Health Scrutiny Panel

12 March 2015

Time 2.00 pm **Public Meeting?** YES **Type of meeting** Scrutiny

Venue Committee Room 3 - Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Membership

Chair Cllr Claire Darke (Lab)
Vice-chair Cllr Zahid Shah (Con)

Labour	Conservative	Liberal Democrat
Cllr Greg Brackenridge	Cllr Mark Evans	
Cllr Jasbir Jaspal		
Cllr Milkinderpal Jaspal		
Cllr Peter O'Neill		
Cllr Bert Turner		
Cllr Daniel Warren		

Quorum for this meeting is two Councillors.

Information for the Public

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**

2 **Declarations of Interest**

3 **Minutes of the previous meeting (15 January 2015)** (Pages 3 - 6)
[To approve the minutes of the meeting as a correct record.]

4 **Matters arising**
[To consider any matters arising from the minutes.]

5 **Mental Health Commissioning Strategy** (Pages 7 - 70)
[To note the development and implementation of the Mental Health Strategy 2014-2016.]

6 **Decommissioning and Disinvestment Policy** (Pages 71 - 100)
[To note the report and offer comments.]

7 **Musculoskeletal (MSK) Services Consultation** (Pages 101 - 112)
[To note the musculoskeletal (MSK) commissioning and consultation plans and comment on the proposed changes.]

Health Scrutiny Panel

Minutes - 15 January 2015

Attendance

Members of the Health Scrutiny Panel

Cllr Claire Darke (Chair)
Cllr Zahid Shah (Vice-Chair)
Cllr Greg Brackenridge
Cllr Mark Evans
Jean Hancox
David Hellyar
Cllr Jasbir Jaspal
Cllr Milkinderpal Jaspal
Cllr Peter O'Neill
Ralph Oakley
Cllr Daniel Warren

Employees

Viv Griffin	Service Director - Disability and Mental Health
Adam Hadley	Scrutiny and Transparency Manager
Ros Jervis	Service Director - Well Being
Jonathan Pearce	Graduate Management Trainee

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
An apology was received from Councillor Turner.

2 **Declarations of Interest**
There were no declarations of interest received for this meeting.

3 **Minutes of the previous meeting (11 December 2014)**
Resolved:
That the minutes of the meeting held on 11 December 2014 be approved as a correct record and signed by the Chair.

4 **Matters arising**
Councillors raised an issue about the Mental Health Commissioning Strategy report that was due to be presented to the Panel in December 2014. A reference had been made to this report in a different report to Children and Young People Scrutiny Panel. Helen Hibbs, Chief Officer at Wolverhampton CCG, confirmed that the report will come to the Panel and that the matter is being pursued.

5 **The Francis update report of The Royal Wolverhampton NHS Trust (RWT)**

Lynne Fieldhouse, Deputy Chief Nurse, introduced the Trust's report by providing an overview of the recommendations of the Francis Report that the Trust had to implement. She explained that many of the Francis Report recommendations have now become national standards, and are now part of the Trust's core business. She added that approximately 70% of recommendations have been closed, with work being undertaken currently to conclude the remaining 30%. Councillors questioned the timescales for the implementation of the outstanding recommendations. The Deputy Chief Nurse expressed confidence that the outstanding areas within the Trust's control will be completed by the Trust Board meeting in March. A detailed overview of how the Trust has responded to these recommendations will be published on the Trust's website as part of the public agenda for this meeting.

Councillors sought information about recommendations relating to complaints handling and the implementation of subsequent changes. They were assured that this has been addressed by introducing a new NHS complaints framework with support from the CQC. This allows patients to make their complaint through a variety of mediums without being hindered by age, first language or proficiency with technology.

HealthWatch members requested specific information about how patients are being put first by the Trust. The Deputy Chief Nurse gave a number of examples of how this was happening:

- publishing a comprehensive action plan
- including a HealthWatch member on the Trust Board
- providing monthly updates to NHS England
- publishing a safer staffing and nursing report online
- publishing Trust policies on the website

Councillors also requested information about concerns raised by constituents with regard to nursing numbers and quality. It was explained the Trust has a 70:30 ratio of registered nurses to healthcare assistants in hospitals. Reassurance was also given that the numbers of staff on wards was more than sufficient, with £1.5 million being invested into the Trust to help provide more night working staff. Supervisory status of band seven sisters has also been rolled out across the Trust, meaning that these employees are able to oversee and manage their wards rather than being involved in more menial tasks. This was a key recommendation in the Francis report.

Further reassurance was given to the Panel about nursing standards for nurses who have been recruited form outside the UK. A large range of measures have been installed to ensure the quality of these nurses as has been discussed at a previous Health Scrutiny Panel meeting (20 November 2014).

The Deputy Chief Nurse explained that the Trust is doing its utmost to respond to duty of candour responsibilities (not aiming to win litigation at all costs but serve the court with accurate findings and the correct result). Therefore it must be more transparent with patients about risks and errors.

Councillors scrutinised the evidence for working practice changes, questioning how improvements have been monitored. The Trust has created a framework to escalate

patients' treatment where necessary; to report concerns in a standardised manner; and to monitor data. This framework is widespread across the Trust and its importance is reiterated to staff frequently.

Councillors also enquired as to how the Trust had adapted to an increase in size especially in the light of Cannock Hospital now being part of the Trust. The Trust has amalgamated successful policies from all the hospitals it has involvement with to ensure quality services are delivered. The Deputy Chief Nurse added that whistle blowing policies were in place across all hospitals.

6 **Black Country Partnership Foundation Trust Response to the Francis Enquiry**

Joyce Fletcher, Deputy Director of Nursing, introduced the BCPFT response to the Francis Enquiry by giving reassurances that the BCPFT Board closely monitors developments on its sites. She added that the Trust has built in a national framework for nursing to develop a strategy ensuring effective and compassionate care. In particular, the Trust aims to monitor patient dignity and has created Dignity Champions who advocate for patients and highlight areas for ward improvement. These champions are also complimented by student nurse 'Care Makers' who are involved in supporting wards where appropriate.

The Deputy Director of Nursing gave an overview of some of the measures implemented by the BCPFT in response to the Francis report:

- A monthly quality and safety reporting mechanism, which gives staff greater ownership of challenges regarding quality of care. Specifically this involves managing complaints more effectively by sharing them with committees and commissioners.

- A weekly incidents report across the organisation to share best practice across sectors.

- A weekly bulletin of lessons learnt which is shared across the Trust quarterly.

- An alignment project with Royal College of Nursing and agency staff to make improvements to the Trust's working culture.

- Director walkabouts - which Councillors clarified are prearranged.

- Unannounced visits from CQC and other groups. Councillors stressed the importance of such visits in providing an accurate impression of a hospital.

- The use of the 15 step challenge which gives ward managers an immediate impression of the quality of a ward and has been used to immediately address and unblock issues.

- Time out days for registered and non-register staff to provide feedback about wards.

- An effort to meet duty of candour requirements. The Panel questioned what evidence there was to prove this. Continued scrutiny and feedback from ward users will provide this proof.

Councillors asked for clarification about protecting meal times. The Deputy Chief Nurse explained this is a period when patients can eat meals with carers without the presence of clinicians. It exemplifies the Trust's efforts to be more people centred by trying to accommodate service users' lifestyle patterns. Assurance was then sought by the Panel about the Trust's confidence in the measures they have implemented. It was explained the BCPFT Board focuses on quality and that all business decisions are followed up by a quality impact assessment. Councillors queried how resources, particularly staff, are constrained by financial pressures. It was clarified that all organisations have introduced safe staffing measures, which they must monitor and report on publicly. It is the BCPFT Board's role to ensure this regardless of financial challenges.

7 **The Francis update report - CCG**

Helen Hibbs, Chief Officer, presented the CCG's action plan report. She explained the specific recommendations for commissioners related to:

- monitoring and holding to account commissioned services
- using independent audits on services commissioned
- being accountable as an organisation
- having powers of intervention and an overview of services

Commissioners set service quality standards by writing performance indicators and then monitoring them through a variety of means, such as:

- CCG and CQC review meetings
- complaints to the CCG
- listening to GPs and the public via Quality Matters (an electronic service that gathers information and spots trends)
- planned quality visits and unplanned night time
- quality monitoring with care homes
- quality surveillance groups where commissioners can share information

Councillors enquired about how the transfer of services between Cannock and New Cross has affected the CCG. The Chief Officer explained it is monitoring developments to assess where services are best located. In response, Councillors questioned the CCG's relationship with the Acute Trust. The Chief Officer assured members that there was a good working relationship; however, further work was being done to improve communication and transparency between the two.

Agenda Item No: **5**

Health Scrutiny Panel

12 March 2015

Report title	Wolverhampton City Council and NHS Wolverhampton Clinical Commissioning Group Mental Health Strategy 2014-2016
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Well-Being
Wards affected	All
Accountable director	Noreen Dowd, Interim Director, Strategy and Solutions, NHS Wolverhampton Clinical Commissioning Group.
Originating service	Commissioning – Wolverhampton CCG
Accountable employee(s)	Sarah Fellows — Mental Health Commissioning Manager Tel — 01902 42573 Email — sarahfellows2@nhs.net
Report to be/has been considered by	N/A

Recommendation(s) for noting:

The Panel is recommended to:

1. Note the development and implementation of the Wolverhampton City Council and NHS Wolverhampton Clinical Commissioning Group Mental Health Strategy 2014-2016, and Wolverhampton Crisis Concordat - including amendments made to address the needs and requirements of key vulnerable groups and the Children and Young People's Task Force CAMHS Tier 3 / 4 Project Pilot.

1.0 Purpose

1.1 The purpose of this report is to provide the Health Scrutiny Panel with an overview of Wolverhampton City Council and NHS Wolverhampton Clinical Commissioning Group Mental Health Strategy 2014-2016 and associated key next steps. This includes amendments made to address the needs and requirements of key vulnerable groups and the development of Better Care Fund Care Pathways, the submission(s) of the Wolverhampton Crisis Concordat Declaration and action plan, and recent amendments to the strategy to address the specific needs and requirements of key vulnerable groups.

2.0 Background

2.1 The NHS Wolverhampton Clinical Commissioning Group and Wolverhampton City Council Adult Mental Health Commissioning Strategy, which covers the period 2014 – 2016 is attached as appendix 1.

2.2 Development of the Mental Health Strategy responds to the recommendations of the Mental Health Strategy review, and key national and local drivers, including the CCG's Operational and Strategic Plans, the Wolverhampton City Council and Wolverhampton Clinical Commissioning Group Emotional and Psychological Health and Well-Being Strategy for Children and Young People (2013-2016), the Suicide Prevention Strategy for England (2013) and Closing the Gap (2013), the National Crisis Concordat (2014), and our health and social care economy's Better Care Fund plans.

2.3 Following discussion at Health and Wellbeing Board on 7 January 2015, the Strategy has been amended to specify how our health and social care economy will work with all stakeholders to address the needs of vulnerable groups and difficulties that arise from the wider determinants of mental ill-health.

3.0 Progress

3.1 A number of key priorities are outlined in the Mental Health Strategy. The priorities are aligned with the revised stepped care model and are outlined as follows:

- Steps 0-5 - Develop an all age approach across the whole service model that incorporates the needs of people under 18 years of age and over 65 years of age.
- Step 0 – Develop a local Resilience Plan (mental health promotion, early intervention and prevention) and include within in this actions regarding the assessment and mapping and scoping of people with key vulnerabilities, actions required to address the broader determinants of mental ill-health and, improved information, marketing and communication to support parity of esteem and end stigma.
- Step 1 Develop a local Suicide Prevention Strategy.
- Step 1 – Develop primary care pathways.

- Step 2 – Review commissioning model of Integrated Access to Psychological Therapies (IAPT).
- Step 3 – Commission the Young Person's Service for young people aged up to 25 years of age.
- Step 3 – Review the commissioning model of the Community Wellbeing Service.
- Step 3 – Commission an integrated urgent mental health care pathway.
- Step 4 – Review the commissioning model of the complex care service.
- Step 4 – Commission and implement an integrated re-ablement and recovery care pathway.
- Step 4 – Review the commissioning model of local specialist care pathways.
- Step 5 – Review the commissioning model of Female PIC and out of area admissions for urgent and planned mental health care.
- Step 5 - Review the commissioning model of Pond Lane and other Learning Disability In-patient Services.

3.2 The strategy outlines the vision to develop integrated health and social care pathways as part of the Better Care Fund. The mental health Better Care Fund care pathways that are in development include urgent and planned mental health care.

3.3 A key national driver regarding the strategy development and implementation, and the development of the urgent mental health care pathway, is delivery of the local Crisis Concordat declaration and action plan. This supports national and local initiatives to prevent people with mental health difficulties developing, or entering crisis, and moving to recovery in a timely manner if this cannot be avoided. The Wolverhampton Crisis Concordat has been submitted to the national programme website. A copy of the declaration is attached as appendix 2. A Wolverhampton Crisis Concordat action plan is in development with local key stakeholders and partners. This must be submitted to the national programme by end March 2015. This is aligned with the outline Wolverhampton Resilience Plan, which is included within the document attached as appendix 1.

3.4 As outlined in appendix 1 the Wolverhampton 2011 census outlines the following points:

- Wolverhampton city's resident population is 248,470.
- The average age in Wolverhampton is 39 years.
- Wolverhampton has a slightly higher proportion of children aged under 16.
- In terms of ethnicity, 68% of Wolverhampton's residents are from a white ethnic background, with the remaining 32% of residents belonging to black minority ethnic backgrounds (BME).
- Wolverhampton has high numbers of new arrivals arriving into the city each year including traveller families (estimated 2700 families in 2012).

- In terms of levels of deprivation in the city, Wolverhampton is the 21st most deprived Local Authority in the country, with 51.1% of its population falling amongst the most deprived 20% nationally.
- Deprivation is disproportionate across the city, with the more affluent wards in the west of the city.

3.5 As outlined in appendix 1, several sources of evidence suggest that a number of in-equalities and demographic factors can have a significant effect on the local need and uptake of mental health services. This information has been validated by local data capture which includes the experiences of the city's stakeholders including service users and carers and providers. As highlighted in appendix 1 key vulnerabilities include matters arising as a result of:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism
- Lesbian, gay, bisexual and transgender people (LGBT) and / or children and young people who are questioning their sexual orientation and / or gender (LGBTQ)
- Substance misuse
- Victims of violence, abuse and crime including domestic violence and bullying
- Victims of sexual abuse, violence and exploitation
- Victims of school, higher education and work place bullying

3.6 On 7 January 2015 the Health and Wellbeing Board members requested that the Mental Health Strategy be amended to specifically outline how the needs and requirements of key groups will be addressed moving forward. The strategy has been amended to include within the document the outline Resilience Plan and to propose how a community development work model will deliver the associated required actions.

3.7 As outlined in appendix 1 the necessary actions and interventions that are needed to deliver the Wolverhampton Mental Health Resilience Plan across the Stepped Care Model will require developing community development work approach which has previously focussed in Wolverhampton on initiatives such as those outlined in: '*Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett' (HM Govt. 2005)*.

3.8 The key building blocks of the CCG's refreshed approach will include:

- **More appropriate and responsive services –** achieved by improving services and upskilling the workforce across the stepped care model to better respond to the needs of key groups. This will enable all members of the population to access all of our services equally. It will also be achieved by working with all key stakeholders to that ensure that there is a joined up approach to challenging and addressing the broader determinants of mental ill-health, stigma and discrimination, whilst simultaneously promoting parity of esteem, compassion, equality and respect diversity and human rights.
- **Wider community engagement –** achieved by extending stakeholder engagement to capture agencies, voluntary groups and organisations that can have a strategic and day to day influence on the wider determinants of mental health. This will be assisted by embedding agreed key deliverables into the Resilience Plan and Implementation Plan supported by our Community Development Workers.
  Better information, communication and marketing - achieved by improved data collation, capture and analysis of the city's vulnerable groups; mapping their needs and requirements; and monitoring agreed actions via the implementation plan. This will include a regular census of mental health patients and public mental health needs across the city and delivery of a pro-active marketing campaign aligned to parity of esteem and national campaigns such as Beat Bullying, Time to Change, Health Poverty Action, and Child Sexual Exploitation of the NSPCC.

3.9 Negotiations and discussions with Sandwell and West Birmingham CCG regarding an aligned health model and jointly developed service specifications continue. To date this has focussed on potentially joint / aligned models in terms of:

- Eating Disorder Services / Care Pathways
- Neurological Conditions Care Pathways
- Early Intervention in Psychosis Services
- Children and Young People's Services

3.10 The national programme to transform the outcomes and experience for service users and carers in receipt of CAMHS is being delivered by the NHS England Children and Young People's Task Force based within the Department of Health. Wolverhampton CCG is one of eight areas across the country that has been awarded a project grant to scope the potential to re-design and/or improve current CAMHS commissioning models, following an invitation to submit EOIs. The Wolverhampton project will focus on CAMHS Tier Four and Tier Three commissioning model(s) and this will include a focus on tri-partite funded placements for children and young people that are 'out of area'. NHS Wolverhampton CCG is the lead agency on behalf of all of the four CCGs across the Black Country. Details of the eight successful EOIs, including the Wolverhampton submission, are included as appendix 3.

3.11 Next Steps are proposed as follows:

- Continued work to develop Mental Health Urgent and Planned Care Better Care Fund Care Pathways.
- Development of Mental Health Strategy Implementation Plan with aligned timelines to Better Care Fund as above, with agreed timelines for implementation of revised service models and care pathways.
- Continued stakeholder engagement to develop and submit Wolverhampton Crisis Concordat action plan to the national programme by the end of March 2015.
- Stakeholder event supported by Health and Wellbeing Board members to develop key actions and associated timelines within the outline Resilience Plan. This can be embedded into the Strategy Implementation Plan and aligned with the Crisis Concordat declaration and action plan and other key initiatives, especially including HeadStart Wolverhampton.
- Review of the current integrated commissioning Community Development Work to scope how the bullet points identified in 3.5 will be developed within the existing model, including a gap analysis of the current programme of community development work.
- Scoping; following delivery of the above actions to explore the QIPP opportunities that could be delivered across mental health and the wider health, social care and criminal justice system on delivery of the Resilience Plan.
- Alignment of the above initiatives with mental health KPIs and dashboards to support monitoring and performance management of key outputs and collation, measurement and aggregation of benefits across the 'whole system'.
  Delivery of Children and Young People's Task Force CAMHS TIER Three/Four Black Country pilot project.

4.0 Financial implications

4.1 The strategy outline financial plan utilises some non-recurrent funds to implement prime service model changes and transformation during the transition to the new service(s). Starter schemes under the Better Care Fund include Liaison Psychiatry Service, Street Triage and the Hospital Discharge Service. Other non-recurrent funds have been used to increase capacity and capability to develop the CAMHS Crisis and Home Treatment service elements, and to increase capacity within Early Intervention in Psychosis Services. Public Health Transformation Funds have been utilised to commission an alternative day service model. However non-withstanding, non-recurrent funds identified above the Mental Health Strategy will be delivered within the current financial envelope which includes cost efficiency requirements and current - and any future - QIPP plans and opportunities.

