Public Document Pack

Health and Adult Social Care and Communities Overview and Scrutiny Committee

Date:	**Thursday, 22nd November, 2018**
Time:	**10.00 am**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

The information on the following pages was received following publication of the committee agenda.

5. **Final Decision-Making Business Case for Adult's and Older Peoples Mental Health Services in Cheshire East** (Pages 3 - 114)

To consider the final decision-making business case for adult's and older peoples mental health services in Cheshire East.

Documents within this supplement:

1. Protocol for Cheshire East Council Health and Adult Social Care and Communities Overview and Scrutiny Committee

2. Report of the NHS Eastern Cheshire CCG, NHS South Cheshire CCG and Cheshire and Wirral Partnership on the final decision-making business case for the adult's and older peoples mental health services in Cheshire East

Please contact	Joel Hammond-Gant on 01270 686468
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CHESHIRE EAST HEALTH OVERVIEW AND SCRUTINY PROTOCOL

1 Introduction

1.1 The Health and Social Care Act 2012 and associated regulations give local authorities the power to review and scrutinise health services. This complements their existing power to promote the social, economic and environmental well-being of local areas. The role of local authorities is to contribute to improvements in health and the reduction of variations in health 'health inequalities' in their local area. Health services are to be viewed in their widest sense in accordance with the Health and Adult Social Care Act 2012 and will include Public Health, and other services which have a major impact on health and wellbeing provided by the local authority and in partnership with the NHS or other bodies. Local authorities are a channel for the views of local people.

1.2 Health scrutiny is the democratic element of the new system for patient and public involvement. This includes Healthwatch, Independent Complaints and Advocacy Services (ICAS) and Patient Advice and Liaison Services (PALS). In addition, the NHS and other bodies which commission (buy) or provide health services are required to make arrangements to consult with and involve the public in the planning of service provision, the development of changes and in decisions about changes to the operation of services.

1.3 The two main elements of health overview and scrutiny are:

- Formal consultation on substantial developments or variations to services.
- A planned programme of reviews with capacity to respond to issues referred by Healthwatch Cheshire East and other referrers.

1.4 The functional responsibility for the overview and scrutiny of the buying (commissioning) and provision of health services in Cheshire East lies with the Health and Wellbeing Scrutiny Committee of the Council ("the Committee").

1.5 The main points of contact for scrutiny of those health organisations who either commission (buy) or provide health services are outlined in Appendix A. Throughout this document they will be referred to jointly as the "responsible health body(ies)" The responsibility to respond to scrutiny is not limited to those mentioned in Appendix A.

2 Policy Statement

Members of the Committee, the responsible health bodies and organisations for patient and public involvement, will work together to ensure that health scrutiny improves the provision of health services and the health of local people.

3 Aims of Health Scrutiny

- To improve the health of local people by scrutinising the range of health services available to local people.
- To secure continuous improvement in the provision of health services and services that impact on health.
- To contribute to the reduction of variations in health 'health inequalities' in the local area.
- To ensure the views of health service users (patients, carers and the public) are taken into account within a strategic approach to the design, commissioning and provision of health services.

4 Principles

4.1 Overview and scrutiny of health services is based on a partnership approach.

4.2 Overview and scrutiny is independent of the NHS and the Cheshire East Health and Wellbeing Board.

4.3 The views and priorities of local people are central to overview and scrutiny, and service users and their organisations will be actively involved in the overview and scrutiny process.

4.4 The overview and scrutiny approach is open, constructive, collaborative and non confrontational. It is based on asking challenging questions and considering evidence. Recommendations are based on evidence.

4.5 Overview and scrutiny will consider the wider determinants of health when/whilst working towards achieving its aims and use wider local authority powers to make recommendations to other local agencies as well as those within the NHS and local authority.

4.6 Overview and scrutiny recognises that there will be tensions between people's priorities and what is affordable or clinically effective, and that local health commissioning and provision takes place within a national framework of policies and standards.

4.7 The impact and effectiveness of health and wellbeing overview and scrutiny will be evaluated by means of an annual report to Council. Development of the annual report will include consultation with partners and Healthwatch Cheshire East.

5 The Role of the Committee

5.1 In the course of a review or scrutiny the Committee will raise local concerns, consider a range of evidence, challenge the rationale for decisions and propose alternative solutions as appropriate. It will need to balance different perspectives, such as differences between clinical experts and the public. All views should be considered before finalising recommendations.

5.2 The Committee will not duplicate the role of advocates for individual service users, the role of performance management of the NHS or the role of inspecting the NHS or Local Authority.

5.3 The Committee has no power to make decisions or to require that others act on their proposals. The responsible health body must respond within 28 days to recommendations of the Committee and give reasons if they decide not to follow these.

6 Organisations to which Health Scrutiny Applies

6.1 Health bodies subject to overview and scrutiny include the organisations that either commission (buys and performance manages) and/or provide health services. The Committee's main focus will be on services commissioned and delivered by those agencies as outlined in Appendix A

6.2 The Local Government and Public Involvement in Health Act 2007 introduced "the Councillor Call for Action (CCfA)" which provides elected Ward Members with a formal means to escalate matters of local concern to an Overview and Scrutiny Committee. Although this is seen as a measure of "last resort" it can lead to recommendations being made to the Council concerned and/or other agencies. The CCfA is one of a number of measures designed to provide Overview and Scrutiny Committees with greater powers to work more closely with Partners and across organisational boundaries. It is likely that any CCfA which is concerned with NHS services will be referred to the Committee in the first instance.

6.3 The Council also has a local Petition Scheme which sets out how petitions will be handled. Should either a CCfA or a formal Petition be received which relates to health services, the Secretary of the Committee will liaise in the first instance with the relevant commissioner or service provider, to assist the Chairman and Vice Chairman of the Committee to determine how to proceed.

7 Matters that can be Reviewed and Scrutinised According to Regulations

7.1 Overview and scrutiny powers cover any matter relating to the planning, provision and operation of health services. Health services are as defined in more detail in the Health and Social Care Act 2012 and cover areas such as health promotion, prevention of ill health and treatment.

7.2 Issues that can be scrutinised include but are not limited to the following:

- Arrangements made by the responsible health bodies to secure hospital and community health services and the services that are provided
- the provision of family health services, personal medical services, personal dental services, pharmacy and NHS ophthalmic services;
- Arrangements made by the responsible health bodies for public health, health promotion and health improvement including addressing health inequalities.
- Planning of health services for Cheshire East residents by health bodies, including plans made in co-operation with local authorities setting out a strategy for improving both the health of the local population and the provision of health services to that population.

- the plans, strategies and decisions of the Cheshire East Health and Wellbeing Board
- The arrangements made by responsible health bodies for consulting and involving service users in Cheshire East.
- Any matter referred to the committee by a local Healthwatch or Healthwatch England under the Health and Social Care Act 2012
- Any appropriate matter raised by a Councillor Call for Action or a Petition.

7.3 More detail about what the commissioners of health services are responsible for can be found in NHS England summary fact sheets on commissioning responsibilities, identified within Appendix A.

8 Substantial Developments or Variations in Services

8.1 The responsible health body will consult the Committee on any proposals it may have under consideration for any substantial development of a health service or any proposal to make any substantial variation in the provision of such services. The responsible health body will give the Committee sufficient notice to make arrangements to consider the proposals and make a formal response.

8.2 This is additional to discussions between the responsible health body and the appropriate local authority(s) on service developments. It is also additional to the duty to consult patients and the public. Guidance indicates that solely focusing on consultation with the Committee would not constitute good practice.

8.3 The Committee has the responsibility to comment on

- Whether as a statutory body the Committee has been properly consulted within the public consultation process
- The adequacy of the consultation undertaken with service users
- Whether the proposal is in the interests of services users in being able to access health services in the area

Arrangements relating to responsible Health bodies – identifying who is the consulting body

8.4 Across Cheshire East, there may be occasions when a proposed service change affects residents across two or more CCG area boundaries or across the local authority boundary. Where the proposed service change affects residents across such boundaries, it will be important for the Committee to understand which health body will be the ***'lead consultor'*** – the body responsible for leading and considering the consultation responses and taking the final decision.

8.5 In a case where the responsible health body is a service provider and the proposed service change relates to services which a CCG(s) and/or NHS

England is responsible for arranging the provision of then the CCG or NHS England is responsible for consulting the Committee.

8.6 Where services are commissioned by more than one health body, those bodies may agree a process of joint consultation or delegate one or more of those bodies to act as 'lead consultor' on behalf of all those bodies.

Substantial developments or variations ("SDV's") – explanation

8.7 Substantial developments or variations are not defined. The impact of the change on service users (patients, carers and the public) is the key concern. The following factors should be taken into account:

- Changes in accessibility of services such as reductions, increases, relocations or withdrawals of service
- Impact on the wider community and other services such as transport and regeneration and economic impact
- Impact on service users – the extent to which groups of service users are affected by a proposed change. Changes may affect the whole population (such as changes to accident and emergency services) or a small group (patients accessing a specialised service). If change affects a small group it may still be regarded as substantial, particularly if patients need to continue to access that service for many years (for example, renal services). There should be an informed discussion about whether this is the case and which level of impact is considered substantial.
- Methods of service delivery – altering the way a service is delivered. The views of service users and Healthwatch are essential in such cases.

8.8 The first stage is for the Committee (acting initially through its Chairman and Vice Chairman) to decide whether or not the proposal is substantial. This initial assessment is conducted at three levels:

8.8.1 Level One

When the proposed change is minor in nature, eg. a change in clinic times, the skill mix of particular teams, or small changes in operational policies.

At level one, the Committee would not become involved directly, but would be notified that the local Healthwatch is being consulted.

8.8.2 Level Two

Where the proposed change has moderate impact or consultation has already taken place on a national basis. Examples could include a draft Local Delivery Plan, proposals to rationalise or reconfigure Community Health Teams, or policies that will have a direct impact on service users and carers, such as the "smoke free" policy. Such proposals will involve consultation with service staff and Healthwatch Cheshire East, but will not involve:

- Reduction in service

- Change to local access to service
- Large numbers of service users being affected

The Committee will wish to be notified of these proposals at an early stage, but would be unlikely to require them to be dealt with formally as an SDV. A briefing may be required for the full Committee or through the Chairman and Vice Chairman, and the Local Ward Councillors concerned will be informed of the proposal by the Secretary. The Committee will wish to ensure that the local Healthwatch and other appropriate Organisations have been notified by the responsible health body lead consultor concerned.

8.8.3 Level Three

Where the proposal has significant impact and is likely to lead to:

- Reduction or cessation of service
- Relocation of service
- Changes in accessibility criteria
- Local debate and concern

Examples would include a major Review of service delivery, reconfiguration of GP Practices, or the closure of a particular unit.

The Committee will normally regard Level Three proposals as an SDV, and would expect to be notified at as early a stage as possible. In these cases the Committee will advise on the process of consultation, which in accordance with the Government Guidelines would run for a minimum 12 weeks period. The health organisation leading the consultation will make it clear when the consultation period is to end. The Local Ward Councillors concerned will be informed of the proposal by the Secretary. The Committee would consider the proposal formally at one of their meetings, in order to comment and to satisfy the requirement for the Overview and Scrutiny Committee to be consulted in these circumstances.

8.9 Officers of the responsible health body(s) leading the consultation will work closely with the Committee during the formal consultation period to help all parties reach agreement.

8.10 The Committee will respond within the time-scale specified by the responsible commissioners. If the Committee does not support the proposals or has concerns about the adequacy of consultation it should provide reasons and evidence.

Responding to the consultation

8.11 The Committee will respond to the consultation by the health body leading the consultation ('lead consultor') by the given deadline with its comments and views in writing and will explain the process it has followed, the evidence it has considered and identify any witnesses that have contributed. The response will summarise any areas of disagreement between the Committee

and the lead consultor and include recommendations and suggestions for reaching a consensus.

8.12 The Secretary of State outlined in 2010 four tests that would shape consultation on substantial variations to health services. When considering its response to a consultation on a proposal for substantial variation, the Committee will ask the following questions:

- Has the development of the proposal been informed by appropriate engagement and involvement of local people and those using the service?
- To what extent have GP commissioners informed and supported the change?
- How strong is the clinical evidence underpinning the proposal and does it have the support of senior clinicians whose services will be affected by the change?
- How does the proposed service change affect patient choice, particularly with regard to quality and service improvement?

8.13 The Committee may request a report on the outcome of all the consultation undertaken by the lead consultor on the proposed service change(s) in order to take a view on how the consulting body has responded to the views it has received and ensure the final decision is in the interests of local people.

Disagreements

8.14 Where there is disagreement about whether a proposal constitutes 'substantial variation,' the lead consultor health body will provide the Committee with information and the reasons why it considers the issue is not substantial. The Committee may seek views from others, such as NHS England when the disagreement involves Clinical Commissioning Groups.

8.15If the disagreement is still not resolved, the responsible health body and Committee may ask the Independent Reconfiguration Panel (IRP) for informal advice on whether the issue should be regarded as substantial. Finally, if agreement is still not reached and the Committee believes the proposal to be 'substantial variation,' it may refer the matter to the Secretary of State on the basis of inadequate consultation. It would then be for the Secretary of State, and then potentially the courts, to determine whether it is substantial

Exemptions

8.16 The Committee will only be consulted on proposals to establish or dissolve a NHS Trust or Clinical Commissioning Group if this represents a substantial development or variation to the provision of health services.

8.17 The Committee does not need to be consulted on proposals for pilot schemes within the meaning of section 4 of the NHS (Primary Care) Act 1997 as these are the subject of separate legislation.

8.18 A responsible health body will not have to consult the Committee if it believes that a decision has to be taken immediately because of a risk to the safety or welfare of service users or staff. These circumstances should be exceptional.

The Committee will be notified immediately of the decision taken and the reason why no consultation has taken place. The notification will include information about how service users and staff have been informed about the change and what alternative arrangements have been put in place to meet the needs of service users and staff.

8.19 Any proposals contained in a trust special administrator's report or the final recommendations of a trust special administrator

8.20 Government guidance on consultations indicates a full consultation should last for a minimum of 12 weeks. It is recognised that this may need to be shorter in some circumstances. Any request to reduce the length of formal consultation should be discussed with the Committee and underpinned by robust evidence that the responsible health body leading the consultation has engaged, or intends to engage local service users, in accordance with statutory requirements.

Report to Secretary of State for Health

8.21 The Committee may report to the Secretary of State (SoS) for Health or, as appropriate, to Monitor for their consideration when it is not satisfied with the consultation or the proposals.

Referral to the Secretary of State may only be made in circumstances where the responsible commissioner and the Committee have attempted, but failed to resolve any disagreements or where the responsible commissioner has failed to attempt to resolve disagreements within a reasonable period of time. Likewise, referrals should <u>not be made</u> if the Committee has failed to respond to consultations by the date provided by the lead consulter health body.

8.22 Specific areas of challenge include:

- The content of the consultation or that insufficient time has been allowed;
- The reasons given for not carrying out consultation are inadequate; or
- Where the Committee considers that the proposal is not in the interests of service users of health services in its area.

NB 'inadequate consultation' in the context of referral to the SoS means only consultation with the Committee, not consultation with service users and the public.

8.23 In response to a referral the SoS may:

- Require the local responsible health body to carry out further consultation with the Committee.
- Make a final decision on the proposal and require the responsible health body to carry out the decision.
- Ask the Independent Review Panel to advise him/her on the matter.

9 Developing a Programme of Reviews

9.1 The Committee will produce an annual overview and scrutiny plan in consultation with the Commissioners and Healthwatch Cheshire East.

9.2 The plan will consider the range of health services, including those commissioned and provided by the local authority, and in partnership arrangements with the NHS.

9.3 The plan will be based on the views and priorities of local people.

9.4 The plan will have the capacity to take into account issues that may be raised through the work of Healthwatch Cheshire East.

9.5 The plan will be realistic, based on the capacity of the Committee and the Committee's partners to undertake meaningful reviews.

9.6 The following factors should be taken into account when planning a programme:

- It is a local priority that can make a difference.
- The topic is timely, relevant and not under review elsewhere.
- If the topic has been subject to a national review it should be clear how further local scrutiny can make a difference.
- There is likely to be a balance between;
  - Public Health improvement and health services,
  - NHS and joint services,
  - Acute services and primary/ community services.
- It may be thematic, e.g. public health, homelessness or services for older people that might impact on the health of local people, or a service oriented priority.
- It should contribute to policy development on matters affecting the health and wellbeing of communities.

9.7 There are a number of methods for scrutiny, including formal reports to the Committee or Reviews conducted by smaller "Task and Finish" Review Panels appointed by the Committee with specific terms of reference.

Sections 10 to 14 apply to both consultation on substantial developments or variations and reviews or scrutiny.

10 Provision of Information

10.1 The responsible health body will provide the Committee with such information about the planning, provision and operation of health services as it may reasonably require in order to discharge its health and wellbeing scrutiny functions. Reasonable notice of requests for information or reports will be given.

10.2 Confidential information that relates to and identifies an individual or information that is prohibited by any enactment will not be provided.

10.3 Information relating to an individual can be disclosed, provided the individual or their advocate instigates and agrees to the disclosure.

10.4 The local authority may require the person holding information to anonymise it in order for it to be disclosed. The Committee must be able to explain why this information is necessary.

10.5 The responsible health body will provide regular briefings for Committee Members on key issues.

10.6 In the case of a refusal by a health body to provide information that is not prohibited by regulation, the Committee may contact the relevant performance management organisation, which should attempt to negotiate a speedy resolution.

11 Attendance at Meetings

11.1 The Committee may require any officer of the relevant health body to attend meetings to answer questions on the review or scrutiny.

11.2 Requests for attendance will be made through the Chief Executive body concerned.

11.3 The Committee will give reasonable notice of its request and the date of attendance. The Committee will provide the officer with a briefing on the areas about which they require information no later than one week prior to the attendance.

11.4 If the scrutiny process needs to consider health services provided by the independent sector on behalf of the NHS or local authority, it will consider the issue through the lead commissioning body. The lead commissioners of these services will need to be cognisant of the requirement to build into its contracts with independent sector providers a requirement to attend a review or scrutiny or provide information at no cost to the Committee.

11.5 The Chairman or Directors of the responsible health body cannot be required to attend before the Committee. They may, however, wish to do so if requested.

11.6 Local independent practitioners such as GPs, dentists, pharmacists and opticians may be willing to attend the Committee but cannot be required to do so. Local independent practitioners may be willing to attend at the request of the responsible health body. An alternative source of information may be the Local Medical Committee or appropriate professional organisations.

12 Reporting

12.1 In their reports the Committee will include:

- an explanation of the issues addressed
- a summary of the information considered
- a list of participants involved in the review or scrutiny
- any recommendations on the matters considered
- evidence on which the recommendations are based.
- where appropriate, recognition of the achievements of the responsible health body concerned.

12.2 The Committee will send draft reports to the responsible health body(s) and other bodies that have been the subject of review to check for factual accuracy.

12.3 The report is made on behalf of the Committee and there is no requirement for the Cabinet or the full Council to endorse it. However the report will be sent to the Cabinet, Cheshire East Health and Wellbeing Board and full Council and, if required, a briefing will be arranged to identify the main implications.

12.4 If the Committee request a response from the responsible health body this will be provided within 28 days. If a comprehensive response cannot be provided in this time, the health body(s) concerned will negotiate with the Committee to provide an interim report, which will include details of when the final report will be produced.

12.5 The response will include:

- The views on the recommendations
- Proposed action in response to the recommendations
- Reasons for decisions not to implement recommendations

12.6 Copies of the final report and the response will be widely circulated and made publicly available.

13 Conflict of Interest

13.1 The Committee must take steps to avoid any potential conflicts of interest arising from Members' involvement in the bodies or decisions they are scrutinising.

13.2 Conflict of interest may arise if councillors or their close relatives are:

- an employee of the health body under scrutiny or
- a non-executive director/Lay member of the health body under scrutiny, or
- an executive member of another local authority
- an employee or board member of an organisation commissioned by the health commissioning body to provide goods or services.

13.2 These councillors are not excluded from membership of overview and scrutiny committees but must follow the Council's Code of Conduct for Members regarding participation and as necessary seek advice from the Monitoring Officer of the Council where there is a risk of conflict of interest.

13.3 Executive (Cabinet) Members and Cabinet Assistant Members of Cheshire East Council are excluded from serving on the Committee in any capacity.

14 Liaison between the Committee and Healthwatch Cheshire East

14.1 The Committee will develop an appropriate working relationship with Healthwatch Cheshire East

- Healthwatch Cheshire East may refer issues to the Committee, which must take these into account. If issues are not urgent they may be considered when planning future work programmes.
- The Committee will, where appropriate, advise Healthwatch Cheshire East of actions taken and the rationale for these actions.
- The outline and process of a scrutiny review will be discussed with members of Healthwatch Cheshire East.

