging.

3.5 Not withstanding this the update of individuals referral as of 20th September 2019 is 5545 individuals of which 3008 were eligible to be randomised. 1439 individuals have been placed into the treatment group with 298 currently having started work. In addition, there are 1091 individuals with vocational profiles completed who are being supported to find work.

3.6 Throughout the trial a Programme Board has been operating with quarterly reporting to the Work and Health Unit Innovation board who have scrutinised the programme budget, referrals, job outcomes and wider connectivity to health and DWP as well as ensuring fidelity of the model and academic rigour is retained. The latest dashboard (Appendix A) is attached which highlights the summary KPIs, referrals, Randomisations into the trial, job starts and industries and quality measures.

3.7 Moving forward the programme is due to finish the trial element of the programme on 31st October 2019. At this stage all referrals will stop for a short time and work with existing trail participants will continue until October 2020. It is then anticipated that the programme will start again in January 2020 and until October 2020. This will enable IPS to run without being a RCT and will seek to work with primary care networks to recruit participants. Based on the level of employee support (IPS) workers maintained to support the existing trial participants it is anticipated that approximately 800 new referrals would be received.

3.8 This approach is currently under review with the Work and Health Unit as there are potential risks around cross contamination of individuals who may be in the control group accessing treatment which would critically affect the trial. It is anticipated that a final decision will be made in mid to late October 2019 to ensure we can continue the non RCT element of the programme in January 2020.

3.9 Finally, working with the CCGs in the West Midlands work is being developed to understand if there is a potential to continue and scale the model moving forward. Within the NHS Long Term Plan, it has been highlighted that IPS should be considered as a model moving forward.

However, it should be noted that the interim report will be published in Spring 2022 with the final evaluation being completed in Autumn 2022. Proposals are being developed within the wider PSR agenda to consider options to continue this programme until the evidence review has been completed.

4. Thrive at Work Wellbeing Awards Programme

4.1 Overview of programme

4.2 Following the cessation of the Work Place Wellbeing Charter the WMCA has worked with multiple partners and experts to create a new Thrive at Work programme. This builds on the existing evidence base and creates a model for improving wellbeing in the work place.

4.3 The development broadens the focus of the wellbeing agenda to create a set of enablers within an organisation, developing a social value contract within the organisation. The programme focuses on mental health, musculoskeletal health, improving physical activity and several risk factors including poor diet, smoking and poor financial health. The Thrive at Work programme is available to view here:

Http://www.wmca.org.uk/media/2565/thrive-at-work-commitment-framework.pdf

4.4 Input - There was limited initial capital to develop the programme, so this was done with the current resources available within WMCA and partner organisations. However as the programme has continued to expand rapidly business cases have supported the recruitment of an accreditation manager and mental health commission coordinator for the programme from the mental health commission budget.

4.5 Output - In addition to the 104 businesses that are continuing the trial and programme another 220 have signed up for just the programme, with a range from 2 employees to over 22,500 employees per organisation. Business from across a range of sectors are registered including universities, hospitals, local authorities, construction, manufacturing, charities, schools etc. Nearly 135,000 employees have the potential to be positively impacted through the businesses that are signed up to the programme.

4.6 Some businesses are already close to achieving accreditation, with a significant number of others making good progress on the journey and reporting positive impacts.

4.7 Scalable plan - Funding from the Midlands Engine will support the running of the programme until March 2022, however as it expands additional sources of revenue including potential franchising of the model, sponsorship and commercialising the awards are being explored. It is anticipated that the cost of running and expanding the programme beyond March 2022 will be approximately 500k per annum.

4.8 Evaluation - Reporting will include numbers on the programme, progress and impact on employers and employees.

5. Wellbeing Premium Trial

5.1 Overview of programme - This is the trial of a model to test the tipping point at which an employer would initiate wellbeing programmes into the workforce. It seeks to work with 148 small and medium enterprises (SMEs) across the WMCA footprint and works on the premise of a RCT. The programme focuses on key enablers within the company as well as developing wellbeing across mental health, musculoskeletal and lifestyles linking it to the wider WMCA wellbeing and physical activity strategies.

5.2 Inputs - The WMCA received 1.4M in funding that was successfully bid for from the Work and Health Unit Innovation Fund with quarterly payments started in April 2018. The funding covers the costs of the programme team, grant payments to SMEs, network meetings and evaluation partners costs.