5.0 Legal implications

5.1 There are currently no outstanding legal implications that should be highlighted in relation to this report.

6.0 Equalities implications

6.1 Section 149 of the Equality Act 2010 outlines the Public Sector Equality Duty to engage with relevant individuals regarding key decisions. A period of consultation will be required regarding any proposed changes to mental health services locally, with a requirement to take the revised strategy to Health Scrutiny Panel.

7.0 Environmental implications

7.1 There are currently no outstanding environmental implications that should be highlighted in relation to this report.

8.0 Human resources implications

8.1 There are currently no outstanding environmental implications that should be highlighted in relation to this report.

9.0 Corporate landlord implications

9.1 There are currently no corporate landlord implications that should be highlighted in relation to this report.

10.0 Schedule of background papers

10.1 The amended Mental Health Strategy is attached as appendix 1. The Wolverhampton Crisis Concordat declaration is attached as appendix 2. Details regarding the Children and Young People's Task Force successful project pilots are submitted as appendix 3.

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Wolverhampton City Council

Community
Health, Well Being and Disability

NHS
WOLVERHAMPTON
Clinical Commissioning Group

MENTAL HEALTH COMMISSIONING STRATEGY

2014-2016

CONTENTS

1. INTRODUCTION

Commissioning and delivery of safe, sound and supportive mental health services and care pathways is a key strategic priority for our health and social care economy and is aligned with a number of other key deliverables such as reducing health inequalities, reducing the impact of long term conditions upon quality of life and improving patient experience as outlined in our Wolverhampton Health and Well-Being Board Strategy, the CCG's Operational Plan and the CCG's 5 Year Strategic Plan.

The Wolverhampton City Council and Wolverhampton Clinical Commissioning Group Mental Health Strategy 2014-2016 is a joint commissioning re-fresh of the Wolverhampton City Primary Care Trust and Wolverhampton City Council Adult Mental Health Commissioning Strategy 2011 – 2015 wherein we outline our commissioning plans to develop our mental health whole system model and to deliver improved outcomes for the people of our City in line with local needs and local and national priorities.

This follows a review period and responds to key local priorities highlighted as an outcome of the review and other local imperatives including plans that form part of the Better Care Fund initiative, and the implementation plans for the Wolverhampton Mental Health and Psychological Wellbeing Services Strategy for Children and Young People 2013-2016.

National statistics show that mental illness is the largest disease burden upon the NHS, up to 23% of the total burden of ill health and the largest cause of disability within the United Kingdom (Royal College of Psychiatry 2010). There are significant personal,

social and economic costs (the latter estimated as £105 million per annum for England alone), with particular risks from birth, into childhood and as young people move into adulthood and as they enter periods of physical and psychological change and development. There is a strong economic case to provide early intervention and prevention mental health services for children and young people especially, to prevent up to 25-50% of adult mental illness (Kim-Cohen et al 2003). We know that physical health is inextricably linked to mental health. Poor mental health is associated with obesity, alcohol and substance misuse and smoking, and with diseases such as cardio-vascular diseases and cancer (HM Government, 2011).

In 2010/11, £12 billion was spent on NHS services to treat mental disorder, equivalent to 11% of the NHS budget. Treatment costs are likely to double in the next 20 years as by 2026, the number of people in England who experience a mental disorder is projected to increase by 14%, from 8.65 million in 2007 to 9.88 million(Royal College of Psychiatry 2010) .

In Wolverhampton our current annual joint commissioning health and social budget for Mental Health services is £35.7 million. Benchmarking data suggests that in Wolverhampton investment in mental health services is comparable with the England average. Our Strategy implementation plan will align our service re-design and development with our plans to ensure value for money across the system however and re-align our investment in services to improve early intervention and prevention, urgent care and re-ablement and recovery. This is to achieve 'parity of esteem' for mental health compared with physical health in terms of access to services, quality of service user and carer experience and service user outcomes within an 'all age' context.

The strategy re-fresh includes a wider all age mental health approach to improve outcomes for all people requiring support from mental health services. This is in keeping with the cross government mental health outcomes strategic guidance for people of all ages detailed in 'No Health without Mental Health' (2011), 'Preventing suicide in England' (HM Government, 2012), 'Closing the Gap' (HM Government 2014), which adopt a life course approach.

Our strategy prioritises the delivery of the 6 key outcomes of 'No Health without Mental Health' (2011) as overarching themes. These are:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Our mental strategy re-fresh outlines the required commissioning actions to achieve all of the 6 key outcomes described above.

2. INFORMATION REGARDING PREVALENCE AND NEED

Our commissioning priorities outlined in this strategy re-fresh will respond to the critical issues and factors that exist in Wolverhampton in terms of levels of social and health inequality and also address our knowledge and understanding of local levels and type of mental health need and our response to tackling inequalities and preventing mental health difficulties occurring wherever possible.

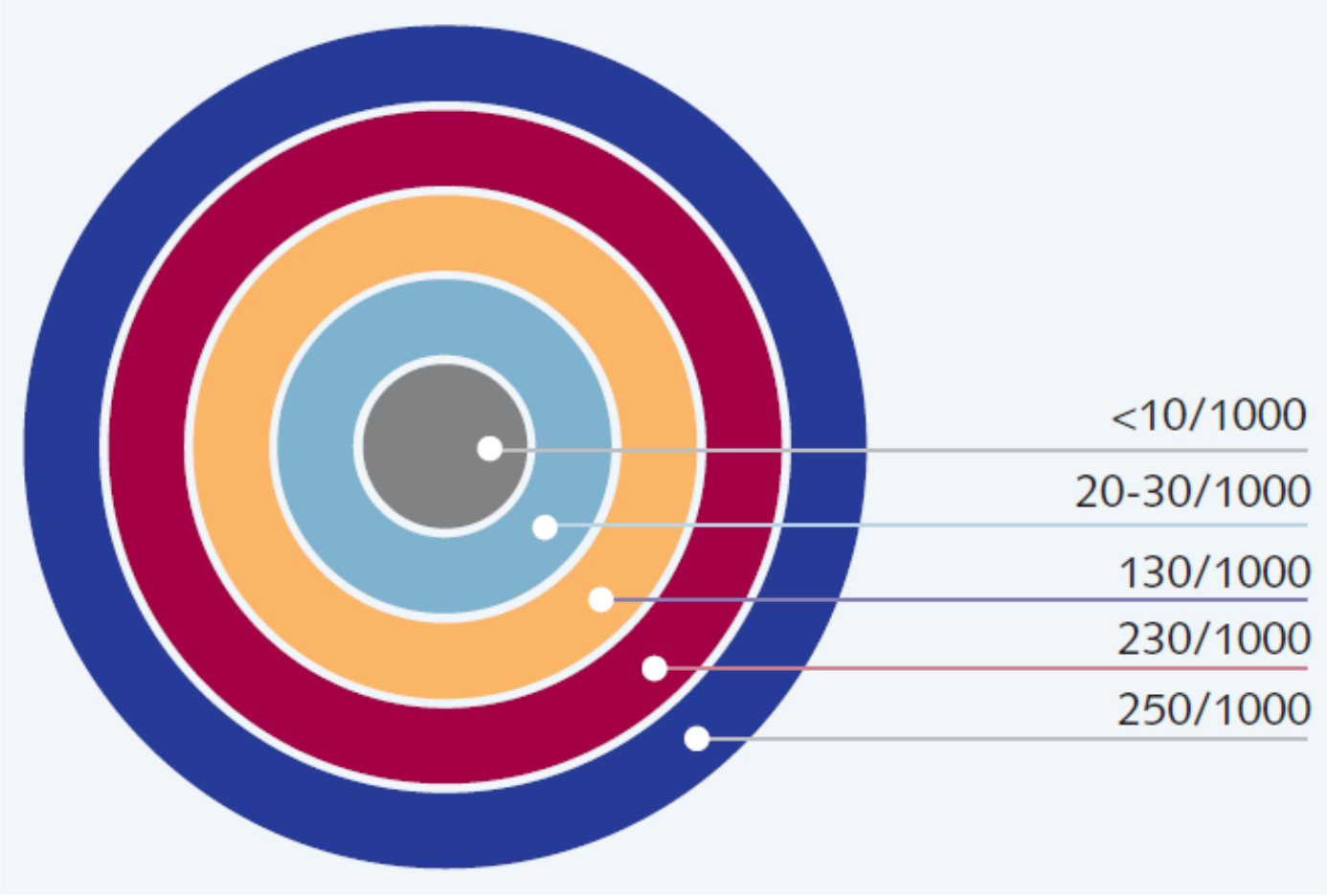
'No Health without Mental Health' (HM Government, 2011) describes three aspects to reducing mental health inequality:

- tackling the inequalities that lead to poor mental health

- tackling the inequalities that result from poor mental health such as unemployment, poor housing, and poor levels of educational achievement and poorer education and physical health
- tackling the inequalities in service provision – in access, experience and outcomes

The illustration below is taken from the Joint Commissioning Panel for Mental Health guidance 'Practical Mental Health Commissioning' (2011).

Numbers of people affected by mental health problems



Mental health problems affect about one in four people – that is, 250 per 1000 at risk (see figure 4). Of those 250 people, the vast majority – about 230 – attend their general practice. Of these 230, about 130 are subsequently diagnosed as having a mental health problem, only between 20 and 30 are referred to a specialist mental health service, and fewer than 10 are ever admitted to a mental health hospital.

A summary of some key demographic and local and national prevalence related data is described below.

The Wolverhampton 2011 census describes our resident population as 248,470. The average age in Wolverhampton is 39 years, which is similar to the England average; however Wolverhampton has a slightly higher proportion of children aged under 16. In terms of ethnicity, 68% Wolverhampton residents are from a white ethnic background with the remaining 32% of residents belonging to black minority ethnic backgrounds (BME). Wolverhampton has high numbers of new arrivals arriving into the City each year including traveller families (estimated 2700 families in 2012). In terms of levels of deprivation in our City Wolverhampton is the 21st most deprived Local Authority in the country, with 51.1% of its population falling amongst the most deprived 20% nationally. Deprivation is disproportionate across the city, with the more affluent wards in the west of the city. A number of sources of evidence suggest that a number of equalities and demographic factors can have a significant effect on the local need and uptake of mental health services, including:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism

- Lesbian, gay, bisexual and transgender people (LGBT) and / or children and young people who are questioning their sexual orientation and / or gender (LGBTQ)
- Substance misuse
- Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying

Interventions to support the specific needs and vulnerabilities of key groups should include disabled people, people with learning difficulties and older people both in terms of social isolation and self-efficacy and barriers to accessing appropriate levels of support (including barriers to communication in the case of people with sensory impairments for example). Particular focus should be placed upon the needs of people of all ages with conditions such as Autism and Attention Deficit Disorder who are at risk of falling between gaps in services, ('No Health without Mental Health', 2011). Mental health services and care pathways and services should also specifically consider and address the mental health needs of pre and post natal mothers, people with co-morbid substance misuse and people with learning disabilities (national prevalence of people with learning disabilities with co-occurring mental health problems is estimated to be 25–40%, 'No Health without Mental Health', 2011).

The over representation of people from BME groups has locally and nationally focussed upon the need to commission culturally sensitive services particularly for particular groups of men and women including new arrivals. In Wolverhampton we need to continue to address over representation of key groups specifically in relating to formal admission under the Mental Health Act 1983. The relatively low prevalence of numbers of children from BME groups referred to Tier 2 and Tier 3 CAMHS (less than 20% of referrals, compared with 41% of the population of children and young people in our City) suggests that prevention and early intervention should include a focus upon targeted interventions for children and young people and their parents and carers from BME groups and communities of new arrivals.

Learning from the needs analysis from our Wolverhampton Emotional and Psychological Well-Being Strategy for Children and Young People has also identified the following key issues in 2012/13:

- An under use of universal and targeted services, an over use of specialist services and a significant increase in the use of in-patient hospital provision.
- Requests for hospital admissions rose by over 100% (75 % of in-patient admissions were related to self-harm)
- The Crisis Support and Home Treatment Service received a 25% increase in routine referrals.

A recent survey of Wolverhampton's LGBT community highlighted significant mental health difficulties and concerns amongst respondents, in excess of what is understood nationally regarding higher levels of suicide, depression and self-harm within this group (LGBT Wolverhampton, 2013). The survey highlighted the prevalence of self-harm, suicidal ideation, depression and experience of bullying amongst the LGBT community locally and the important role of peer support in terms of improving outcomes and facilitating access to care pathways and services within the City.

Data highlighted in 'No Health without Mental Health' (2011) identifies that although women are at greater risk of childhood sexual abuse and sexual violence (an estimated 7–30% of girls), 3–13% of boys have also experienced childhood sexual abuse. Whilst we need to understand more about the impact of sexual violence locally, nationally it is understood that 1 in 10 women have experienced some form of sexual victimisation, including rape and some studies have shown that 50% of female patients in psychiatric wards have lifetime experience of sexual abuse 'No Health without Mental Health' (2011).

The Community Mental Health Profile 2013 for Wolverhampton identifies that Wolverhampton is **'significantly worse'** than the England average in the following key factors in terms of deprivation and indicators of mental health prevalence and performance against key outcomes:

- Working age adults who are unemployed
- Percentage of the relevant population living in the 20% most deprived areas in England
- Episodes of violent crime
- Statutory homeless households
- Percentage of 16-18 year olds not in employment, education or training
- Percentage of the population with a limiting long term illness
- Percentage of adults (18+) with learning disabilities
- Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders
- Rate of Hospital Admissions for alcohol attributable conditions
- Percentage of referrals entering treatment from Improving Access to Psychological Therapies
- Numbers of people on a Care Programme Approach, rate per 1,000 population

The Community Mental Health Profile 2013 for Wolverhampton identifies that Wolverhampton is **'significantly better'** or **'not significantly different'** than the England average in the following key factors:

- Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population **(significantly better)**
- First time entrants into the youth justice system 10 to 17 year olds
- Percentage of adults (16+) participating in recommended level of physical activity
- Percentage of adults (18+) with dementia
- Ratio of recorded to expected prevalence of dementia
- Percentage of adults (18+) with depression **(significantly better)**
- Directly standardised rate for hospital admissions for mental health **(significantly better)**

- Directly standardised rate for hospital admissions for unipolar depressive disorders
- Directly standardised rate for hospital admissions for Alzheimer's and other related dementia **(significantly better)**
- Allocated average spend for mental health per head
- In-year bed days for mental health, rate per 1,000 population **(significantly lower)**
- Number of contacts with Community Psychiatric Nurse, rate per 1,000 population **(significantly better)**
- Number of total contacts with mental health services, rate per 1,000 population **(significantly higher)**
- People with mental illness and or disability in settled accommodation **(significantly better)**
- Indirectly standardised mortality rate for suicide and undetermined injury
- Improving Access to Psychological Therapies - Recovery Rate
- Excess under 75 mortality rate in adults with serious mental illness **(significantly better)**

3. Vision

Our vision for mental health services in Wolverhampton is an integrated 'whole system' of health and social care pathways and services that will deliver early intervention and prevention, assessment, treatment and intervention and re-ablement and recovery across the life course.

Our aim is to prevent people entering statutory services where possible and to provide care pathways into and through services to provide the right type and level of intervention, when this is required, including within primary care and non-statutory services and with a focus upon public mental health as part of our Resilience Strategy.

Our commissioned model will support the delivery of aligned health and social care outcomes to promote independence, improve physical health, optimise recovery and increase social inclusion at all stages of the care pathway and across the 'whole system' of integrated care.

Our vision is based on national and local prevalence and risk issues as well as local and national policy and strategic priorities and imperatives have informed our commissioning mental health strategy for Wolverhampton. This includes the 2013 Mandate to NHS England sets the Government's commitment to give mental health parity of esteem with physical health, including a commitment to:

- Removing the stigma attached to mental illness.
- Implementing access and/or waiting times standards for mental health services in 2015.
- A specific focus on mental health and wellbeing from Public Health England.
- A dedicated transformation programme for children and young people's services to enhance access to evidence-based therapies.

- Providing settled accommodation for people with mental illness to support their recovery.
- Support for CCG's commissioning Mental Health services from NHS England to commission evidence based services locally that are compliant with NICE Guidance and Quality Standards.
- Pro-active crisis support.
- Initiatives to reduce the inequalities in life expectancy for people with severe mental illness.
- Further roll out of improving access to psychological therapies.
- Improved offender mental health.
- Using the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children's mental health services.

The vision outlined above includes all elements of commissioned service delivery, including Health, Social Care, Education, Voluntary and Community and Third Sector and Independent Sector Services, Specialised and Secure Services and 'out of area' placements. The service development changes outlined in our priorities and implementation plan will increase capacity and capability within services locally to improve individual, familial and community resilience by increasing protective factors and promoting independence, increasing self-efficacy, reducing risk and enabling recovery.

For our local Wolverhampton 'whole system' to work effectively each service will have a clear role; understand how it relates to other elements of the system and work to a set of clear care pathways and specified outcomes to meet the needs of our population. This will involve commissioning to increase the effectiveness and efficiency of services, improve care pathways and communication across the whole system and reduce duplication across service providers. This will include increasing capacity and capability locally to support people with severe and enduring and / or complex mental health needs and ensure effective and robust care coordination using the Care Programme Approach guidance 'Refocusing the Care Programme Approach Policy and Positive Practice Guidance' (HM Government 2008).

