NHS
Wolverhampton
Clinical Commissioning Group

Commissioning Intentions Engagement for 2017/18

You said – We did

Care Closer to home – Acute and Community Care services

You Said	We Did
Top three priorities were: • Shifting hospital services into the community • Community Services review • Frail elderly / dementia *Attendees said:* • **Choice** – the right information/advice is important. Good structure to after care. Quality is still key. • **Frail elderly** – focus on support in the community from health, social care, community / family and faith groups. This is a joint responsibility for organisations to work	**Community Neighbourhood Teams** An integrated model of care called Community Neighbourhood Teams are currently under development and is part of a large programme of work being delivered under the umbrella of the Better Care Fund. The programme consists of all health and social care organisations in Wolverhampton who have agreed to work together better together to ensure safe, high quality and financially sustainable services for the residents of Wolverhampton. By adopting a more integrated approach it is aimed to prevent people having unnecessary stays in hospital and improve health and social care outcomes for everyone in Wolverhampton. A large part of this work is the development of a multi-agency meeting to discuss and agree patient care and the sharing of this information via an electronic shared care record. In the early stages this information will be shared with Health & Social Care professionals. We hope that we will be able to build on this work and see the sharing of records across all providers of health & social care/ The delivery of Community Neighbourhood Teams is underpinned by the following underlying 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

on. Keeping safe through appropriate risk assessments and falls prevention. • **Care closer to home** – keep continuity of care and use appropriate buildings with suitable facilities. Choice important. • **Planned care – use of private services (particularly for physiotherapy) possible.** Better patient education and support in the community. Not always need to go to New Cross, investigations and support can be delivered in the community.	Community Neighbourhood teams will be wrapped around localities, locality 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 (including care homes) 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. An Intermediate Care Plan has been developed which aims to offer an exciting opportunity for organisations and professionals to work in partnership to provide a truly integrated approach to care delivery. Our vision is that the future of intermediate care within Wolverhampton will encompass a wide number of services that are currently in place, expanding their capacity to meet additional demand, whilst additional provision to address currently unmet needs, is designed and delivered. • Risk Stratification/Case Management - Community matrons will work closely with GP practices to risk stratify and 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.. • Mental Health- The addition of a mental health component of care is critical to the delivery of person centred care 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 community neighborhood teams have commenced the shift to delivering seven day services. The Rapid intervention teams have expanded to deliver services 8am -8pm Monday to Friday and 9am-5pm Saturday & Sunday. Next steps are to move to 8am-8pm working on Saturday & Sunday. The CCG has commenced closer working with the Voluntary Sector with the introduction of 10 grant recipients to support the work of the statutory workforce and to ensure patients and carers are appropriately supported in the community. As the community neighbourhood teams become embedded the longer term plan is to review services to identify areas/access clinics (including acute setting clinics) that could be shifted and centred and run around CNT localities/GP practices. **Frail Elderly Pathway** Work has commenced on the development of a Frail Elderly pathway. The CCG recognises that these patients need to be cared for by skilled staff who are engaged, understand the particular needs of older people and have time to care. The CCG has started working closely with Royal Wolverhampton Hospital on the development of a ‘frail elderly team’ in

A&E. The team will be work with all colleagues to undertake a comprehensive assessment of frail elderly people that takes into account the persons person's medical conditions, mental health, functional capacity and social circumstances so that they can better determine the most appropriate treatment for them.

We recognise that frail people at different stages of the pathway will require a range of interventions that are clinically effective and appropriate for their level of frailty. These interventions may well involve voluntary and community sector groups, in addition to clinical assessment and support, particularly at the early stages of frailty when the focus should be on maintaining independence and optimising function and health.

This work takes into account Primary Care services (GP's) Hospital services and Community services (district nursing, intermediate care etc) and also our Voluntary Sector partners.

The CCG is also working in partnership with Public Health to review its current falls service with the aim of delivering a more proactive integrated service model.

D2A - A Discharge to Assess programme is well underway with the aim of creating a "home first" approach to ensure that patients are discharged in a timely manner with the support that best suits their needs. These new pathways are being developed with City of Wolverhampton Council and with The Royal Wolverhampton NHS Trust.

Integrated MSK Community Service

The CCG has undertaken an exercise to design and procure 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 design of the service was informed by a three month patient, public and stakeholder consultation exercise and the procurement was supported by a patient representative involved in evaluating the bidders. The findings from the consultation have been used to inform the service design as well as the quality and performance indicators that will indicate the success of the service. There were four key themes from the consultation; service location, access and referral, communication and quality of service. Using this feedback, the CCG has specified minimum criteria in the design of the service against all four of these themes and will continue to seek patient feedback and work with the provider, to ensure successful delivery.