15 Conclusion

15.1 This Protocol was considered and adopted by the Committee on (date) and is endorsed by the responsible health bodies.

Appendix A

List is not exhaustive

Commissioners of Health & Care Services in the Cheshire East area

- NHS England / Public Health England – Cheshire, Warrington and Wirral
- NHS Eastern Cheshire Clinical Commissioning Group
- NHS South Cheshire Clinical Commissioning Group
- Cheshire East Council

Providers of Health & Care Services in the Cheshire East area

- East Cheshire NHS Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- Cheshire & Wirral Partnership NHS Foundation Trust
- Cheshire East Council
- North West Ambulance Service
- Vernova CIC

NHS England Summary fact sheets on commissioning responsibilities:

http://www.england.nhs.uk/wp-content/uploads/2012/07/fs-ccg-respon.pdf

Appendix B Signatory List

Organisation	Name and designation	Signature	Date
Cheshire East	Councillor Hilda Gaddum, Chairman of Committee		
Cheshire East	Brian Reed, Head of Democratic Services		
Cheshire East	Lorraine Butcher, Director of Strategic Commissioning		
Cheshire East	Dr Heather Grimbaldeston, Director of Public Health		
NHS Eastern Cheshire CCG	Jerry Hawker, Chief Officer		
NHS South Cheshire CCG	Simon Whitehouse, Chief Officer		
NHS England			
East Cheshire NHS Trust			
Mid Cheshire Hospitals NHS Foundation Trust			
Cheshire & Wirral Partnership NHS Foundation Trust			
North West Ambulance Service			

Governing Body Meetings in Common of the Governing Bodies of NHS Eastern Cheshire CCG, NHS South Cheshire CCG and NHS Vale Royal CCG

held in public

22 November 2018 at 9.30am

Main Hall, Congleton Town Hall, High Street, Congleton, CW12 1BN

Chair: Dr Paul Bowen, NHS Eastern Cheshire CCG
Chair: John Clough, NHS South Cheshire CCG
Chair: Dr Jonathan Griffiths, NHS Vale Royal CCG

A G E N D A

9.15 ARRIVAL - tea and coffee available

Time	Agenda No.	Title / Description	Speaker	Delivery & Decision
9.30	**1.**	**PRELIMINARY BUSINESS**		
	1.1	**Welcome & apologies for absence**	Chair	*Verbal*
	1.2	**Declaration of any interests relevant to the agenda item**	Chair	*Verbal*
9.45	**1.4**	**Public Speaking Time**		
9.55	**2.**	**STANDING ITEM**		
	2.1	**Redesign of Adult and Older Peoples Specialist Mental Health Services – Decision Making Business Case**	Jacki Wilkes	*Paper attached* ***For decision***
11.25	**2.2**	**Any other business and close**	Chair	Verbal
11.30 CLOSE				

NHS Eastern Cheshire Clinical Commissioning Group
NHS South Cheshire Cheshire Clinical Commissioning Group
NHS Vale Royal Cheshire Clinical Commissioning Group

Governing Body Meetings in Common of the Governing Bodies of NHS Eastern Cheshire CCG, NHS South Cheshire CCG and NHS Vale Royal CCG

held in public

22 November 2018 **Agenda Item 2.1**

Report on:	**Redesign of adult and older peoples specialist mental health services – Decision Making Business Case**
Report by:	**Jacki Wilkes,** Associate Director of Commissioning, NHS Eastern Cheshire CCG
Sponsor:	**Alex Mitchell,** Interim Chief Officer, NHS Eastern Cheshire CCG **Clare Watson,** Chief Officer, NHS South Cheshire CCG & NHS Vale Royal CCG
Appendices:	**Appendix One:** Decision Making Business Case (DMBC) **Appendix Two**: DMBC Supporting Appendices

Action required:	Approve		Ratify		**Decide**	☑	Endorse		For information	

1. Purpose

1.1 This report outlines the recommended commissioning decision to be considered by the Governing Bodies of NHS Eastern Cheshire Clinical Commissioning Group (CCG), NHS South Cheshire CCG and NHS Vale Royal CCG and should be read alongside the Decision Making Business Case (DMBC) in **Appendix One** that describes the evidence and rationale for the decision being recommended.

2. Recommendation(s) for consideration:

2.1 The Governing Bodies are asked to:

- **note** the work undertaken to date by the consultation partners and the invaluable support and feedback received from service users, the public and stakeholders
- **note** the recommendation of the Adults And Older Peoples Specialist Mental Health Service (AOPSMHS) Steering Group and CCG Chief Officers that **Option 2 Plus** be progressed
- **note** that if Option 2 Plus is adopted to progress for implementation that there will be an additional £0.73m to be funded recurrently by the CCGs.
- **note** the additional consideration being undertaken by Cheshire East Health and Adult Social Care, and Communities Oversight and Scrutiny Committee concerning Option 2 Plus, with a response expected during the Governing Bodies meeting in common.
- **consider** the information provided within this report and the supporting DMBC and **decide** on the final option to progress towards the implementation of the new model of care for Adult and Older Peoples Specialist Mental Health Services.

3. Executive Summary

3.1 The Five Year Forward View for Mental Health[1] is a national framework for improvement. It recognises the need to address capacity in the community and reduce the over reliance on hospital services. It is a mandate to improve and modernise mental health services to reflect a proactive, timely response to the needs of people requiring mental health support in the community and provide care in the least restrictive environment.

3.2 NHS Eastern Cheshire Clinical Commissioning Group (CCG), NHS South Cheshire CCG and NHS Vale Royal CCG, working in partnership with the local mental health services provider Cheshire and Wirral Partnership Foundation NHS Trust (CWP), users of the service and Cheshire East Council have undertaken a programme of work to redesign existing adults and older peoples specialist mental health services across the Eastern Cheshire, South Cheshire and Vale Royal areas.

3.3 The redesign programme commenced in July 2017 and has followed an established process with regards proposed changes to NHS services, as outlined in the NHS England guidance *'Planning, assuring and delivering service change for patient'*[2] against a case for change and robust needs analysis. The Clinical Commissioning Groups (CCGs) have worked closely with CWP, service users and their carers and families, social care and other public sector partners to ensure that a system approach to proposals has been adopted and puts the service user at the center of their care.

3.4 The three Governing Bodies considered and approved a Pre-consultation Business Case (PCBC) for the AOPSMHS redesign at their meetings in November 2017 and December 2017, and confirmed their support for the CCGs to progress towards a formal public consultation in early 2018. The PCBC was also considered by the health and care scrutiny committees of both Cheshire East Council and Cheshire West and Chester Council and support received to progress towards public consultation.

3.5 The public consultation ran from 6th March to 29th May 2018 and took three shortlisted options forward to the population for consideration. Externally facilitated by NHS Midlands and Lancashire Commissioning Support Unit (MLCSU), the consultation partners issued 10,000 copies of the consultation document and questionnaire ,held seven public meetings, attended 26 additional meetings and used a variety of media channels to publicise the consultation and encourage people to 'have their say'. This included focused engagement with mental health user interest groups and a range of other community groups and mental health user interest groups where consultation partners explained the options and encouraged attendees to attend public meetings and complete the formal questionnaire. Copies of the consultation document and questionnaire were sent to every one of the 7,000 people currently receiving support from specialist mental health services with easy read versions distributed to case workers and placed in clinical areas.

3.6 Consultation partners engaged and observed legal advice and received the support of external experts on consultation delivery so as to ensure that a robust, legally sound

[1] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf (last accessed 15.11.18)
[2] Planning, assuring and delivering service change for patient (NHS England, March 2018). Available at https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf (last accessed 15.11.18)

approach was taken to the local consultation process. A review of this local approach to consultation delivery demonstrated that the approach followed best practice guidance and upheld the Gunning Principles[3] in terms of undertaking public consultation. All consulting CCG Governing Bodies, NHS England and Health Scrutiny committees in both Cheshire East and Cheshire West and Chester Local Authorities have indicated that they are satisfied that the consulting partners followed due process in undertaking their legal duty to consult, and undertook sufficiently robust and transparent means to engage, inform and consult with the public, service users and stakeholders.

3.7 The University of Chester was commissioned to undertake an independent review of the consultation survey feedback and findings.[4] Consultation and research experts from MLCSU worked closely with the consultation partners and was contracted to provide a range of support services, including the production of a summary report on the findings of the consultation and the analysis of the public events, correspondence and other information collected at 'pop-in' events and meetings.

3.8 Following completion of the consultation and analysis of the findings and feedback, it was identified that the public indicated that ***'improving outcomes for people with specialist mental health needs'***, was seen as the most important priority of, followed by ***'access to crisis services'*** and ***'ability to visit people in hospital easily'***.

3.9 The findings of the consultation confirmed that Option 2 was identified as the option receiving the highest scores, and therefore support from respondents to the consultation. Option 2 was also considered the most likely option to deliver on the top two outcomes people said were important - Improving outcomes for people with mental ill health' and 'access to crisis services'. It is however important to note that the third most important outcome was 'being able to visit hospital easily' and this was not considered possible under Option 2 or Option 3 for some people, but could be achieved for many under option one.

3.10 Feedback identified that there was recognition that current services had to change, however there were strong concerns regarding the difficulties this would cause. In particular, transport costs, travel time, less opportunity for carers, family, friends and staff to visit and the detrimental impact on recovery of patients, were raised as the main concerns regarding implementation of the preferred option and Option 3. For all options there were also concerns regarding the implementation of proposed changes and the associated costs.

3.11 On 15th August 2018 representatives from the three Governing Bodies met to receive and give conscientious consideration to the consultation findings. Taking account of the information within the PCBC alongside the findings from the public consultation, commissioners fed back to the programme redesign team on what additional work would

[3] Gunning Principles http://www.nhsinvolvement.co.uk/connect-and-create/consultations/the-gunning-principles (last accessed 15.11.18)
[4] CONSULTATION REPORT Redesigning: Adult and Older People's Specialist Mental Health Services Consultation from 6th March - 29th May 2018 University of Chester 10th September 2018 https://www.easterncheshireccg.nhs.uk/Downloads/Your-Views/MH%20Consultation/MH%20Findings%20Sept2018/AOPSMHS%20Consultation%20Findings%20Appendix%20B%20-%20UoC%20CONSULTATION%20REPORT%20V6.pdf (last accessed 15.11.18)

be required to support the development of the DMBC ahead of being considered at a future Governing Body meeting.

3.12 The programme redesign group undertook the further work in relation to:

- re visiting activity data to reconfirm the impact of a new model of care on admissions to hospital length of stay and clinical outcomes
- further understanding the impact of Options 2 and Option 3 on travel time for visitors (family/carers) and develop robust proposals for supporting people to stay in touch
- re-examining the potential to utilise existing CWP or other partners estate to accommodate more inpatient activity within the local foot print
- revisiting the workforce model and recruitment and retention plans to provide assurance that proposals are achievable
- exploring further with health and social care partners the unintended consequences of each of the options and develop mitigation plans where required
- reviewing financial profiles against each of the options and provide more detail in relation to both capital and revenue investment.

3.13 Through the course of undertaking this work with health and care system partners, progress was made in identifying a viable amended option for consideration and which addressed many of the concerns raised and heard throughout the consultation whilst continuing to meet the ambitions outlined within the case for change. This option is known as Option 2 Plus.

3.14 The AOPSMHS DMBC has been written in partnership between the three CCGs and CWP and outlines two viable options for consideration for adoption for the future commissioning and delivery of AOPSMHS. Both options are evidenced based, high quality and affordable upholding the programme ambition to 'provide the best possible services within the resources available'. Its purpose is to inform the Governing Bodies of the work undertaken and provide sufficient information for the Governing Bodies to make a decision.

3.15 An external clinical review of the proposals to introduce a new model of care for AOPSMHS was undertaken in October 2018 by the Cheshire and Merseyside Clinical Senate.[5] To ensure an independent view of proposals the panel comprised members from outside Cheshire and Merseyside and was overseen by clinical experts in the area of specialist mental health services and expert by experience patient representative. A number of service delivery approaches were reviewed, including additional work on the amended option (Option 2 Plus). The main objective of the senate review was to gain an independent view on how proposals would address the issues raised in the case for change, the robustness of planning, particularly the needs analysis and workforce plans, and how the redesign team have responded to the feedback gathered through the public consultation.

3.16 A final formal report on the findings will be provided later this year however the senate has already provided feedback on the main findings from the review. These were as follows:

[5] Cheshire and Merseyside Clinical Senate https://www.nwcscnsenate.nhs.uk/clinical-senate/cheshire-merseyside-senate/ (last accessed 15.11.18).

- the new model of care is in line with national best practice and should be introduced.
- plans are robust, based on good intelligence and data analysis, linked to the new model of care and workforce and capacity plans.
- amended proposal (Option 2 Plus) takes account of consultation feedback and the travel concerns of service users, carers and health and care partners. This option was believed to be the one that would best deliver the case for change given the clear support for a new model of care, and would significantly address concerns raised around travel in relation to inpatient provision moving to Chester
- the opportunity to provide more inpatient services locally is a positive outcome but will need to be delivered in a facility which is fit for purpose.
- that the partnership approach to improving quality and outcomes is the right approach and should continue.

3.17 The two options that are being submitted for consideration are summarised in Table One. Further detail on each option is provided within the DMBC.

Table One – Summary of options

Option 2	Option 2 Plus
Description	
Enhanced community services including dementia outreach. Crisis care services established including up to 6 local short stay crisis beds in the community. Re-provide the inpatient and bed-based care currently available at Millbrook within an older people's service at Lime Walk House in Macclesfield and an adult service within the current provider footprint at Bowmere in Chester. There will be 3 additional beds available to enable CWP to manage service user flow across a wider geographical footprint. In total these services provide 53 beds (including 6 crisis beds in the community). Specialist rehabilitation service users currently at Lime Walk House would be transferred to a specialist rehabilitation facility at Soss Moss in Nether Alderley.	Enhanced community services including dementia outreach. Crisis care services established including up to 6 local short stay crisis beds in the community. Transform inpatient and bed-based care currently available at Millbrook by providing an acute all-age (adult and older people) 26 bed service at Lime Walk House Macclesfield, and a 15-bed dementia service at the former Complex Assessment & Recovery Services (CARS) ward on the MDGH site. There will be 7 additional beds available to enable CWP to manage service user flow across a wider geographical footprint. In total these services provide 54 beds (including 6 crisis beds in the community). Specialist rehabilitation service users currently at Lime Walk House would be transferred to a specialist rehabilitation facility at Bowmere in Chester.
New model of care	
Community and crisis model as described in the PCBC	Community and crisis model as described in the PCBC

Option 2	Option 2 Plus
Bed Model Overview	
• <u>Older people</u> o 22 beds provided at Lime Walk House, Macclesfield: o 12 Older People with functional illness o 10 Dementia beds • <u>Adults functional illness</u> o 22 Beds at Bowmere, Chester o 3 Beds, Wirral (adults and older people) • Psychiatric Intensive Care, Bowmere, Chester (no change) • Rehabilitation patients – 13 beds at Soss Moss, Nether Alderley	• <u>Adults and older people with functional illness</u> o 26 beds provided at Lime Walk House, Macclesfield o 7 beds (Bowmere and Wirral) complex service users • <u>Dementia</u> o 15 Beds at CARS Ward, Macclesfield • Psychiatric Intensive Care, Bowmere, Chester (no change) • Rehabilitation patients – 13 beds at Bowmere, Chester
Workforce	
Community service teams increasing by 40 WTE • 30 WTE in CMHS • 8 WTE in HTT • 2 WTE dementia outreach • Increased service user access to therapeutic interventions 24/7 access to crisis services; and community beds	
Consultation	
• The new model of care received over whelming support from the service users, carers and members of the public as it was considered the approach most likely to improve outcomes for people • This option **would not** respond to the significant travel concerns raised by service users and the public or locally and nationally elected politicians	• The new model of care received over whelming support from the service users, carers and members of the public as it was considered the approach most likely to improve outcomes for people • This option **would respond** to the significant travel concerns raised by service users and the public however a ***small number of rehab patients would be required to travel to Chester***
Service delivery model (inpatients: acute and rehabilitation)	
• Adult inpatient beds would be provided in **Chester, older adult beds in Macclesfield** • Adults requiring PICU and ECT during their treatment would be supported in inpatient units in Chester, giving them quick access to the treatment they require	• Adult and older adult inpatient beds would be provided in Macclesfield. Adults requiring PICU and ECT during their treatment would be supported in inpatient units in Chester, giving them quick access to the treatment they require • **Negligible travel impact on service users due to most inpatient services remaining in**

Option 2	Option 2 Plus
• Potentially **260 service users will have a travel impact** with adult inpatient services in Chester • **Potential impact on care partners** such as social workers and approved mental health professionals who would have to travel to undertake statutory assessments • Specialist rehabilitation services will move from Lime Walk House to **Soss Moss in Nether Alderley**	**Macclesfield** • **Reduced impact on care partners** such as social workers and approved mental health professionals • Specialist rehabilitation services will move from Lime Walk House **to Chester**
Finance	
• Current overall deficit in 2018/19 is £2million, this option **reduces the cost pressure to £0.8m** • Capital monies have been identified by the provider for renovation of estates to bring in line with national standards and guidance • Additional funding is required to facilitate the implementation of the wider Crisis Service vision • Delivers **improvement** on the local health economy financial position, delivering on the redesign ambition of providing the best possible care within the resources available	• Current overall deficit is £2million, this option **reduces the cost pressure to £1.5million, prior to taking account of the additional funding** • **Requires additional funding of £0.73m to be provided by Commissioners** • Additional capital monies would be required by provider for renovation of estates to bring in line with national standards and guidance **in addition to option 2** • Additional funding is required to facilitate the implementation of the wider Crisis Service vision • Delivers **improvement** on the local health economy financial position, delivering on the redesign ambition of providing the best possible care within the resources available
Financial Impact 2018/19 Overall Deficit (£2.0m) Saving of redesign <u>£1.2m</u> Overall Deficit **(£0.8m)** Additional Funding (CCGs) £0.0m	**Financial Impact** 2018/19 Overall Deficit (£2.0m) Saving of redesign <u>£0.5m</u> Overall Deficit (£1.5m) **Proposed Additional Funding (CCGs) £0.73m** Revised Overall Deficit **(£0.8m)**

3.18 The current financial deficit being incurred by CWP is £2m (difference between the cost of providing the services versus the value commissioned by CCGs) and is not a sustainable position that can be maintained. The net financial impact of implementing Option 2 improves the overall deficit by £1.2m whilst Option 2 Plus improves the overall deficit by £0.5m. The reduced financial benefit is associated with the amendments made that addressed the majority of concerns raised as part of the consultation feedback. The CCGs propose, as part of Option 2 Plus to fund the reduced financial benefit of £0.73m and will be the first call on any national mandate re the Mental Health 5 Year Forward View, Mental Health Investment Standard or pending NHS 10 Year Plan.

3.19 Regardless of the option chosen for implementation, all services will be available to people aged 18 and over registered within GP Practices within NHS Vale Royal, NHS South Cheshire and NHS Eastern Cheshire CCG areas. Those individuals who may be homeless, living in the area temporarily or yet to register with a GP will not be excluded from receiving care. Those aged 14 to18 will have access to these secondary care services but will be supported concurrently via CAMHS inpatient, community and outreach staff in a way that best meets the needs of the individual. In both options the community and crisis provision is equal.

3.20 It should be noted that under Option 2 Plus, the specialist rehabilitation service users currently at Lime Walk House would be transferred to a specialist rehabilitation facility in Chester (instead of locally in Soss Moss, Nether Alderley as proposed in Option 2 and Option 3) to allow Lime Walk House to become the acute all age functional unit. This move would be a medium term solution as the service may at some point move back to the Cheshire East locality, dependent on the strategic developments nationally and locally around rehabilitation services and NHS estates strategies.

3.21 CWP has long term strategic plans to develop an enhanced rehabilitation pathway where high dependency patients have access to an inpatient centre of excellence where service users can move to community, supported accommodation, residential care and/or supported tenancies with in-reach and out-reach support from an enhanced community rehabilitation team. This strategic direction is in line with the direction of travel and ambitions as outlined within the Cheshire East Council mental Health draft strategy.

3.22 There is a National drive towards enhancing rehabilitation provision in the community, (most recently CQC report on Locked Rehabilitation). The CWP strategy is supported by the FYFV which recommends that rehabilitation services should reduce their dependency on hospital beds through increasing community rehabilitation provisions including residential rehabilitation and supported housing. The regional Cheshire and Merseyside Health Care Partnership has a priority around investing in mental health services delivered outside of hospital settings and is currently reviewing supported housing provisions.