It will also include interventions and actions that support the needs and requirements of people in Wolverhampton that have particular vulnerabilities and these include those vulnerabilities highlighted on page 8 and detailed again below:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism
- Lesbian, gay, bisexual and transgender people (LGBT) and / or children and young people who are questioning their sexual orientation and / or gender (LGBTQ)
- Substance misuse
- Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying

Responding to the specific needs and requirements of key vulnerable groups will form a key element of the Wolverhampton suicide prevention plan and the Wolverhampton Crisis Concordat Declaration and Wolverhampton Crisis Concordat Action Plan. The Wolverhampton suicide prevention plan is known as the Wolverhampton Mental Health Resilience Plan and describes those

interventions highlighted within the Wolverhampton Health and Well-Being Strategy that focus upon mental health promotion, early intervention and prevention and are detailed within the table below and which will be aligned with the Mental Health Strategy Implementation Plan and our local Crisis Concordat Action Plan and Declaration:

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	**WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN** **Action Required**
1. DEVELOP LOCAL SUICIDE PREVENTION GROUP.	Mental Health Stakeholder Forum will develop small working group to take forward key actions. (Could meet immediately before as discussed). **<u>The local suicide prevention group needs to:</u>** • Map current practice and service provision with any gaps forming the basis of a WOLVERHAMPTON Suicide Prevention Action Plan. • Ensure all WOLVERHAMPTON mental health, suicide and self-harm data is captured. • Link with the WOLVERHAMPTON Health and Well-Being boards and feed into local Joint Strategic Needs Assessments (JSNAs) and Joint Health and Well-Being Strategies (JHWSs). • Link with the Mental Health, Dementia, and Neurology Intelligence Network to map, understand and address mental health issues in WOLVERHAMPTON. • Ensure data mapping includes the needs and requirements of key vulnerable groups including vulnerabilities related to: ▪ Age and gender ▪ Black and minority ethnic communities ▪ Persons in prison or in contact with the criminal justice system

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Required
	▪ Service and ex-service personnel ▪ Deprivation ▪ Unemployment ▪ Housing and homelessness ▪ Refugees and asylum seekers (new arrivals) ▪ People with long term conditions or physical and or learning disabilities including autism ▪ Lesbian, gay, bisexual and transgender people (LGBT) and / or children and young people who are questioning their sexual orientation and / or gender (LGBTQ) ▪ Substance misuse ▪ Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying
2. DEVELOP LOCAL ACTION PLAN.	• Develop a suicide prevention action plan • Monitor data, trends and hot spots • Engage with local media • Work with transport to map hot spots • Work on local priorities to improve mental health Include • Assessment of impact on equalities • Prompts for local leaders on suicide prevention • Statistical update (September 2012) / **plan by March 2015** • Sources of information and support for families **Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives.**

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Required
Page 32	Working with: • CCGs • Local Authority • Public Health • Mental health Trusts / Providers • West Midlands Police • West Midlands Ambulance Service • Coroners • Families bereaved by suicide • The Voluntary and Community Sector • National Suicide Prevention Alliance • Mental Health, Dementia, and Neurology Intelligence Network **6 Key Action Areas** 1. Reduce the risk of suicide in key high-risk groups 2. Tailor approaches to improve mental health in specific groups 3. Reduce access to the means of suicide 4. Provide better information and support to those bereaved or affected by suicide 5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour 6. Support research, data collection and monitoring.
3. ALIGN WITH HEALTH AND WELL-BEING BOARD MENTAL HEALTH PRIORITY AREA.	This draws heavily on The Joint Commissioning Panel for Mental Health *'Guidance for Commissioning Public Mental Health Services' (JCP-MH, 2012)*, identifies that mental well-being is associated with a wide range of improved outcomes in health, education and employment, as well as reduced crime and antisocial behaviour such as, better physical health, longer life expectancy, reduced inequalities, healthier lifestyles, improved social functioning and better quality of life.

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Required
Page 33	http://www.wolverhampton.gov.uk/CHttpHandler.ashx?id=2944&p=0 Ensure data mapping includes the needs and requirements of key vulnerable groups including vulnerabilities related to: • Age and gender • Black and minority ethnic communities • Persons in prison or in contact with the criminal justice system • Service and ex-service personnel • Deprivation • Unemployment • Housing and homelessness • Refugees and asylum seekers (new arrivals) • People with long term conditions or physical and or learning disabilities including autism • Lesbian, gay, bisexual and transgender people (LGBT) and / or children and young people who are questioning their sexual orientation and / or gender (LGBTQ) • Substance misuse • Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying
4. ANALYSE AND AGGRAGATE AND MONITOR DATA, TO IDENTIFY TRENDS,	Data Analysis Needs Assessment Hotspots • Focus Vulnerable Groups • Identify hotspots / areas of vulnerability

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Required
OT SPOTS AND VULNERABILITIES IN TERMS OF MENTAL ILL HEALTH AND SUICIDE.	• Work with transport police to map hot spots • Reduce access to the means of suicide • Focus on cyber bullying • Focus on education providers, employers and un-employed
5. WORK ON LOCAL PRIORITIES TO IMPROVE MENTAL HEALTH INTERVENTIONS.	Focus on: • Medication Management and Prescribing • Better Care Fund Care Pathways • Clinical Interventions • Learning from LPS, CRISIS CAR and CAMHS CHRT and EIS pilots • IAPT and Primary Care Depression Care Pathway • Development of Community Hub • Improved Care Pathways complex Care and Well-Being • Focus on monitoring outcomes • Help lines • Single Point of Access
6. FOCUS ON SELF-EFFICACY AND LOCUS OF CONTROL.	• Align with HeadStart • Scope Tier 1 and Tier 2 • Develop Mental Health Education, Information and Awareness and Psycho-education and Self-Help • Develop Public Health campaign • Identify potential sources of revenue
7. DEVELOP CRISIS CONCORDAT.	• Make Wolverhampton Declaration by December 2014. • Submit Local Wolverhampton Crisis Concordat Plan by March 2015. **Mental Health Crisis Care Concordat principles:** **A. Access to support before crisis point.** A1. Early intervention – protecting people whose circumstances make them vulnerable. **B. Urgent and emergency access to crisis care.**

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Required
	B1. People in crisis are vulnerable and must be kept safe, have their needs met appropriately and be helped to achieve recovery.
	B2. Equality of access.
	B3. Access and new models of working for children and young people.
	B4. All staff should have the right skills and training to respond to mental health crises appropriately.
	B5. People in crisis should expect an appropriate response and support when they need it.
	B6. People in crisis in the community where police officers are the first point of contact should expect them to provide appropriate help. But the police must be supported by health services, including mental health services, ambulance services and emergency departments.
	B7. When people in crisis appear (to health or social care professionals, or to the police) to need urgent assessment, the process should be prompt, efficiently organised, and carried out with respect.
	B8. People in crisis should expect that statutory services share essential 'need to know' information about their needs.
	B9. People in crisis who need to be supported in a health-based place of safety will not be excluded.
	B10. People in crisis who present in emergency departments should expect a safe place for their immediate care and effective liaison with mental health services to ensure they get the right on-going support.
	B11. People in crisis who access the NHS via the 999 system can expect their need to be met appropriately.
	B12. People in crisis who need routine transport between NHS facilities or from the community to an NHS facility will be conveyed in a safe, appropriate and timely way.
	B13. People in crisis who are detained under Section 136 powers can expect that they will be conveyed by emergency transport from the community to a health-based place of safety in a safe, timely and appropriate way.
	C. Quality of treatment and care when in crisis.
	C1. People in crisis should expect local mental health services to meet their needs appropriately at all times.
	C2. People in crisis should expect that the services and quality of care they receive are subject

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Required
	to systematic review, regulation and reporting. C3. When restraint has to be used in health and care services, it is appropriate. C4. Quality and treatment and care for children and young people in crisis. **D. Recovery and staying well / preventing future crises.**
8. DEVELOP SERVICE USER AND CARER INVOLVEMENT.	Provide better information and support to those bereaved or people affected by suicide. • Establish self-help group – support learning. • See Focus on Self-Efficacy and Locus of Control • Align with Community Hub and PA4MH
9. WORK ON LOCAL PRIORITIES TO IMPROVE MENTAL HEALTH BY FOCUSSING ON VULNERABILITIES AND THE BROADER DETERMINANTS OF MENTAL HEALTH.	Use Community Development Work model to engage with local groups, stakeholders and partners to focus on: • Housing • Employment • Debt Counselling • Benefits • Bullying • Leisure • Dual Diagnosis • Parents • Employers • Schools Develop Stake Holder Forum to engage with and involve local groups, stakeholders and partners so that agreeing interventions that improve mental health are embedded in al key strategic deliverables across our City.
10. WORK ON LOCAL PRIORITIES TO IMPROVE THE PHYSICAL HEALTH OF PEOPLE WITH MENTAL HEALTH	• Physical Health • Parity of Esteem • 5 Ways to Well-Being

WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Area	WOLVERHAMPTON MENTAL HEALTH RESILIENCE PLAN Action Required
DIFFICULTIES.	
11. COMMUNICATION AND MEDIA.	Develop a communication strategy regarding mental health which supports mental health awareness, promotion, early intervention and prevention and anti-stigma campaigns locally and also supports the media in delivering sensitive approaches to suicide and suicidal behaviour: Include focus on: • Help lines • Twitter • National campaigns
12. TRAINING.	Identify suitable stakeholder training Consider Peer Support Model Align with HeadStart Resilience training

The necessary actions and interventions that are needed to deliver the plan outlined above across the Stepped Care Model described on page 25 will require a community development work approach which has previously focussed in Wolverhampton on initiatives such as those outlined in 'Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett' (HM Govt. 2005).

The key building blocks of our refreshed and broader approach will include:

- **More appropriate and responsive services –** achieved by improving services and up skilling the workforce across the stepped care model to better respond to the needs of key groups to enable all members of the population to access all of our services equally and by working with all key stakeholders to that ensure that together we have a joined up approach to

challenging and addressing the broader determinants of mental ill-health and stigma and discrimination and promote parity of esteem, compassion, equality and respect diversity and human rights. .

- **Wider community engagement –** achieved by extending stakeholder engagement to capture agencies, voluntary groups and organisations that can have a strategic and day to day influence on the wider determinants of mental health and embedding agreed key deliverables into the Resilience Plan and Implementation Plan. Supported by our Community Development Workers.

- **Better information, communication and marketing -** achieved by improved data collation, capture and analysis of the City's vulnerable groups, mapping their needs and requirements and monitoring agreed actions via the implementation plan. This will include a regular census of mental health patients and public mental health needs across the City and delivery of a pro-active marketing campaign aligned to parity of esteem and national campaigns such as Beat Bullying, Time to Change, Health Poverty Action, and Child Sexual Exploitation of the NSPCC.

Stepped Care Model

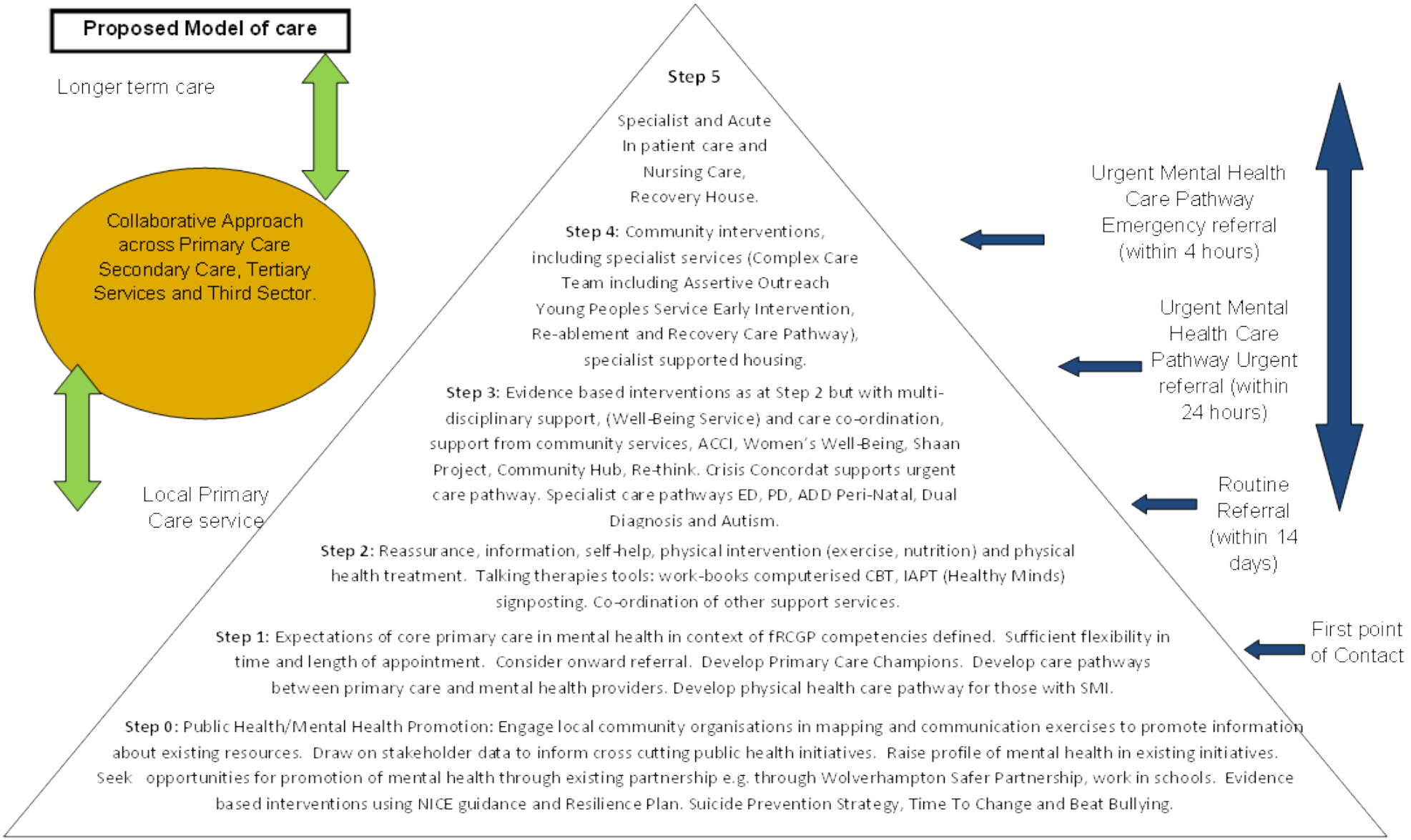
Mental Health services will be commissioned across the 'whole system' using the 'Stepped Care' Model which has formed the basis of previous service re-design in Wolverhampton.

The 'Stepped Care' model allows service users to transition through and into and out of secondary mental health services and into primary care, and re-enter components of the system if / as required. Fundamental principles underlining this approach will include:

- A 'whole system' of services and providers delivering recovery orientated interventions and support.

- Improved integrated health and social care pathways within existing services using the Better Care Fund.
- Improved communication between primary care, secondary and tertiary mental health services.
- Clear access and / or referral criteria.
- Transition into and out of services as appropriate and in keeping with the Care Programme Approach.
- Access to services 24/7 and improved urgent care.
- Greatest level of service provision for those with the highest levels of need.
- Promoting independence and improving recovery rates across the whole service model.
- Increased flexibility regarding the application of the care cluster model in terms of access to and treatment with health services.

The refreshed Stepped Care Model is described in the diagram below.


Proposed Model of care
Longer term care
Collaborative Approach across Primary Care Secondary Care, Tertiary Services and Third Sector.
Local Primary Care service
Step 5
Specialist and Acute In patient care and Nursing Care, Recovery House.
Step 4: Community interventions, including specialist services (Complex Care Team including Assertive Outreach Young Peoples Service Early Intervention, Re-ablement and Recovery Care Pathway), specialist supported housing.
Step 3: Evidence based interventions as at Step 2 but with multi-disciplinary support, (Well-Being Service) and care co-ordination, support from community services, ACCI, Women's Well-Being, Shaan Project, Community Hub, Re-think. Crisis Concordat supports urgent care pathway. Specialist care pathways ED, PD, ADD Peri-Natal, Dual Diagnosis and Autism.
Step 2: Reassurance, information, self-help, physical intervention (exercise, nutrition) and physical health treatment. Talking therapies tools: work-books computerised CBT, IAPT (Healthy Minds) signposting. Co-ordination of other support services.
Step 1: Expectations of core primary care in mental health in context of fRCGP competencies defined. Sufficient flexibility in time and length of appointment. Consider onward referral. Develop Primary Care Champions. Develop care pathways between primary care and mental health providers. Develop physical health care pathway for those with SMI.
Step 0: Public Health/Mental Health Promotion: Engage local community organisations in mapping and communication exercises to promote information about existing resources. Draw on stakeholder data to inform cross cutting public health initiatives. Raise profile of mental health in existing initiatives. Seek opportunities for promotion of mental health through existing partnership e.g. through Wolverhampton Safer Partnership, work in schools. Evidence based interventions using NICE guidance and Resilience Plan. Suicide Prevention Strategy, Time To Change and Beat Bullying.
Urgent Mental Health Care Pathway Emergency referral (within 4 hours)
Urgent Mental Health Care Pathway Urgent referral (within 24 hours)
Routine Referral (within 14 days)
First point of Contact