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 undertake specialist triage of musculoskeletal referrals to ensure patients are seen in the right place by the right person at the right time.
- To deliver a service which is equitable, effective, efficient and affordable, which meets the needs of the local health community across Wolverhampton
- To ensure patients receive appropriate triage, assessment, diagnostics and treatment in a timely manner
- To ensure an appropriate workforce skill-mix, competency and qualification, to deliver a high quality service across the care pathways described

- To reduce the need for patients to attend secondary care, thus promoting care closer to home and right care, right place, right time
- To implement choice at the point of onward referral
- To communicate and educate patients about their condition and empower patients to self-manage where appropriate
- To increase knowledge/promote the service across primary/community services to enable referral 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

The procurement process has now been completed and the CCG will contract with Connect Physical Health Centre's Ltd [Connect] to deliver the Integrated MSK Service.

The CCG and Connect are currently working together to mobilise the new service and it will open on 1 April 2017. A key element of this process is the identification of locations, access and referral processes to ensure high quality robust processes that meet the needs of our patients; these were key priorities from the consultation and engagement exercise. We have had high levels of patient engagement throughout the process so far and plan for this to continue with Connect ensuring mechanisms are in place to capture patient feedback, and internal systems to act on this feedback. Patient reporting, including satisfaction surveys, comments, complements, and complaints, will be reported and monitored by the CCG throughout the term of the contract. GP education/awareness is a key responsibility of the service and further information will be shared with Wolverhampton GPs throughout the mobilisation period and contract commencement, to enable prompt referral for patients with a musculoskeletal condition and appropriate information sharing and communication.

Review of Community Services
Review of all community services 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.

Wound care pathway
A comprehensive review of the current wound care pathway has taken place. Following this review the CCG will look to redesign the current service to ensure that patients are receiving the most appropriate care in the most appropriate place at the right time and are fully informed of what to expect from the services we commission.

End of Life care
The CCG has worked with partners across Wolverhampton to develop an integrated End of Life care Strategy. The Strategy sees a shift to deliver person centred, coordinated care to those approaching the end of their lives.

There are a number of elements to this work but the CCG now plans to review all current specifications and redesign services to ensure we can deliver the strategy across all partners and make sure we improve End of Life care services.

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Lets talk about Primary Care

You Said	We Did
• **Improving access** – need better management of booking appointments and emergency appointments. Telephone appointments good. Telephone triage. Possibility of using email and website. Accessibility for refugees and migrants and those with English not as a first language sometimes difficult. Training is required for surgery staff on customer care. Weekend and out of hours access still sometimes challenging – maybe use of rotating GP to improve weekend access. • **Increasing range of services** – prevention and better use of Stay well messages. GPs working together more to increase range available. Sexual health services cluster and phlebotomy services to increase. Increasing services in community settings – services that could be delivered in a community setting – phlebotomy, dermatology, cancer treatments, dieticians, dialysis, dressings, ear syringing • **GP's priorities?** – Managing expectations and use of voluntary and community services • **Proper medication reviews**	You said you would like better access to appointments and in response to this we are preparing to introduce **more appointments offered evenings and Saturdays for carers**... from 2017 you will see more appointments made available evenings/weekend that should not only be available the same day if urgent but also practices working together to improve access to appointments. **Consultations will also be available by phone, email and video calling very soon.** Our admin and reception staff are going to receive **training in social prescribing to help signpost patients to services** that can help them, they will also be undertaking more administrative work for the GPs so that more time can be freed up for GPs to see patients. The Stay Well campaign this year provides better guidance for patients and carers to make choices about how to **access care in the right place at the right time**. There will be a lot more work taking place with patients and practices to promote and support patients to care for themselves, this may be advice and guidance, regular reviews or even support groups or expert patient programmes and will include stay well messages too. You said you would prefer to see **more services available in your local community or at a practice closer to home.**....we have been considering what services can be provided in the community these include ECGs, echocardiogram, children's clinics and other diagnostic tests. There are projects beginning shortly to determine how we provide these services in the community at a range of community sites rather at hospital. We are also intending to explore with our practice groups how we can introduce more community based care for phlebotomy, dermatology, cancer treatments, dieticians, dialysis, dressings, ear syringing and many of our practices are working together to provide sexual health services too. You would like to know more about the work of your patient participation group....we have met with the PPG Chairs and are regularly providing them with information to share at their meetings i.e. Practices working together, GP survey, CQC inspection ratings etc and intend to provide regular updates from our Primary Care Team.

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Lets talk about the health of children and young people

You Said	We Did
• **Appointments** – numerous appointments sometimes challenging and to be looked into. Text message reminders. Use of digital technology such as Skype instead of face to face. • **Choice - is important** and understanding of the range of services available should be better communicated. • **Relationships between professionals** should be strengthened, particularly between GP's and consultants. Integration is important, some good working here, but not always.	You said it was incredibly **difficult to manage the numerous appointments** and this is going to be a focus of pathway reviews across the children and young people's services to ensure that there is no duplication. Services are working with Voices for Parents to ensure that information sent out in appointment letters is clear. Also there will be improved communication available on websites about what each service will be providing to ensure parents and young people are aware of what they are going to see each professional about. This information will be located on the Local Offer pages of the City of Wolverhampton Council website and will be reviewed regularly. Use of digital technology will be considered as part of the pathway redesign. **Range of services available for children and young people -** The range of services available for children will be accessible on the Local offer pages of the City of Wolverhampton council website. However, these pages are currently being reviewed as they are not easily accessible. Access to the information on the website ensures that it is the most up to date material for the services and it is regularly reviewed by parents/carers, children and young people. **Relationships between professionals –** Work is being undertaken to further strengthen the relationships between GPs and consultants as well as other health professionals. This will be further considered as part of the service pathways review and redesign.