5.3 Outputs - WMCA successfully recruits above requirement of SMEs onto the trial. The recruit businesses represent a wide range of business sectors across the WMCA footprint which support generalisability and scalability of findings. There have been some drop out of businesses from the trial due to barriers facing them as an organisation, however we continue to have sufficient power and a well designed trial that serves the objective of doing the research and ill report and analyse appropriately and transparently. Currently 104 SMEs continue the trial.

5.4 Scalable plan for the future - The pilot is due to run until December 2019 with reporting to be complete by March 2020 to support wider discussion around roll out and policy change within government departments.

5.5 Evaluation - The programme is being formally evaluated by our academic partners – RAND Europe, Warwick Medical School and Warwick Business School. The evaluation will include impact, process and accreditation assessments.

5.6 A significant amount of learning about the behaviour of SMEs from both those that stay in the trial and those that drop out will be gained from the trial.

6. Providing safe and stable places to live

6.1 Developing a housing first model was a key outcome of the Thrive Action Plan. In the early stages of development, the wellbeing scrutiny board sought to gather evidence from the national stage and international settings to support the development of the business case to Ministry for Homes and Local Government (MHCLG). The focus of the work was to ensure that where mental health and /or wider health and social challenges where determinant factor in the loss of housing, that support was provided to individuals to retain their homes or in the case of rough sleepers to help stabilise them during the tenancy.

6.2 Funding was obtained through MHCLG of 9.6M with similar funds to Liverpool and Manchester to create a Housing First Programme which would be academically evaluated. Birmingham City Council is the accountable body for the funds with WMCA retaining oversight of the programme through the Homeless Task force and PSR Team. The reporting is through the PSR Board with the task force and dedicated PSR resource aligned to ensure the programme is managed and delivered effectively.

6.3 Outputs - As of 27th September 2019, 77 people have even housed through the programme. It is expected that a maximum of 617 individuals will receive support during the 3 year pilot.

6.4 Evaluation - Formal evaluation will take place through MHCLG in association with Herriot Watt University and will seek to evaluate outcomes and financial benefit and potential returns of investment. Soft evaluation is taking place regarding the fidelity of the model through several commissioned pieces within the programme and a separate review of access to and support from health and addiction partnerships through the wellbeing budget which is due to commence in October 2019 and report in early 2020.

7. Improved Mental Health Outcomes in the Criminal justice System

7.1 The Thrive Action plan focused on a few key areas to try and influence the current operating model where offenders or persons detained in the justice system who present with poor mental health have access to improved support at an early opportunity.

7.2 Building on work undertaken within the West Midlands Police, trialling the roll out of the Liaison and Diversion from custody where mental health nurses worked in custody to support diversionary options and the multi disciplinary Street Triage Team who supported individuals in crisis in the street and in their homes a decision was made to maintain the focus on improving the system.

7.3 Community Sentence Treatment Requirements

7.4 A key opportunity was the introduction of a pilot to test Mental health treatment Requirements (MHTRS).

7.5 Many offenders experience mental health and substance misuse problems, but the use of treatment requirements as part of a community sentence remains low and has been declining over recent years. Improved partnership working can increase the use of treatment requirements, particularly as an alternative to short term prison sentences and so reduce the number of vulnerable people in custody. There are three types of treatment requirement:

- Mental Health Treatment Requirement (MHTR);
- Drug Rehabilitation Requirement (DRR – which includes drug testing);
- Alcohol Treatment Requirement (ATR)

7.6 All three treatment requirements were introduced as a sentencing option in the Criminal Justice Act in 2003. 'Treatment' covers a broad range of interventions (for example talking therapies, a course of medication or inpatient treatment). As members of the general population, offenders in the community should access treatment in the same way as anyone else via mental health services, commissioned by NHS Clinical Commissioning Groups (CCGs) and drug and alcohol treatment services commissioned via Local Authorities. However, due to the multiple complexities of health and social needs affecting this cohort, there are few services in the community that are providing appropriate holistic treatment and care to support these Service users and requirements. ATRs/DRR are provided through substance misuse services commissioned by the Local Authority.