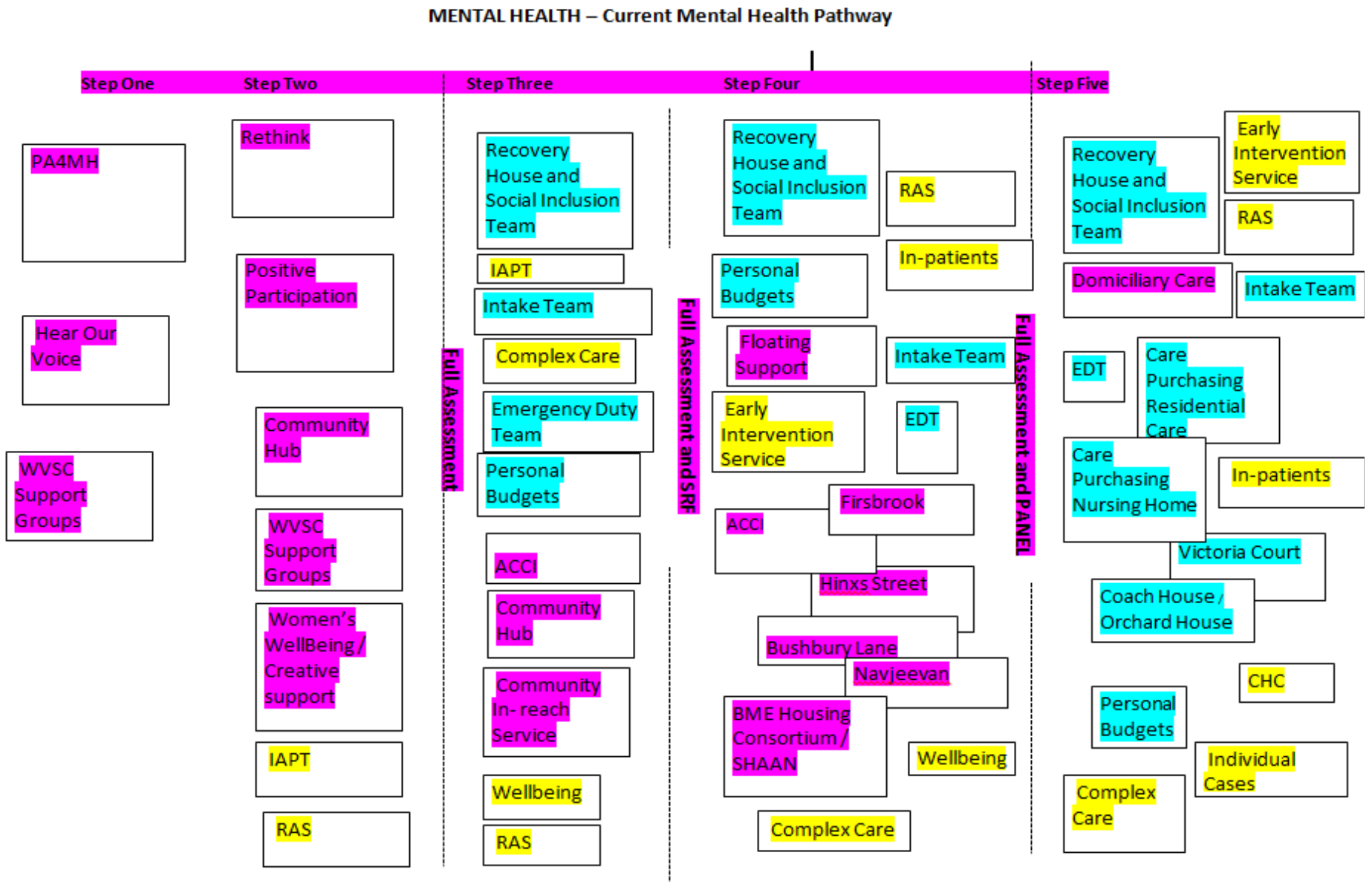
The Better Care Fund

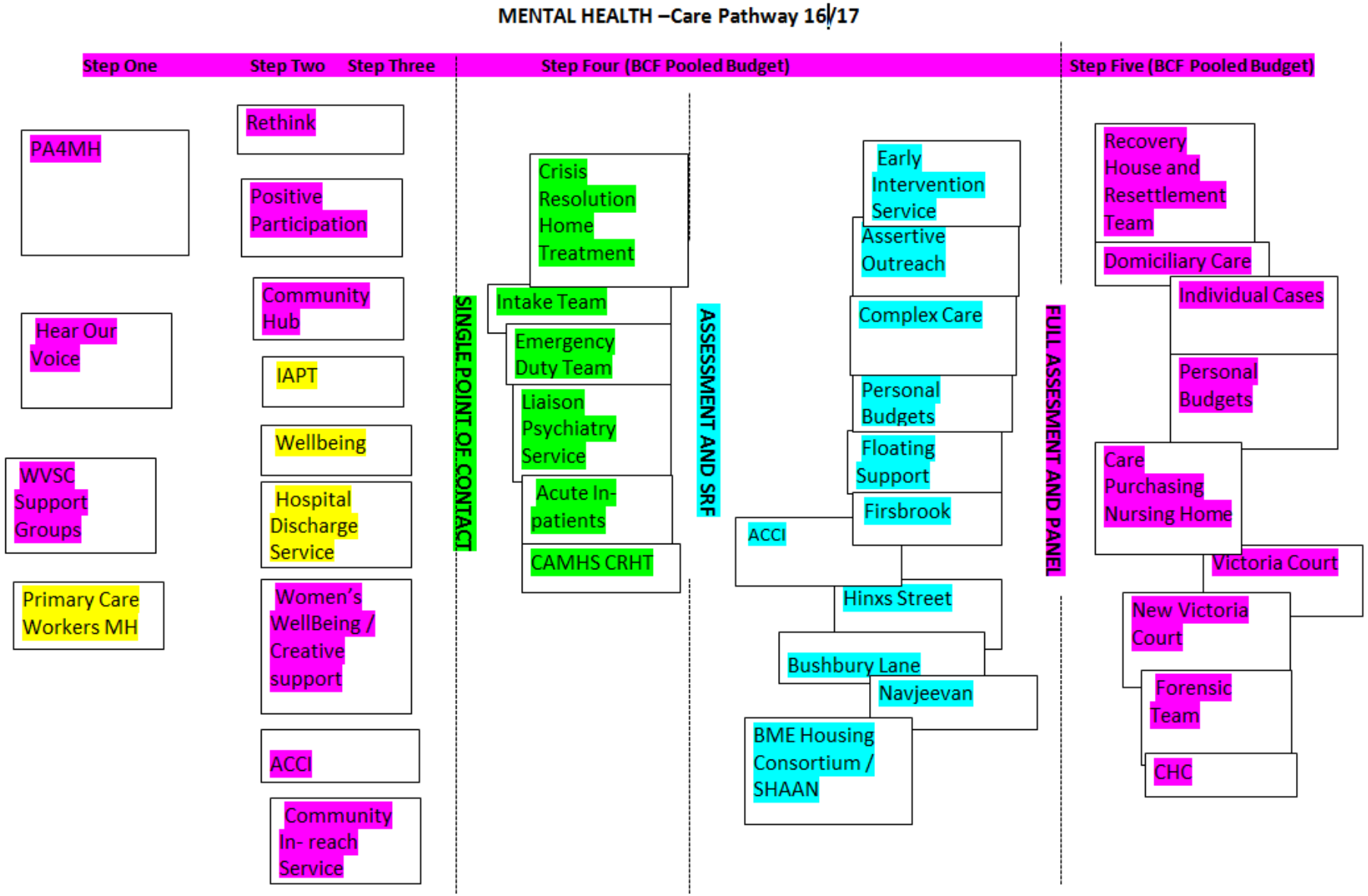
The Better Care Fund provides an opportunity to develop a single pooled budget to allow health and social care services to work together more closely. Wolverhampton's Better Care Plans are an integral and important component of our vision for mental health services in Wolverhampton. Wolverhampton's Better Care Plans include two integrated care pathways in mental health services, the Integrated Re-ablement and Recovery Care Pathway and the Integrated Urgent Mental Health Care Pathway.

The integrated Mental Health Re-ablement and Recovery Care Pathway will provide specialist re-ablement and recovery focussed assessment, interventions and support for adults with severe and enduring mental illness (SMI). This will include nursing and residential care, step-down, specialist community support and intervention, specialist mental health supported accommodation and floating support and day services and also individualised packages of care for people with high levels of need.

The integrated Urgent Mental Health Care Pathway will provide emergency and urgent assessment, treatment, intervention and care and support within an integrated health and social care model for adults and children with acute and severe mental health difficulties who require high levels of care and support in urgent and / or emergency situations.

Illustrations describing the current and future service mental health 'whole system' models are described below.


MENTAL HEALTH – Current Mental Health Pathway
Step One
Step Two
Step Three
Step Four
Step Five
PA4MH
Hear Our Voice
WVSC Support Groups
Rethink
Positive Participation
Community Hub
WVSC Support Groups
Women's WellBeing / Creative support
IAPT
RAS
Full Assessment
Recovery House and Social Inclusion Team
IAPT
Intake Team
Complex Care
Emergency Duty Team
Personal Budgets
ACCI
Community Hub
Community In- reach Service
Wellbeing
RAS
Full Assessment and SRF
Recovery House and Social Inclusion Team
RAS
In-patients
Personal Budgets
Floating Support
Intake Team
Early Intervention Service
EDT
ACCI
Firsbrook
Hinxs Street
Bushbury Lane
Navjeevan
BME Housing Consortium / SHAAN
Wellbeing
Complex Care
Full Assessment and PANEL
Recovery House and Social Inclusion Team
Early Intervention Service
RAS
Domiciliary Care
Intake Team
EDT
Care Purchasing Residential Care
Care Purchasing Nursing Home
In-patients
Victoria Court
Coach House / Orchard House
CHC
Personal Budgets
Individual Cases
Complex Care


MENTAL HEALTH –Care Pathway 16/17
Step One
Step Two
Step Three
Step Four (BCF Pooled Budget)
Step Five (BCF Pooled Budget)
PA4MH
Hear Our Voice
WVSC Support Groups
Primary Care Workers MH
Rethink
Positive Participation
Community Hub
IAPT
Wellbeing
Hospital Discharge Service
Women's WellBeing / Creative support
ACCI
Community In- reach Service
SINGLE POINT OF CONTACT
Crisis Resolution Home Treatment
Intake Team
Emergency Duty Team
Liaison Psychiatry Service
Acute In-patients
CAMHS CRHT
ASSESSMENT AND SRF
Early Intervention Service
Assertive Outreach
Complex Care
Personal Budgets
Floating Support
Firsbrook
ACCI
Hinxs Street
Bushbury Lane
Navjeevan
BME Housing Consortium / SHAAN
FULL ASSESMENT AND PANEL
Recovery House and Resettlement Team
Domiciliary Care
Individual Cases
Personal Budgets
Care Purchasing Nursing Home
Victoria Court
New Victoria Court
Forensic Team
CHC

4. KEY ISSUES / PRIORITIES

The final report of the adult mental health strategy review is attached as Appendix 2. The priorities for implementation will be aligned with those outlined in the CCG Operational Plan, the CCG Five Year Strategic Plan, Wolverhampton City Council Strategic Plan and the Joint Health and Well-being Strategy. Key priorities for future mental health commissioning have been drawn from the strategy review recommendations and key other local and national imperatives. In summary the key issues and priorities include the following:

- Integrated and / or aligned health and social care pathways are required across all stages of the service user journey, including primary, secondary and tertiary care. This will require remodelling some aspects of the commissioned service provision.
- Clear pathways for engagement with primary care are also needed to support the mental and physical health needs of people with differing requirements to achieve parity of esteem. This will require dedicated mental health support in primary care and primary care champions in all secondary and tertiary services.
- Consultant Psychiatry and medical support and expertise require re-focussing and balancing across the secondary, tertiary and primary care facing elements of the system. Our re-commissioned model will require increased access to Consultant Psychiatry expertise across the 'whole system' to improve access to assessment and treatment interventions and to achieve parity of esteem.
- Greater flexibility is needed regarding the application of the care cluster model (this is the model that is the framework for the payment system that is mental health payment by results). This is required both in terms of access to and treatment with health services so that the unique and specific needs of people are adequately supported and to allow greater alignment between services where the cluster model does not apply such as CAMHS, Learning Disabilities and Neurological Disorders.

- Achieving and sustaining recovery within the health model for patients of all clusters and especially for those patients clusters 3 and above experiencing non-psychotic conditions should re-focus to move include treatment support and interventions beyond an IAPT model of care and to provide continuing support as required.
- The application of the Care Programme Approach must be re-focussed across the 'whole system' to ensure appropriate levels of community support, relapse prevention and crisis plans and support for carers. Our re-commissioned must achieve an approach to CPA locally that is consistent with national guidance.
- An 'all age approach' is required in keeping with national guidelines so that there is flexibility regarding transition into age specific services and the unique needs of individuals are recognised and to achieve parity of esteem across the life span.
- There is a need to improve access to assertive support and treatment at home, and increase capacity and capability within day services and step-down services, to increase recovery rates, support sustained recovery and reduce relapse and prevent admission to hospital wherever possible.
- Access to care pathways including those providing access to specialised services must be un-impeded by and differing commissioning arrangements for different elements of the care pathway (i.e. into and out of secure and specialised care).
- Further development of local care pathways for people with Autism, Attention Deficit Disorder, Eating Disorders, Personality Disorders and Peri-Natal Mental Health is required to provide access to specialised assessment and treatment that is co-ordinated with across primary, secondary and tertiary care.
- Access to services and support across providers of re-ablement and rehabilitation services should be commissioned using a care pathway approach that improves access to the correct level of support and allows transition through services to services to promote independence and facilitate recovery and optimise effective and efficient use of resources within the market locally.

- To achieve parity of esteem improved waiting times and improved patient and carer experience in terms of emergency, urgent and routine response times and improved access to multi-disciplinary support in a crisis are required. This will involve some service re-modelling to provide dedicated support within the Acute Urgent Care Pathway at RWT. This will require local development of the Crisis Concordat with key local partners.
- Access to local female psychiatric intensive care is required.
- A refreshed approach to both the stepped care and the care cluster model is required to allow greater flexibility across the service model and to ensure that people receive the right level of continuing support and achieve sustained recovery.
- A collaborative approach with other local commissioners of mental health services is required, to pool resources and provides economies of scale.
- Improved access to information and communication for service users and carers and all key stakeholders regarding all matters pertaining to mental health and emotional wellbeing is required. This should harness and optimise the potential of the internet and social media and simple tele-health.
- In line with the Mental Health and Psychological Wellbeing Services Strategy for Children and Young People 2013-2016 there is a requirement re-commission services for children and young people to extend the upper age limit to 25 years where appropriate to provide access to care pathways and services that are age sensitive to prevent or facilitate transition to adult services as required.
- Improved access to and recovery rates within IAPT for people of all ages and specifically for children and young people aged 14-25 years and for people aged over 65 years is required. This should include re-commissioning to deliver value for money and improved access to e-CBT.

- Improved joint working across adults and children's services is required to ensure that the needs of families in contact with mental health services are addressed in entirety, and that the needs of children and young people are assessed and monitored when parents / guardians are experiencing mental health difficulties and vice versa.
- Improved and co-ordinated commissioning approaches with substance misuse commissioning colleagues is required to ensure clearly commissioned care pathways between and across mental health and substance misuse services, and to co-ordinate health promotion campaigns.

In response to the above identified key issues an implementation plan is included as Appendix 3.

5. IMPLEMENTATION

For the purposes of delivery of a 'whole system' model the implementation plan attached as Appendix 3 is structured across the stepped care model, as described below.

STEPS 0-5 DEVELOP AN ALL AGE APPROACH ACROSS SERVICE MODEL THAT INCORPORATES THE NEEDS OF PEOPLE UNDER 18 YEARS AND OVER 65 YEARS

We will develop a commissioning plan / care pathway/s that align all initiatives within the implementation plan with existing and future plans regarding CAMHS and Older People's Services so that services are consistent, seamless, age related and inclusive. This will also be aligned with simple tele-health and FLO and the Emotional and Psychological Health and Well-Being Strategy (2013-2016) and Dementia Strategy re-fresh.

STEP 0 - DEVELOP A LOCAL RESILIENCE PLAN (MENTAL HEALTH PROMOTION, EARLY INTERVENTION AND PREVENTION)

We will develop a local multi-agency Resilience Plan with key stakeholders described in Wolverhampton's Health and Well-Being Strategy. This will help us to deliver targeted mental health promotion and early intervention and prevention interventions cross our commissioned services, and to work with partners involved in education, employment, leisure and housing, for example to focus initiatives upon the wider determinants of health . This will include initiatives to address the broader determinants of mental ill-health including issues pertaining to:

- Parental mental health
- Mental Health Promotion
- Physical health and disability
- Leisure and physical activity
- Bullying
- Mental Health in the work place
- Self-harm
- Substance misuse
- Improved information and communication
- Targeted Interventions for carers
- Targeted interventions for at risk groups (BME, LGBT/Q)
- Debt Advice
- Un-employment
- Educational attainment

- Ending stigma attached to mental health

In addressing those issues highlighted above the Resilience Plan will incorporate the Suicide Prevention Plan and will assess, map and scope the needs of the City's key vulnerable groups people affected by vulnerabilities related to and including:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism
- Lesbian, gay, bisexual and transgender people (LGBT) and / or children and young people who are questioning their sexual orientation and / or gender (LGBTQ)
- Substance misuse
- Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying

This will be taken forward using a Community Development Work model as out lined on page 23.

STEP 1 DEVELOP A LOCAL SUICIDE PREVENTION STRATEGY

We will develop a local multi-agency Suicide Prevention Strategy with key stakeholders. This will be aligned with the local Crisis Concordat and will respond to local needs across each of the National Suicide Prevention Strategy areas for action:

- Reduce the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

This will incorporate learning from the Preventing Suicide in England: One year on First Annual Report (2014), and local data regarding current trends and new messages from research, including the use of social media, learning regarding 7 day follow up, health and social care assessments, treatment and clinical interventions for people with depression and people at risk of self-harm, and specific vulnerabilities related to age, gender and ethnicity and the specific needs of the LGBT/Q community and people who misuse substances.

STEP 1 - DEVELOP PRIMARY CARE PATHWAYS

To ensure best practice in terms of early intervention and prevention, improving the physical health of people with mental health difficulties and improving care pathways into and out of secondary services for people of all ages, we will commission mental health care pathways in primary care supported by primary care champions and workers in primary care facing and secondary services.

This will include pathways of care for people with specialised mental health needs such as autism, attention deficit disorder, eating disorders, peri-natal mental health, depression and personality disorder and the primary care support needs of people taking anti-psychotic medication. This will include review of all of our well-being and support services commissioned from community and voluntary sector organisations and third sector organisations to strengthen early intervention and prevention initiatives and deliver the resilience plan as described above.

STEP 2 - REVIEW COMMISSIONING MODEL OF INTEGRATED ACCESS TO PSYCHOLOGICAL THERAPIES

We will review our current commissioning model of IAPT services for patients clusters 1-3 to improve waiting times and access, so that all routine referrals are offered an appointment within 14 days for those patients meeting 'caseness' and within 28 days for those who do not. This will include increasing the accessibility of the service for targeted groups and to extend provision to children and young people aged 14-25 years and older people and people with co-morbid mental and / or physical health needs. We will look for opportunities to commission on an economies of scale basis and will seek to achieve cost efficiency savings for re-investment elsewhere in the mental health system and to balance the proportion of spend across the mental health 'whole system'. We will look for opportunities to commission E-CBT packages, with access to peer support and signposting and information and communication online. The model will also be reviewed to include primary care gateway workers to facilitate pathways for engagement with primary care to support the mental and physical health patients with differing levels and types of need.

STEP 3 – COMMISSION THE YOUNG PERSONS SERVICE MODEL

We will work with the providers of health and social care services to implement the service model changes required to complete implementation of the Young Person's service which will extend children's services and pathways to accommodate young adults up to 25 years. This will allow young people to receive dedicated treatment and support from a designated team of clinical experts supporting their transition from CAMHS to adult services and care pathways up to the age of 25 years if required.

STEP 3 – REVIEW COMMISSIONING MODEL OF THE COMMUNITY WELLBEING SERVICE

We will review our current commissioning model of the Community Wellbeing Service for patients clusters 4 and above to improve waiting times and access, so that all routine referrals are offered an appointment within 14 days. This will include reviewing the capacity and capability of the service to offer support and interventions beyond a psychological based therapies service and to increase access within the service to multi-disciplinary and Consultant Psychiatry expertise. The model will be reviewed to allow patients to receive on-going support from the service and for services users in the service to receive care planning support and intervention that are compliant with the national guidance regarding the Care Programme Approach. The model will also be reviewed to include primary care gateway workers to facilitate pathways for engagement with primary care to support the mental and physical health patients with differing levels and types of need. This will be aligned with the review of the complex care service (as per Step 4).

STEP 3 – COMMISSION AN INTEGRATED MENTAL HEALTH URGENT CARE PATHWAY

As part of our Better Care Fund development plans to implement the Integrated Mental Health Urgent Care Pathway we will review the health components of the current model. We will re-commission Liaison Psychiatry to provide an all age model. We will review the current model of Crisis Resolution and Home Treatment to provide an integrated Crisis Resolution / Home Treatment Team.

We review pathways and referral criteria into each service within the health system to improve waiting times so that waiting times (not including Wolverhampton Healthy Minds) are up to 4 hours (emergency), up to 24 hours (urgent) and up to 14 days (routine). We will review the capacity and capability of the health and social care urgent mental health care pathways to increase the capacity and capability of the service to meet the needs of people of all ages outside normal working hours and respond to requests for assessment under the Mental Health Act. We will commission a service model and care pathway that provides an integrated collocated and aligned approach to mental health urgent care within a multi-disciplinary context, including access in an emergency to specialist medical and Consultant Psychiatry support that is consistent with Royal College guidelines and the Care Programme Approach.