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Lets talk about the mental health of children and young people

You Said	We Did
• Support services - **Support and intervention to be delivered locally.** Culture of 'no referrals or handoffs' and seamless – referrer to navigate system with child. Flexible delivery of services to meet need. Move resources downstream – early intervention. Telephone number for potential referrers to discuss referral. • Schools - **Closer working with schools** in local area – risk sharing as well as financial contribution. Schools buying into central commissioning. • Workforce - **Workforce education and training** to enable flexible working and skills interventions. Equip workers with skills to identify problems, introduce appropriate resources • **Commissioning** - Commissioners from different organisations **to work together and commission in a joined up way**, including joined up budgets. Commissioning a system, not a service. Commissioners working together to commission services that are holistic, individually centred, family focussed, and flexible. **All organisations to sign up and be committed to 'what is best for child/family – no organisational boundaries**. Agency agnostic. True partnership.	The Child and Adolescent Mental Health Local Transformation plan has recently been refreshed taking the concerns raised into account and ensuring that consideration is given as to how service delivery can be flexible. This has included the development of CAMHS link workers in the community. Although there will be a drive to move resources downstream, there is a need to continue to have resources available at a specialist level to ensure that the needs of this cohort of children and young people can be met as part of a community setting without a need for admission to inpatient facilities. Workforce education and training will be available to equip workers with the skills required to meet the needs identified – this will focus on Increasing access to psychological therapies for children and young people. Commissioners from the Clinical Commissioning Group and City of Wolverhampton Council are developing a comprehensive way of working together to ensure that we are commissioning in a more joined up manner. We are working towards removing barriers in the system so that children and young people can access appropriate services as and when required.

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Lets talk about mental health

You Said	We Did
• **Support – low level / long-term support is needed**. Eg advocacy, community groups • **Early intervention** – community nursing and drop in centres including preventative. • Information – choice and improved awareness. Signposting. Possible use of a directory. • GP's to have better understanding and information around mental health services. Training for staff on issues such as abuse etc. Use less medication. • Long term commitment to funding groups. • Smoother transition from child to adult services. • Support for carers and families. • **Talking therapies / counselling available in primary care.** • Services more integrated – Third Sector / Health / LA. *Planned mental health pathway* • Talked about "Toms experience" • **Support and education to recognise how to avoid crisis** • **Seamless pathways – continuity and consistency important** • Look at whole person • Social prescribing • Service user led groups • Access is better, but could still improve • Transition issues • Planned and supported discharge *Urgent mental health pathway*	You said you would like better access to waiting times for mental health difficulties, and increased and on-going access to low levels of support provided by secondary and primary care services including community groups. We have used this information to inform our care pathway re-design of planned mental health services. All of the information contained in the feedback sessions has been used to inform our commissioning of our care pathways for counselling and IAPT and development of our mental health and primary care strategy which will go out to consultation this year. In addition we have commissioned the following: • **Increased investment in Early Intervention in Psychosis to increase capacity** and capability and meet new targets • Creation of new all age Eating Disorder Service • **Creation of new Urgent Care Pathway** (includes remodelled Single Point of Access and Adult Mental Health Liaison, and Adult Crisis Resolution and Home Treatment services, and new services of Street Triage and Hospital Discharge). Fundamental to delivery of Crisis Concordat. In addition we have undertaken the following : • Re-modelling Well-Being Service and Complex Care continues – additional investment has gone into Well Being Service (forms part of Planned Care Pathway). • Have continued pro-active programme of repatriation of out of area placements. • **Re commissioned new diagnostic care** pathways for adults for Autism and Attention Deficit Disorder – now have joint Autism Strategy with CWC. • Delivery of our Local CAMHS Transformation Plan with Future in Mind Funds. • Delivery of Transforming Care Plan for people with Learning Disability on a Black Country wide foot print.

- When does de-escalation / planned stop / start and become urgent?
- Improved access and shorter waiting times needed – too long wait for assessment and treatment
- Crisis is care is good
- Evenings and weekend support unclear

Dementia mental health pathway

- Early screening and signposting important
- Staff in all services should have dementia training
- Treat patients with dignity and respect.

Our next steps are to:

- Mental Health Five Year Forward View
- Sustainability and Transformation Plans – Mental Health Work Stream
- Primary Care and Mental Health
- All Age new Mental Health Strategy (will include Learning Disability Services and Dementia Services)
- Will incorporate CAMHS LTP