7.7 MHTRs can be split into those provided by:

7.7.1 Secondary care mental health services: When an individual's mental health condition reaches the threshold of secondary care services. This provision should already be provided through locally commissioned frameworks for secondary care.

7.7.2 Primary care services: The majority of MHTRs don't reach the threshold of secondary care service. The testbed sites have demonstrated that the addition of clinically supervised mental health practitioners providing assessment in court and 1:1 short, individualised psychological interventions has been required to deliver primary care MHTRs. This is a commissioning gap in non CSTR site areas.

7.8 MHTRs: In 2017, out of all the requirements commenced under community orders or suspended sentence orders:

- Less than 1% (538) were MHTRs;
- 5% (8,719) were DRRs;

- 3% (5,419) were an ATRs.
- In addition, uptake has been decreasing consistently since 2008/09. Between 2016 and 2017
- MHTRs decreased by 20% and by 51% between 2009 and 2017;
- DRRs decreased by 10% and by 46% between 2009 and 2017;
- ATRs decreased by 11% and by 41% between 2009 and 2017.

7.9 This is in the context of a decrease in the volume of offenders starting community orders and suspended sentence orders by 6% between 2016 and 2017, and 29% between 2009 and 2017.

7.10 Inputs - In 2018 Five Test Bed Sites where created including Birmingham with a mix of funding from NHS England 100k and 60K from the Police and Crime Commissioner. This enable a programme to be commissioned into court from a primary care provider linked to the Liaison and Diversion from Custody Team.

7.11 Outputs - Figures in year one where low with only 27 orders being applied. This was due to host of complexities through the court process including initially trialling overnight remand offenders as the source of referral but over time recognised that 60% of these offenders would not plead guilty on first remand hearing. Further testing took place in the guilty anticipated plea court but again trying to balance assessment and the demands on the judicial speedy justice process meant that many offenders who may have been eligible but would require a short adjournment until the afternoon court where sentenced without orders being granted.

7.12 Year one outcomes across the five testbed sites have been published, which demonstrates that by strengthening partnerships, processes and governance pathways the increased use of treatment requirements is achievable. The evaluation also provides feedback from testbed site workforce and Services Users, who collectively agree that increased use of CSTRs would be beneficial in addressing some of the underlying causes of the offending behaviours, reduce short term sentences and enable rehabilitation within the community.

7.13 A published study by the MoJ has provided the first evidence to show that including an MHTR or ATR into a community order or suspended sentence order can have a positive impact on reducing reoffending.

7.14 The study found that for those with identified mental health issues, mental health treatment requirements (MHTRs) attached to community orders or suspended sentence orders were associated with significant reductions in reoffending where they were used, compared with similar cases where they were not. Over a one-year follow-up period, there was a reduction of around 3.5 percentage points in the incidence of reoffending where such requirements were used as part of a community order, and of around 5 percentage points when used as part of a suspended sentence order. In the case of ATRs, for those with identified alcohol misuse issues, ATRs were associated with similar or slightly lower reoffending where they were used compared with similar cases where they were not.

7.15 The Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012 made changes to the administration of the MHTR by amending provisions linked to the Criminal Justice Act 2003 and the Mental Health Act 1983:

“The LASPO Act sought to make it easier for courts to use the MHTR as part of a Community Order or Suspended Sentence Order by simplifying the assessment process and ensuring that those who require community-based treatment receive it as early as possible. The Act removed the requirement that evidence of an offender’s need for mental health treatment is given to a court by a Section 12 registered medical practitioner”

7.16 This change means that the Courts may seek views and assessments from a broader range of appropriately trained mental health professionals. The intention was to ensure that Courts receive appropriate advice based on mental health assessments quicker, thus reducing the avoidable time delay leading to adjournments and unnecessary psychiatric court report costs of using the MHTR as part of a community sentence.

7.17 Barriers: A few barriers have been identified by the testbeds which may contribute to the low uptake of the three treatment requirements. Some of these are also identified in a paper published by the Centre for Mental Health and the full year one CSTR evaluation. Some barriers to developing CSTR provision include:

- Uncertainty as to who should receive community sentence treatment requirements
- MHTR: the criteria hasn’t been made clear as to who may be suitable, especially for those with lower level mental health and complex social needs
- Uncertainty over who has responsibility for commissioning services for offenders in the community
- Uncertainty around drug testing as part of the DRR
- Lack of availability and access to community services that can provide appropriate MHTRs for offenders with multiple complexities including dual diagnosis
- Low awareness and confidence among both criminal justice and health professionals around mental health/substance misuse and associated vulnerabilities in court.