3.23 In finalising the options for consideration and ahead of the Governing Bodies considering the DMBC on the 22 November 2018, the consulting partners have undertaken to do further focused engagement with the current service users at

Limewalk House, their carers / families and mental health support forums so as to seek their views and feedback on the Option 2 Plus proposal and implications. Consulting partners have also been mindful of the need to further engage with the Cheshire East Health and Adult Social Care, and Communities Oversight and Scrutiny Committee (OSC) to seek their opinion on the extent of engagement needed with regards Option 2 Plus. Consulting partners are due to receive the opinion of OSC during the Governing Bodies meeting in common on the 22 November 2018.

Access to further information

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Governing Body Meetings in Common of the Governing Bodies of NHS Eastern Cheshire CCG, NHS South Cheshire CCG and NHS Vale Royal CCG
in-public

22 November 2018

Agenda Item 2.1

Report Title	**Redesign of adult and older peoples specialist mental health services – Decision Making Business Case**

Appendix A

Decision Making Business Case – main document

Adult and Older Peoples Specialist Mental Health Services Redesign

Decision Making Business Case

Version 3.0
Published online on 15 November 2018

NHS Eastern Cheshire Clinical Commissioning Group
NHS South Cheshire Clinical Commissioning Group
NHS Vale Royal Clinical Commissioning Group

Version Control

Date	Version	Amendments (brief details)	Responsible (name/group)	New Version Number
05/11/18	1.1	RC changes based on initial feedback from Clinical Senate.	RC	1.2
05/11/08	1.2	Travel information added	JS	1.3
06/11/18	1.3	Information added on viable options. Flow of document amended	JS/JW	1.4
12/11/18	1.4	Finance and recommendations section added plus further amendments	JW	1.5
12/11/18	1.5	Contents Page	JS	2.0
13/11/18	2.0	Incorporation of feedback	JS	2.1
14/11/18	2.1	Incorporation of feedback	JS	2.2
14/11/18	2.2	Glossary Page	JS	2.3
15/11/18	2.3	Updated financial information and executive summary	AM/JW	2.4
15/11/08	2.4	Incorporation of CWP comments	RC/KW/SE	2.5
15/11/18	2.5	Final amendments	AM/MC	3.0

Contents

1.0 Executive Summary

1.1 The Five Year Forward View for Mental Health[1] is a national framework for improvement. It recognises the need to address capacity in the community and reduce the over reliance on hospital services. It is a mandate to improve and modernise mental health services to reflect a proactive, timely response to the needs of people requiring mental health support in the community and provide care in the least restrictive environment

1.2 The current model of care and ways of working for delivering adult and older peoples specialist mental health services in the NHS Eastern Cheshire CCG, NHS South Cheshire CCG and NHS Vale Royal CCG areas are not consistent with either national policy, best practice or local transformation plans, leaving room to improve service user experience and outcomes of care.

1.3 There is rising demand for care and support for adults and older people with mental health problems. Since 2010 there has been an increase in activity across the three CCGs of 35% in functional services for people with moderate to severe mental health needs and 60% in dementia services.

1.4 The majority of people experiencing mental health problems can be effectively managed in community settings with the right level of support. Local evidence shows up to 50% of adults and 30% of older people accessing in-patient hospital services could have been supported in the community as an alternative to hospital admission. In addition over 40% of adults and 69% of older people were fit for discharge from hospital but awaiting community support or long term placement

1.5 Service users and carers state there is limited choice and access to care for service users who are experiencing crisis, with only A&E department's offering consistent 24/7 support. Lack of capacity in the home treatment teams, who offer step up care, and community mental health teams, who offer ongoing support for service users with complex needs, leads to an over reliance on inpatient (hospital based) mental health services of up to 16% which equates to approximately 10 additional beds[2].

1.6 The local health and social care system is experiencing a deteriorating financial position. The cost of the current adult and older people's specialist mental health service configuration in Eastern Cheshire, South Cheshire and Vale Royal exceeds the funding provided by local commissioners and change is required for local NHS organisations to operate within their financial controls, and deliver locally the Governments Mandate[3] requirement for the NHS to balance its books, whilst maintaining delivery of quality patient care.

[1] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf and https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf
[2] https://docs.wixstatic.com/ugd/0e662e_a93c62b2ba4449f48695ed36b3cb24ab.pdf
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/601188/NHS_Mandate_2017-18_A.pdf

1.7 In order to address the issues described, a programme of redesign has been undertaken by the CCGs in partnership with the main provider of local specialist and community mental health services, Cheshire and Wirral Partnership NHS Foundation Trust (CWP) In line with national guidance on *'Planning, assuring and delivering service change for patients'*[4]

1.8 The programme redesign group engaged clinicians from secondary and primary care along with service users to develop an alternative model of secondary mental health care, based on national best practice and service user feedback, and which is consistent with local plans for transformation. Three options were shortlisted and taken through a 12 week public consultation.

1.9 Following completion of the consultation and analysis of the findings and feedback, it was identified that the public indicated that *'improving outcomes for people with specialist mental health needs'*, was seen as the most important priority of, followed by *'access to crisis services'* and *'ability to visit people in hospital easily'*.

1.10 The findings of the consultation confirmed that Option 2 was identified as the option receiving the highest scores, and therefore support from respondents to the consultation. Option 2 was also considered the most likely option to deliver on the top two outcomes people said were important - Improving outcomes for people with mental ill health' and 'access to crisis services'. It is however important to note that the third most important outcome was 'being able to visit hospital easily' was not considered possible under Option 2 or Option 3 for some people, but could be achieved for many under option one.

1.11 There was recognition that current services had to change, however there were strong concerns regarding the difficulties this would cause. In particular, transport costs, travel time, less opportunity for carers, family, friends and staff to visit and the detrimental impact on recovery of service users, were raised as the main concerns regarding implementation of the preferred option and Option 3. For all options there were also concerns regarding the implementation of proposed changes and the associated costs.

1.12 On 15th August 2018 representatives from the three Governing Bodies met to receive and give conscientious consideration to the consultation findings. Taking account of the information within the PCBC alongside the findings from the public consultation, commissioners fed back to the programme redesign team on what additional work would be required to support the development of the DMBC ahead of being considered at a future Governing Body meeting.

1.13 The programme redesign group undertook the following further work in relation to:

- re visiting activity data to reconfirm the impact of a new model of care on admissions to hospital length of stay and clinical outcomes

[4] https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf

- further understanding the impact of Options 2 and Option 3 on travel time for visitors (family/carers) and develop robust proposals for supporting people to stay in touch
- re-examining the potential to utilise existing CWP or other partners estate to accommodate more inpatient activity within the local foot print
- revisiting the workforce model and recruitment and retention plans to provide assurance that proposals are achievable
- exploring further with health and social care partners the unintended consequences of each of the options and develop mitigation plans where required
- reviewing financial profiles against each of the options and provide more detail in relation to both capital and revenue investment.

1.14 Through the course of undertaking this work with health and care system partners, progress was made in identifying a viable amended option for consideration and which addressed many of the concerns raised and heard throughout the consultation and which also continued to meet the ambitions outlined within the case for change. The option is known as Option 2 Plus.

1.15 In association with Option 2 Plus, the consulting partners have undertaken to do further focused engagement with the current service users at Lime Walk House, their carers / families and mental health support forums so as to seek their views and feedback on the Option 2 Plus proposal and implications. Consulting partners have also been mindful of the need to further engage with the Cheshire East Health and Adult Social Care, and Communities Oversight and Scrutiny Committee (OSC) to seek their opinion on the extent of engagement needed with regards Option 2 Plus. Consulting partners are due to receive the opinion of OSC during the Governing Bodies meeting in common on the 22 November 2018.

1.16 The proposals within the Decision Making Business Case have been subjected to an equality impact assessment which shows an overall positive service impact and independent clinical review. Initial feedback from the independent review supports the proposed model of care, confirms that proposals meet the case for change and that they create a springboard for future improvement, The review panel were also assured that the views of the public had shaped the recommendations

1.17 The recommendation of the adults and older peoples specialist mental health service (AOPSMHS) steering group and Chief Officers from Eastern Cheshire and South Cheshire/Vale Royal CCGs, with regards the preferred option for care model implementation, is **Option 2 Plus.**

2.0 Introduction

2.1 Purpose and Scope of the Decision Making Business Case

NHS Eastern Cheshire Clinical Commissioning Group (CCG), NHS South Cheshire CCG and NHS Vale Royal CCG, working in partnership with the local mental health services provider Cheshire and Wirral Partnership Foundation NHS Trust (CWP), users of the service and Cheshire East Council have undertaken a programme of work to redesign existing adults and older peoples specialist mental health services in the Eastern Cheshire, South Cheshire and Vale Royal areas. Specialist or secondary care is the term used to differentiate services from those provided in primary mental health such as GP only care and universal psychological therapies (IAPT). Secondary care services include specialised community support, crisis response and inpatient care.

The redesign programme commenced in October 16 and has followed an established process with regard to proposed changes to NHS services, as outlined in the NHS England guidance *'Planning, assuring and delivering service change for patient*[1] which includes a case for change and robust needs analysis. The CCGs have worked closely with CWP, service users and their carer's and families, social care and other public sector partners to ensure that a system wide approach to proposals has been adopted which puts the service user at the centre.

This Decision Making Business Case (DMBC) has been written in partnership between the three CCGs and CWP and outlines two options for consideration for adoption for the future commissioning and delivery of adult and older people's specialist mental health services. Both options are evidenced based, high quality and affordable upholding the programme ambition to 'provide the best possible services within the resources available'. Its purpose is to inform the Governing Bodies of the work undertaken and provide sufficient information for the Governing Bodies to make a decision.

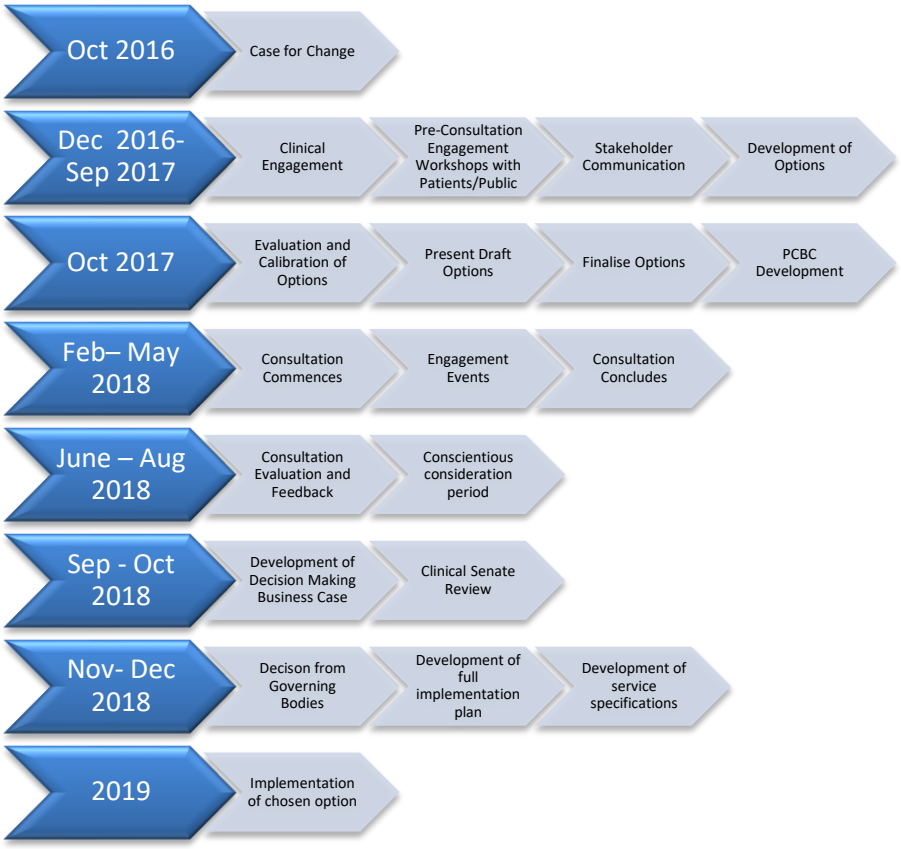
The two options for consideration and recommendations for adoption will be presented to the Governing Bodies of the three CCGs at a Meeting in Common on the 22 November 2018. As the commissioners of these services, the Governing Bodies of each of these CCGs have the responsibility to decide on the adoption of the preferred option for progression.

3.0 Overview of Process to Date

The process for the redesign of the adult and older people's specialist mental health services began in October 2016. The production of this DMBC is a key milestone within this. Figure 1 shows the process undertaken to date at a high level.

[1] Planning, assuring and delivering service change for patient (NHS England, March 2018). Available at https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf (last accessed 15.11.18)

Figure 1 Service redesign programme timeline



3.1 Case for Change

3.1.1 National Drivers

The Five Year Forward View (FYFV) for Mental Health[2] is a national framework for improvement. It recognises the need to address capacity in the community and reduce the over reliance on hospital services. It is a mandate to improve and modernise mental health services to reflect a proactive, timely response to the needs of people requiring mental health support in the community and provide care in the least restrictive environment.

Table 1 provides a summary of the key standards to be achieved by 2021 for the services within scope of this programme:

[2] The Five Year Forward View for Mental Health (NHS England, 2016) Available at https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf (last accessed 15.09.18)

Table 1: Five Year Forward View (FYFV) Standards to be achieved by 2021

Adult community mental health services will provide timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary and social care and other sectors.
A reduction in premature mortality of people living with severe mental illness (SMI); and 280,000 more people having their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.
Increased access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.
All areas will provide crisis resolution and home treatment teams (CRHTTs) that are resourced to operate in line with recognised best practice – delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute in-patient admissions.

The FYFV for Mental Health describes a new model of clinical care, based on needs and built around the person. It outlines the importance of aligning mental health and physical health and the importance of early intervention and prevention. The principles within the national framework are entirely consistent with locally developed transformation plans which provide the vehicle through which change can be achieved.

3.1.2 Local Drivers for Change

There is rising demand for care and support for those with mental health needs. Since 2010 there has been an increase in activity across the three CCGs of 35% for people with moderate to severe mental health needs and 60% in Dementia services. Local evidence, gathered during a one day spot audit undertaken in June 2017, identified up to 50% of adults and 30% of older people in hospital services could have been supported in the community as an alternative to hospital admission. In addition the same audit identified, over 40% of adults and 69% of older people were fit for discharge from hospital at the time of the audit but were awaiting community support or long term placement.

Service users and carers stated, during the Preconsultation listening events undertaken in September 2017, that there is limited choice and access to care for service users who are experiencing crisis, with only Accident and Emergency (A&E) departments offering consistent 24/7 support. Service users who present in crisis currently do not have access to crisis beds in the community (e.g. crisis house) to de-escalate and often end up in A&E out of hours, resulting in mental health inpatient admission. An inpatient ward is not the optimal environment for many service users during a crisis and will often exacerbate their condition, sometimes resulting in a poor experience and outcomes.

The current crisis service provision for Eastern Cheshire, South Cheshire and Vale Royal is delivered via the Crisis Resolution Home Treatment (CRHT) team, which operates between the hours of 8:30am-9pm, 7 days a week, and comprises

comprising mainly of nursing staff with nominal medical input, with an A&E based nurse practitioner for Out of Hours. Feedback from external reviews[3] shows that whilst the CRHT approach scored high on the quality of care provided, the service need to be expanded to meet the needs of a greater number of people in a timely manner, and provide support to individuals upon discharge from hospital. The service also needs to be extended to support 24/7 cover. Gaps in service provision were identified as medications managements, psychological therapies and a wider choice of crisis services which could be utilised to support people.

The current configuration in the community teams impacts the ability to provide interventions at an early stage, causes increased acuity, care burden and leads to an over reliance on inpatient services, of up to 16%, which equates to approximately 10 additional beds[4]. The configured model of care, and ways of working, are not fully consistent with national policy, best practice or local transformation plans leaving room to improve service user experience and outcomes of care. The provider scores highly in a range of measures, but there are significant financial and clinical sustainability issues.

Inpatient services are currently provided at a number of sites across the Cheshire and Wirral geographical footprint, including the Millbrook unit in Macclesfield which is part of the East Cheshire NHS Trust estate. Despite significant financial investment, to improve the inpatient environment within Millbrook, the facilities within still fall short of what is expected from a modern mental health inpatient environment. Significant refurbishment is required to comply with Care Quality Commission (CQC) standards for privacy and dignity[5]. Due to the layout of the building; the wards require a disproportionately higher staffing model to maintain clinical safety.

The rising demand, and the pressure this puts on community and crisis services is significantly impacting the current workforce; staff morale is low and this is affecting the ability to recruit and retain staff locally. The local health and social care system is facing significant financial challenges. The cost of the current adult and older people's mental health service delivery configuration significantly exceeds the funding available by circa £2.5m and therefore requires change in order to ensure services can be delivered sustainably within available funding.

3.1.3 Needs Analysis

There are 479,000 people living in Eastern Cheshire, South Cheshire and Vale Royal. Based on national prevalence data we would expect to see around 119,750 people locally with a diagnosable mental health problem, but of these people only 10,778 will have Serious Mental Illness and require care and support from specialist mental health services with 60-70% of these individuals in active treatment at any one time.

Specialist services provide care for people with a range of conditions whose complex needs cannot solely be met in general practice. There are currently in excess of

[3] https://www.ucl.ac.uk/core-resource-pack/fidelity-scale (last accessed 15.09.18)
[4] https://docs.wixstatic.com/ugd/0e662e_a93c62b2ba4449f48695ed36b3cb24ab.pdf (last accessed 15.09.19)
[5] The Care Quality Commission. Fundamental Standards. Available at https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards (last accessed 15.09.18)

7,000 people receiving CCG commissioned care and support from the main local provider of specialist mental health, CWP, via the community mental health teams. Other people are accessing care commissioned by other commissioners, such as NHS England and Cheshire East Council, and through third sector and alternative mental health providers.

Prior to identifying the model of care and the options for service delivery it was important to first understand the needs of the population in relation to mental health. A number of planning assumptions were agreed in relation to the needs analysis:

- it would include registered population rather than resident.
- a number of information sources would be used such as projected population statistics and actual activity data as it was found that there was limited national benchmarking data available to check assumptions relating to prevalence vs incidence.
- professional judgement, local and national benchmarking data was used to 'check assumptions'.
- activity data reviewed was by primary diagnostic codes but it is possible that there are overlaps with secondary diagnosis numbers.

The starting point was public health prevalence data, or the types of mental health and numbers of people affected likely to be seen in any given population. The categories of health need related to dementia, depression, psychosis, bipolar disorder, personality disorder, and anxiety. This data was compared to current activity by looking at the numbers of people known to services, which showed that that it was as expected and therefore there was no 'hidden demand'

The needs analysis was then used to develop a more responsive and evidenced based model of care with an emphasis on early intervention and timely access to services mapped to individual need. The completed needs analysis can be found in **DMBC Appendix 1**.

3.2 Developing a New Model of Care

Locally developed transformation plans describe a programme of co-design across the health and social care economy where commissioners and providers respond to service user needs and work together to redesign care services. They represent a system wide commitment to implementing the changes required to deliver a care system that is entirely consistent with the national vision for future mental health services described in the 5YFV for Mental Health.

The aim is to develop an enhanced, model of care for adult and older people's specialist mental health services, to achieve a responsive, community focussed, personalised care system that is wrapped around the empowered individual. It enables professionals to fully utilise their skills in working together to target the support and care to people most in need.

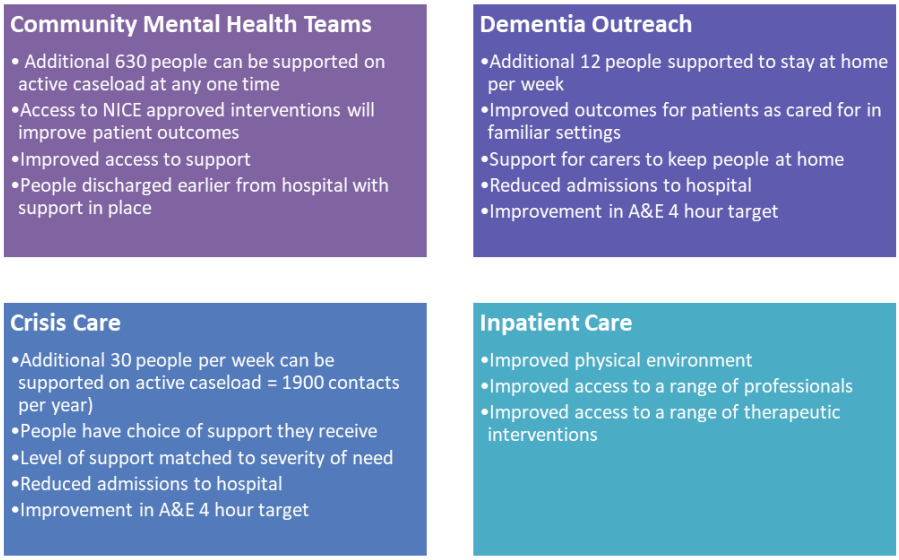
Components of the new model of care will improve service user outcomes through:

- Increased access to an enhanced multi professional community mental health service delivering early intervention and prevention;
- Timely response to crisis support with wider choice of services;
- Improved inpatient experience; and
- An integrated service/pathway for people with dementia.

