NHS
Wolverhampton
Clinical Commissioning Group

Commissioning Intentions Engagement for 2016/17

You said – We did

Lets talk about mental health

You said	We did
Access to services needs to be easier and quicker, with single points of access where possible.	We reviewed Key Performance Indicators (KPIs) and the service model with provider in terms of Improving Access Psychological Therapies (IAPT) and Urgent Mental Health Care - also aligning it with Crisis Concordat. As the service is very nationally prescribed in terms of KPIs, we have taken on board broader comments re: self-referral, timeliness of appointments, and closer working with GPs. We also reviewed the IAPT model with provider to review **access to group support** and to **improve access to treatment** and numbers of people moving to recovery.
Services need to be more integrated and, where possible, community based. Group therapy was noted as being useful.	We have **developed Urgent and Planned Care Pathways with social care and provider colleagues to develop and strengthen integrated model across mental health**. This work will continue into 2016/17. We have aligned with service initiatives as required as part of the Wolverhampton Crisis Concordat, with a **focus on supporting people in crisis** pro-actively and preventing crisis and ensuring **timeliness of access to evidence-based interventions across both care pathways to support people into and through recovery.**
Post diagnosis care for both patients and their carers could be supported by community groups and third sector organisations.	Our provider has **developed dementia support groups** to strengthen post diagnosis support. We have worked with our provider to develop our Early Intervention in Psychosis model to **improve access to early diagnosis** and referral to treatment times. We are **working with all providers to strengthen the service user and carer voice** across service re-design and delivery including evaluation of initiatives across the life span to develop self-efficacy and quality of life.

Lets talk about care closer to home

You said	We did
Access to services need 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 (complied pre-discharge) and a follow up visit/phone call where possible**	**Community Neighbourhood Teams** An **integrated model of care** called Community Neighbourhood Teams is currently under development and is part of a large programme of work being delivered under the umbrella of the Better Care Fund. More information can be found here https://wolverhamptonccg.nhs.uk/your-health-services/better-care-wolverhampton By adopting a more **integrated approach** it is aimed to prevent people having unnecessary stays in hospital . The delivery of these teams is underpinned by the following principles: • Services should be **accessible, convenient and responsive** • Patients should receive **high quality care** which is centred on their social, physical and health needs rather than the needs of professionals and organisations. • Patients should be empowered to manage their own care and self-care. • **Services should be local** wherever possible • Services should be centralised where necessary (to ensure clinical safety). • **Care should be seamless across health and social care**. • **Information and communications should be centred** on the patient not the organisation/professional. • High quality **care should be accessible quickly** regardless of the time or day of the week Community Neighbourhood teams will be wrapped around localities, **locally based** and aligned around a number of GP practices and their populations, providing a **single point of access** for both healthcare professionals and patients. The different functions of the community neighbourhood team include: • **Rapid Response** which provides an urgent response (within two hours of referral to service) for assessment, diagnostics and support to safely manage patients in their own home and avoid unnecessary admissions to hospital. • **Intermediate Care** which helps facilitate discharge from hospital, and offers care and support services to enable you to maintain or regain the ability to live independently in your own home or avoid premature admission to residential care. • **Risk Stratification/Case Management - Community Matrons** will work closely with GP practices to identify patients who are have either complex needs or at risk admission who would benefit from case management or would benefit from joint health and social care multidisciplinary team discussion..

Services need to be more integrated, where possible, community based and spread across the borough, one person such as community worker to co-ordinate all health and social care needs **Information and communication is also key, help to self-care where possible** **Advice and ongoing support for patients and carers to be provided by community groups and third sector organisations**	**Joint health and social care management plans** will be developed which will be accessible by both primary and secondary care services. Patients will have a named care co-ordinator who will facilitate and co-ordinate the care plan. The long term plan for the community neighbourhood teams is to shift to delivering seven day services. Future plans entail working closely with the voluntary sector to ensure patients and carers are appropriately supported in the community and developing a frail elderly pathway. **Integrated MSK Community Services** We are currently in the process of procuring an integrated MSK community service with the overall aim of providing a multi-disciplinary team approach for the care of people with a musculoskeletal condition. The overall aims and objectives of this service are: • To act as a **single point of access** for patients with a musculoskeletal condition to include orthopaedic, rheumatology, physiotherapy, pain management and orthotics. • To include the specialist triage of musculoskeletal referrals to ensure patients are seen in the right place by the right person at the right time and actively manages inappropriate referrals through education and support • To reduce the need for patients to attend secondary care, thus promoting care closer to home and right care, right place, right time • To educate patients on their condition and empower patients to self-manage where appropriate • To increase knowledge of the service across primary/community care to enable signposting of patients to the service, and other support services as appropriate • To adopt a **multidisciplinary approach** to ensure an holistic approach is undertaken when developing treatment plans **Review of Community Services** A review of all community services is being undertaken over the next two to three years to ensure services are providing value for money and are meeting patients' needs and are delivering outcomes required.