7.18 Scalability -_Recognising the challenges posed, wave one pilot in Birmingham has broaden to include Solihull individuals too. Funding has been secured from NHS England for the next year (100k) plus a small amount of funding from the WMCA (20k).

7.19 Wave 2 is one being developed across the Black Country with an early funding discussion being had with CCGS and the Police and Crime Commissioner. Funding has been agreed from the PCC (100k) to enable this service to run for one year. This will seek to develop the programme in the Black Country in early to Spring 2020.

7.20 It is anticipated that wider discussion with the MOJ and NHS England (Offender Health) will take place later this year for a broader national roll out of the broader CSTR approach in England. A commitment to the programme is outlined in the NHS Long Term Plan.

7.21 Police detention

7.22 Two key outcomes where described within the Thrive Action Plan that related to the police use of cells for individuals detained under s136 Mental Health Act 1983. The force were proud of its position in significantly reducing the number of the people detained contrary to the national position.

7.23 This element has been introduced as business as usual no into mainstream police business with oversight through the Police and Crime Board.

7.24 For information to support this report the figures for 2018/2019 have been received from the Force. There are six section 136's for this year which state "police station" as the First Place of Safety:

- 2 – as a result of being refused detention after being arrested for substantive offences so it was recorded at the first POS as they were detained under s136 in the car park of the custody suite before transferred to the health-based place of safety.

- 2 – Where the patient was taken by officers to the police front office to await ambulance transport to the health-based place of safety.

- 2 – are recorded on the system but where the details of detention cannot be verified as to why this occurred

7.25 There have been no further use of the custody suite in West Midlands Police as a place of safety where the assessment is to take place and there have been no under 18's taken into the custody suite under s136 Mental Health Act 1983.

7.26 It should be recognised that this is still a challenging area with wider work being undertaken by partners to develop a stronger approach to ensure that police custody is not the right place for most persons suffering a mental health crisis. A formal stakeholder engagement event took place on 30th September 2019 with West Midlands Police and the regional health partners to ensure the spotlight remain on this area.

8. Developing Approaches to Health and Care

8.1 The Thrive Action Plan sought to address a number of key areas in this arena, but two areas remain a key focus of activity.

8.2 Zero Suicide Ambition - The Thrive Action Plan encouraged the region to support a zero suicide ambition where Local Authority Areas would work in partnership with WMCA and PHE to create local Suicide Reduction Plans. Each area across the West Midlands have now completed these and there is a regional group that oversees the implementation and opportunities to learn lessons and share best practice.

8.3 In the West Midlands region in 2018, 514 people are recorded by coroners as having died by suicide, representing a 2.8% increase on 2017 suicide registrations. Within the West Midlands Combined Authority, recorded deaths were down 3% on 2017 figures, with 231 people reported to have died by suicide.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	15-16	17-18
								Rate /100,000			
B'ham	64	54	57	77	138	61	70	74	74	7.6	8.1
Coventry	27	35	27	28	28	27	13	36	29	8.8	8.6
Dudley	29	21	11	20	31	30	17	30	33	9.4	9.7
Sandwell	22	25	17	25	28	29	31	26	30	10.4	10.6
Solihull	10	12	9	7	29	14	12	26	30	9.5	12.2
Walsall	14	12	19	19	28	25	19	21	19	9.1	8.2
W'ton	13	24	19	20	25	21	20	25	15	9.9	9.0
WMCA	179	183	159	196	307	207	182	238	231	*	*
WM region	450	433	453	477	571	477	446	500	514	9.5	9.7
England	rate									9.2	9.8

8.4 Within the Combined Authority, most constituent authorities have seen a small reduction in deaths by suicide during 2018, except for Solihull and Sandwell, which reported small respective rises and Birmingham where the number of suicides is the same as in 2017.

8.5 The overall three-year rolling average rate of suicide in the West Midlands region has risen to 9.7 cases per 100,000 population, roughly in line with the national average suicide rate. Within the Combined Authority, both Solihull and Sandwell appear to report rates above the national rate, but for both areas the difference is not statistically significant.