Feedback from both service users and care professionals is that there needs to be better links with primary care mental health services to ensure the wider determinants of health are addressed. There is also recognition of the importance of managing physical and mental health together in the application of person centred care.

A full explanation of the methodology undertaken to develop the care model can be found in the Preconsultation Business Case (PCBC) for the Adult and Older Peoples Specialist Mental Health Services redesign[6]. The anticipated benefits developed as part of the pre-consultation work are shown in Figure 2.

Figure 2 Anticipated benefits



3.2.1 Model of Care

The new model of care for secondary care services aims to support a seamless transition between community and inpatient care, with a wide range of services, easily accessible to service users depending on their acuity and need. The secondary care services will work closely with primary care when service users require entry to services and on discharge with the aims of ensuring that service users are assessed quickly, receive appropriate intervention and support, in an appropriate setting and, when discharged, have wrap around care and the support they need.

[6] https://www.easterncheshireccg.nhs.uk/Downloads/Your-Views/MH%20Consultation/AOPSMHS%20PCBC%20Website%20version%20171122.pdf (last accessed 15.09.18)

Early intervention and prevention

When a service user requires support beyond primary care, this will initially be provided through the Community Mental Health Service (CMHS). This service will be accessible to primary care via referral to a single point of access. Teams will use an outcome focussed, recovery-based approach to provide service users with a range of evidence based physical, pharmacological, psychological and social interventions, in the community, dependent on the needs of the individual, their family and/or carers. The service comprises a multidisciplinary team and where appropriate, a Care Coordinator will be appointed.

CMHS teams will be based locally within communities throughout the CCG footprints to enable close working with other local services, service users, their family and/or carers. CMHS teams will work closely with Early Intervention Teams to ensure effective transfers of care. The redesign process has described the need for increased access to these services and has identified the required capacity to achieve this within the financial envelope. Future development will focus on the integrate delivery of CMHS within the developing care communities and provide greater support for local populations for their health and social care needs; thus becoming more integrated and allowing holistic planning and service user care.

Crisis Support

If a service user experiences a crisis, that requires a specialist mental health response, they will now have access to a range of crisis services that they can utilise depending on their choice and their need. While this redesign will not deliver the full crisis service described in the FYFV, it will act as a springboard to the future delivery of this full crisis service; through local service planning and collaboration with the Cheshire and Merseyside Health and Care Partnership.[7] There are a number of national best practice models that the project team have reviewed which will inform the development of services locally. Of particular interest are services in place in Cumbria and more locally in Wirral which are leading to a reduced requirement for hospital inpatient care and which services users are evaluating positively.

The crisis service proposed in this model requires joint working between the secondary care provider, third sector organisations, primary care, and other secondary care services and public sector agencies together with local authorities, to provide a holistic service to people in differing stages of crisis including people currently unknown to secondary services who present either via their GP, GP Out of Hours services and A&E.

The crisis response within this model is supported by an enhanced crisis resolution home treatment service (CRHTT) that will be in operation 24/7, resourced to operate in line with best practice, thus supporting more service users at home during crisis and delivering against more of the FYFV standards for crisis cares. The service will be accessible via liaison psychiatry, community mental health services and primary care. Once referred, the team will determine, with the service user, their family and/or carers, the most appropriate support for an individual's crisis.

[7] https://www.cheshireandmerseysidepartnership.co.uk/ (last accessed 15.11.18)

Service users will have greater access to intensive therapies at home, including development of support plans, psychological interventions and supported with self-help and coping strategies. CRHTT will be based locally within community mental health services throughout the CCG footprints to enable closer working with other local services, the service user, their family and/or carers.

The new model of care also allows CRHTT to facilitate an admission to a short stay sanctuary bed. This provides an alternative to hospital admission when a service user can no longer appropriately be cared for in their own home, but who do not require a hospital admission, upholding the principle of care within the least restrictive environment. Sanctuary beds will be commissioned separately and will look to the third sector for both facilities and core staffing with the CRHTT providing enhanced support. The placements are for short term recovery in a non-clinical environment (home from home); with the aim being that the service user returns to their home environment as soon as possible with ongoing support from community mental health and CRHTT. New sanctuary beds will be provided, locally within communities where the need is greatest and where easy access is achievable.

The concept of crisis friendly support centres including cafes, described in the PCBC remain an important aspiration for future planning. The crisis service proposed will link closely with the wider system work led by the CCG and local authority, developing care communities, based on the National Association of Primary Care (NAPC) Primary Care Home model,[8] to support the development of integrated health and social care.

Dementia Outreach

The model of care includes provision for a new dementia outreach service, accessible via secondary or primary care, to provide support within a service user's home including care and nursing homes. The service will prevent hospital admissions, facilitate discharge from hospital, advice on management of challenging or aggressive behaviours, minimise risk, ensure smooth transition between services and support a joint approach to physical and mental health needs of service users. The service will also provide education for, and support staff within, care settings working in partnership with formal and informal carers, statutory and non-statutory agencies. This service will link into the wider commissioned dementia and end of life services within the CCG footprint. The service will integrate into the evolving care communities.

Inpatient Care

In some instances a service user's condition will escalate to a point where they can no longer be safely managed in the community. In this instance the crisis resolution team will facilitate admission to an inpatient unit. Inpatient care provides high quality assessment, treatment and care in a safe environment for people in the most acute stage of their illness.

Inpatient services assess, formulate and treat mental health disorders and support physical health conditions. They reduce the risk of harm to self and others, manage violence and aggression and provide a time-limited, evidence based (including NICE

[8] NAPC Primary Care Model http://napc.co.uk/primary-care-home/ (last accessed on 15.11.18)

guidance), recovery focused, therapeutic programme. They also provide a range of meaningful activities such as gym, outside space, faith areas, communication services, lifestyle support. Inpatient services provide a range of care and treatment options such as psychological interventions, medication, physical treatments, social care support, occupational therapy, dietetics/nutritional care, spiritual care/cultural needs, advocacy and nicotine management.

Inpatient environments will be developed in accordance with national standards and evidence based practice, for example the inpatient dementia unit will be refurbished in line with the University of Sterling audit tool[9].

Service users who require hospital care will be supported to return home as soon as possible and this may include a period of enhanced 'step down' support in the community to enable timely discharge from hospital.

Discharge from Specialist Services

When preparing for discharge, the inpatient and community teams will ensure that assessment of needs is undertaken in partnership with the service user. If the decision is made that the individual no longer requires support from the specialist community based mental health services discharge back to primary care will be coordinated including any appropriate treatment recommendations for ongoing support and treatment and any wrap around support required.

To ensure smooth transition between services within this model and those that support the model it is vital that strong links are developed with the service users, their families and/or carers and a range of other professional and organisations to maintain and/or improve the social and health structure which support the individual's functioning at home, such as; primary care, local authority, social care, housing, benefits, advocacy, voluntary or third sector service providers, acute providers, nursing/care homes. The clinical team, have developed the model for specialist mental health within the context of the wider determinants of health and wellbeing.

3.2.2 Care Model Diagram

Figure Three displays the proposed new local care model which shows how mental health secondary care services will be delivered within a wider, holistic model of care where service users can access services that meet their needs. More support in the community will enable service users to move easily between differing levels of support combining low level interventions and complex care packages where required.

[9] http://dementia.stir.ac.uk/design/building-accreditation (last accessed 15.11.18)

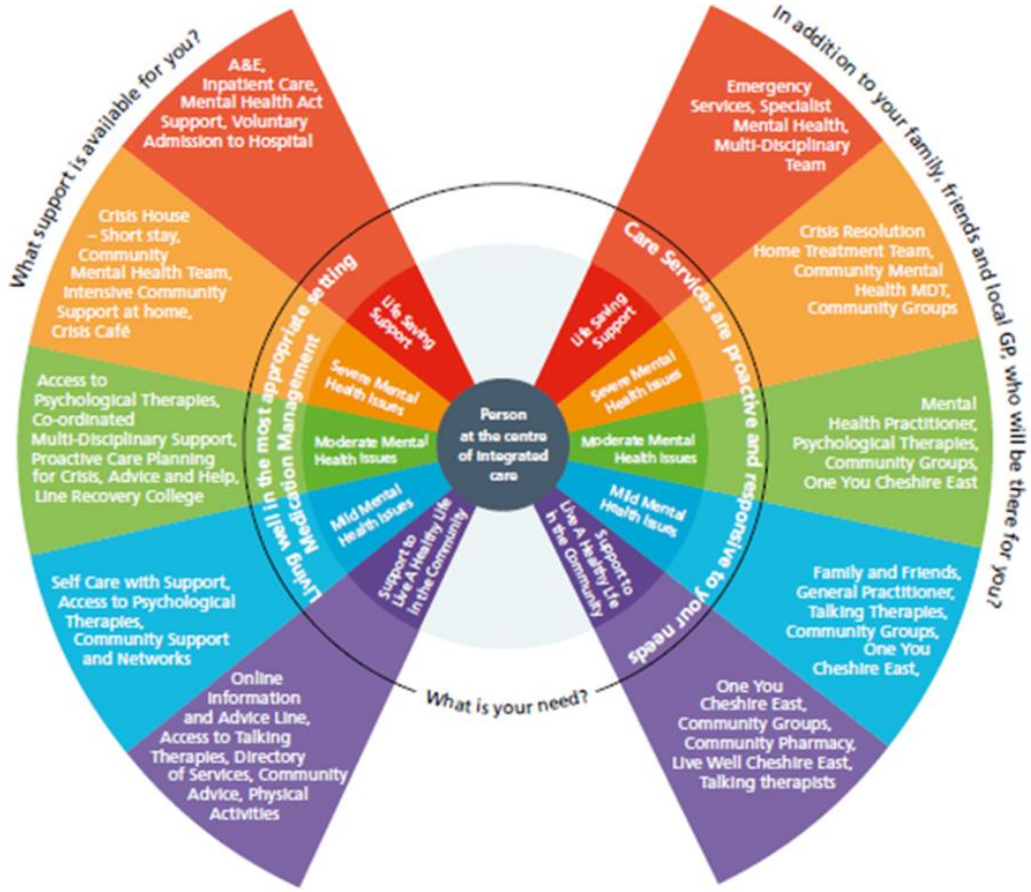


Figure 3 Care Model

3.2.3 Understanding capacity and developing a workforce plan

The national shortage of workforce with the right knowledge, skills and behaviours in some NHS professions has created a very competitive market providing a challenge to building capacity to take plans forward. Nationally there are professions and roles where the vacancy rates are high and recruitment is difficult. This includes qualified nurses across all specialties, medical staff including Doctors in Training and GPs and specialised roles such as IT and Finance.

It has therefore been necessary therefore to extend local thinking beyond the traditional roles within mental health services and learn from some of the new and exciting developments that are occurring within the workforce as a whole.

It is essential that local services attract and employ individuals with key skills and experience, along with the right attitudes, behaviours and values to deliver person centred care. However as a system it is recognised that this is influenced by factors which include an ageing workforce; increasingly attractive career opportunities outside the NHS; the effect on staff of changes in the healthcare economy as a whole that impact on workloads, work place stress and perception of job security.
System leaders believed that the plans outlined in the PCBC will improve staff retention and attract new people by:

- Introducing new roles;

- Training and education opportunities to improve skills and deliver NICE; recommended interventions;
- Creating opportunities for career progression and succession planning;
- Extending the practice of existing roles and professions;
- Providing opportunities for flexible working;
- Linking in with educational establishments to improve recruitment to training and educational programmes; and
- Capitalising on the apprenticeship levy.

The changes described in the new model of care will provide existing staff with an opportunity to move into different roles within both inpatient and community services. This would be managed through existing HR processes and procedures.

3.2.4 Modelling capacity and workforce plan linked to finance

Using the needs analysis as a baseline in relation to numbers of staff, and evidenced based pathways of care to determine what people needed in relation to care and support, local capacity requirements were modelled. The skill mix of staff was determined by service user needs for a safe and effective service. The cost modelling work was undertaken in parallel and determined by the skill mix and numbers required. The workforce plan is presented in detail in **DMBC Appendix 2 Initial Workforce Modelling.**

The results of the modelling represented a starting position against which future developments could be delivered. It described the community and crisis response which will deliver improved outcomes for service users and reduce the over reliance on inpatient services.

According to NICE guidelines care coordinators should be carrying a caseload of 35, and there should be 1 consultant per 50,000. The current caseload for coordinators is in excess of this however a recent review of working practices has highlighted that some service users are on active caseload for longer than required and following discussion with the service user and the primary care team will be discharged back to the care of the GP.

Community Mental Health Service

The Community Mental Health Teams will benefit from an additional 30 staff, identified following reconfiguration of inpatient facilities. The staff will be pivotal in increasing the multidisciplinary skill mix within the team to ensure these include medical staff, nurses, occupational therapists, psychological practitioners, pharmacists, peer support workers and staff who lead on physical health conditions. The increased skill mix will allow teams to be more responsive and provide increased access to a holistic and recovery focused service, with improved access to psychological therapies and interventions.

Crisis resolution service

The crisis resolution team will be increased by up to 8 staff. This will ensure that a 24/7 service can be provided, in line with national standards. The new model of care will enable the current skill mix to be reviewed. It will include pharmacists, to aid

medication compliance and prevent admissions, and peer support workers to support a recover focused model of care.

The new community sanctuary beds will be commissioned through a third party provider both in terms of facilities and core staff with 'in reach' supported by the CRHTT.

Dementia Outreach
Up to 2 additional staff will be taking a case load of around 6 service users each to support an additional 12 service users being cared for in the community each week. The case load is low due to the high intensity support these staff will be providing the service users, across multiple home/care home visits and are comparable to other services CWP provide requiring such high intensity support. The demand for this service, service users and carers experience will be monitored closely and will shape future commissioning plans.

3.3 Pre-Consultation Phase - service user and clinical engagement

Full details of the pre-consultation engagement can be found in the PCBC. The development of the care model and options have been strongly influenced by the involvement and leadership from a variety of clinical professionals including public health, consultant psychiatrists, therapy staff and GPs. This took the form of a multi-disciplinary clinical advisory group. The development and scoring of options ensured the clinical input, as did workshops which enabled a wider range of health and social care staff including GPs to identify, across the three CCGs, how proposals could be shaped to align with local transformation plans.

During development of the proposals a commitment to proactively seek the views and experiences of our local populations has been demonstrated. Engagement has taken place with a number of interest groups. Site visits have been undertaken by experienced service users and experiences and views shared in a range of meetings from bespoke user listening events and CCG Annual Fairs to individual case studies. Partners used this information alongside carer and staff views and experiences in the development of the PCBC.

Service user and carers workshops took place at the Millbrook Unit and the Recovery Colleges. There were a series of briefings and drop-in sessions for frontline staff towards the end of 2016. At this time, there was engagement with Cheshire East Healthwatch, Eastern Cheshire Health Voice and Cheshire East Council's Health and Adult Social Care and Communities Overview and Scrutiny Committee (OSC). This included providing a site visit for scrutiny committee members to existing CWP services.

Listening events took place in September 2017 at Crewe Alexandra and Macclesfield Town Football Clubs. Over 50 people attended the events, the majority of whom were service users and carers. Table-based discussions gave participants an opportunity to describe what had worked well for them, what had not worked well and how secondary care services might be improved. An online survey was also made available to those who were unable to attend the sessions.

The views and experiences of users and carers informed the development of plans and were referenced throughout.

A detailed engagement and communications strategy[10] was developed to ensure service users, health care professionals and other key stakeholders had a wide range of opportunities to shape developments as they emerged. The full report outlining all engagement activity undertaken can be found in **DMBC Appendix 3 Engagement Report**.

3.3.1 Development of options for implementing the model of care

A long list of options for future service delivery was drawn up for consideration. In addition to the mandated 'do nothing' and 'do minimum options the following were taken into consideration during option development:

- The range of services required in response to the needs analysis
- New models of care in place elsewhere demonstrating improved outcomes
- Existing service providers to maintain quality and continuity of care
- New service providers including the private sector to increase capacity locally
- Travelling time for service users in response to user feedback.

Eight options were considered in total. These can be seen in **DMBC Appendix 4: Options for Service Delivery**. Set criteria were developed which enabled each option to be scored based on service user acceptability, developed using feedback from service user engagement events, and clinical safety and sustainability, determined by clinicians. The resulting scores can be seen in Table 2 Non financial scoring of options.

Table 2 Non financial scoring of options

	Option							
Grouping	**1**	**2**	**3**	**4a**	**4b**	**5**	**6**	**7**
Clinical safety and sustainability	273	291	561	645	606	483	501	486
Patient/Carer acceptability	106	108	190	180	146	154	156	144
Quality of care	54	58	86	100	92	75	81	70
Strategic fit	82	81	159	195	181	166	172	171
Total score	**515**	**538**	**996**	**1,120**	**1,025**	**878**	**910**	**871**
Maximum score per option:	**1,430**							

[10] https://www.easterncheshireccg.nhs.uk/Downloads/Your-Views/MH%20Consultation/AOPSMHS%20Communications%20and%20Engagement%20Strategy%20180306.pdf (last accessed 15.11.18)

Each option was assessed against defined affordability gateway set on the current cost of the 'do nothing' option. Where the cost of an option exceeded the current cost of service provision it was excluded.

This resulted in 3 options, 1, 4a and 4b, passing the financial affordability gateway. Full details can be found in the PCBC. The financial summary table can be found in **DMBC Appendix 5: Financial Impact**

Equality Impact Assessments were undertaken for the options put forward for consultation. These documents can be seen in the PCBC.

For the purposes of going out to formal public consultation, the shortlisted options were renamed as Option 1, Option 2 and Option 3.

Option 1 (also option 1 in the PCBC)
Do not introduce a new model of care: No enhancement of community care or crisis support. No enhancement in Home treatment teams or dementia outreach developed. Retain all inpatient care (58 beds) on the Millbrook unit. If selected there would be the need to redirect funding from other current care services, in order to maintain, safe and sustainable services and is therefore defined as "do minimum".

Option 2 (originally Option 4a in the PCBC)
This was stated as the preferred option of the consultation partners. - Enhance community and crisis services, including up to 6 local short stay beds. Provide the inpatient and bed-based care currently available at Millbrook within an older people's service at Lime Walk House in Macclesfield and an adult service within the current provider footprint at Bowmere in Chester with 3 additional beds available to enable CWP to manage service user flow across a wider geographical footprint. In total these services provide 53 beds. Specialist rehabilitation service users currently at Lime Walk House would be transferred to a specialist rehabilitation facility at Soss Moss in Nether Alderley.

Option 3 (originally Option 4b in the PCBC)
Enhance community; and crisis services, including up to 6 local short stay beds. Provide the inpatient and bed-based care currently available at Millbrook within as an adults service at Lime Walk House in Macclesfield, and an older people's service within the current provider footprint at Bowmere in Chester with 3 additional beds available to enable CWP to manage service user flow across a wider geographical footprint. In total these services provide 53 beds. Specialist rehabilitation service users currently at Lime Walk House would be transferred to a specialist rehabilitation facility at Soss Moss in Nether Alderley.

3.3.2 Clinical Engagement

The redesign process has been led from the beginning by specialist clinicians across various disciplines and clinical leaders within primary care. At all stages in the development and appraisal of proposals, the clinical voice, alongside the service user voice has been strong and have been critical in ensuring that proposals are evidenced based and aligned to wider strategic intentions such as the development of care communities.

Colleagues representing other health and care partners, such as social care and police have influenced plans and contributed to the process. This enabled the redesign team to gain insight and understanding into the wider impact of proposed changes and created an opportunity for partners to work closely to deliver benefits to service users and mitigate risk relating to unintended consequences. A full list of redesign clinical leaders can be seen at **Appendix 6: Care Professional Engagement.**

3.4 Consultation Phase

3.4.1 The Public Consultation Process

The public consultation ran from 6th March to 29th May 2018 and took the three shortlisted options forward to the population for consideration. Externally facilitated by NHS Midlands and Lancashire Commissioning Support Unit (MLCSU),[11] the consultation partners issued 10,000 copies of the consultation document and questionnaire ,held seven public meetings, attended 26 additional meetings and used a variety of media channels to publicise the consultation and encourage people to 'have their say'. Focussed meetings were had with new mothers and mental health user interest groups. Copies of the consultation document and questionnaire were sent to every one of the 7000 people currently receiving support from specialist mental health services with easy read versions distributed to case workers and placed in clinical areas.