STEP 4 – REVIEW COMMISSIONING MODEL OF THE COMPLEX CARE SERVICE

We will review our current commissioning model of the Complex Care Service, for patients clusters 5 and above to improve waiting times and access, so that all routine referrals are offered an appointment within 14 days. This will include reviewing the capacity and capability of the service to offer support and interventions of an assertive outreach model, the function of the personality disorder hub and the forensic team. This is to increase the capacity and capability of local services to support people with the highest levels of need, and provide step-down from secure care and specialised services locally and 'out of area' and reduce relapse and re-admission/s. The model will also be reviewed to allow patients to receive on-going support from the service and for services users in the service to receive care planning support and interventions that are compliant with the national guidance regarding the Care Programme Approach.

STEP 4 – COMMISSION AND IMPLEMENT AN INTEGRATED RE-ABLEMENT AND RECOVERY CARE PATHWAY

We will re-commission and implement an integrated re-ablement and recovery pathway as part of Better Care Fund plans. This will promote independence, facilitate recovery and allow service users to progress along the care pathway and prevent relapse and re-admission. The integrated pathway will also allow pooled and effective deployment of and efficient use of resources across the 'whole system' that responds to local need and demand management. This will facilitate step-down from in-patient, specialised and secure care, allow repatriation to local services from 'out of area placements' and consolidate commissioning approaches for people requiring continued support in supported housing, nursing and residential care and hospital placements into an aligned care pathway of continued support. Our commissioned integrated care pathway will provide capacity and capability locally to support people with the highest levels of need, promoting independence and recovery, and will allow the re-allocation of resources from acute, specialised, 'out of area' and complex care to recovery and re-ablement in the mid to long term.

STEP 4 – REVIEW COMMISSIONING MODEL OF LOCAL SPECIALIST CARE PATHWAYS

We will work with providers of health and social care services to commission and implement specialist care pathways for the following:

- Eating Disorders
- Personality Disorder
- Peri-natal Mental Health
- Dual Diagnosis (Substance Misuse)
- Attention Deficit Disorder
- Autism

This will increase capacity and capability, providing specialist assessment and intervention within mainstream mental health services within the local system and facilitating effective liaison with specialist services commissioned by NHS England.

STEP 5 – REVIEW COMMISSIONING MODEL OF FEMALE PIC AND OUT OF AREA ADMISSIONS FOR URGENT AND PLANNED MENTAL HEALTH CARE

We review of our current commissioning of all out of area mental health admissions to identify opportunities to maximise the resources available within local services as alternatives to out of area admissions and to identify 'preferred providers' for Female Psychiatric Intensive Care (PIC) in the short term, whilst liaising with local providers and commissioners regarding a medium to longer term solution. We will optimise the available capacity within re-ablement and recovery services within our local health and social care economy both with the public sector and independent sector services as an integral part of the local 'whole system' as required. We will realise cost efficiency savings by reducing the numbers of all types of out of area placements and reducing lengths of stay. We will work with local providers to develop capacity and capability of locally commissioned services to meet the needs of people who are discharged and / or transferred from secure and specialised services, so that we can optimise deployment of and efficient use of resources across the 'whole system' that is consistent with local need, allow repatriation to local services from 'out of area placements' and consolidate commissioning approaches sub –specialisms including hospital placements for rehabilitation. Our commissioned integrated care pathway will provide capacity and capability locally to support people with the highest levels of need, promoting independence and recovery.

STEP 5 - REVIEW THE COMMISSIONING MODEL OF POND LANE AND OTHER LEARNING DISABILITY IN-PATIENT SERVICES

As part of the mental health strategy implementation plan we will review the current commissioning of all LD in-patient admissions to optimise resources available within local services as alternatives to admissions to BCPFT In-patient services and out of area

admissions. We will also commission to optimise the available capacity and capability within community services within our local health and social care economy both with the public sector and independent sector services as an integral part of the local 'whole system' as required. This will be to develop the capacity and capability of locally commissioned services to meet the needs of people with LD who are discharged and / or transferred from secure and specialised services. Identify opportunities for collaborative commissioning. We will identify opportunities for collaborative commissioning (e.g. SWBCCG) and others and align our commissioning plans with Autism Strategy and Winterbourne Plans.

Summary

The priorities outlined in our re-freshed joint commissioning mental health strategy have been developed from our knowledge of local need and national best practice and policy implementation guidance. The priorities outlined above will commission a 'whole system' of integrated health and social care fit for the future which operates across the stepped care model to offer parity of esteem and the right care, in the right place at the right time. This will include targeted supportive and preventative interventions to strengthen community resilience and a programme of investment in evidence based services, care pathways and initiatives to deliver improved access to early intervention and prevention, urgent and crisis care and re-ablement and recovery. This will achieve 'parity of esteem' for mental health services and care pathways in comparison with physical health services in terms of access to services, quality of service user and carer experience and service user outcomes.

6. LIST OF APPENDICES

- Appendix 1 - Final Report of the Strategy Review
- Appendix 2 – Strategy Implementation Plan

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Crisis Care Concordat
Mental Health

WOLVERHAMPTON Declaration statement

The 2014 WOLVERHAMPTON Declaration on improving outcomes for people of all ages experiencing mental health crisis NOVEMBER 2014.

We, as partner organisations in WOLVERHAMPTON will work together to put in place the principles of the National Concordat to improve the system of care and support so that people of all ages in crisis as a result of a mental health difficulty are kept safe and well supported. We will help them to find the help they need whatever the circumstances and from whichever of our services they turn to first.

We will work together to prevent crises occurring whenever possible. We will do this by intervening to support people at risk of mental health crisis an early stage and by ensuring that all of our interventions focus on helping people experiencing mental health difficulties to achieve recovery and stay well.

We will support individuals, families and communities who are particularly vulnerable or at risk and we will ensure that targeted interventions in terms of mental health promotion and crisis prevention and support reach people and communities with the greatest levels of need and vulnerability.

We will respond with awareness and sensitivity to our City's diverse demographic in terms of culture and ethnicity and acknowledge the unique needs of seldom heard groups and communities such as the LGBT community.

We will work together to make sure that we focus on mental health prevention and the development of personal resilience skills across the lifespan.

We will work together to co-ordinate our responses to meeting the needs of vulnerable people in urgent situations. We will ensure that our services work together to make sure that people of all ages receive the right care at the right time from staff who respond with professionalism and compassion to ensure the best possible outcomes.

We will do our very best to make sure that all relevant public services, contractors and independent sector partners support people with a mental health problem to help them recover. We will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis.

We are responsible for delivering this commitment in WOLVERHAMPTON by putting in place reviewing and regularly updating an action plan.

We will do this working in partnership with service users and carers and working across agencies and with a focus upon the broader determinants of health and mental health.

This declaration supports 'parity of esteem' between physical and mental health care in the following ways:

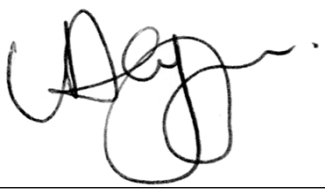
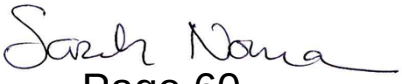
- By agreeing a shared 'care pathway' to safely support, assess and manage anyone who asks any of our services in WOLVERHAMPTON for help in a crisis. This will result in the

best outcomes for people with suspected serious mental illness, provide advice and support for their carers, and make sure that services work together safely and effectively.

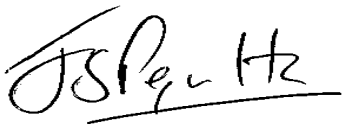
- By working together to improve individuals' experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.
- By making sure there are safe and effective services with clear and agreed policies and procedures in place for people in crisis, and that organisations can access services and refer people in the same way as for physical health and social care services.
- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to patients and service users, their families and carers, the staff that work in our services and the wider community and by working together to support people of all ages to recover and achieve improved quality of life and wellbeing.

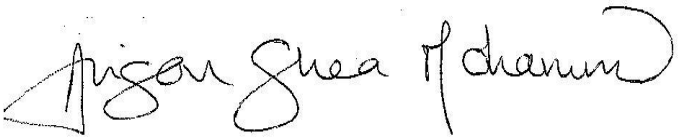
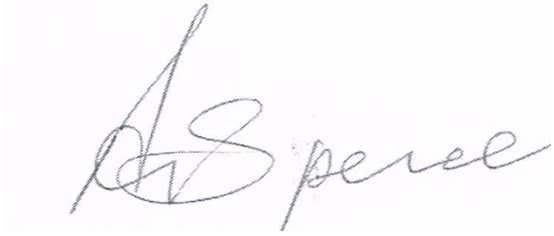
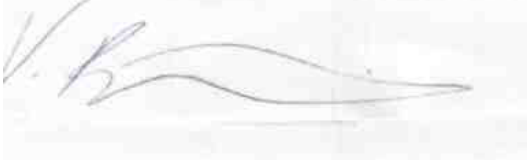
We, the organisations listed below, support this Declaration. We are committed to working together to continue to improve crisis care for people with mental health needs in WOLVERHAMPTON**.**

Electronic signatures of Chief Executive Officers and Directors of concordat partners

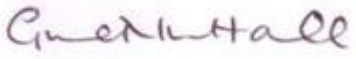
Name	Signature
Helen Hibbs Chief Accountable Officer NHS Wolverhampton Clinical Commissioning Group.	
Noreen Dowd Interim Director Strategy and Solutions, NHS Wolverhampton Clinical Commissioning Group.	
Vivienne Griffin Service Director – Disability & Mental Health, Wolverhampton City Council.	
Sarah Norman Strategic Director – People Wolverhampton City Council.	

Name	Signature
Emma Bennett **Service Director – Children & Young People.**	
Councillor Sandra Samuels - **Cabinet Member for Health and Well Being.**	
Ros Jervis **Director –** **Public Health and Wellbeing.**	
David Ashford **Head of Clinical Practice – Mental Health** **West Midlands Ambulance Service NHS Foundation Trust.**	
Superintendent Allan Gregory **Midland Sub-divisional Commander** **British Transport Police.** 	

Name	Signature
Jas Pejatta **Head of Walsall & Wolverhampton Probation – SWM Community Rehabilitation Company.** Staffordshire & West Midlands Community Rehabilitation Company PROBATION	
David Jamieson **West Midlands Police and Crime Commissioner.** west midlands police and crime commissioner	
Dave Edwards **Operations Commander** **West Midlands Fire Service.** WEST MIDLANDS FIRE SERVICE	
Anna Lunts **Chief Executive** **Creative Support**	 creative SUPPORT

Name	Signature
Mr Melvin Passmore **Wolverhampton Mental Health Stakeholder Forum.**	
John Wade **Managing Director for Support, Innovation & New Ventures Bromford Housing Association.**	John Wade Bromford.
Alison Shea Mohammed **Chief Operating Officer** **Rethink.** Rethink Mental Illness.	
Alicia Spence **Afro-Caribbean Cultural Initiative.**	
Vanessa Biddulph **Service Manager** **Voiceability.** **Black Country** VoiceAbility	 Advocacy Q P M Quality Services

Name	Signature
Lesley Roberts **Chief Executive Officer** **Wolverhampton Homes.** Wolverhampton Homes	
Janet Meredith, Project Co-ordinator **Base 25.** base 25	
Jamie Edwards **National Probation Service**	

Name	Signature
Mike O'Hara **Superintendent – Local Policing** **Wolverhampton LPU**	
Karen Dowman, Chief Executive Black Country Partnership NHS NHS Foundation Trust	
Gwen Nuttall **Chief Operating Officer** **Royal Wolverhampton NHS Trust** The Royal Wolverhampton NHS NHS Trust	

Glossary of terms used in this declaration

Concordat	A document published by the Government. The Concordat is a shared, agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental-health crisis need help. It contains a set of agreements made between national organisations, each of which has a formal responsibility of some kind towards people who need help. It also contains an action plan agreed between the organisations who have signed the Concordat. Title: Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis Author: Department of Health and Concordat signatories Document purpose: Guidance Publication date: 18th February 2014 Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf
Mental health crisis	When people – of all ages – with mental health problems urgently need help because of their suicidal behaviour, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control or irrational and likely to put the person (or other people) in danger.
Parity of esteem	Parity of esteem is when mental health is valued equally with physical health. If people become mentally unwell, the services they use will assess and treat mental health disorders or conditions on a par with physical illnesses. Further information: http://www.england.nhs.uk/ourwork/qual-clin-lead/pe
Recovery	One definition of Recovery within the context of mental health is from Dr. William Anthony: "Recovery is a deeply personal, unique process changing one's attitude, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability" (Anthony, 1993) Further information http://www.imroc.org/

Accelerating and sharing good practice in co-commissioning arrangements for child and adolescent mental health services (CAMHS) : successful pilot areas

A. Co-commissioning a comprehensive care pathway from Tier 1 – 4* (See note below)

- **NEW Devon - £75k**

Builds on NEW Devon CCG and Plymouth City Council integrated working. This will involve working closely with Plymouth Teaching School Alliance to develop whole systems approach for children and young people who may not meet specialist CAMHS criteria but who have significant issues such as self-harm or substance misuse. The pilot will work with education to develop a co-commissioned "Single Point of Contact" for professionals and parents that will identify family risk factors and enable whole family care planning and early help.

Other partner agencies involved in the application
Plymouth City Council

- **Derbyshire - £40k**

This pilot will provide commissioning capacity to enable schools to identify and manage emotional wellbeing and behaviour through early help and will be piloted with five schools as co-commissioners. The commissioned pilot service will build on good practice in integrated working, including 'team around the school', with multi-agency meetings to support children, young people and families. The pilot will test a single point of access, with a set of referral and threshold criteria which has been drafted for targeted and specialist services. The aim is to improve appropriateness and timeliness of access to specialist services.

Other CCGs involved in the application
Southern Derbyshire CCG
Erewash CCG
North Derbyshire CCG
Hardwick CCG

Other partner agencies involved in the application
Derbyshire County Council
Derby City Council
Local schools
Primary care
Voluntary and community sector
Children and Young People Derbyshire Healthcare NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust
Derby Hospitals NHS Foundation Trust

- **Newcastle - £75k**

A joint bid across Newcastle and Gateshead LAs and CCGs. They have already established a joint project to design a whole system approach to family mental health including wellbeing promotion, early support and evidence based practice. The pilot will create new commissioning arrangements by mapping CAMHS services and exploring a variety of contracting and payment methods, including personal budgets. It will build on the existing local waiting times initiative and Targeted Mental Health in Schools project. A group of children, young people and parents will be trained to be involved in the commissioning process.

Other CCGs involved in the application
Newcastle West CCG, Gateshead CCG

B. Joint commissioning across health, social care and education at Tier 2/3.

- **Tameside and Glossop - £75k**

The pilot will equip all front line staff to be able to identify and respond to mental health issues within an agreed framework for intervention providing clear pathways and access supported by consultation, advice and guidance model. The pilot will review existing thresholds for Tier 2 and Tier 3 Child and Adolescent Mental Health Services (CAMHS), benchmarked with other similar partnership services. They will ensure open consultation into developing thresholds and a service 'core offer' at Tiers 2 – 3, with all partners including children, young people and families.

Other CCGs involved in the application
Through co-commissioning partners of the CAMHS contract and as wider partners of the Pennine Care contract, Stockport, Oldham, Bury and HMR.

Other partner agencies involved in the application
Tameside Metropolitan Borough Council (including Public Health and Education)
Derbyshire County Council
Tameside and Glossop CAMHS (Pennine Care Foundation Trust)
42nd Street (voluntary sector organisation)

- **Norfolk - £40k**

This is a consortium of Norfolk CCGs and the County Council. The pilot will focus on the learning disabilities pathway. This will allow specialist time to be dedicated to reviewing and jointly commissioning more robust pathways, from a range of agencies, with piloting of how CAMHS and LA outreach teams jointly manage a number of cases.

Other CCGs involved in the application
North Norfolk CCG, Norwich CCG, West Norfolk CCG, Great Yarmouth & Waveney CCG
Other partner agencies involved in the application
Norfolk County Council, Norfolk CAMHS Strategic Partnership (members include a range of Norfolk's statutory and voluntary sector providers and commissioners)

- **Southampton - £45k**

Currently Southampton City Council and Southampton City CCG undertake joint commissioning within an Integrated Commissioning Unit. The Headstart Project covers 21 schools within the city and includes Emotional First Aid training, school counselling and mindfulness training. The pilot will develop a framework for extending joint commissioning and integrated services to help young people address a range of inter-related personal, practical, emotional, health, social welfare and legal needs simultaneously. The pilot will also identify future opportunities for re-commissioning services looking at all resources currently spent on children and young adults in order to support improved transitions, including extending to a 0-25 service.

Other partner agencies involved in the application
Southampton City Council
No Limits (Southampton) Ltd

C. Co-commissioning by clusters of CCGs with NHS England for Tier 4 CAMHS.

- **Wolverhampton - £75k**

Bid from Black Country CCGs and Wolverhampton LA to scope, map and analyse commissioning of CAMHS Tier 4 and other health funded out of area placements, with the aim of preventing the large numbers of children from the Black Country being placed 'out of area'. The pilot will develop specialist care pathways, improving early intervention and prevention to reduce the use of Tier 4 provision. It will include commissioning urgent care at Tier 3 / Tier 3+ to include focus upon delivering a Black Country wide solution to children and young people requiring admission to a place of safety (under Section 136 of the Mental Health Act).

Other CCGs involved in the application
NHS Sandwell and West Birmingham CCG
NHS Dudley CCG
NHS Walsall CCG
Specialised Commissioning within the Birmingham Black Country and Solihull NHS England Area Team

Other partner agencies involved in the application
The Black Country Partnership NHS Foundation Trust
Wolverhampton City Council
The Children's Society

D. Collaborative commissioning across the transition age span to 25.

- **South Sefton - £75k**

Wide consortium bid including LA and VCS partners. Builds on DfE-funded BOND project (which focused on VCS role in brokering and co-ordinating youth-focused emotional wellbeing services in the community). The pilot will build on existing mapping to enable clearer support pathways for 5-25 year olds, and will work with children, young people and families to design the process. The pilot will use voluntary sector services within the partnership to deliver specific services that meet the needs of young people currently being referred to Tier 3 CAMHS but do not meet the threshold.

Other CCGs involved in the application
Southport and Formby CCG

***CAMHS tiers:**

Tier 1 (Universal services)

These are services whose primary remit is not that of providing a mental health service, but as part of their duties they are involved in both assessing and/or supporting children and young people who have mental health problems. Universal services include GPs, health visitors, schools, early years' provision and others. Universal services are commissioned by CCGs and Local Authorities and schools themselves, and may be provided by a range of agencies.