8.6 It should be noted that during 2018, the criminal standard of proof required to conclude a suicide has occurred changed to civil standard. The implications of this change are that we might expect an artefactual rise in the number of suicide conclusions during 2018. As such, any non-significant upward trends should be treated with caution.

8.7 Improving Perinatal Mental Health - Creating the best start in life was a key thought within the Action Plan. Working with NHS England the plan sought to shine a light on perinatal Mental Health and support the excellent work led by Dr Giles Beresford. NHS England have established a business as usual approach to this are of business by developing a formal network.

8.8 NHS England has committed to fulfilling the ambition in the Five Year Forward View for Mental Health, so that by 2020/21 there will be increased access to specialist perinatal mental health support in all areas of England, allowing nationally at least an additional 30,000 women each year to receive evidence-based treatment, closer to home, when they need it.

8.9 A phased, five-year transformation programme, backed by £365m in funding, is underway to build capacity and capability in specialist perinatal mental health services, focused on improving access to and experience of care, early diagnosis and intervention, and greater transparency and openness. Funding is a mixture of local funding (including through CCG baselines and targeted transformation monies for allocation) and national investment (including commissioning of Mother and Baby Units through specialised commissioning, workforce development and regional perinatal MH networks) with an increase each year, reaching £140m nationally in 2020/21 as outlined in the Implementation Plan.

8.10 Within the West Midlands a service is now in place within each STP since 1st April 2019. Nationally all services are working towards seeing: 4.5% of their local birth rate in 2019/20, 6.4% of their local birth rate in 2020/21

STP/Service Footprint	**Funding received in year 2018/19**	**Service in place since 1st April 2019**
Birmingham and Solihull	Expansion of Wave 1 service across footprint (previous funding for expansion of locally funded service)	Yes
Black Country	Formulation of new service	Yes

Coventry and Warwickshire	Formation of a new service/expansion of small locally funded service	Yes

8.11 To support the local development of new services and this work within the West Midlands, in 2016 NHS England through the West Midlands Clinical Network established the West Midlands Perinatal Mental Health Network. Over the last three years this network has continued to grow and provide support across the area. This has included regular network meetings and opportunities for sharing learning and good practice.

8.12 The Clinical Network has also delivered a programme of training, funded by NHS England and Health Education England, to support the development of these services and enable women to receive evidence-based treatment, closer to home, when they need it.

9.0 Getting the Community Involved

9.1 At the heart of the Thrive Action Plan was a commitment to engage the public and create heightened levels of mental health literacy in the region as well as developing programmes to tackle stigma.

9.2 Mental Health First Aid England - Mental Health First Aid (MHFA) England is a training and campaigning organisation. They offer a range of evidence-based training courses from awareness to skill development. WMCA and MHFA England are working in partnership to increase mental health literacy in the region. The overall target is to train 500,000 people in mental health awareness and skills by 2026 (Thrive Action Plan, 2016), with 200,000 of these being trained with MHFA England courses.

9.3 In line with the development of the Lord Stevenson and Paul Farmer review (2017) there has been a significant shift in the push to improve work place mental health. Challenging the assumption that the Health and Safety at Work Act 1974 a movement is growing to ensure that Mental Health First Aid trained staff are included in the work force at a similar level to physical First Aiders. Equally there is an anticipatory duty under the Equality Act 2010 which puts a responsibility on businesses and employers to provide accessible support as they would do for all other protected characteristics.

9.4 Input - MHFA England fund a Regional Development Coordinator for 3 days a week to work in the region, based at the WMCA head office. WMCA provide office space, IT equipment and most valuably the local contacts and opportunity for partnership working across the West Midlands.

9.5 Output - In total 42 000 people have been trained by MHFA England in the region. There has been a significant increase in people being trained year on year. In 2017 at the launch of the Thrive Action Plan there were 4,896 people trained, in 2018 there were 10,878 people and this year to 31 August there have been 13,223 people trained.

9.6 Within this total there is also a campaign led by WMCA and MHFA England to train 5,000 people from the sport and recreation sector by the start of the Birmingham Commonwealth Games 2022. As part of MHFA England's commitment to give back part of their profit to the community they have fully funded 6 courses with more to follow in the coming months for people working with young people in sport and recreation organisations.