Consultation partners engaged and observed legal advice and received the support of external experts on consultation delivery to ensure that a robust, legally sound approach was taken to the local consultation process. A review of this approach to consultation demonstrated that it followed best practice guidance and upheld the Gunning Principles[12] in terms of undertaking public consultation. All consulting CCG Governing Bodies, NHS England and Health Scrutiny committees in both Cheshire East and Cheshire West and Chester Local Authorities support the consulting partners and agree that due process has been followed in undertaking their legal duty to consult, and undertook sufficiently robust and transparent means to engage, inform and consult with the general public, service users and stakeholders.

3.4.2 Public Consultation Results

The University of Chester was commissioned to undertake an independent review of the consultation survey feedback and findings.[13] Consultation and research experts from MLCSU worked closely with the consultation partners and was contracted to provide a range of support services, including the production of a summary report on the findings of the consultation and the analysis of the public events,

[11] https://www.midlandsandlancashirecsu.nhs.uk/ (last accessed 15.11.18)

[12] Gunning Principles http://www.nhsinvolvement.co.uk/connect-and-create/consultations/the-gunning-principles (last accessed 15.11.18)
[13] CONSULTATION REPORT Redesigning: Adult and Older People's Specialist Mental Health Services Consultation from 6th March - 29th May 2018 University of Chester 10th September 2018 https://www.easterncheshireccg.nhs.uk/Downloads/Your-Views/MH%20Consultation/MH%20Findings%20Sept2018/AOPSMHS%20Consultation%20Findings%20Appendix%20B%20-%20UoC%20CONSULTATION%20REPORT%20V6.pdf (last accessed 15.11.18)

correspondence and other information collected at 'pop-in' events and meetings. The summary report draws on several supporting documents, which are referenced in the main report. All these documents can be found on the website of NHS Eastern Cheshire CCG.[14]

Following completion of the consultation and analysis of the findings and feedback, it was identified that 'improving outcomes for people with specialist mental health needs', was seen as the most important priority by the public , followed by 'access to crisis services' and 'ability to visit people in hospital easily'.

The findings of the consultation confirmed the pre-consultation scoring of the options with Option 2 being the most supported. Option 2 was also considered the most likely option to deliver on the top two outcomes people said were important - Improving outcomes for people with mental ill health' and 'access to crisis services'. It is however important to note that the third most important outcome was 'being able to visit hospital easily' and this was not considered possible under option two or three for some people, but could be achieved for many under option one.

Feedback received identified that there was recognition that current services had to change, however there were strong concerns regarding the difficulties this would cause. In particular, transport costs, travel time, less opportunity for carers, family, friends and staff to visit and the detrimental impact on recovery of service users, were raised as the main concerns regarding implementation of the preferred option and Option 3. For all options there were also concerns regarding the implementation of proposed changes and the associated costs.

3.4.3 Conscientious Consideration

Following the completion of the public consultation, 22 representatives from the Governing Bodies of Eastern Cheshire South Cheshire and Vale Royal met to give 'conscientious consideration' to the public consultation findings on proposals to redesign adults and older people's specialist mental health services. The workshop was independently facilitated by a consultation expert and the objectives agreed were:

- for Governing Body Members and CCG clinical leads to receive the independent report on the AOPSMH redesign consultation
- to consider the findings and decide if the DMBC should be based on the three options put forward or if additional information/ work is required
- agree outline timescales and check points for DMBC and full business case

Table 3 below captures the feedback from Governing Body members and describes further work undertaken to inform the DMBC.

[14] https://www.easterncheshireccg.nhs.uk/Your-Views/ccg-consultations.htm (last accessed 15.11.18)

Table 3

GB Feedback	Response	Reference
There needs to be a clear narrative around the publics preferred option weighted against finance, clinical case etc.	• There was overwhelming support for the introduction of a new model of care with Option 2 receiving the most support. • There were significant concerns raised regarding travel for carers and other health and social care professionals. • The development of Option 2 into an enhanced offer which addresses these concerns, have been evaluated against the case for change and mitigates the issues raised during the public consultation.	Section 3.7.4 Table 5
Revisit the activity modelling specifically around the numbers of people travelling under options 2 & 3 Explore transport options to assist those visiting loved ones. How can we make their journey as stress free as possible?	• A full travel analysis was undertaken building on the work undertaken at the pre-consultation phase. • Option 2 would see approximately 260 people having to undertake additional travel for some of up to 40 miles. In many cases it was not possible to travel by public transport and where it was possible travel time was up to 2 hours one way. • The project team explored the possibility of commissioning a bespoke travel support service for visitors. • National examples were mostly concerned with patient transport. Shuttle buses were limited to a maximum journey of 30 miles and a contribution was requested for each journey. The number of people required to travel each week to make this viable is between 200 -350 people. • Were contracts were in place the value was between £33,000 –	Section 2.1.3 Appendix 10

	£90,000 a year however many had been decommissioned.	
Explore further opportunities to redesign and work in collaboration between all partners. Describe how the new model aligns to the community model incorporating other services. Explore low risk step up options for crisis beds. It should be branded in order to give the public confidence in the service.	• The options to work with multiple providers for the provision of specialist mental health care was not progressed at the pre-consultation phase due to clinical and quality concerns. • In describing how the new model of care will be delivered there is a commitment to work with the wider health and social care team, including the newly developing care communities. Dementia outreach and mental health rehabilitation at home will be priorities for action. • Further work is planned, beginning in December to work with additional providers to develop services for the commissioning of crisis care beds.	Section 2.2.1
Consider using permanent assets.	• Following discussion with East Cheshire NHS Trust it has been agreed to transfer CARS ward to CWP NHS Trust. • This has supported a revised estates solution which sees the majority of inpatient care now possible within the current CWP estate in Macclesfield.	Section 3.7 Section 3.7.4
If option 2 is presented in the DMBC, some residents may feel worse off. Can we assure them they	• There is evidence to show that the introduction of a new model of care will reduce the reliance on hospital services by 16%. Local intelligence suggests this could be higher.	Section 2.2.1

will have a shorter length of stay and get home quicker? Or possibly avoid being admitted at all? This may help to mitigate some of the concerns with travel.	• The introduction of a dementia outreach will ensure up to 12 people per week can be supported in their own home and the provision of crisis beds locally will not only reduce the length of stay but in many cases prevent a hospital admission. • Further work has been undertaken to show how more inpatient beds can be provided locally significantly reducing the number of people required to travel.	

On 15th August 2018 representatives from the three Governing Bodies met to receive and discuss the independent analysis of the public consultation and give 'conscientious consideration to the consultation findings. Taking account of the information within the PCBC alongside the findings from the public consultation, commissioners fed back to the programme redesign team on what additional work would be required to support the development of the DMBC ahead of being considered at a future Governing Body meeting.

The programme redesign group undertook the following further work in relation to:

- Revisiting activity data to reconfirm the impact of a new model of care on admissions to hospital length of stay and clinical outcomes
- Further understanding the impact of Options 2 and Option 3 on travel time for visitors (family/carers) and develop robust proposals for supporting people to stay in touch
- Re-examining the potential to utilise existing CWP or other partners estate to accommodate more inpatient activity within the local foot print
- Revisiting the workforce model and recruitment and retention plans to provide assurance that proposals are achievable
- Exploring further with health and social care partners the unintended consequences of each of the options and develop mitigation plans where required
- Reviewing financial profiles against each of the options and provide more detail in relation to both capital and revenue investment.

Through the course of this work with health and care system partners, progress was made in identifying a viable amended option for consideration and which addressed many of the concerns raised and heard throughout the consultation and which also continued to meet the ambitions outlined within the case for change. The option is known as **Option 2 Plus**.

3.4.4 Clinical Senate Review

An external clinical review of the proposals to introduce a new model of care for Adults and Older people's specialist mental health services was undertaken in October 2018 by the Cheshire and Merseyside Clinical Senate.[15] To ensure an independent view of proposals the panel comprised members from outside Cheshire and Merseyside and was overseen by clinical experts in the area of specialist mental health services and expert by experience service user representatives. A number of service delivery approaches were reviewed, including additional work on an amended option (Option 2 Plus) undertaken to respond to public feedback as a result of the public consultation.

The main objective of the senate review was to gain an independent view on how proposals would address the issues raised in the case for change, the robustness of planning, particularly the needs analysis and workforce plans, and how the redesign team have responded to the feedback gathered through the public consultation.
The full terms of reference for the visit can be found in **DMBC Appendix 6: Clinical Senate Visit Terms of Reference.**. A final formal report on the findings will be provided later this year however the senate has already provided feedback on the main findings from the review. These were as follows:

- The new model of care, as outlined in section 2 above, is in line with national best practice and should be introduced.
- Plans are robust, based on good intelligence and data analysis, linked to the new model of care and workforce and capacity plans.
- Amended proposal (Option 2 Plus) takes account of consultation feedback and the travel concerns of service users, carers and health and care partners. This option was believed to be the one that would best deliver the case for change given the clear support for a new model of care, and would significantly address concerns raised around travel in relation to inpatient provision moving to Chester.
- The opportunity to provide more inpatient services locally is a positive outcome but will need to be delivered in a new facility which is fit for purpose.
- That the partnership approach to improving quality and outcomes is the right approach and should continue.

3.5 Decision Making Process

In forming a view as to recommendations to be put forward to the CCG Governing Bodies for consideration , the options put forward for consultation and the amended option were reviewed against the case for change outlined in the PCBC and feedback from the public consultation which included preferences, concerns and additional ideas.

In reviewing these options, two have been discounted and two have been supported to go forward to the Governing Bodies of the three CCGs for consideration and for a decision on the preferred option to commission and progress towards implementation.

[15] Cheshire and Merseyside Clinical Senate https://www.nwcscnsenate.nhs.uk/clinical-senate/cheshire-merseyside-senate/ (last accessed 15.11.18).

The CCGs are the legal bodies responsible for making decisions on these commissioned services.

3.6 Discounted Options

Option 1 – Rational for not progressing
This Option does not support the increasing demand for care as there would be no investment in community services and therefore no opportunity to reduce the reliance on inpatient services. This option is not considered best practice, would offer limited access to early intervention and prevention services and would not provide additional choice for people at risk of, or in crisis. The numbers of people admitted with complex dementia would continue to rise, often where an admission could be avoided

This option would not improve outcomes for people with complex mental health needs, or provide more support for people at risk of or in crisis, the two most important factors identified by service users, carers and the public.

This option would not improve the financial position for the health economy and would not deliver on the redesign ambition to provide the best possible care within the resources available. It would destabilise services across health and social care as additional financial resources would need to be moved across to maintain safe and effective specialist mental health care moving forward. A detailed financial breakdown of the capital costs associated with Option 1 can be seen in **DMBC Appendix 8: Option 1 Cost Analysis.**

Option 3 – Rational for not progressing
Whilst this option delivers all the benefits of introducing a new model of care, it was not the preferred option within the PCBC as the transfer of older people's services to Chester was considered less acceptable to service users and carers than the transfer of adults' services. This was due to the implications of travel particularly for people who generally stay in hospital longer and whose carers are also likely to be older. This was clearly articulated at a number of pre-consultation engagement events and again during the consultation process.

3.7 Options to be progressed

Two options are being submitted for consideration by the Governing Bodies of the three CCGs - Option 2 and Option 2 Plus. Both options deliver the Model of Care as outlined within the PCBC and both work towards the delivery of the benefits identified.

Option 2 Plus was scored using the same criteria as with the other options considered. Indicative results show Option 2 Plus gaining a greater average weighted score than Option 2 (67 and 52 respectively).

Regardless of the option chosen for implementation, all services will be available to people aged 18 and over registered within GP Practices within NHS Vale Royal, NHS South Cheshire and NHS Eastern Cheshire CCG areas. Those individuals who may be homeless, living in the area temporarily or yet to register with a GP will not be excluded from receiving care.

Those aged 14 to18 will have access to these secondary care services but will be supported concurrently via CAMHS inpatient, community and outreach staff benefits outlined earlier in a way that best meets the needs of the individual.

In both options the community and crisis provision is equal.

Table 5 in section 3.7.4 is provided for ease of reference to enable comparison of the two submitted options for consideration, however further detail is provided in the following sections.

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3.7.1 Option 2

Enhance community and crisis services, including up to 6 local short stay beds. Provide the inpatient and bed-based care currently available at Millbrook within an older people's service at Lime Walk House in Macclesfield and an adult service within the current provider footprint at Bowmere in Chester with 3 additional beds available to enable CWP to manage service user flow across a wider geographical footprint. In total these services provide 53 beds. Specialist rehabilitation service users currently at Lime Walk House would be transferred to a specialist rehabilitation facility at Soss Moss in Nether Alderley.

This option is being submitted for consideration for the following reasons:

- The rising demand for care is better supported through the introduction of a new model of care with its emphasis on early intervention and prevention including a more comprehensive and timely response for people at risk of or in crisis.
- The new model of care received over whelming support from the service users carers and members of the public as it was considered the approach most likely to achieve the two most important factors identified by service users, carers and the public which is improve outcomes for people with complex mental health needs, and provide more support for people at risk of or in crisis
- The provision of adult inpatient services in Chester, whilst attracting concerns in relation to travel, was considered preferable than for older people.
- This option delivers a significant improvement on the local health economy financial position and includes the investment required for the new model of care, delivering on the redesign ambition of providing the best possible care within the resources available**.**

Identified risks of implementation of Option 2 and suggested mitigation can be found in Error! Reference source not found..

3.7.1.1 Bed Model Overview

- Older people
  - 22 beds provided at Lime Walk House, Macclesfield
  - 12 Older People with functional illness
  - 10 People with dementia beds
- Adults functional illness
  - 22 Beds at Bowmere, Chester
  - 3 Beds, Wirral (adults and older people)
- Rehabilitation patients – 13 beds at Soss Moss, Nether Alderley

In this option the beds currently provided at the Millbrook site in Macclesfield will be reconfigured. Lime Walk House in Macclesfield would become an older peoples unit providing a total of 22 beds. 12 beds will be available for older people with functional illness and 10 beds for those with dementia.

Adults with functional illness will be accommodated at Bowmere in Chester where 22 beds will be available for adults with functional illness at Bowmere in Chester with an additional 3 bed for adults and older people with functional illness at Lakefield in Wirral.

Specialist rehabilitation service users currently at Lime Walk House would be transferred to a specialist rehabilitation facility at Soss Moss in Nether Alderley to allow Lime Walk House to become the older peoples unit.

3.7.1.2 Travel Impact

In the year previous to the completion of the PCBC(2016), 12 people from Eastern Cheshire and 57 people from South Cheshire and Vale Royal travelled to and received treatment at the Bowmere facility in Chester. It was originally estimated that 305 people would need to travel further to receive care as outlined under Option 2.

The travel impact modelling has been revisited during October 2018, following the consultation process and which has confirmed previous estimates that approximately 300 service users would have to travel further to receive care. This is based on 2016-2017 Millbrook Unit Speciality Data analysis. With further analysis based on the introduction of an enhanced community service and access to crisis beds this reduces to approximately 260 people being affected.

For the majority of people living in the towns in South Cheshire and Vale Royal, the journey to Bowmere would require less than 10 miles additional travel by car (as compared to travel to Macclesfield) and in some cases the Bowmere facility could be closer to home.

For most towns in Cheshire East the average additional miles travelled to Bowmere would be approximately 30 miles.

For those who are unable to travel by car, there are additional financial and time implications involved in finding other methods of travel. Travel time using public transport ranges from 25 minutes to 3 hours for a one way trip. Costs for a return journey using public transport can range from approximately £2 to £25. In a number of locations, using public transport to access Bowmere is not feasible, and so the

prices of a single taxi journey from a range of locations has been calculated. This ranges from £5 to £136 based on the individuals postcode..

The redesign team has gathered evidence from around the country in relation to support for travel and has been unable to identify a bespoke service for visitors. Where transport for service users have been provided, for example shuttle buses these have been restricted to a maximum journey of 30 miles, and many have been since decommissioned due to inefficient numbers of users and financial viability. A detailed travel analysis can be found in **Appendix 10: Travel Analysis.**

3.7.1.3 Financial Impact

Implementation of Option 2 improves the financial position by £1.2m which improves the overall deficit from its current £2m to £0.8m[16]

3.7.2 Option 2 Plus

Enhanced community and home treatment teams, including dementia outreach. Crisis care services established including 6 local short stay beds. Re-provide inpatient care from Millbrook to other facilities within current provider footprint with adult and older people functional services at Lime Walk House Macclesfield, and dementia services at CARS ward, Macclesfield (48 + 6 beds).

This option delivers the full proposals in relation to an enhanced community service offer, including 6 crisis beds but also maintains the majority of inpatient bed provision within Macclesfield.

This option is currently being submitted for consideration for the following reasons:

- The rising demand for care is better supported through the introduction of a new model of care with its emphasis on early intervention and prevention including a more comprehensive and timely response for people at risk of or in crisis.
- The new model of care received over whelming support from the service users carers and members of the public as it was considered the approach most likely to achieve the two most important factors identified by service users, carers and the public which is improve outcomes for people with specialist mental health needs, and provide more support for people at risk of or in crisis.
- Allows for the provision of the majority of inpatient care services in Macclesfield (41 beds) which also addresses the main concerns raised by service users, carers and the public during the consultation in relation to travel and is considered to have less impact on care partners such as social workers and approved mental health professionals who would, under option 2, be required to travel to undertake statutory assessments.
- Delivers some improvement on the local health economy financial position and includes the investment required for the new model of care, delivering, in

[16] The current deficit of £2m reflects the difference between CWP costs of providing all mental health services and the value currently commissioned by all of the three CCGs.

part, on the redesign ambition of providing the best possible care within the resources available.

Identified risks of implementation Option 2 Plus and suggested mitigation can be found in **Appendix 9: Risks and Mitigation.**

3.7.2.1 Bed Model Overview

- Adults and older people with functional illness
  - 26 beds provided at Lime Walk House, Macclesfield
  - 7 bed (Bowmere and Wirral) complex service users
- Dementia
  - 15 Beds at CARS Ward, Macclesfield
- Rehabilitation patients – 13 beds, Bowmere, Chester

Under this option the beds currently provided at the Millbrook site in Macclesfield will be reconfigured. 26 beds will be provided at Lime Walk House in Macclesfield for adults with functional mental health illnesses. An additional 7 beds will be provided across Wirral and Chester.

An organic ward (dementia) would be provided in a segregated part of the existing Millbrook Unit, CARS ward. The CARS ward is 15 bedded unit and in the past has been used to decant the current Croft ward whilst it was refurbished.

Specialist rehabilitation service users currently at Lime Walk House would be transferred to a specialist rehabilitation facility in Chester (instead of locally in Soss Moss) to allow Lime Walk House to become the adult acute care functional unit. This move would be a medium term solution as the service may at some point move back to the Cheshire East locality, dependent on the strategic developments nationally and locally around rehabilitation services and NHS estates strategies.

CWP has long term strategic plans to develop an enhanced rehabilitation pathway where high dependency service users have access to an inpatient centre of excellence where service users can move to community, supported accommodation, residential care and/or supported tenancies with in-reach and out-reach support from an enhanced community rehabilitation team.

There is a National drive towards enhancing rehabilitation provision in the community, (most recently CQC report on locked rehab). The CWP strategy is supported by the FYFV which recommends that rehabilitation services should reduce their dependency on hospital beds through increasing community rehabilitation provisions including residential rehabilitation and supported housing. . The regional Cheshire and Merseyside Care Partnership has a priority area of focus around investing in mental health services delivered outside of hospital settings and is currently reviewing supported housing provisions.

3.7.2.2 Travel Impact

The travel impact modelling for Option 2 Plus has been undertaken, using the same methodology as for Option 2. Within this option there is no change to the location of the 41 beds for both adults and older people with functional and organic (dementia) illness. The individuals currently receiving inpatient care in Macclesfield would

continue to do so. Those individuals currently receiving more intensive support, including Psychiatric Intensive Care, do so at Bowmere and under this option would continue to do so therefore, there would no change to existing arrangements for adults and older people with organic and functional illness.

There will be an impact on the rehabilitation patients, currently at Lime Walk House in Macclesfield (20 beds in total, 13 beds commissioning by the 3 CCGs and the remainder commissioned by Specialised Commissioning (NHS England) as low secure rehabilitation) as they will be accommodated in Chester under this option.

The travel impact for the service users, families and carers of the 13 service users within this setting would be the same as that outlined for Adults under Option 2.