Tier 2 (Targeted services)
These include services for children and young people with milder problems which may be delivered by professionals who are based in schools or in children's centres. Targeted services also include those provided to specific groups of children and young people who are at increased risk of developing mental health problems (e.g. youth offending teams and looked after children's teams, paediatric psychologists based in acute care settings). Targeted services are commissioned by CCGs and Local Authorities and schools, and are provided by a range of agencies.

Tier 3 (***Specialist services***)
These are multi-disciplinary teams of child and adolescent mental health professionals providing a range of interventions. Access to the team is often via referral from a GP, but referrals may also be accepted from schools and other agencies, and in some cases self-referral. These services are commissioned by CCGs although there may be a contribution from Local Authorities.

Tier 4 (Specialised CAMHS)
These include day and inpatient services and some highly specialist outpatient services including services for children/young people.

ENDS

Agenda Item No: **6**

Health Scrutiny Panel

12 March 2015

Report title	Wolverhampton Clinical Commissioning Group Decommissioning And Disinvestment Policy
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Well Being
Wards affected	All
Accountable director	Linda Sanders, People
Originating service	Commissioning – Wolverhampton CCG
Accountable employee(s)	Jane Woolley — Turnaround PMO, Wolverhampton CCG Tel — 01902 443075 Email — janewoolley@nhs.net
Report to be/has been considered by	WCCG Public Governing Body Meeting

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Recommendation(s) for action or decision:

The Heath Scrutiny Panel is asked to note, review and comment on the report.

1.0 Purpose

1.1 The purpose of this report is to provide the Panel with the Wolverhampton Clinical Commissioning Group (WCCG) Decommissioning and Disinvestment Policy.

2.0 Background

2.1 At the private WCCG Governing Body (GB) meeting on Tuesday 11 November, it was agreed that a WCCG Efficiency Review Group (ERG) would be established on a task and finish basis to review expenditure - this work would be completed in as short a timescale as possible.

2.2 To ensure that resources are consistently directed to the highest priority areas, the CCG has developed a “Decommissioning and Disinvestment Policy”. The policy sets out the agreed principles that the CCG will follow when decommissioning or disinvesting a service(s).

2.3 WCCG faces financial pressures and must act accordingly to protect health care service and ensure that the tax payer funding is as effectively used as possible.

3.0 Progress

3.1 The policy was approved at the WCCG Public Governing Body meeting on the Tuesday 9 December 2014. A WCCG communications approach has begun to ensure that all stakeholders are aware of the policy and the impact of the current procedures that the CCG will be undertaking to review expenditure.

3.2 By documenting the decommissioning and disinvestment process, the CCG is:

- Setting out the agreed principles for decommissioning / disinvesting a service (so that funds can be redirected where appropriate)
- Clearly defining the process that will be followed, when approval has been given to decommissioning / disinvesting a service(s)
- Defining the clear lines of accountability and responsibility throughout the process

3.3 The disinvestment and decommissioning policy is to be applied when making both clinical and non-clinical disinvestment and decommissioning decisions.

4.0 Financial implications

4.1 The CCG has a strategic plan that is transformational in its intentions; however, this level of change will take time. The establishment of the ERG has prompted immediate actions to protect the resources of the CCG, so that short term stability can be achieved whilst longer term change is initiated and embedded.

4.2 There is an immediate and substantial risk that the CCG will fail to meet its financial targets for 2015/16 and will overspend in a number of its budget areas. This undermines the foundation for the financial position in future years and potentially destabilises the CCG's commissioning strategy.

4.3 Whilst the CCG is forecasting that it will meet its 2014/15 expenditure limit, in doing so it will consume a significant amount of its recurrent reserves. This carries increased pressures into future financial years and impacts on sustainability in the medium to long term.

5.0 Legal implications

5.1 Consultation and engagement will be undertaken in line with the decommissioning and disinvestment process and in line with our legal duties.

6.0 Equalities implications

6.1 Equality Impact Assessments will be completed with each ERG recommendation to the Governing Body.

7.0 Environmental implications

N/A

8.0 Human resources implications

N/A

9.0 Corporate landlord implications

N/A

10.0 Schedule of background papers

10.1 The attached policy was agreed at the WCCG Public Governing Body on the Tuesday 9 December 2014.

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NHS
Wolverhampton
Clinical Commissioning Group

Decommissioning & Disinvestment Policy
Version 1.2

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1.2	**09/12/14**	**Final Version Approved by Governing Body**

REVIEWERS

This document has been reviewed by:

NAME	TITLE/RESPONSIBILITY	DATE	VERSION
Tim Rideout	Interim Turnaround Director	26/11/14	1.0
Claire Skidmore	Chief Finance and Operating Officer	27/11/14	1.0

APPROVALS

This document has been approved by:

GROUP/COMMITTEE	DATE	VERSION
Efficiency Review Group	02/12/14	1.1
WCCG Governing Body (Public)	09/12/14	1.2

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Contents Page

Executive Summary

Due to the current challenging financial climate, it is important for the CCG to demonstrate that it is making the most effective use of public money to commission the right care, in the right place, at the right time within the context of our resources, and in order to deliver our statutory responsibilities, and meet the needs of the Wolverhampton population.

To achieve this, effective contracting arrangements and strong performance management are essential to meet these challenges, and secure the best possible healthcare for our local population.

The CCG will ensure that our commissioning decisions are fully informed and based on health outcomes data by utilising all reliable data sources combined with public health data and clinical analysis.

To ensure that limited resources are consistently directed to the highest priority areas the CCG has identified the need to develop a Decommissioning and Disinvestment policy that sets out the agreed principles for decommissioning a service, so that funds can be redirected where appropriate.

There is also a need to ensure that when approval has been given to decommission, or disinvest a service that a clearly defined process is followed, with clear lines of accountability and responsibility.

For the purpose of this policy the following definition have been applied:

- **Decommissioning:** This relates to the withdrawal of funding from a provider organisation that is subsequently re-commissioned in a different format.

- **Disinvestment:** This relates to the withdrawal of funding from a provider organisation and the subsequent stopping of the service.

In the event that decommissioning or disinvestment is proposed, the CCG will need to recognize that a number of steps will be required prior to a final decision being taken by the CCG Governing Body.

These include consideration as to whether a consultation exercise is required with partner organizations, patients, public and the Health Overview and Scrutiny Committee.

1. Introduction

The CCG's long term commissioning strategy and financial challenges has inevitably led to the need to clarify the circumstances of when services should be decommissioned, and the need to describe the approach and processes, that will be adopted to ensure decommissioning and disinvestment decisions are fully informed and managed.

Following any service review a number of options will be available to the CCG.

These will include:

- The need to re commission part of the service,
- Amend the threshold / restrict access to a service or
- Provide a modified service to ensure that there are no gaps in healthcare delivery.

In line with best practice the CCG has identified the need to describe the approaches that will be used to identify services that require review, describe how the 'Case for Change' for service decommissioning will be produced and how disinvestment decisions will consulted upon, Furthermore, the roles and accountability of decision making have been set out.

The disinvestment and decommissioning policy is to be applied when making both clinical and non-clinical disinvestment and decommissioning decisions.

2. Our approach to Decommissioning and Disinvestment

The aim of this policy is to:-

1. Provide a rationale and process to allow services to be identified for review prior to any decision to decommission or disinvest.

2. Deliver best value for money by ensuring that local health care resources are directed to the most effective services for the local population.

3. Ensure all commissioned services are monitored in terms of performance, health outcomes, efficiency, demand management and fitness for purpose to allow for a robust decision to be made regarding the continuation of that service.

4. Contribute to the delivery of the CCG's commissioning plan and QIPP agenda, to ensure that resources are directed to the highest priority area in order to achieve the best possible health outcomes for the local population against available resources.

5. Ensure all decommissioning and disinvestment decisions are taken in a fully informed manner and follow a set procedure agreed by the CCG Governing Body.

6. Ensure the safety of patient remains paramount.

3. Structure and Accountabilities

3.1 CCG Governance Processes

3.1.1 Clinically-led structure

The CCG's Operating Plan 2014-16 sets out our two-year roadmap and explains how the CCG will start to transform local care for the better, the plan describes the structure for the planning and delivery of the CCG's commissioning strategy through the delivery of QIPP priorities and the release of benefits associated with assuring and improving quality, harnessing innovation, improving productivity and reducing demand for services.

The Operating Plan is clinically driven and designed so that clinical expertise and decision-making can be combined with the rigour of Programme Management using a commissioning cycle approach to deliver QIPP improvements and therefore improved health outcomes for the Wolverhampton CCG population.

3.1.2 Locality ownership and accountability

The broad role of the CCG localities within this planning and delivery framework is two-fold. Firstly, localities are required to work with Delivery Boards in order to design service transformation, integration and quality improvement strategies and plans.

Secondly, localities will have delegated responsibility for delivering QIPP benefits for the segment of the Wolverhampton population for which they are responsible. This will involve an operational business planning process whereby individual localities will agree the most appropriate way (for their constituent practices), to deliver against QIPP benefits targets which contribute to improved health outcome.

The overarching Commissioning Business (delivery) Plan for the CCG is therefore chiefly a composite of Locality Business Plans and Better Care Fund plans.

3.1.3 Wolverhampton CCG Commissioning Strategy

The Business Planning Framework is informed by and developed within the context of the CCG's Strategic Plan.

The Strategic Plan identifies how the organisation intends to shape the commissioning and provision of health care for the Wolverhampton population over the next 5 years in order to improve health outcomes.

3.1.4 Commissioning Committee – Strategic Planning

The delivery of the CCG's Commissioning Strategy plan is overseen by the Commissioning Committee which has a strategic, governance and assurance remit and is composed of the senior managerial and clinical leadership of the CCG. The Commissioning Committee is a decision-making body which is supported by the CCG's programme management structure.

It will oversee the development of the CCG Strategic Plan; ensure all commissioning plans - Operating Plan, locality plans and Better Care Fund plans - are aligned to the strategic objectives of the CCG.

3.1.5 Finance and Performance Committee – strategic delivery

The Finance & Performance Committee (FPC) is accountable to the Governing Body and its remit is to provide assurance on issues related to the finances, including financial health, of the CCG and the achievement of performance objectives and targets.

Part of the remit of the committee is to review plans for and delivery of initiatives under QIPP and any subsequent programme of that nature; and to make recommendations as necessary to the Governing Body on the remedial actions to be taken with regard to finance and performance issues and risks, including in-year changes to budgets.

3.1.6 QIPP Portfolio Board – operational planning and delivery

The QIPP Portfolio Board has a dual function within this structure and is the fulcrum upon which effective commissioning business planning and delivery is balanced.

The QIPP Portfolio Board will report on progress on delivery to the Finance & Performance Committee and the localities using standard reporting formats.

The QIPP Portfolio Board is a high level board which oversees the CCG's delivery of QIPP programme by holding the lead Executive directors of each Programme Delivery Board to account for performance against their QIPP target. Chaired by the DCFO and supported by Business and Performance and Quality, the Board receives exception reports for schemes which are not delivering to plan or are no longer viable.

The QPB acts as an escalation vehicle to ensure delivery of schemes are not compromised and the PDBs deliver their target. It is for the PDBs to operationally manage the QIPP delivery within their areas identifying new schemes as appropriate.

The Board also oversees the whole QIPP planning cycle (over 5years in line with the LTFM) and takes the strategic view of QIPP schemes (over 5years in line with the LTFM), including their fit with the CCG strategic direction including Better Care Fund.

3.1.7 Delivery Boards

Delivery Boards are the key mechanism for clinical discussion and agreement regarding the delivery of effective and efficient care which improves health outcomes across the local health community. They are key engagement mechanisms for local stakeholders, clinical or otherwise, and are chiefly concerned with how the benefits and outcomes for their portfolios are to be achieved.

They will act as the key decision-making bodies for their sector of care; they will include primary care clinicians in agreeing optimum means by which the challenge of QIPP and improvement in health outcomes can be met.

The Delivery Boards are chiefly concerned with the development and evaluation of strategies and plans that are delivered through localities and a number of QIPP work streams

3.2 Efficiency Review Group.

3.2.1 Role

The Governing Body, as the legally accountable body in Wolverhampton, will ultimately take the decision with regard to the decommissioning of any service following the criteria and process set out in this policy.

The vehicle for managing the task of reviewing expenditure and making recommendations to the Governing Body will be the 'Efficiency Review Group' (ERG). The group will report directly to the Governing Body and whilst it will not have delegated responsibility to make disinvestment decisions it will be required to make clear recommendations to the Governing Body.

The ERG will be established on a task and finish basis with challenging deadlines for the review of expenditure in order that benefits can be realised in as short a timescale as possible.

Once recommendations are made and the Governing Body have agreed actions to be implemented the CCG will follow all necessary steps for consultation; notice periods and transition to alternative services where necessary and appropriate. At this point the ERG will refocus its work to oversee delivery of the work programme.

3.2.2 Principles

The following principles will be adopted throughout the ERG process.

These are as follows:

4. Roles and Responsibilities of the CCG & of the wider teams

The following describes the role and responsibilities within the CCG, and how each role will influence and interact in the disinvestment / decommissioning process.

4.1 Accountable Officer

The Accountable Officer is accountable for the actions undertaken by the CCG Heads of Service, as noted below.

4.2 CCG Heads of Service

The CCG Heads of Service are responsible for the commissioned service and are required to undertake the following actions when considering disinvestment / decommissioning proposal:

- Secure any appropriate legal advice through discussions with the Chief Finance Officer and Corporate Operations Manager.

- Assess the benefits the service has realised and assess the potential for any further improvement to the services effectiveness.

- Inform the relevant department(s) of the benefits identified; and plan with them how to obtain valid evidence of positive progress.

- Review the monitoring of the benefits realised.

- Undertake an initial service impact analysis.

- Prepare a case to be considered by the ERG in respect of decommissioning / disinvestment of the Service.

- Adopt a programme management approach to manage the processes to inform the ERG of the development of a “Disinvestment Impact Assessment” document that will be used to consult and ultimately be presented to the Governing Body.

  The case for change will include:-

  - The evidence behind why the case for the case is being proposed for a decommissioning / disinvestment decision.

  - Undertake all appropriate impact analysis prior to these being presented to the CCG Quality Committee / QiPP

  - Keep log of the risk and issues identified.

4.3 Quality

The CCG Quality Committee is a key forum to notifying commissioners when concerns are raised in terms of the quality and safety of the services provided.

The team utilizes information from a variety of sources to assess the safety, efficacy and service user experience of clinical commissioned services. This information along with site visits and other intelligence is used to assess the relative quality of services commissioned or contracted by the CCG.

The Heads of service will work with the Quality Team, proposing the decommissioning of service(s) to ensure that a reduction in services does not have a direct or indirect negative impact on patient safety or the quality of any other related service.

The availability of good quality information is important to the decision making process in commissioning, NICE guidance and commissioning guides are used to inform all relevant commissioning decisions.

4.4 Contracting

The CCG is responsible for ensuring that providers who have been commissioned to provide health care services have a contract with the CCG that specifies the services to be provided, the value of that service and the means by which the CCG will be able to hold the provider to account for the delivery of the service.

The contracting team works with our providers to ensure day to day operational issues that affect the service delivery are resolved effectively.

In most cases the contracting team will assess the performance of a particular contract or contractor by the use of monthly monitoring data, by contract meetings with the commissioned providers; these would typically take place on a monthly basis.

Any remedial actions required would be clearly agreed in an action plan and a follow up meeting, where necessary providers will be recompensed for unavoidable costs incurred following the cessation of services.

4.5 Strategy and Solutions

The Strategy and Solutions teams are a key part to reviewing the services against health outcomes and identifying service / programme areas to be reviewed prior to more in depth analysis to identify specific commissioned services.

Areas for review will be identified using the following tools:

- Analysing trends by care setting e.g. Acute Care, Primary Care, community services, mental health etc. and comparing these trends of spend with other areas, to identify the reasons for the difference in trends between PCTs.

- Expected and current prevalence figures to understand the population demographics.

4.6 Finance Team

Our Finance team are key to reviewing expenditure against health outcomes and identifying service areas to be reviewed.

Reviews are done using the following tools:

- Programme Budgeting Results: Using the programme budgeting benchmarking tool to identify how much is spent by the organisation for each programme compared with similar CCGs. It also analyses the relationship between spend and the health outcomes, and investigates variances to understand the reasons for investing these resources.

- Various other benchmarking tools: Using various benchmarking tools to analyse the trends in activity over time in comparison to national, regional and local benchmarks on activity/spending trends.

4.7 Performance Team
The CCG's Performance Team are responsible for providing key performance information to commissioners to ensure that services are appropriately reviewed.

The information behind a decision to decommission must be of high quality, be auditable and able to be presented as evidence which can withstand challenge should the decision be disputed.

The tools referred to in section 5 are utilised by the team to identify areas for further consideration by commissioners.

The team look for areas of:

- Poor performance against targets
- Poor health outcomes
- Poor value for money
- Inequality of service provision
- Reduced impact on health outcomes and identify potential areas for resources to be redirected to achieve better health outcomes for the population we serve.

4.8 Public Health Team
When considering service for decommissioning or disinvestment the Wolverhampton County Council Public Health team will be able to help assess the effectiveness of the intervention(s) provided by the service and contribute to the health impact assessments required in making informed decommissioning / disinvestment decisions.

The Public Health team have the skills and ability to add to the interpretation of population based data that are used to highlight areas for decommissioning, such as benchmarking tools which compare the cost and / or outcomes of services compared to other CCG and previous PCTs.

The Public Health Team are a core member of the ERG.

4.9 Human Resources Advice
HR expertise will be sought should the decommissioning of services be confirmed, to ensure all legal obligations and any potential workforce planning issues are appropriately managed.

4.10 Communications Engagement Team
If decommissioning or disinvestments is proposed due to the introduction of a new service model, then the commissioner needs to seek expert advice from the communications team in relation to whether any engagement / consultation exercise is required to comply with Section 242 of the NHS Act (2006).

This advice must be sought at the earliest possible opportunity due to the length of time required for informal engagement and public consultation.

Health Scrutiny Panels / Committees, Key Stakeholders and Health Watch should be advised and involved from the outset.

The timescales required plus other guidance on engagement/ consultation criteria can be found through national best practice guidance.

4.11 Procurement Lead
Specialist Procurement advisors within the CSU and the CCG Procurement lead will ensure that the rules and principles relating to any decommissioning (and disinvestment) activity will follow the principles and rules of cooperation and competition.