9.7 Scalable Plan - The appointment of a Regional Development Coordinator by MHFA England was for 2 years from April 2018. An extension to this partnership is in discussion to allow for the concentrated work on the mental health literacy target in the Thrive Action Plan and to continue with and further increase the amount of people being trained in the West Midlands.

9.8 In addition, Work Programme 8 of the Midlands Engine Mental Health Productivity Programme includes mental health literacy and training targets and so it is planned to extend the effective work done in the West Midlands to the whole of the Midlands this will include a further 45,000 work place staff being trained in the wider region.

9.9 Evaluation of Mental Health First Aid training courses can be found at:
https://mhfaengland.org/mhfa-centre/research-and-evaluation/

9.10 This is Me - This is me is a workplace mental health campaign created by Barclays 2013 and adopted by the Lord Mayor's Appeal which seeks to change attitudes around mental health and create more inclusive workplaces though:

- Storytelling; encouraging employees to share their experiences of mental health challenges to help normalise the conversation around mental health
- Green Ribbon campaign: encouraging staff to wear the Lord Mayor's Appeal Green Ribbon as a way of raising awareness of mental health.
- Samaritans E-learning: an interactive training tool which teaches employees the skills to look after their emotional health and look out for others, before they reach crisis point.

9.11 Input and staffing - This is Me West Midlands has one member of staff working part time on this project and has a budget of 10K from WMCA the budget (current in year spend total of £360.50) to go towards programme literature, events to raise awareness of This is Me and maintaining engagement with registered organisations of campaign across the West Midlands.

9.12 Outputs - With the launch of This is Me in the West Midlands in January 2019, there was an aim to get 120 organisations signed up by January 2020. So far, 99 organisations have signed up to date.

9.13 Evaluation – the evaluation of This is Me is completed by the Lord Mayor's Appeal who own This is Me nationally and conduct an annual survey to capture engagement and perceived impact of the campaign in organisations who are registered. The 2019 survey is currently live, and findings and impacts will be shared later this year.

9.14 Scalable plan for the future - With the Midlands Engine Mental Health and Productivity Pilot, This is Me West Midlands is being scaled up to be launched in the East Midlands with a target of 400 organisations to be signed up to This is Me in the Midlands by July 2022. To reach target, 33 organisations are to be signed up to This is Me every quarter over the next three years. To raise awareness of This is Me, showcase events will be provided to small, medium and large enterprises across the Midlands along with other programmes including Thrive at Work, Every Mind Matters, Mental Health first Aid and Time to Change.

10 Conclusion

10.1 This report has sought to give an overview of the current work streams within the Thrive Action Plan and a view of the current inputs, outputs and options for scalability.

10.2 The programme team employed by the WMCA is small with only 6 FTE posts and a budget of 110K for non-staff discretionary spend to seek support and design for future programmes. It has however been successful in generating significant commissioned work and additional staff either seconded or supporting through various models due to the high level of support from regional partners connected with the programme.

10.3 The programmes although challenging for a variety of different reasons have started to show a positive shift in the way mental health is viewed in the region. It is however recognised that there is still significance work to do and the team value the continued support from the Wellbeing Scrutiny Committee, Wellbeing Board and wider partnerships established throughout the last three years.

11.0 Financial Implications

11.1 Funding for the delivery of the programmes is a mixture of Grant funded programmes and funding within the WMCA. The funding is outlined within the body of the report. Further scalability will require additional funding sources from outside the WMCA funding envelope.

12. Legal Implications

12.1 WMCA legal team have advised upon all the current relevant work strands. Any additional strands of work including any new programmes or extensions will seek appropriate authority.

13. Equalities Implications

13.1 An equality forum (Citizen Jury) was established as part of the Mental Health Commission which sought to identify the underpinning inequality presenting through the project strands. This approach is developing into a wider Independent Advisory Group which will seek to support programmes of work and the wider system to tackle stigma and discrimination.

14. Inclusive Growth Implications

14.1 Data and intelligence has driven the development of targeted inclusivity and geographical areas to reduce levels of inactivity and inequalities in those who take part.

15. Geographical Area of Report's Implications

15.1 Delivery is either West Midlands or in targeted locations as a trial or where evidence suggests impact could be greatest.

16. Other Implications

None

17. Schedule of Background Papers