Inpatient rehabilitation placements have a duration of approximately 12 months. During this time service users can come and go easily as part of their rehabilitation. Service users receive support with travel by CWP and this would remain unchanged. The facilities available at Bowmere are superior to those available in the current facility.

3.7.2.3 Additional Engagement

Prior to the release of the DMBC CWP are engaging with staff/service users/carers around the potential changes for rehabilitation; including the proposals detailed in the redesign consultation document as well at the local and national strategic direction of the rehabilitation services. This has provided further opportunity for staff, carers, families and service users to share their views, comments and concerns around the proposed changes impacting on them specifically. Specific engagement will be undertaken with service users and carers to explore Option 2 Plus and gain feedback on this, specifically in relation to the move of rehabilitation services to Chester. Feedback will be provided for the Governing Bodies meeting in common and OSC detailing the process taken, the feedback and any mitigating actions to address any concerns raised.

Alongside this clinicians are reviewing individual service users to determine if dependent on their rehabilitation journey they will be required to move to Bowmere or whether a community based support package maybe be more appropriate. This will take place once the decision has been made on the preferred option.

3.7.2.4 Financial Impact

Implementation of Option 2 Plus improves the overall financial position by £0.5m which improves the overall deficit from its current £2m to £1.5m before taking account of the additional funding,

The impact of adopting this option will require all Commissioners to provide an additional £0.73m of funding on a recurrent (ongoing) basis to offset the reduced

financial savings as identified with Option 2. This will improve the overall deficit from the opening £2m to £0.8m[17] .

3.7.3 Financial Impact

The current financial position for CWP is a recurrent deficit for 2018/19 of £2m which is the difference between the value of services commissioned by all three CCG's and the overall costs of delivery. This position is not sustainable in the long term and a number of steps, including the proposed redesign of adult and mental health specialist services have been identified as a way of making the service delivery model financially sustainable.

The summary table below shows that the current cost of delivering inpatient services from the Millbrook Unit is £5.6 million per annum which includes facilities, rental and staffing costs. The summary also shows how Options 2 and Option 2 Plus reduce the overall cost of providing the inpatient service and redirecting funds to support the enhanced community and crisis service described in the new model of care. The outcome of both Options improves the overall financial deficit by £1.2m or £0.5m respectively.

In relation to Option 2 Plus, there are increased costs associated with the delivery of this option due to the higher building costs which would require additional capital. The cost of capital required for the conversion is circa £5m.

Both CWP and the Commissioners have agreed an open book policy associated with the costs of implementing the new model and that the costs are likely to reduce for Option 2 Plus, from the "worst case scenario" figures outlined within the table. In particular, it is estimated that the costs of capital for Option 2 Plus are likely to be lower as the detailed plans are progressed.

One of the key drivers of the redesign was to improve the financial position and improve the overall deficit of £2m on a recurrent (ongoing) basis. It is noted that Option 2 Plus, whilst improving the overall position by £0.5m does not generate the same level of financial benefit as Option 2 i.e. £0.73m less. Therefore, in line with the system aims of making the services financially sustainable, the commissioners have agreed to fund the additional £0.73m associated with Option 2 Plus if agreed by the Governing Body.

The source of funding will be linked to the NHS 2019/20 planning process for CCG's and will be the first call on funding identified to deliver the Mental Health 5 Year Forward View, pending NHS 10 Year Plan and Mental Health Investment Standards. This will also take account of any agreed contributions towards any one off (non-recurrent) transitional costs associated with implementing the agreed option. These costs will be kept to a minimum and will be identified via a wider governance group

[17] The current deficit of £2m reflects the difference between CWP costs of providing all mental health services and the value currently commissioned by all of the three CCGs.

being created from January 19 onwards linked to the implementation of the agreed option.

Table 4 AOPSMH Redesign Revenue Impact

	Option 2	Option 2 Plus	
	£000's	£000's	Key
Total Direct Clinical Resource	3,565	3,565	
Total of current estimated staffing costs in excess of budget	812	812	
Resource for related SLA	586	586	
Estates and Facilities Resource	640	640	
Total Resource currently employed in delivery	**5,603**	**5,603**	
Adult/Older Functional Inpatient	2,817	2,751	1
Infrastructure Costs	140	361	2
Estimate for Patient Test SLA	100	100	
Capital Costs		575	3
Cost of Inpatient Provision	**3,057**	**3,787**	
Total Saving	**2,546**	**1,816**	
Investment into Non Inpatient Care and Crisis Housing	**1,338**	**1,338**	4
Total Saving	**1,208**	**478**	
Shortfall against Option 2		**730**	
Overall Deficit	***(2,000)***	***(2,000)***	5
Saving	***1,208***	***478***	
Additional Funding		***730***	
Revised Deficit	***(792)***	***(792)***	

Key

1. Option 2 Plus staffing costs inline with clinical model for provision of Inpatient Wards under this option

2. Under option 2 Plus increased infrastructure costs required to support identified units in comparison to units identified under Option 2. Having the additional Ward on the East Cheshire Trust site requires an increase in staffing to support, in excess of using CWP sites under option 2

3. Additional Capital Expenditure required for Option 2 Plus resulting in yearly revenue charge

4. The PCBC identified £1.17m investment into non inpatient services to support this model. Additional development in confirming required clinical models has increased the cost to £1.34m into Home Treatment and Community Mental Health Teams

5. The current deficit of £2m reflects the difference between CWP costs of providing all mental health services and the value currently commissioned by all of the three CCGs

3.7.4 Comparison of Option 2 and Option 2 Plus

Table 5 Comparison of options

Option 2	Option 2 Plus
Description	
Enhanced community services including dementia outreach. Crisis care services established including up to 6 local short stay crisis beds in the community. Re-provide the inpatient and bed-based care currently available at Millbrook within an older people's service at Lime Walk House in Macclesfield and an adult service within the current provider footprint at Bowmere in Chester. There will be 3 additional beds available to enable CWP to manage service user flow across a wider geographical footprint. In total these services provide 53 beds (including 6 crisis beds in the community). Specialist rehabilitation service users currently at Lime Walk House would be transferred to a specialist rehabilitation facility at Soss Moss in Nether Alderley.	Enhanced community services including dementia outreach. Crisis care services established including up to 6 local short stay crisis beds in the community. Transform inpatient and bed-based care currently available at Millbrook by providing an acute all-age (adult and older people) 26 bed service at Lime Walk House Macclesfield, and a 15-bed dementia service at the former Complex Assessment & Recovery Services (CARS) ward, Macclesfield. There will be 7 additional beds available to enable CWP to manage service user flow across a wider geographical footprint. In total these services provide 54 beds (including 6 crisis beds in the community). Specialist rehabilitation service users currently at Lime Walk House would be transferred to a specialist rehabilitation facility at Bowmere in Chester.
New model of care	
Community and crisis model as described in the PCBC	Community and crisis model as described in the PCBC
Bed Model Overview	

• Older people
  ○ 22 beds provided at Lime Walk House, Macclesfield:
  ○ 12 Older People with functional illness
  ○ 10 Dementia beds
• Adults functional illness
  ○ 22 Beds at Bowmere, Chester
  ○ 3 Beds, Wirral (adults and older people)
	• Adults and older people with functional illness
	  ○ 26 beds provided at Lime Walk House, Macclesfield
	  ○ 7 beds (Bowmere and Wirral) complex service users
	• Dementia
	  ○ 15 Beds at CARS Ward, Macclesfield
	• Psychiatric Intensive Care, Bowmere, Chester (no change)

Option 2	Option 2 Plus
• Psychiatric Intensive Care, Bowmere, Chester (no change) • Rehabilitation patients – 13 beds at Soss Moss, Nether Alderley	• Rehabilitation patients – 13 beds at Bowmere, Chester
Workforce	
Community service teams increasing by 40 WTE • 30 WTE in CMHS • 8 WTE in HTT • 2 WTE dementia outreach • Increased service user access to therapeutic interventions 24/7 access to crisis services; and community beds	
Consultation	
• The new model of care received over whelming support from the service users, carers and members of the public as it was considered the approach most likely to improve outcomes for people • This option **would not** respond to the significant travel concerns raised by service users and the public or locally and nationally elected politicians	• The new model of care received over whelming support from the service users, carers and members of the public as it was considered the approach most likely to improve outcomes for people • This option **would respond** to the significant travel concerns raised by service users and the public however a ***small number of rehab patients would be required to travel to Chester***
Service delivery model (inpatients: acute and rehabilitation)	
• Adult inpatient beds would be provided in **Chester, older adult beds in Macclesfield** • Adults requiring PICU and ECT during their treatment would be supported in inpatient units in Chester, giving them quick access to the treatment they require • Potentially **260 service users will have a travel impact** with adult inpatient services in Chester • **Potential impact on care partners** such as social workers and approved mental health professionals who would have to travel to undertake statutory	• Adult and older adult inpatient beds would be provided in Macclesfield. Adults requiring PICU and ECT during their treatment would be supported in inpatient units in Chester, giving them quick access to the treatment they require • **Negligible travel impact on service users due to most inpatient services remaining in Macclesfield** • **Reduced impact on care partners** such as social workers and approved mental health professionals • Specialist rehabilitation services will move from Lime Walk House **to Chester**

Option 2	Option 2 Plus
assessments • Specialist rehabilitation services will move from Lime Walk House to **Soss Moss in Nether Alderley**	
Finance	
• Current overall deficit is £2million, this option **reduces the cost pressure to £0.8m** • Capital monies have been identified by the provider for renovation of estates to bring in line with national standards and guidance • Additional funding is required to facilitate the implementation of the wider Crisis Service vision • Delivers **improvement** on the local health economy financial position, delivering on the redesign ambition of providing the best possible care within the resources available	• Current overall deficit is £2million, this option **reduces the cost pressure to £1.5million, prior to taking account of the additional funding** • **Requires additional funding of £0.73m to be provided by Commisisoners** • Additional capital monies would be required by provider for renovation of estates to bring in line with national standards and guidance **in addition to option 2** • Additional funding is required to facilitate the implementation of the wider Crisis Service vision • Delivers **improvement** on the local health economy financial position, delivering on the redesign ambition of providing the best possible care within the resources available

4.0 Implementation of Model of Care

4.1 Proposed Timelines

Table 6 and Table 7 outline a possible high level implementation timeline for each of the potential options if adopted for implementation.

Table 6 High level implementation timeline for Option 2

Milestone	Dates
Lakefield development	Finished
Juniper development	Finished
Governing Body decision on DMBC	22/11/2018
Soss Moss development	February - August 2019
Lime Walk house management of change and move to Soss Moss	July - October 2019

Lime Walk house development	November- June 2020
Management of change for Millbrook	February 2020
Additional HTT staff in place	March 2020
Crisis beds open	March 2020
Advanced inpatient staff community training	April-June 2020
Croft and Adelphi move to Lime Walk house	July 2020
Bollin and Adelphi move to Maple	July 2020
Increased community staff	July 2020
Community staff training	July-September 2020

Table 7 High level implementation timeline for Option 2 Plus

Milestone	**Dates**
Lakefield development	Finished
Juniper development	Finished
Governing Body decision on DMBC	22/11/2018
Application for capital (CWP)	December 2018
Lime Walk House management of change and move to Chester	November-February 2019
Lime Walk House development	March- August 2019
CARS development	March- August 2019
Management of change for Millbrook	April 2019
Additional HTT staff in place	May 2019
Crisis beds open	May 2019
Advanced inpatient staff community training	June-August 2019
Croft move to CARS	September 2019
Bollin and Adelphi move to Lime Walk house	September 2019
Increased community staff	September 2019
Community staff training	September- November 2019

5.0 Conclusions and Recommendation

When evaluated against the case for change both Option 2 and Option 2 Plus address all of the issues identified and meet the ambitions of the redesign programme. Both options

- Improve access to early intervention and prevention.
- Offer a wider choice of services for those at risk of or currently in crisis.
- Improve the service response to increasing demand
- Improve outcomes for people with specialist mental health needs by offering evidenced based services

- Improve the financial position for the local health economy and deliver against the redesign ambition to 'provide the best possible care within the resources available.

Specifically however:

Option 2 whilst significantly improving the financial position across the health economy, only delivers against the top two priorities identified by services users, carers and the public;

- Improvement of outcomes for service users with specialist mental health needs
- Offering more choice for those in or at risk of crisis.

The consequential additional travel for adults requiring inpatient care is considered by service users and their carers unacceptable, and it has not been possible to identify a mitigating solution to this issue

.The impact of additional travel on health and care partners, in particular social care staff is considered detrimental and problematic, from both a practical and continuity of care perspective

Option 2 Plus;

- Responds to the significant concerns raised by the public and other health and care partners in relation to travel;
- Improves the financial position across the health economy;
- Meets all three top priorities identified by service users and carers which includes being able to visit hospital easily, without the need for mitigating actions; and
- Enables health and social care partners to maintain contact and undertake assessments as required, maintaining continuity of care and efficiency.

Option 2 Plus – if chosen - however does impact more so on the rehabilitation patients within the existing Lime Walk House facility in Macclesfield in terms of travel, although the location of the specialist rehabilitation service in Chester rather than Nether Alderley does address some concerns raised throughout the consultation with regards the isolation of the rehabilitation patients in a more rural setting as compared to a more urban setting and impact on the treatment plans.

Following consideration of the benefits and risks associated with implementing either of the shortlisted options, it is the recommendation of the programme redesign group that the Governing Bodies of the three CCGs approve the adoption of **Option 2 Plus** to progress towards implementation.

6.0 Next Steps

Regardless of which option is chosen a number of next steps are required to enable implementation. This includes the implementation plan (as referenced above), workforce (see below) and procurement of community crisis beds.

6.1 Workforce

As part of the transition, a management of change process will be undertaken, supported by staff side representation and recognised trade unions, by the trust to reduce the inpatient staff and increase the community staff. The first steps to delivering this change will be to understand staff skills, aspirations and progression plans, and to determine where staff could potentially work. The management of change process will be undertaken and staff will be allocated to the inpatient wards or community services.

There will be the need for some bespoke recruitment for certain posts that increase the current teams, and this recruitment will begin pre closure so that critical posts are established in advance of the beds being reconfigured. The trust will recruit with bespoke recruitment drives as it does currently with vacant posts.

A skills audit will be undertaken to determine any skills gaps that remain after the management of change process. To address these gaps the trust will develop and deliver training programmes to staff; in some key staff areas this training will occur pre reconfiguration of beds to ensure safe services are maintained at all times and service users are adequately supported.

7.0 Glossary of Terms

Access to Psychological Therapies: Psychological therapy is a general term for treating mental health problems by talking with a psychiatrist, psychologist or other mental health provider.

Acute Care: A branch of healthcare where a service user receives active, but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery.

Care Quality Commission: The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England.

Cheshire and Wirral Partnership NHS Foundation Trust (CWP): CWP provides mental health, substance misuse, learning disability and community physical health services.

Clinical Commissioning Group (CCG): Clinical Commissioning Groups (CCGs) were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning (buying) of health care services for their local area.

Community Care: Social care and treatment provided outside of hospitals.

Crisis: If a person's mental or emotional state quickly gets worse or deteriorates, this can be called a mental health crisis.

Dementia: A condition that is associated with an ongoing decline of the brain.

Early Intervention: Services to detect and treat illnesses, in the very early stages, and before they can develop into a more serious illness.

NHS Eastern Cheshire Clinical Commissioning Group (CCG): The CCG is made up of 22 GP practices. It plans, buys and monitors health care services for approximately 204,000 people in and around Alderley Edge, Bollington, Chelford, Congleton, Disley, Handforth, Holmes Chapel, Knutsford, Macclesfield, Poynton and Wilmslow.

Five Year Forward View for Mental Health: Published in 2016, this national strategy was developed for NHS England by an independent Mental Health Taskforce, established in 2015.

Inpatient: Refers to a service user who has been admitted to hospital for an overnight stay. The length of time a person will remain an inpatient varies on a case-by-case basis.

Prevention: The promotion of mental health and well-being strategies to potentially prevent, or reduce the severity of some mental health disorders.

Practitioners: A person who is qualified to treat service users.

Primary Care: This is day-to-day healthcare given by a healthcare provider.

Psychiatrist Intensive Care Unit (PICU): A PICU provides mental health care and treatment for people who need a secure environment beyond that which can normally be provided on an open psychiatric ward.

Rapid Response: Rapid Response aims to respond quickly to those experiencing a mental health crisis.

Recovery College: Recovery Colleges offer educational courses to people who access services.

Rehabilitation services: Help support people's well-being and recovery from a mental health illness.

NHS South Cheshire Clinical Commissioning Group (CCG): The CCG is made up of 17 GP practices. It plans, buys and monitors health care services for approximately 173,000 people in and around Alsager, Crewe, Middlewich, Nantwich and Sandbach.

Specialist Mental Health Services: These are services for people who require additional support to those provided in primary care settings (i.e. GP or Talking Therapies). Specialist services are currently provided in this locality by dedicated community mental health teams, home treatment (crisis) teams or inpatient services.

Talking Therapies: The term 'talking therapy' covers all the psychological therapies that involve a person talking to a therapist about their problems.

NHS Vale Royal Clinical Commissioning Group (CCG): The CCG is made up of 12 GP practices. It plans, buys and monitors health care services for approximately 102,000 people in and around Nantwich, Weaverham and Winsford.

Governing Body Meetings in Common of the Governing Bodies of NHS Eastern Cheshire CCG, NHS South Cheshire CCG and NHS Vale Royal CCG
in-public

22 November 2018

Agenda Item 2.1

Report Title	Redesign of adult and older peoples specialist mental health services – Decision Making Business Case

Appendix A

Decision Making Business Case – supporting appendices

Adult and Older Peoples Specialist Mental Health Services Redesign

Decision Making Business Case

APPENDICES

Version 3.0
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Contents

Appendix 1: PCBC Needs Analysis

Process applied:

1. Data upload of all people registered as being in contact with a CMHT in South, East and Vale in mid-May 2017
2. 2. Data sorted into:
   a) CCG
   b) Diagnostic code by PbR cluster
   c) Each care cluster shown as a percentage of the entire diagnostic group

3. Diagnostic groups clumped into 'Super Clusters' - Dementia, Depression, Psychosis, Bipolar, Personality Disorder, Anxiety
4. Data sense checked by clinicians. Some specific issues clarified:
   a) absence of people with personality disorder within older adult services - clinical advice suggests that symptoms tend to become less problematic with age and other MH issues tend to come to the forefront - dementia, depression, etc that then become the primary diagnostic code
   b) Care Cluster breakdowns for Cognitive Impairment (Clusters 18 - 21) showed an unexpected spread with significant numbers of people with a low level of need being in service compared to very low number of people in cluster 19-21 where there was a greater level of need. Teams explained that this had been a pragmatic decision to manage the administrative burden associated with keeping the clusters live due to the need to recluster on a 12-month basis rather than three-monthly. In addition changes to NICE Guidance and 'best practice' pathways was only just starting to be adopted meaning that the breakdown for clusters 18-21 will change. This will mean that a different approach requiring clinical judgement will be required to provide a costed model for these pathways.
   c) Secondary diagnostic codes reviewed: a number of people identified with a secondary code of personality disorder. This identified a further 75 people with a diagnosis of personality disorder who also had a primary diagnosis of a different mental health condition. The numbers are broken down by CCG as below but not included within the overall data

Table showing the number of people identified with a secondary code of personality disorder	
CCG	**Number of people**
EC CCG	22
SC CCG	36
VR CCG	17
Total	**75**

   d) Secondary diagnostic codes were reviewed for the subsections .5 and .7 which indicate the presence of psychotic symptoms but is NOT included within Public Health Prevalence Data. A further 36 people were identified with either a primary or secondary diagnostic code from the secondary care community mental health team caseloads

CCG	Primary Code	Secondary Code	Older Adults	Total
EC CCG	8	8	0	16
SC CCG	9	5	0	14
VR CCG	2	4	1	7
Total	**19**	**17**	**1**	**37**

5. Application of PH Prevalence data - Data for South, East and Vale Royal (with the exception of dementia) provided by Rory and Dementia and Wirral prevalence data obtained from POPPI and PANSI sites
6. Dementia prevalence rates only available on LA footprint, therefore divided into CCG on a pro-rata basis. Population figures used:
    a) Western Cheshire 260,000
    b) Vale Royal 109,000
    c) Eastern Cheshire 201,000
    d) South Cheshire 173,000
    e) Wirral 320,000

7. Percentage of people in contact with CWP within each of the super clusters calculated against the PH prevalence data for the corresponding disorder – sense check of data completed where there were significant numbers of people clustered but not diagnosed against specific clusters, e.g. clusters 18-21 for cognitive deficits and where appropriate this was added to the current activity numbers - current admin issue meant that diagnosis was included on clinic letter but hadn't been added to the service user's clinical record within the electronic record it so had therefore not been reported within the data download
8. Attempted to understand whether the proportion of people within CWP services was appropriate or whether there was information to suggest the recommended proportion (taking account of hidden need) in order to build/ cost a service with appropriate levels of capacity based upon Nice compliant pathways using a PbR Care Cluster approach. Methods used to understand appropriate proportions included:
    a) comparison with other areas within CWP where different services were commissioned to review differences in caseload composition eg Wirral where there is a mature Personality Disorder treatment team, however caseload analysis revealed little difference in the number of people with a personality disorder in contact with services across the areas. What will however be different is the service offer.
    b) Review of Rightcare, JSNA and National Benchmarking data together with NICE Guidelines and Care Pathways from leading MH Providers (SLAM). None of these data sources provided suggestions on the recommended proportion of people with given disorders who should be in contact with services in any given year. NHSE provides some data re: incidence rates and for dementia and IAPT suggests the proportion of people that should have a diagnosis of dementia and the gap in diagnosis and the number of people with mild - moderate mental health conditions that should access IAPT treatments. It also suggests the prevalence for First Episode Psychosis.