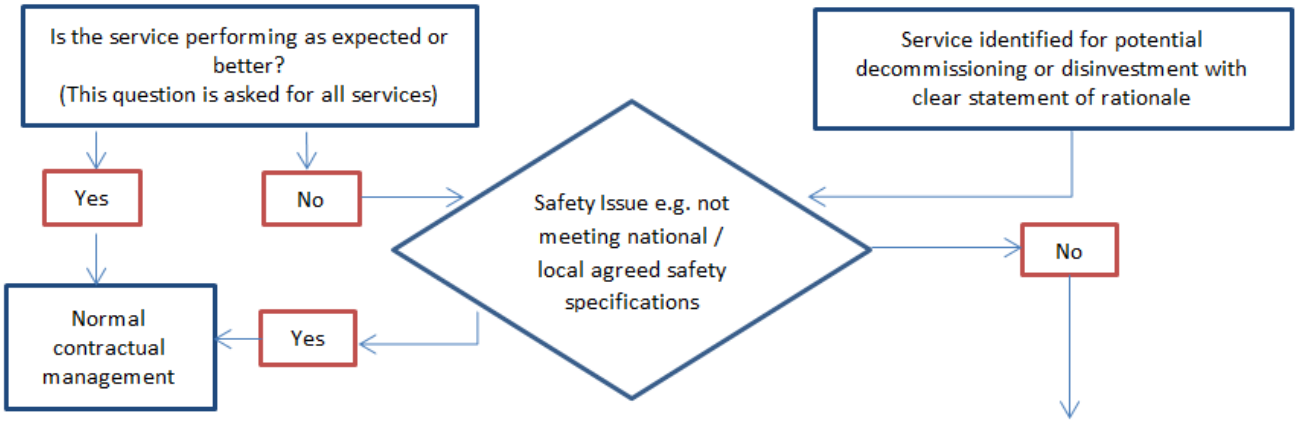
Monitor Guidance must be considered to ensure that no sector of the provider market is given any unfair advantage during the decommissioning process, and the CCG will retain an auditable documentation trail regarding all key decisions around procurement law. The Procurement advisors will also ensure market assessments are completed to analyse any impact on the provider market.

5. Decommissioning and Disinvestment Processes for Commissioned Services

5.1 Process Flow Chart

The Disinvestment / Decommissioning tool flow chart (appendix one) provides at a glance the agreed process for commissioners to follow prior to commencing decommissioning / disinvestment discussions.

5.2 Step One



5.2.1 Identification of service for review

The Process for identifying services for review and potential decommissioning / disinvestment needs to be systematic and there are a number of mechanisms utilised to evidence the need for review.

In line with commissioning best practice there is a need to ensure that WCCG apply performance and contract management principles to all contracts and subsequently service reviews.

Each commissioned service, shall be initially reviewed to confirm if the “service is performing as expected or better?”

The CCG can then identify commissioned services that:

1. Do not meeting the needs of the population (as identified through the Joint Strategic Needs Assessment, Enhanced JSNA and demand analysis);

2. Of low quality and do not demonstrate value for money.

3. Of high expenditure and low outcomes.

4. Has continued poor performance identified through the contract monitoring process and / or feedback from patients, public and partners.

5. Are not meeting the health needs of the population (as demonstrates via a health needs Assessment

6. Do not maximise the health gain that could be achieved by reinvesting the funding elsewhere.

7. Do not meet the standards of a modern NHS as defined by:
    - Professionally driven change i.e. provider driven business case which delivers modern innovative service.
    - Nationally driven change i.e. National policy or guidance requires change in service delivery.
    - The service is one with limited clinical evidence, quality or safety.

5.2.2 Tools to be used to Identifying Service Review Areas

The CCG is committed to ensuring that our local population receives the best care, for the best value and subsequently ensures that there is a continual review of CCG contracts and expenditure against measurable health outcomes.

As a matter of policy the CCG will prioritise those areas where high expenditure and low outcomes are identified to enable / undertake further analysis into the provision of commissioned services .

- **NHS Comparator**

NHS Comparators data provided analysis of quarterly inpatient activity and expenditure data by programme budget at England, a SHA, previous PCT and Practice level. Prescribing expenditure and volume data linked to programme budget are also available. NHS Comparators allow commissioners to track expenditure and outcomes over time.
https://nww.nhscomparators.nhs.uk/

- **Programme Budgeting**

Programme budgeting information is used to examine the current deployment of resources, and to make decisions on how resources should be invested to achieve better value outcomes. There are a number of tools that can be used to consider areas for review including the Department of Health benchmarking toolkit below:
http://www.networks.nhs.uk/nhs-networks/health-investment-network/news/2011-12-programme-budgeting-data-now-available

The above toolkit provides a means of considering our expenditure compared to other Trusts both locally and nationally.

- **The Spend Outcomes Tool**

The Spend and Outcomes tool (SPOT) was developed by the Association of Public Health Observatories.

The tool allows comparison between expenditure and outcome data for each of the Programme Budget disease categories on a single page. It is interactive and allows the selection of different outcome measures and different views of the data, including a comparison with any other organizations therefore enabling the ability to identify areas of expenditure that warrant further investigation. Data is at previous PCT level.

- **Ssentif Benchmarking System**

The Ssentif benchmarking website which enables benchmarking outcomes and expenditure against other Trusts / Providers both locally and nationally

- **Programme Budgeting Atlases**

Programme budgeting expenditure has also been linked to health outcomes, Quality Outcomes Framework (QOF) data and Hospital Episodes Statistics (HES) activity in the Programme Budgeting Atlases.

These interactive atlases present programme budgeting expenditure data alongside clinical and health outcome indicators in a user friendly graphical format that can be used to support commissioners when considering areas for service review.

The following link http://www.rightcare.nhs.uk/index.php/nhs-atlas takes the user to the Information Centre website where the interactive atlas can filter and benchmark outcome indicators

- **Mosaic**

Mosaic is a national geo-demographic segmentation that splits the UK population into 11 groups and 61 types based on national characteristics. Mosaic enables us to gain a greater understanding of the differing health need of the local population and supports commissioners to consider whether services are placed in appropriate locations, are being advertised appropriately and are being accessed by those that need it.
The utilisation of services by their target population groups will be a consideration when making decommissioning or disinvestment decisions.

- **Contract Register**

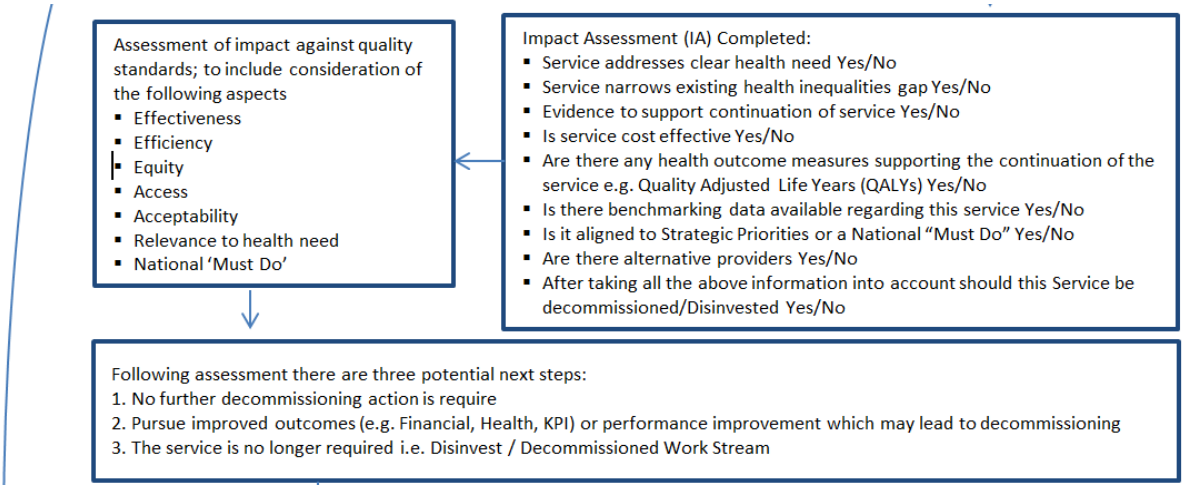
The contract register holds records of all contracts currently held by the CCG. The register will be able to provide information on all providers delivering services and contractual information to support decommissioning decisions and the procurement work stream.

- **Service Users**

A key mechanism for identifying potential services for review is feedback from service users via, complaints, compliments, the CCG's Patients Groups, patient survey results and Healthwatch.

The CCG Executive Nurse will also proactively seek views from relevant community groups and feedback from patients who have been service users, or are likely to be service users in the future.

5.3 Step Two



5.3.1 Initial Assessment and Assessment of impact

In the event that a case for change is validated by sufficient supporting evidence, the lead identified via the ERG will be responsible for developing an impact assessment (IA) (appendix two).

The impact assessment (IA) will identify the anticipated or actual impacts of any disinvestment / decommissioning on health, social, economic and workforce.

The impact assessment will also include reference to: -

- Health outcomes – the effect on health outcomes will be assessed to identify potential adverse consequences of disinvestment or decommissioning and what might to done to minimise them.

- Quality of services – to ensure that the quality of services will not deteriorate following any proposed changes. The CCG will use its agreed Quality Impact Assessments tools to carry out the reviews.

- Equality and diversity implications – underpinned by the principle that people should have access to health care on the basis of need. However enshrined in law there are a number of identified protected groups, categories of the population that require specific consideration

In addition to the above, the leads will consider the following areas when completing a IA:-

- Workforce implications
- Market implications
- Geographic implications e.g. impact on transport links etc.
- Value for money
- Impact on partner organisations e.g. Sustainability including impact on partners.

5.3.2 Preparing the case for change

Once the IAs have been prepared they will be presented to the ERG for review, The ERG will review each IA fully.

The following will be considered by the ERG when developing the case for change for services under the review for disinvestment or decommissioning:

- Gaps in care created by disinvestment or decommissioning the service
- Managing the negative impact on the services identified for potential disinvestment or decommissioning and mitigated against them.
- The patient experience need must be paramount in informing any decision, action should be taken to minimize the impact of gaps in service provision once the service is decommissioned or disinvested.
- The outcomes of the Quality and Equity Impact assessments must be considered in order to quantify and clarify and positive or negative impact on patient care and the wider community (i.e. carers)
- The potential destabilising effect on other service and organisations e.g. third sector, of a decision to decommission/disinvest should be fully considered.
- The clinical impact of decommissioning or disinvesting from the provision

All proposed changes will be communicated clearly back to the leads as part of the process to create the final case for change.

All IA's must be approved via the ERG prior to being presented to the Governing Body; The ERG will not have delegated responsibility to make disinvestment decisions, only recommendations to the Governing Body.

The CCG is committed to engaging patients, carers, the public and wider stakeholders at all stage of commissioning, As part of this the CCG will communicate clearly, fully and continuously with all stakeholders before, during and following any decision to disinvest in or decommission services.

5.3.3 Decision making framework

Making good decisions regarding health care priorities involves the exercise of fair and rational judgment and at times discretion.

Although there is no single objective measure on which such decisions can be based, decisions will be fully informed taking into account the needs of individuals and the community, Whilst recognising the CCG need to achieve a financial balance its discretion will be affected by factors such as the NHS Constitution, national Planning Framework, NICE technology appraisal guidance and Secretary of State Directions to the NHS.

The CCG will adopt a robust approach to its decommissioning / disinvestment decisions by ensuring decisions are lawful and consistent.

This will be achieved by:

- Providing a coherent structure for discussion, ensuring all important aspects of each issue are considered prior to decisions being made.

- Promoting fairness and consistency in decision making and with regard to different clinical topics, reducing the potential for inequity.

- Providing a means of explaining the reasons behind the decisions made.

- Reducing risk of judicial review by implementation of robust decision-making processes that are based on evidence of clinical and cost effectiveness and adopting a decision making framework so that decisions are made in a manner which is fair, rational and lawful.

- Ensuring the Vision, values and goals of the CCG are reflected in business decisions.

- Providing a consistent approach for the development of strategy and plans across the whole health care system.

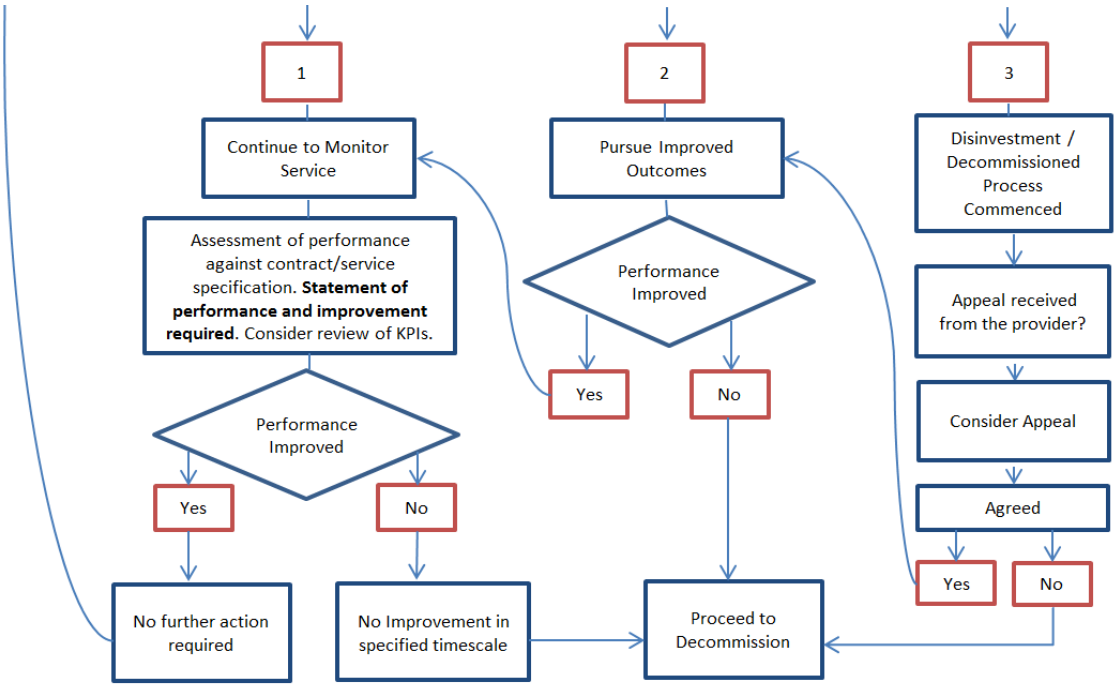
- Ensuring any potential or actual conflicts of interest are managed effectively in line with established policies

5.4 Step Three

The Governing body will review the recommendations presented by the ERG and it's supporting Impact Assessments.

The ERG will make one the following three recommendations to the Governing Body on the services reviewed:

1. Continue to monitor the service
2. Purse improved Outcomes
3. Disinvest or Decommission the service



5.4.1 Monitor the service

If the recommendation of the ERG is to continue to monitor the service, the service will be notified and a statement of performance and improvement will be developed with the service. The service will have a set timescale to improve the service and achieve key KPIs.

5.4.2 Pursue Improved outcomes

The service will be informed by the CCG, that improved outcomes are to be completed within a set time, failure to achieve the required outcomes within the timescale confirmed, will result in the CCG recommending to the Governing Body that the service is decommissioning or disinvesting.

The service will receive an action plan of improvement and will provide updates to the CCG at key points with the timescale. A full report will be presented to the Governing Body at the end of the agreed timescale.

5.4.3 Decisions to Decommissioning or Disinvesting

The CCG Governing Body will use the following criteria to inform its decisions to decommissioning or disinvesting from services:

- The recommendation(s) of the CCGs ERG.
- A needs assessment demonstrates existing services are not meeting the health needs of the population.
- There is a clear and objective reason for the decommissioning of a service that is based on assessment of the current providers' performance, value for money and the need for service redesign to improve services for patients.
- The original decision to fund a service was made on assumptions that have not realised.
- There are demonstrable benefits for the decommissioning of a service.
- There is inability to demonstrate delivery of agreed outcome measures or failure to deliver outcomes, despite agreed remedial action as detailed in the relevant contract.
- Service does not deliver value for money, as demonstrated through financial review, utilising programme budgeting tools such as the Spend and Outcome Tool and other similar modelling tools.
- The investment in a service does not maximise the health gain that could be achieved by reinvesting the funding elsewhere.
- Service fails to meet the standards of a modern NHS as defined by the NHS constitution, professionally driven change and nationally driven changes.
- The service is unable to demonstrate clinical and cost effectiveness.
- The service provided is no longer the statutory responsibility of the CCG.
- The service is no longer shown to be a component of the CCGs core provision.
- The service is unsafe or of poor quality.

Where decommissioning is a direct result of the provider's breach of contract, a service must be maintained in the short to mid-term - options for recovering any excess cost shall be pursued via the contractual terms and conditions.

Where a service is decommissioned but the health need for a service remains - this should be recorded in the IA and the funding ring-fenced for on-going investment in meeting that health need. This should be approved at the point of ratification.

Where decommissioning is the result of an insufficient health need, the funding should be identified as a QIPP saving and any reinvestment in alternative services as per the current investment planning and prioritisation process(es).

5.5 Principles of Decommissioning / Disinvestment
Following the governing body's approval, The Decommissioning / Disinvestment Process will commence.

The CCG will communicate clearly, fully and continuously with all stakeholders following any decision to disinvest in or decommission services. **10 operational days** will be allowed for this communication and queries from stakeholders to be dealt with before notice is served on the provider. The responsibility for serving notice on the provider is with the contract manager or as otherwise determined by the CCG Accountable Officer.

For any substantial service change an appropriate period of consultation will be undertaken before any decision to disinvest or decommission is made. The feedback from all statutory and non-statutory consultation will be fully reviewed and analysed and will be used to assist in the decision making process.

Formal public consultation in line with "Overview and Scrutiny Committee" guidelines must take place where the decommissioning of the service or contract results in a material change to the delivery of the re-commissioned service (except when the service is recommissioned by Any Qualified Provider procurement), or where the service will not be recommissioned. https://www.gov.uk/government/publications/advice-to-local-authorities-on-scrutinising-health-services

This occurs where:

- There is insufficient need/demand to warrant the current volume of service and/or number of providers,
- The service is no longer a clinical priority and is classed as 'non-essential',
- A mismatch is demonstrated between need and the current profile of services following a health needs assessment.

The CCG in line with the approach for transparency and openness will provide intelligence to the provider (as part of the notification letter) as to why the service has been decommissioned or ceased through disinvestment, i.e. the decommissioning / disinvestment of a service has been based on assessment of the current providers' performance, value for money and the need for service redesign to improve services for patients.

Following the stakeholder communication, the provider will be notified in writing of the plan to Decommission / Disinvest the service.

The CCG will communicate clearly and fully why the service, as to the reason to Decommission / Disinvest, and the "next steps" that will be undertaken in the process.

The provider (following notification of decision to decommission) will provide the commissioner with an 'Exit Plan' outlining actions required by both parties for smooth service cessation.

The plan will cover a minimum

- Patient continuity of care
- Patient records
- Staff
- Estate
- Equipment
- Stock (where funded by the commissioner)

The commissioner will ensure mechanisms are in place where, in conjunction with the provider, execution of the exit plan is actively managed.

