

Communications and Participation Report Summary For Commissioning Engagement Cycle – Commissioning Intentions (CI)

1. Background

This report highlights the engagement findings and recommendations during an engagement exercise from Dec 2014 through to July 2015, on the CCG's proposals to develop, inform and guide the Wolverhampton Clinical Commissioning Group (WCCG) CI 2016/17. Work in 2015/16 will inform the financial year 2016/17. The Commissioning Department were asked to provide key themes for discussion with the stakeholders.

2. Communications and Participation approach

Seven scheduled CCG meetings took place to plan and deliver CI in 14/15. There was also one public engagement event in December 2014 in the form of a pop up shop, which attracted 80-100 general public attendees and asked general questions about topics for CI in the CCG. Two further, more targeted engagement events were held in 2015. The June event asked for engagement around mental health topics and the July event asked for engagement around care closer to home. Both events were well attended by approx. 40 stakeholders and general public. All events were supported by both paper and electronic forms of communications to advertise them. A variety of engagement methods were used to share information about the CCG CI and encourage people to share their feedback.

3. Findings from June and July targeted engagement events

3.1 Lets talk about mental health

Dementia care and older adult mental health services

It was felt that, current waiting times for assessment and diagnosis were too long at 4-5 weeks. Respondents also felt that to lower the screening age for Dementia would be beneficial. The Dementia Hub was welcomed, with respondents asking for it to be advertised more and to increase the numbers of Dementia Cafes across the city. More care homes were also identified as being needed.

To "live well" with Dementia, it was identified that:

Each person should be treated individually, with bespoke care plans in place. Better domicillary care should be available and, when an individual with dementia requires acute care (including A&E), there should be fast tracking and care for them, and appropriate environments whilst waiting. Services should be more joined up and, where possible in the community. It was also queried as to whether or not dementia services should be available prior to formal diagnosis, as this was felt to be beneficial to the patient.

Those we engaged with did however acknowledge that, length of time for diagnosis varied greatly dependent on the type of dementia and that this could probably not be altered, but it was felt that it would be beneficial to both patient and carer to access services prior to formal diagnosis.

Improving Access to Psychological Therapies (IAPT)

Respondents saw the strengths of the current service being particularly in a group setting, low intensity sessions and trained buddies. They wanted more use of computers and apps and more group therapy and CBT.

They were not too keen on the name IAPT and preferred it being called 'talking therapies', or the fact that there was no continuous pathway. They wanted more support for childhood sexual abuse

issues and more flexibility. Lengthy waiting times were also an issue, along with no feedback to the GP about the diagnosis or treatment given.

Third sector organisations could help with social issues such as debt (which may lead to mental health issues) and support post treatment.

Outreach and Community Recovery Services

Services need more integration, including one platform for records, assessments and single point of access. There is a delay in discharge, with no 'safe space'/respite for people in the city. GP's need a range of tools to be better equipped to signpost. Waiting times are currently too long for Healthy Minds and CBT is seen as the only treatment. A support line would also be good.

Post diagnosis needs a multidisciplinary team sharing full details upon discharge. The team needs to have a consistent approach for both the patient and their carers. There is a need for quality services. Information should be more accessible, maybe via app or more use of social media, with education on the next steps in a patients recovery.

It was felt that carers are left when patients refuse to access services. More support for carers is needed, particularly at evenings, weekends and bank holidays.

The third sector organisations need support to invest in their structures to become more effective at supporting service users.

3.2 Let's talk about care closer to home – 30 July 2015

Community services

Respondents indicated that they wanted to access services by telephone and that they wanted services spread evenly across the borough. They felt that, at the moment, the North West and North East of the city was poorly serviced. They wanted more shared working between organisations and providers and integration of services. There was a lack of information about what services there are available and where to go to access them.

Managing long term conditions and accessing ambulatory care services

Good care requires access when necessary (24 hour), in a timely manner with quality community services and a care plan that matches the needs of the patient, not the service. Respondents were keen to foster a partnership between patient and professional, with one person co-ordinating care (GP or specialist nurse) and able to self-care where appropriate. Respondents wanted all services at GP surgeries or health centres with one care plan for all professionals to access.

Patients want to be listened to, with easy access to advice and support provided by third sector organisations, preferably self-help and community groups. Expert Patient programmes were also suggested.

Flexibility and ease of access were important. Single point of access and suitably qualified person answering call 24/7 and reasonable response times flexible to need. Use technology better such as Skype. Good basic services needed with better joined up working between health and social care services that are appropriately funded. Better planning in place ready for crisis times.

Promoting independence in the elderly

Respondents told us that we needed closer working with other organisations including local authority and voluntary sector services to help get people home. This closer working should also include joined up assessments (including the home environment), both before admittance to hospital (where possible), as well as pre-discharge. The discharge should be completed before 6pm and should include support at home (where assessed as necessary). A planned discharge pathway should be used.

Upon return to home, the appropriate social and nursing care plan should be in place with a follow up visit / phone call the next day, and/or on-going visits from the District Nursing service.

To keep people at home, you told us that the right support should be in place which has been assessed by health, not social services.

On-going communication should take place with the GP and relevant consultants where necessary. This could be facilitated by an allocated community worker, such as a district nurse. The community nurse should co-ordinate the domiciliary care, nurse assessments, medicine management, access to telecare etc. to facilitate stay at home health care.

On-going support and signposting to social interaction groups such as cafes, churches and hobby groups etc. should also be sourced from local support groups, run by third sector organisations. Support should also be in place for carers.

3.3 Other information shared by attendees

Attendees informed us that they would like to see the following ideas to be looked at in services in the coming years:

- Information/communication
- Integration/continuity of care
- Access to services
- Specialist services
- Housing
- Third and private sector partners
- Community services at community venues
- Primary Care
- Acute care

4. Recommendations to influence the Commissioning Intentions for 2016/17

Mental health services

Access to services needs to be easier and quicker, with single points of access where possible.

Services need to be more integrated and, where possible, community based. Group therapy was noted as being useful.

Post diagnosis care for both patients and their carers could be supported by community groups and third sector organisations.

Care closer to home

Access to services needs to be easier and quicker (24/7), with single points of access where possible.

One multi-professional care plan for all professionals to access. Assessments should take place, before and during acute care and post discharge. Discharge should be supported by an appropriate care plan (compiled pre-discharge) and a follow up visit/phone call when possible.

Services need to be more integrated and, where possible, community based and spread evenly across the borough. One person, such as a community worker to co-ordinate all health and social care needs.

Information and good communication is also key. Help to self-care where possible.

Advice and on-going support for both patient and carers to be provided by community groups and third sector organisations.