What rapidly became evident was the lack of information regarding the proportion of suggested prevalence that would require service input in any one year. As a result it was necessary to survey clinical opinion.
Additional information provided by:

- Projecting Adult Needs and Service Information System[1]
- National Benchmarking data
- Dementia Diagnostic Rate Workbook[2]
- Public Health Data[3]

Table to show Public health prevalence data analysis mapped to current activity				
Dementia Prevalence	**Incidence**	**Prevalence**		**Predicted need**
Eastern Cheshire	1249 + 204 = 1,453	3,301	44.02%	
South Cheshire	1042 + 316 = 1,358	2,812	48.23%	
Vale Royal	379 + 208 = 586	1,466	39.97%	
Western Cheshire		3,406		
Wirral	604 + 600 + 55 = 655	4,834	26.04%	
Psychosis Prevalence	**Incidence**	**Prevalence**		**Predicted need**
Eastern Cheshire	372	924	40.26%	
South Cheshire	331	797	41.53%	
Vale Royal	211	455	46.37%	
Wirral	458	1,478	30.99%	
Bipolar Prevalence	**Incidence**	**Prevalence**		**Predicted need**
Eastern Cheshire	208	3,357	6.20%	
South Cheshire	171	2,898	5.90%	
Vale Royal	75	1,656	4.53%	
Wirral		5,375		
Borderline Personality Disorder Prevalence	**Incidence**	**Prevalence**		**Predicted need**
Eastern Cheshire	55	4,086	1.35%	
South Cheshire	116	3,528	3.29%	
Vale Royal	29	2,016	1.44%	

[1] Projecting Adult Needs and Service Information System

[2] https://www.england.nhs.uk/publication/dementia-diagnosis-rate-workbook/
[3] Public Health Profiles

Wirral	221	6,544	3.38%	
Generalised Anxiety Prevalence	**Incidence**	**Prevalence**		**Predicted need**
Eastern Cheshire	98	10,096	0.97%	
South Cheshire	141	8,717	1.62%	
Vale Royal	41	4,981	0.82%	
Wirral		16,167	0.00%	
Depressive Disorders Prevalence	**Incidence**	**Prevalence**		**Predicted need**
Eastern Cheshire	279	5,647	4.94%	
South Cheshire	296	4,875	6.07%	
Vale Royal	90	2,786	3.23%	
Wirral		9,042	0.00%	

Table to show Public health prevalence data analysis mapped to current activity

Disorder	CCG	Current Secondary Care Activity	Public Health Prevalence Data	%
Dementia Prevalence data collected from POPPI	Eastern Cheshire CCG	1,453	3,301	44.02%
	South Cheshire CCG	1,358	2,812	48.23%
	Vale Royal CCG	586	1,466	39.97%
Psychosis	Eastern Cheshire CCG	372	924	40.26%
	South Cheshire CCG	331	797	41.53%
	Vale Royal CCG	211	455	46.37%
Bipolar Disorder	Eastern Cheshire CCG	208	3,357	6.20%
	South Cheshire CCG	171	2,898	5.90%
	Vale Royal CCG	75	1,656	4.53%
Personality Disorder	Eastern Cheshire CCG	55	4,086	1.35%
	South Cheshire CCG	116	3,528	3.29%
	Vale Royal CCG	29	2,016	1.44%
Anxiety	Eastern Cheshire	98	10,096	0.97%

Disorder secondary care activity only	CCG			
	South Cheshire CCG	141	8,717	1.62%
	Vale Royal CCG	41	4,981	0.82%
Depressive Disorder secondary care activity only	Eastern Cheshire CCG	279	5,647	4.94%
	South Cheshire CCG	296	4,875	6.07%
	Vale Royal CCG	90	2,786	3.23%

The 21 cluster groups enable care to be categorised in relation to service users' needs which can range from low level to complex. Professional judgement was used to estimate within each of the diagnostic groups what proportion of people would be in each category:

- **Cluster 1:** Common Mental Health Problems – low severity
- **Cluster 2:** Common Mental Health Problems – low severity with greater need
- **Cluster 3:** Non psychotic – moderate severity
- **Cluster 4:** Non psychotic - severe
- **Cluster 5:** Non psychotic - very severe
- **Cluster 6:** Non psychotic disorder of over-valued idea
- **Cluster 7:** Enduring non psychotic disorder – high disability
- **Cluster 8:** Non psychotic, chaotic and challenging disorders
- **Cluster 10:** First episode psychosis
- **Cluster 11:** Ongoing recurrent psychosis – low symptoms
- **Cluster 12:** Ongoing recurrent psychosis – high disability
- **Cluster 13:** Ongoing recurrent psychosis – high symptoms and disability
- **Cluster 14:** Psychotic crisis
- **Cluster 15:** Severe psychotic depression
- **Cluster 16:** Dual diagnosis
- **Cluster 17:** Psychosis and affective disorder – difficult to engage
- **Cluster 18:** Cognitive Impairment – Low need
- **Cluster 19:** Cognitive Impairment or Dementia Complicated -Moderate need
- **Cluster 20:** Cognitive Impairment or Dementia Complicated - High need
- **Cluster 21:** Cognitive Impairment or Dementia – High physical or engagement

Table 1 Needs analysis data mapped against level of care need

	Dementia	Psychosis	Bipolar Disorder	Personality Disorder	Anxiety Disorder	Depressive Disorder	Other	Total Number	Total %
Cluster 1	2	0	1	2	8	7	13	33	0.5
Cluster 2	1	2	3	8	11	21	15	61	0.9
Cluster 3	5	4	11	29	70	112	69	300	4.2
Cluster 4	1	4	3	19	17	37	36	117	1.6
Cluster 5	1	0	2	4	6	12	8	33	0.5
Cluster 6	2	0	0	2	12	1	3	20	0.3
Cluster 7	1	4	5	55	69	176	95	405	5.7
Cluster 8	0	9	0	38	6	14	14	81	1.1
Cluster 10	3	187	11	2	4	27	39	273	3.8
Cluster 11	14	378	187	6	10	79	42	716	10.1
Cluster 12	10	355	78	5	9	49	33	539	7.6
Cluster 13	6	125	17	2	2	14	12	178	2.5
Cluster 14	0	15	7	0	0	0	2	24	0.3
Cluster 15	0	1	0	0	2	4	2	9	0.1
Cluster 16	0	5	0	1	0	1	7	14	0.2
Cluster 17	0	20	6	1	0	2	2	31	0.4
Cluster 18	1,693+520	9	2	1	10	22	10	2,267	31.8
Cluster 19	794+197	3	1	0	1	10	7	1,013	14.2
Cluster 20	32 + 4	2	2	0	1	0	3	44	0.6
Cluster 21	50 + 7	0	0	0	0	0	1	58	0.8
Null cluster	100	20	17	25	40	78	622	1,002	14.1
Total no.	3,443	1,143	353	200	278	666	1,035	7,118	100

Appendix 2 : Initial Workforce Modelling

Community Mental Health Team

Community mental health services are embarking upon a wholescale transformative process. This will result in:

- A revised service user journey based upon new ways of working that will increase the time that staff spend providing direct service user care, through the introduction of new technologies such as digital dictation and through new job roles, skill-mix and team structures, enabling evidence-based clinical pathways to be implemented.
- The Care Programme Approach (CPA) will continue to be the framework in which mental health services are delivered. CPA is a national model of assessing, planning, implementing / delivering care and then evaluating that care or intervention
- New evidence-based treatment pathways will be available for service users to ensure that they benefit as quickly as possible and outcomes are maximised
- Services will provide a recovery-focused culture.
- Decisions around care and treatment will be made collaboratively with service users and their carers.
- Service users will be educated and supported where possible to self-manage their condition with clear plans for staying well, including at discharge.

Current Workforce	Current Capacity	Current Demand	Proposed Workforce	Proposed Capacity	Proposed Benefits
The Community Mental Health Teams currently operate on a Clinical Commissioning Group footprint The Community Mental Health Teams are multi-disciplinary and are comprised of a mix of medical staff, nurses, occupational therapists, psychological practitioners and support workers and work in partnership with social care staff. The clinical workforce currently represents **37.02 w.t.e**.	Based upon the CMHT Policy Implementation Guide (PIG) suggests that the teams currently have the capacity to support **1,170** people with functional mental health difficulties at any time based upon: - Care Coordinators carrying an individual caseload of 35 people under enhanced care of the CPA; and - Consultant psychiatrists capacity should be based on	Referrals to community mental health services have grown by **35%** since 2010. The teams collectively hold a caseload of 2,652 people. Some of these individuals no longer need the support of specialist mental health team Consultant Psychiatrists carry individual caseloads in excess of 300 people Teams lack the capacity to respond to more urgent pieces of work without	The proposed workforce is based upon a new way of working underpinned by a transformative approach to ensure a more recovery-focused and person-centred approach to treatment and support by the community mental health team. This process will require a fundamental change in the way that services currently operate and that staff have the right skills to support service users to	Capacity within the enhanced community mental health service for people with functional mental health difficulties would be positively affected as a result of: Teams aligning to the developing care communities reducing travel requirements Improved IT to support agile working Enhanced staffing levels. As a result of the proposed investment, it is envisaged that	Increased recovery focus resulting in people remaining within services for as long as is necessary Increased ability to achieve NICE recommended interventions through the delivery of clear treatment pathways Improved availability of senior clinical and medical support enabling a proactive/ early intervention approach. Investment would allow a service redesign that would:

Medical support and senior clinical leadership is provided by the Consultant Psychiatrists that cover inpatient care and community care.	1 consultant per 50,000 adult population	cancelling other routine pieces of work. The current operational model, its systems and processes are not wholly recovery focused and as a result many people stay within services for lengthy periods of time despite them not requiring input from a specialist mental health team/service – the current average length of stay in service is in excess of two years.	recovery. This would include: - Releasing senior clinical staff [including medics] from routine tasks to ensure a more responsive and proactive and early intervention approach. - Increase the number of therapy staff that are available to plan and deliver specific elements of the treatment plan. With an additional investment of £700k across the three locality teams there would be a potential increase in staffing of up to of 30 wte clinical staff of B3 – B6 to include increased therapy staff. These figures are indicative based upon demand and capacity modelling and further refinements and developments will occur as we progress to a full business case	the team's capacity should result in the ability to support **1,800** people in line with CPA. Increasing the capacity by an additional 630 (current capacity 1,170) Whilst this may be a reduction in the current caseload figures, this reflects a move to actively managing caseloads, bring the capacity in line with demand, by moving to a recovery-focused and goal orientated treatment packages of treatment and support This will enable a focus on people with severe mental illness who require active treatment from a specialist mental health team	A central point of referral to and triage for community-based specialist mental health services allowing for improves response and better access Nominated care coordinators for both standard and enhanced care in accordance with CPA, to assess and coproduce a treatment plan that reflects NICE recommended interventions. The introduction of wellbeing hubs that would provide increased support people's physical health monitoring in addition to delivering specific pharmacological interventions resulting in improved capacity and capability to monitor the physical health and wellbeing of people with severe mental health needs

Dementia Outreach

Development of a dementia outreach service will support:

- A more joined up approach to the care and treatment of people with dementia by primary care, social care and community mental health services.
- Assessment, diagnosis and initiation of treatment where clinically indicated for people with memory difficulties will be quicker
- A joined up approach to monitoring the impact of memory drugs would see this undertaken as part of the annual physical health review completed by Primary Care services for people who have mild cognitive impairment and low level needs.
- Reduce the need for hospital admissions
- Reduce inappropriate admissions
- Reduce the number of emergency readmissions

As a result, people with more complex and challenging presentations will be seen more quickly with increased support and advice available to the individual, their family and/ or carers over an extended week. Consequently more people will be supported to remain within the usual place of residence – whether that is their own home or a residential/ nursing care placement

Current Workforce	Current Capacity	Current Demand	Proposed Workforce	Proposed Capacity	Proposed Benefits
The Older Peoples Community Mental Health Team currently supports individuals with complex and challenging presentations. However this service is limited in its ability to respond to crisis situations, provide intensive home based support and is limited to Monday to Friday cover. Currently there is a limited resource specifically aligned to support people in nursing homes who present with challenging behaviours. This currently equates to **4.5 w.t.e**. B6 nurses across Central and	The current care home service links with all nursing and residential care homes across South Cheshire, Vale Royal and Eastern Cheshire resulting in them completing over **2,500 contacts** in the last 12 months, with each practitioner seeing an average of 12 service users a week. As this service will be a new development baseline data is not currently available	There is currently no available data regarding the number of requests made to specifically support people reaching a crisis as a result of dementia however benchmarking data reflects that emergency admissions to hospital for people with a diagnosis of dementia are higher than the national average with admission rates in excess of 2,500 per 100,000 population. We also know that current demand outstrips the available capacity due to anecdotal evidence suggesting that a	The proposed service would see the development of a 7-day, extended hours, multi-disciplinary/ multi-agency team that crosses between primary and secondary care services. Bringing together geriatricians, physiotherapy and 'falls' advisors as well mental health staff experienced in managing challenging presentations associated with dementia. The initial phase would see an increase in workforce of 2 wte Although reflective of work that is currently underway as part of the	The resource initially identified would support the development of '*proof of concept'* for the service, whilst allowing for flexibility to adapt to emerging models based upon demand Up to an additional 12 people could be supported	Increased ability for people to maintain their usual care arrangements and to remain in their usual place of residence. Increased confidence in the ability of carers [both formal and informal] to support people with dementia. Enhanced hours of support. Reduction in the number of attendances at A+E and admissions to hospital. Greater integration with primary care services to ensure seamless support.

East footprint and dedicated medical input in only the South Cheshire CCG footprint		number of requests for support are currently being managed via the wider older peoples'/ memory team,	'frailty' work, 'Home First' and 'Primary Care Home' developments that form part of the wider health and social care system transformations of '*Caring Together*' and '*Connecting Care*', this development seeks to consolidate these various schemes with mental health as an intrinsic factor. Consequently further work outside of the remit of this redesign will need to be undertaken with health and social care partners to develop the overall scope and vision for the service It is proposed that the initial phase would be to redesign the current older adult/ memory workforce to focus upon more complex rather than routine work would maximise the resource available within the older people's teams and then aligning with the *Primary Care Home* models to focus upon supporting people with dementia whose usual care package is at risk. In addition, a project manager (0.5wt) for a twelve-month period would enable the identification of all projects currently underway together with opportunities for these to be integrated to maximise their impact whilst identifying gaps requiring future investment.	to stay at home per week	

Home Treatment Team

An enhanced home treatment team would provide a range of offers to people who are experiencing a mental health crisis that include:

- Enhanced resource within the Home Treatment Team will ensure their ability to support people at home 24/7
- A single phone number will be available 24/7 for people who are experiencing a crisis in their mental health.
- The provision of crisis beds and a crisis café will provide an appropriate alternative for those people who require a period of increased support away from home but do not need to be admitted to an acute mental health unit.

As a result there will be greater choice about the range of support available when experiencing a mental health crisis and fewer people will require admission to a specialist acute mental health bed for support and treatment.

Current Workforce	Current Capacity	Current Demand	Proposed Workforce	Proposed Capacity	Proposed Benefits
The Home Treatment Teams currently operate on a Local Authority footprint with the service for Vale Royal based alongside that for Western Cheshire and is based at Chester. The team covering South and Eastern Cheshire operates from a central base in Congleton. The Home Treatment Team is currently comprised of a limited multi-disciplinary team. The team is primarily made up of mental health nurses at B5 and B6 together with some community support workers at B3. The clinical workforce [excluding medical staff] currently represents **27.31**	The team's capacity is impacted upon by a number of variables – the distance from base, the number of people required to visit, the number of assessments required, etc. as such it is difficult to establish a clear capacity for the team The Mental Health Policy Implementation Guide (PIG) suggests that a Home Treatment Team covering the population of South Cheshire, Vale Royal and Eastern Cheshire should have a caseload of approximately 50-60 service users at any one time, allowing for the geography. The current capacity meets **900-**	The Home Treatment team receives in excess of **900** referrals a year for people resident in South Cheshire, Vale Royal and Eastern Cheshire. Referrals are for a number of reasons including: All admissions to the inpatient unit must go via the Home Treatment Team Gatekeeping requests to assess whether admission to hospital admission is required or whether care could be provided safely at home A period of home treatment to avoid the need for hospital admission; or To facilitate early discharge due to the degree of risk reducing to	Through a redesign of Home Treatment services, it is proposed to bring together the resources for South Cheshire, It is proposed that approximately £500,000 will be allocated to crisis support following the redesign, this would support the following: Enhance current Home Treatment Team by 8 additional staff to offer a 24/7 service, this will include nursing, support staff and therapy staff Crisis Café supported by the Voluntary and Third Sector with support from the Home Treatment and Community Mental Health teams	Capacity within the enhanced service would be positively affected as a result of: Locality based teams reducing travel Improved IT to support agile working Enhanced staffing levels. As a result it is envisaged that the team's capacity should double resulting in up to 1,900 contacts per year Based on the increased number of staff and national workforce recommendations the team would have a caseload of up to 50 people	Creation of additional 'crisis/ emergency respite' beds as an alternative to hospital admission following a crisis in their mental health. Creation of a crisis café for people who require additional support due to a mental health crisis. Reduced time spent travelling due to creation of small locality based teams that are centrally coordinated resulting in increased clinical contact time/ capacity. Creation of a 24 hour service with the capacity to visit people at home outside of current hours (09:00 – 21:00). Creation of an 'out of hours'

w.t.e. Medical support and senior leadership is provided by the Consultant Psychiatrists that sit within the acute care pathway and work intro the inpatient unit.	**950** episodes of care per year which on average is a caseload of 20.	a level that can be safely managed within the community. As such these episodes of care ranged from a single contact to contact over several weeks	Up to 6 Crisis / Emergency Respite Beds supported by the Third Sector with around the clock support from the Home Treatment Team on an in-reach basis. These figures are indicative based upon demand and capacity modelling and further refinements and developments will occur as we progress to a full business case		telephone line for people who experience a mental health crisis. Increased choice regarding appropriate alternatives to hospital admission. Reduced admission to mental health unit and reduced attendance at A+E. Increased ability to achieve NICE recommended treatment for disorders. A service that provides the same level of response 365 days a year. Meets the requirements of the Crisis Care Concordat and move to achieving the requirements of the 5 Year Forward View for Mental Health

Inpatient services

Improvements to inpatient services would result in:

- Increased space available and greater attention to privacy and dignity, for example, the elimination of shared bedrooms and the introduction of en-suite facilities.
- Adopting new roles including Advanced Practitioners to enhance senior clinical leadership
- Introducing nurse associates to support the qualified nurse role
- Introduction of psychological therapists to ensure the delivery of NICE recommended interventions