Decommissioning of any service will be managed in line with the “Principles and Rules for Co-operation and Competition” regulation (2012) and related Monitor Guidelines. https://www.gov.uk/government/publications/principles-and-rules-for-cooperation-and-competition

Disinvestment of any decommissioned service will also be processed in line with NHS Wolverhampton Standing Orders and Prime Financial Polices. In addition an assessment of potential contestability should be undertaken in line with the CCG procurement strategy.

5.6 Recordkeeping

An auditable record/trail of decision making and all communication relating to each decommissioning decision and contract termination will be kept by the CCG.

This is vital, both to demonstrate that the decommissioning process was robust and transparent, and as evidence in the event of any challenge, legal or otherwise.

5.7 Decommissioning or Disinvestment review process

A decommissioning or disinvestment review process will be put in place so that any affected stakeholder can request a review of the decision making process, in line with the approach to transparency and openness.

In the event of a service being decommissioned or ceased through disinvestment, the service will have the opportunity to provide evidence to appeal against the decision.

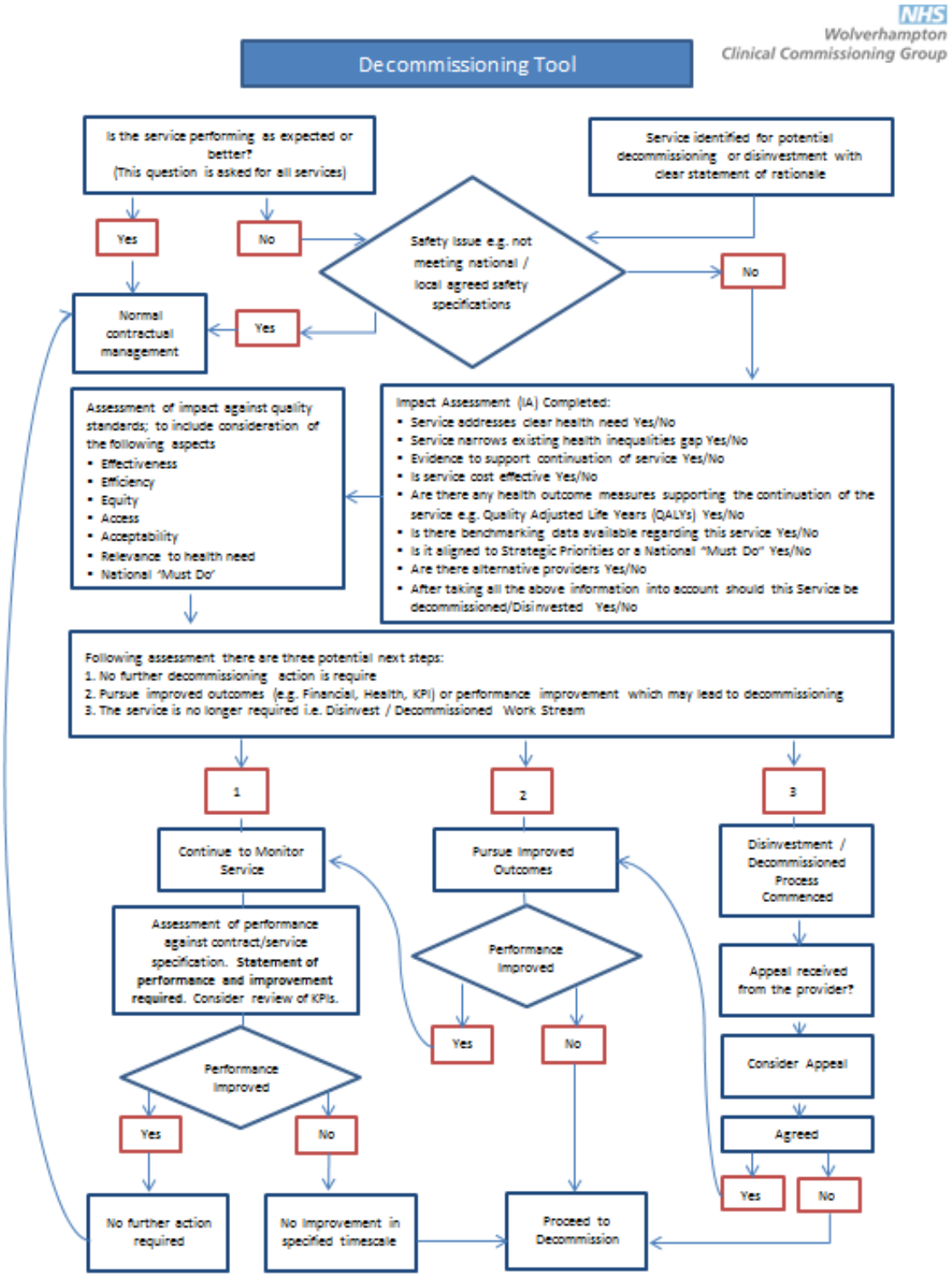
An appeal against the decision will be accepted from the provider if the appeal is received within **10 operational days of the notice being given.**

The ERG will review the evidence presented by the provider along with the supplementary evidence of the IA and ERG review, to re-examine the decision process made.

If the ERG concludes at the end of the review process, that the decision is valid, the CCG will provide further intelligence to the provider as to why the CCG advocates its decision.

If the ERG concludes that the provider’s evidence supports a further review, then the ERG will report its evidence to the Governing Body for final decision.

Appendix One



Appendix Two

Impact Assessment Template

IMPACT
ASSESSMENT (IA) Te

NHS
Wolverhampton
Clinical Commissioning Group

Wolverhampton Clinical Commissioning Group
Technology Centre
Wolverhampton Science Park
Glaisher Drive
Wolverhampton
WV10 9RU

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Agenda Item No: **7**

Health Scrutiny Panel

12 March 2015

Report title	Musculoskeletal (MSK) Services Consultation	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Well Being	
Wards affected	All	
Accountable director	Noreen Dowd, Interim Director of Strategy and Solutions	
Originating service	Wolverhampton Clinical Commissioning Group	
Accountable employee(s)	Sharon Sidhu	Solutions & Development Officer (Planned Care)
	Tel	01902 444317
	Email	Sharon.sidhu@nhs.net
Report to be/has been considered by	N/A	

Recommendation(s) for action or decision:

The Panel is recommended to:

1. Receive and note the Musculoskeletal (MSK) commissioning and consultation plans.

2. Comment on the proposed consultation plans

1.0 Purpose

1.1 To provide health scrutiny with an overview of the proposed musculoskeletal (MSK) commissioning and consultation plans.

2.0 Background

2.1 The Orthopaedic Community Assessment Service (OCAS) was originally established and managed by the PCT (pre CCG) to provide efficient and effective management of adult non-emergency musculoskeletal (MSK) patients registered with general practices within Wolverhampton. OCAS became part of the Orthopaedic Directorate at RWT in 2011 under Transforming Community Services.

2.2 The service was developed to improve the management of patients with MSK problems by ensuring appropriate and timely management of referrals through high quality triage assessment and management, and a source of accessible and expert advice on conservative management. Its other functions included ensuring patients were seen by the right person in the right place at the right time, minimising multiple steps or delays, and supporting the treatment of patients within the 18 week RTT targets.

2.3 Within the current system, the services that deliver MSK (OCAS, Physiotherapy, and Orthopaedics) are disjointed, inefficient and slow. There are many steps in the patient's journey which could be deemed unnecessary and this drives down efficiency in terms of time, capacity and cost.

2.4 The procurement and implementation of an integrated MSK service will provide a more streamlined and efficient service for patients. The development of a new service model could encompass and be extended to include all aspects of MSK care, including secondary care treatment which could be undertaken in a community setting. A new integrated MSK model could help facilitate an MDT (Multi-Disciplinary Team) approach to care planning with the skills and expertise of each clinician being accessed as needed in a streamlined efficient way.

3.0 Public Consultation

3.1 As part of any procurement process the CCG has a duty to engage with patients and the public on any proposed service changes, and ensure that any feedback is considered in the development of the service specification.

3.2 As part of the pre-engagement the CCG held a number of focus groups which were promoted through the following forums: Patient Participation Groups, Patient Partnership Database, Citizens Forum and the CCG website. In addition a pop-up shop was held in the Mander Centre during December 2014.

3.3 Feedback from the focus groups and pop-up shop has helped inform and shape our consultation document (see appendix 1). Stakeholder consultation will run for twelve weeks commencing on Monday 16 March 2015 and ending on Monday 8 June 2015, and will be available in hard copy and via the CCG website.

3.4 The table below provides an overview of the consultation plan.

Stakeholders	Event/Activity	Location and Date
Pubic and stakeholders	South East Locality workshop	19 March 2015 Bilston Town Hall 6.30pm to 8.30pm
Public and stakeholders	South West Locality workshop	24 March 2015 Linden House, Tettenhall 6.30pm to 8.30pm
Public and stakeholders	North East Locality workshop	26 March 2015 Lowhill Community Centre 6.30pm to 8.30pm
GPs	North East GP Locality Meeting	14 May 2015
Public and Stakeholders	City wide event workshop	15 May 2015 Linden House, Tettenhall 2pm to 5pm
GPs	South East GP Locality Meeting	27 May 2015
Public and stakeholders	Patient Participation Group (PPG) Chairs Meeting	28 May 2015
GPs	South West GP Locality Meeting	4 June 2015
Engagement with existing service users of MSK Services	Drop-in sessions Survey/questionnaire	Outpatient clinics - June 2015 (Dates TBA)
Public and stakeholders	Citizens Forum Meeting	TBC
Healthwatch and stakeholders	Joint Engagement Advisory Group (JEAG)	TBC
Public and Stakeholders	Consultation Document available online via CCG Website	16 March 2015 to Monday 8 June 2015
Public and Stakeholders	Consultation Documents and/or posters will be distributed to GP practices, libraries, health centres, pharmacies, outpatients and Patient Advice and Liaison Services (PALS).	16 March 2015

4.0 Financial implications

4.1 The key drivers for the development of an Integrated MSK service are to provide a local, accessible and cost effective service for patients.

5.0 Legal implications

5.1 Wolverhampton CCG is responsible for engaging with patients and the public regarding proposed changes to existing services.

6.0 Equalities implications

6.1 The Integrated MSK Service Specification will adhere to equalities legislation, a Equality Impact Assessment will be undertaken on the new proposed service.

7.0 Environmental implications

7.1 Not applicable.

8.0 Human resources implications

8.1 Not applicable.

9.0 Corporate landlord implications

9.1 Not applicable.

10.0 Schedule of background papers

10.1 Not applicable.

NHS
Wolverhampton
Clinical Commissioning Group

A Consultation on the Redesign of Muscle, Bones and Joint Services

DOCUMENT STATUS:	**To be Approved /Approved**
DATE ISSUED:	
DATE TO BE REVIEWED:	

AMENDMENT HISTORY

VERSION	DATE	AMENDMENT HISTORY
V1	**12.02.2015**	**First Draft**
V2	**24.02.2015**	**First review by Task and Finish Group**
V2	**25.02.2015**	**Shared with service users for comments re language/accessibility**

REVIEWERS

This document has been reviewed by:

NAME	TITLE/RESPONSIBILITY	DATE	VERSION

APPROVALS

This document has been approved by:

GROUP/COMMITTEE	DATE	VERSION

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RELATED DOCUMENTS

These documents will provide additional information:

REF NUMBER	DOCUMENT REFERENCE NUMBER	TITLE	VERSION

Glossary

Trauma and Orthopaedics

Trauma and Orthopaedics is the surgical specialty concerned with bones and joints. Orthopaedic trauma includes fractures and dislocations as well as musculoskeletal injuries to soft tissues (including muscles, ligaments, tendons and nerves). T&O also undertake surgery such as hip and knee replacements.

Rheumatology

Rheumatology is a term referring to the study and treatment of conditions involving the muscles, bones and joint and covers conditions like Rheumatoid Arthritis, Osteoarthritis,

Orthotics

Orthotics (also known as orthotic insoles, shoe inserts, or orthoses) are devices placed inside the shoes with the purpose of restoring our natural foot function. This is necessary when the natural biomechanical balance of our lower body has been disrupted by over-pronation. Many common complaints such as heel pain, knee pain and lower back pain are caused by poor foot biomechanics

Physiotherapy

Physiotherapists help people who've been affected by injury, illness or disability. Approaches include movement, exercise and manual therapy techniques where the physiotherapist helps recovery by using their hands to relieve muscle pain and stiffness

Pain Management

Pain management clinics usually offer a variety of treatments aimed at relieving long term pain, such as painkilling drugs; injections; hypnotherapy and acupuncture.

Orthopaedic Community Assessment Service (OCAS)

The Orthopaedic Community Assessment Service (OCAS) provides a Clinical Assessment Service for patients over the age of 18 years old, registered with a GP in Wolverhampton, with musculoskeletal problems, who have not responded to initial conservative management through General practice or Physiotherapy

Welcome, Your Voice Counts

We are asking for your views about improving muscle, bone and joint (musculoskeletal) services for the residents of Wolverhampton City. This is an opportunity for you to have your say and help shape the future design of musculoskeletal services.

Wolverhampton Clinical Commissioning Group (CCG) is responsible for purchasing the provision of health services for our local residents in Wolverhampton City. Our mission is to be an expert clinical commissioning organisation, working collaboratively with our patients, practices and partners across health and social care, to ensure evidence-based, equitable, high quality, and sustainable services for all of our population. We need to find new ways of purchasing high quality care to the best standards and this means transforming how we currently deliver services.

What are musculoskeletal (MSK) services and how are they delivered now?

Musculoskeletal services primarily diagnose, treat and care for conditions or injuries that affect muscles, tendons, ligaments, bones, joints and associated tissues for example arthritis, back pain, and osteoporosis. Such services can include treatment by a physiotherapist, podiatrist, rheumatologist or orthopaedic surgeon.

The majority of services that would comprise MSK care are delivered across a number of departments at The Royal Wolverhampton NHS Trust. Patients access services predominantly through their GP who, where necessary, would refer a patient into the Orthopaedic Clinical Assessment Service, Orthopaedic Service, or Physiotherapy services, for example.

Why does this need to change?

The residents of Wolverhampton have changing health needs; there is an ageing population and more people are living with long term conditions. The World Health Organisation (WHO) AND Bone and Joint Health strategies Project (2005 cited by DOH) identified that up to 30% of all GP consultations are about musculoskeletal complaints and Musculoskeletal problems are cited by 60% of people on long term sickness. The current model of delivery is unsustainable for the future and we are unlikely to be able to afford future demand for services if they continue to be delivered in the current way.

Musculoskeletal services are primarily delivered in outpatient settings; outpatient settings are provided for those patients whose treatment does not require them to be admitted or stay in hospital therefore a hospital setting is not essential for the delivery of musculoskeletal care.

We have looked at patterns across the patient journey and found that some patients need care and treatment from multiple services, for example orthopaedics and physiotherapy. Often a patient is referred back to their GP to make a further referral rather than the services working together and communicating to ensure the needs to the patient are met. This is inefficient in terms of waiting time, capacity and cost for both the NHS and the patient.

Early feedback from patients has been that they want access to specialist in one place with the technology and support services needed; better information and education for patients; improved communication across health professionals; access to alternative therapies and group therapy; clear and informative treatment plans; and better accessibility.

Proposal

Our proposal is to commission a single provider to deliver a high quality, comprehensive service to deliver MSK care. We are not proposing to reduce services nor limit the treatment options that are provided; our aim is to integrate services in order to have a single, streamlined service with clear accountability.

We don't envisage changes to how patients will access the service; patients will continue to go to their GP in the first instance. The provider will be expected to deliver services from a number of locations across the City ensuring accessibility for all patients.

By having a single provider of MSK services, the overall experience by the patient will be improved with increased continuity of care, a smoother more efficient journey and faster access to treatment.

Questions and Answers

Q Can I still choose where I will receive treatment?
A Yes. Patients will still be able to exercise their choice of service provider in line with Department of Health's Choice Framework.

Q How will the new provider be chosen?
A Wolverhampton CCG will run a fair and transparent process to identify the most suitably qualified and experienced provider to deliver this service. This process will adhere to national regulation and best practice.

Q When will the new service be up and running?
A We have set out a timescale for procuring these new services and, at this stage, hope to have services in place and operational mid-2016.

Q How do I have my say?
A We aim to involve patients and the public throughout the process to ensure feedback we receive informs how we develop the details of this service. We have started this process with early engagement highlighted within this document and are seeking to expand on this through this consultation. You have until XXX to have your say using any of the methods described below.

How to Have Your Say

Getting involved couldn't be easier. You can either fill out the response form at the back of this booklet or complete the form online.

You have until the *XXX 2015* to share your thoughts with us so please get in touch.

Here's how:

- Electronically
- In writing
- In person

Response Form

Do you support our proposal?

I agree strongly with the proposal	☐
I agree with the proposal	☐
I disagree with the proposal	☐
I disagree strongly with the proposal	☐

I am responding to these plans as:

An individual	☐
A representative of an organisation or group (Please state name and location):	☐

In addition, what features of a musculoskeletal service are important to you?
Please indicate how important the following features are to you
(please tick only one box on each line)

		Very important	Somewhat important	Slightly important	Not important	No opinion
Q1	Booking an appointment					
a.	Not having to wait very long until my appointment date	☐	☐	☐	☐	☐
b.	An appointment which fits around my commitment, eg early evening/weekends	☐	☐	☐	☐	☐
Q2	Location and access					
a.	Access to the majority of treatments in the community	☐	☐	☐	☐	☐
b.	Being able to park at or close to the clinic	☐	☐	☐	☐	☐
c.	A clinic that is accessible by public transport	☐	☐	☐	☐	☐
Q3	Design of the service					
a.	A single point of access for all MSK services where services communicate with each other	☐	☐	☐	☐	☐
b.	Good communication between my GP and MSK services so that everyone understands my condition and treatment	☐	☐	☐	☐	☐
c.	Being seen on time in the clinic	☐	☐	☐	☐	☐
d.	Having a named individual to coordinate all of my MSK care	☐	☐	☐	☐	☐
e.	Consistency in the clinical staff providing my treatment	☐	☐	☐	☐	☐
f.	Being given information so that I am clear about my condition and treatment	☐	☐	☐	☐	☐

g.	Ability to input into the decisions about the care that I receive	☐	☐	☐	☐	☐
h.	Being able to discuss my diagnosis and treatment further with my consultant and other staff after my appointment	☐	☐	☐	☐	☐
Q4	Monitoring and feedback					
a.	Mechanisms for the CCG to assess the quality of care provided and to monitor patient outcomes	☐	☐	☐	☐	☐
b.	Having outpatients services which provide a user group for patients to share their experiences	☐	☐	☐	☐	☐
c.	Having a process through which I can provide comments on the care that I received	☐	☐	☐	☐	☐

Q6	Any other comments? Please use the space below if you would like to explain any of your responses in more detail or if you have any additional comments.

About you – equality and diversity questions