Current Workforce	Current Capacity	Current Demand	Proposed Workforce	Proposed Capacity	Proposed Benefits
Inpatient services for adults and older people are provided in three inpatient units which are based in Macclesfield, Chester and Wirral. The quality of physical provision within each of these units varies due to the differing amounts of space available resulting in the requirement for higher levels of staff within Millbrook than within the other units to ensure service user privacy, dignity and safety is maintained. The current workforce model for inpatient care is based upon traditional roles and pay structures. The current resource does not allow for the recruitment of psychological therapists leaving gaps in the ability to deliver NICE compliant interventions. Inpatient care is led by Consultant Psychiatrists who traditionally	There are currently a total of **167** beds across the three units (Bowmere, Spingview and Millbrook): **36** beds for dementia **131** beds for functional mental illness. Millbrook currently has **58** beds: **14** beds for dementia **44** beds for functional mental illness. With a current workforce of 122.08 w.t.e including clinical and clerical staff between B3 and B7 B7 4.4 B6 11.96 B5 49.51 B4 3 B3 53.21	Whilst demand is high, benchmarking data shows that both admission rates are below the national average and that bed occupancy and lengths of stay are in line with the national average.	Whilst the final workforce profile will depend upon the options developed within the Consultation paper, however using the National Safe Staffing levels under option 4a and 4b there would be the following staff: 4a Older People = 36.52 w.t.e. comprised of clinical and clerical staff between B3 and B7 4b Adults = 31.75 w.t.e. comprised of clinical and clerical staff between B3 and B8a Bowmere = 31.75 w.t.e. comprised of clinical and clerical staff between B3 and B8a Springview – an increase of 3.0 wte clnical staff between B3 and B5	Whilst the final capacity will depend upon the options developed within the Consultation paper, the models developed may result in an overall reduction of 5 beds with: **22** beds being provided in Macclesfield; **22** additional beds being provided in Bowmere, Chester; **3** additional beds being provided in Springview, Wirral; and **6** newly commissioned crisis	Improved physical environment resulting in: - Improved service user and carer experience and satisfaction - Improved compliance with CQC standards regarding privacy and dignity Enhanced senior clinical leadership due to the introduction of new, enhanced roles and new ways of working. Introduction of psychological therapist resulting in increased ability to deliver NICE recommended interventions. Improved flow with shorter periods of admission as a larger range of community services would be on offer Reduced reliance on inpatient provision as access to a larger range of community services will be available

would have been supported by junior doctors. This is becoming increasingly difficult as a result of the national decline in doctors filling these posts. In order to providing the staffing for the Millbrook unit in its current format that meets the 2015 National Safer Staffing requirements there is currently a cost pressure of **£800,000**.				beds	

Appendix 3 : Engagement Report

Engagement Report for the Adult and Older People's Specialist Mental Health Service Redesign

Public Consultation – led by **NHS Eastern Cheshire CCG and NHS South Cheshire and Vale Royal CCG** and worked in partnership with **Cheshire and Wirral Partnership NHS Foundation Trust**

10 September 2018

Summary of Activity:

Hard copy of Consultation document sent to all 7000 service users on the caseload
A further 3,000 copies of the consultation document, including an easy read version, widely distributed in healthcare and community settings.
7 formal public meetings with 220 attendees.
A further 500+ people engaged with at an additional 26 events/meetings/briefing opportunities at local mental health forums and other health/community settings.
Widespread print, broadcast and social media reach, including over 2,000 people actively engaging with social media content such as videos, which reached 160,000 newsfeeds.
Over 100 media articles/adverts/advertorial generated across all platforms including TV, print, radio and internet.
Targeted updates to over 500 CWP members in Central, South and East Cheshire.
97 enquiries via the Freephone Patient Advice and Liaison Service (PALS) line

Consultation Products

Product	Purpose	Content	Formats
31 page consultation document with response form	To provide a narrative for the context of the consultation, as well as outline the options available.	• Message from clinical leaders • Introduction and purpose of document • AOPMHS's in Eastern Cheshire, South Cheshire and Vale Royal • Why Redesign? • The development journey • A new model of care • The options for care delivery • How would the proposed changes look in practice? • How you can get involved • What happens next and how decisions are made • Glossary	• Hard Copy • Electronic, available from CWP and CCGs' websites • Easy Read Also available in: • Large Print • Translated copies • Braille • Audio

PCBC	To provide the case to change services, the long list of options available and the options proposed to go forward to consultation.	• Executive summary • Introduction and background • Improving quality and outcomes • Options for delivery of adult and older peoples mental health services • Capacity and workforce plan • Finance • Risks and mitigation plan • Next steps	• Electronic version available at ECCCG website. • Presented at local authority health overview and scrutiny committees. • Presented to governing bodies and boards • Shared with stakeholders.
Animation	To provide a concise, visual outline of the consultation process and aims, including the case for change, the options and how to get involved.	• Mental Health services now • How mental health services could look in the future • How we have listened to you • Option 1 • Option 2 • Option 3 • Tell us what you think	• Electronic, available to view on the CCG website and also shared on social media. • Hosted on the Eastern Cheshire CCG YouTube channel.
Call to action videos – Dr Anushta Sivananthan, Dr Paul Bowen and Dr Jonathan Griffiths	To encourage people to get involved in the consultation and to make their views known through the various channels available	How people can get involved in the consultation.	Videos available on the Eastern Cheshire CCG, South Cheshire CCG, Vale Royal CCG and CWP websites and also shared on social media.
Online questionnaire	Electronic version of the survey.	• Tell us about you • The three most important things to you • Comment on our proposals • Demographic profiling	Electronic version available on the ECCCG website and through the CSU
Frequently Asked Questions	A series of documents outlining the questions that consultation partners had received, or been asked at consultation events. The first document was produced at	• Original general document published on 6th March • Comments and ideas	• Electronic versions hosted on the ECCCG website.

	the beginning of the consultation (6th March) and subsequent documents were produced which were tailored to different categories of questions.	• Funding • New care model and crisis care • Process • Staffing • Travel distances and facilities.	
Communications and engagement strategy to support consultation and pre-consultation.	To set out the approach to communications and engagement supporting the redesign of adult and older people's specialist mental health services in Eastern Cheshire, South Cheshire and Vale Royal.	• Introduction • Background • Communications, engagement and consultation • The approach • Media	• Electronic version available on the website of Eastern Cheshire CCG.
Consultation poster for public display	To outline the aims of the consultation, the proposed new model of care and how people can join the conversation by giving details of upcoming public consultation events.	• Service users have told us they… • Our proposed new model of care will provide… • You can join the conversation and have your say on our proposals by…	• Electronic version hosted on the Eastern Cheshire CCG website • Print versions distributed to services to put on display.
Bowmere Hospital Video	To outline the services that are available at Bowmere Hospital, which is a focal point of the preferred option, in response to requests at first public meetings.	• Outline of the facilities that are available • Outline of additional activities that service users can take part in	• Available electronically and shared on social media.
Travel Analysis document	Summarising the impact of relocating some services to Chester and the proposed support available in this event.	• Introduction • Summary of findings • Mode of transport • Support for carers	• Electronic version of the document hosted on the Eastern Cheshire CCG website.
Needs Analysis and Workforce Model	Intended to provide additional information to that contained within the consultation document relevant to workforce-related issues.	• Background • Methodology • Needs Analysis • Workforce Model	• Electronic version hosted on the website of Eastern Cheshire CCG.
Evidence Documents	A variety of documents that displayed the evidence upon which information contained within the consultation was based.	Documents included: • Financial Appraisal • Options Appraisal Process • Crisis Care Evidence and Best Practice • Equality Impact Assessment: Option 1	• Electronic versions of the documents were hosted on the Eastern Cheshire CCG website.

		• Equality Impact Assessment: Option 2 • Equality Impact Assessment: Option 3	

Communication and Distribution:

During the course of the consultation the local NHS has used a variety of promotional methods and channels to reach a wide and varied audience with information about the consultation, in line with the Communications and Engagement Strategy. More detail is below:

Print Media

- Issued 16 adverts to 12 local publications advertising the events, website and Freephone number
- Issued a press release at launch to publications across the footprint of the consultation and follow-up press releases with reminders about public consultation events.
- Produced three health columns for the Macclesfield Express and Congleton Chronicle
- Contributed to 83 articles generated by local publications across the footprint

<u>Weekly circulation figures for major print newspapers:</u>

- Congleton Chronicle series (plus Alsager, Biddulph and Sandbach titles) = 15,842
- Crewe Chronicle = 6,821*
- Knutsford Guardian = 3,763
- Northwich, Winsford and Middlewich Guardian series = 9,083**
- Maccesfield Express = 7,839
- Wilmslow Guardian = 1,235

Total circulation figures each time print media carried consultation content = 44,583.

Social Media and Digital Activity

- Website features on four NHS websites – three clinical commissioning groups and CWP.
- 200+ Tweets issued
- Reaching over 160,000 timelines.
- Facebook posts reached over 50,000 Facebook accounts
- Over 2000 engagements ie retweets/shares.

Broadcast Media

Interviews on:

- BBC Radio Stoke

- BBC Radio Manchester
- Signal 1
- Silk 106.9.

Stakeholder Engagement

Regular briefings to locally elected officials and public sector partners:

- MPs
- Elected members
- Members of the Health Overview and Scrutiny Committees
- Health and Wellbeing Board leads
- Local authority leads
- Local NHS hospital leads.

In addition, a communications pack was shared with partners to promote the consultation via their channels, it included:

- Text for website and/or newsletter
- Digital images to use on social media
- Example social media posts
- Links to the website.

Groups representing service users, carers and the general public also received detailed information to share via their channels. A list of the groups contacted was contained within the communications and engagement strategy published at the start of the consultation. They received:

- A briefing cover letter
- Consultation document
- Link to the website for further information
- Advice on how to obtain further copies of the consultation document.

In addition:

- Direct communication to all CWP foundation trust members in East and South Cheshire and Vale Royal, at the start of the consultation and at the mid-point – reaching over 500 members;
- The Patient Advice and Liaison Service (PALS) teams responded to 97 enquiries from members of the public in the 12 week period;
- Over 20 written submissions were received from members of the public and representative groups directly to the NHS partners during this period.

Specific targeted work included:

- Engagement with the Polish community;
- Engagement with young people via drop-in sessions in Crewe and Macclesfield;
- Outreach work to the Young Farmers' Association, providing information and offers to attend meetings;
- Offer of 1:1 meetings with people who found the public consultation meeting environment not conducive to talking about their experiences (see log below);
- In addition, range of informal events organised at outpatient clinics etc (see log below).

Engagement Events

Public consultation events:

Venue	Date	Time
Macclesfield Town Hall, Macclesfield	21/03/18	14.30
Hartford Golf Club, Northwich	23/03/18	09.30
Congleton Town Hall, Congleton	28/03/18	14.30
Crewe Alexandra Football Club, Crewe	26/04/18	18.30
Macclesfield Town Football Club, Macclesfield	03/05/18	14.30
Canalside Conference Centre, Middlewich	04/05/18	14.40
Macclesfield Town Football Club, Macclesfield	23/05/18	18.30

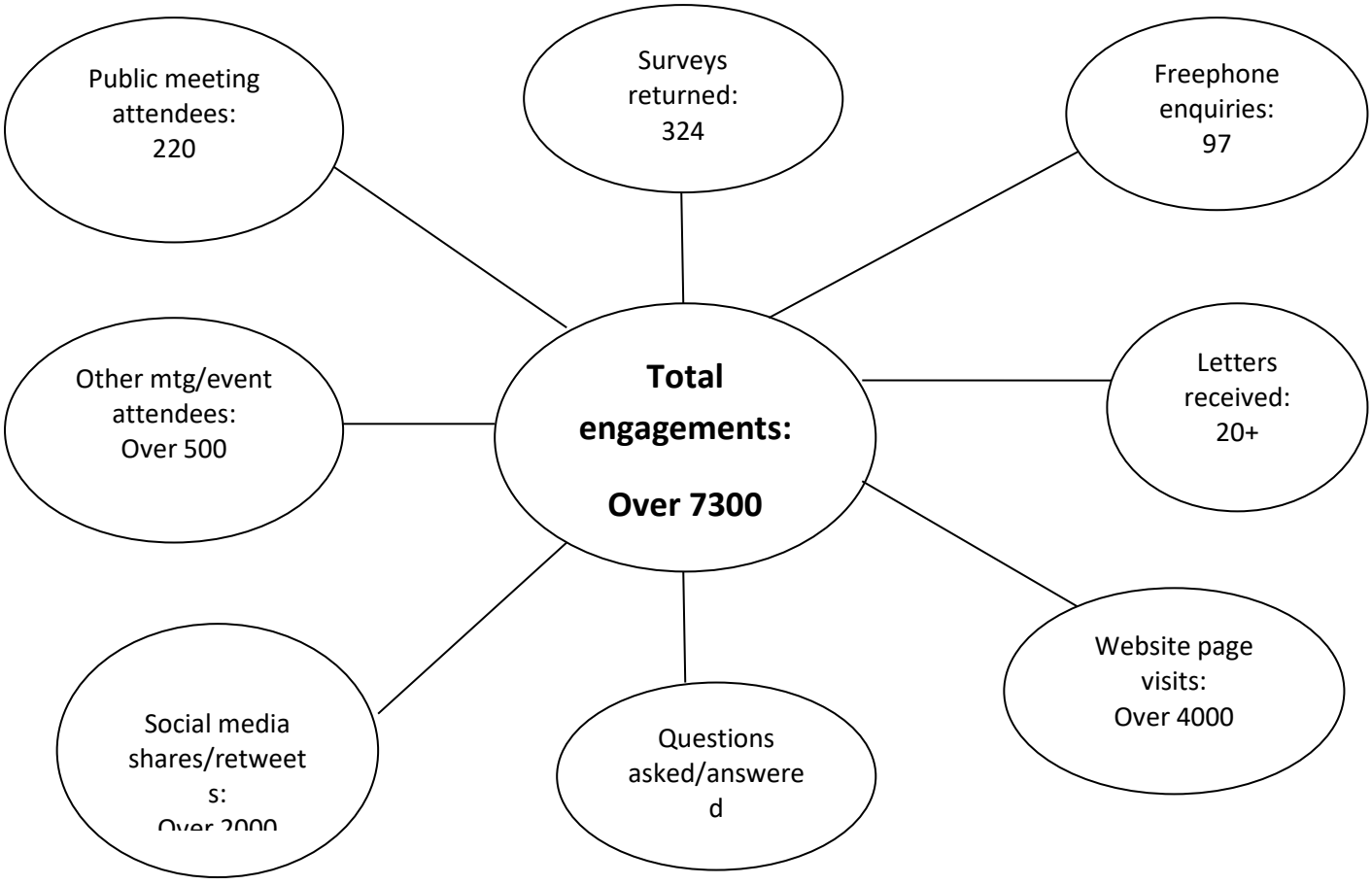
Engagement meetings

Date	Meeting
09/03/18	Crewe and Nantwich Open Minds
28/03/18	Healthwatch Meeting
03/04/18	East Cheshire Mental Health Forum
04/04/18	One to one meeting with Miss C
09/04/18	Mental Health Partnership Board
10/04/18	West Cheshire Mental Health Forum
10/04/18	Healthvoice
13/04/18	Crewe and Nantwich Open Minds
14/04/18	One to one meeting with Mr B
25/04/18	One to one meeting with Mrs A
11/05/18	Crewe and Nantwich Open Minds
21/05/18	Presentation to Cheshire East Councillors

Other engagement events

Date	Meeting
30/04/18	Pop Up Event – Lime Walk
01/05/18	Pop Up Event – Jocelyn Solly
11/05/18	Pop up Event – Congleton Hospital
15/05/18	Pop Up Event – Knutsford Hospital
15/05/18	Pop Up Event – Delamere Resource Centre, Crewe
16/05/18	MCHFT health and wellbeing event (attended by 450 people)
16/05/18	Audlem Village Community event
18/05/18	Pop Up Event – Vale House, Winsford
18/05/18	Pop Up Event – Macclesfield District General Hospital
21/05/18	Bevan House walkaround
22/05/18	Pop up event – Waters Green Medical Centre
22/05/18	Mill Street, Crewe, CAMHS Drop in
22/05/18	Polish mum and baby drop-in group, Crewe
23/05/18	Elm House, Macclesfield, CAMHS Drop in

Overall Summary of Feedback/Engagement:



Appendix 4 :Options for Service Delivery

In total eight options were developed as outlined below:

Option 1: Do nothing: No enhancement of community care and no crisis care placements provided. No enhancement in Home treatment teams or dementia outreach developed. Retain all inpatient care (58 beds) on the Millbrook unit

Option 2: Do minimum: No enhancement of community care and no crisis care placements provided. No enhancement in Home treatment teams or dementia outreach developed. Retain reduced inpatient care on Millbrook Unit and upgrade the facility. (52 beds)

Option 3: Enhanced community and home treatment teams. Crisis care services established including up to 6 local short stay beds. Retain all inpatient care on the Millbrook unit (58 + circa 6 beds)

Option 4a: (preferred option) Enhance community and home treatment (crisis) teams. Provide the inpatient and bed-based care currently available at Millbrook within new crisis care services established locally, including up to 6 local short stay beds, as well as a new older peoples service at Lime Walk House in Macclesfield, and an adult functional service within the current provider footprint at Bowmere in Chester. In total these services provide 53 beds.

Option 4b: Enhance community and home treatment (crisis) teams. Provide the inpatient and bed-based care currently available at Millbrook within new crisis care services established locally, including up to 6 local short stay beds, as well as a new adults functional service at Lime Walk House in Macclesfield, and an older peoples service within the current provider footprint at Bowmere in Chester. In total these services provide 53 beds.

Option 5: Enhanced community and crisis care services (circa 6 local beds) Re-provide adult inpatient care (25 beds) from Millbrook to other facilities within current provider footprint. Procure older peoples dementia services (10 beds) from the private sector Older peoples functional re (12 beds) at Lime Walk. Total 53 beds

Option 6: Enhance community and crisis care services (circa 6 local beds). Re-provide older peoples services to Lime Walk site in Macclesfield (22 beds) and utilise multiple NHS providers for adult inpatient (25 beds). Total 53 beds

Option 7: Transfer some community, crisis care (circa 6 local beds) and inpatient services (45 beds) to alternative providers closer to the users home. Re-provide older peoples dementia services (10 beds) at Lime Walk site in Macclesfield. Total 55 + 6 beds

Appendix 5: Financial Impact

Financial Impact of Each Option									
	Option 1	Option 2	Option 3	Option 4a	Option 4b	Option 5	Option 6	Option 7
Brief Description	Do Nothing	Do minimum: upgrade Millbrook, no enhanced community/crisis offer	Enhance Community/Crisis Offer. Maintain Inpatients "as is".	Enhanced community and crisis care service and re-provide inpatient care from Millbrook to other facilities within current provider footprint (older people Macclesfield site, adults Bowmere)	Expand community and crisis care services and relocate all inpatient care from Millbrook to other facilities within current provider footprint (Adults Macclesfield site, Older people Bowmere	Enhance Community/Crisis Offer. relocate inpatients. 12 beds move to Lime Walk. 22 beds move to Bowmere and 3 on the Wirral and 10 from Private Sector	Enhance Community/Crisis Offer. Older People move to Lime Walk 10 beds and 12 for Adults with other 25 provided by other NHS Providers	Older People move to Lime Walk, other inpatients across alternative NHS beds, re-contract Community/Crisis offer with neighbouring NHS Trusts.
Revenue Costs £000								
Baseline Cost - Inpatient Care	6,134	6,134	6,134	6,134	6,134	6,134	6,134	6,134
Baseline Cost - Community and Crisis Care	10,714	10,714	10,714	10,714	10,714	10,714	10,714	10,714
Annual charge for Millbrook improvements	0	560	0	0		0	0	0
Additional Cost of Enhanced Community and Crisis Care	0	0	1,170	1,170	1,170	1,170	1,170	1,170
Change in Cost for revised inpatient provision	0	0	0	(2,500)	(2,500)	(445)	2,072	2,072
Total Revenue Cost In-scope Services	16,848	17,408	18,018	15,518	15,518	17,572	20,090	20,090
Commissioner Income for Adult MH	14,848	14,848	14,848	14,848	14,848	14,848	14,848	14,848
Cost Pressure Adult MH	(2,000)	(2,560)	(3,170)	(670)	(670)	(2,724)	(5,242)	(5,242)
Total Revenue Cost All CWP Services	39,806	40,366	40,976	38,476	38,476	40,530	43,048	43,048
Total Contract Income from Commissioners	37,306	37,306	37,306	37,306	37,306	37,306	37,306	37,306
System Cost Pressure (Total Contract)	(2,500)	(3,060)	(3,670)	(1,170)	(1,170)	(3,224)	(5,742)	(5,742)
Capital Costs								
Cost of Millbrook Improvements	0	14,000	0	0	0	0	0	0
Total Capital Cost	0	14,000	0	0	0	0	0	0

Appendix 6: Care Professional Engagement

- Kate Chapman (modern matron)
- Zoe Ball (clinical psychologist/ rehabilitation and recovery)
- Katherine Wright
- Jane Tyrer (therapy lead/professional advisor/HTT interim)
- Sabu Oomman (consultant psychiatrist, community)
- Sadia Ahmed (Consultant Psychiatrist Older Adults, and clinical lead for the project)
- Julia Cottier (Service Director)
- Suzanne Edwards (Service Director - CWP)
- Sally Sanderson (Transformation Manager)
- Anushta Sivananthan (medical director, consultant psychiatrist)
- Jacki Wilkes (Associate Director of Commissioning)
- Ian Hulme (GP)

Appendix 7 : Clinical Senate Visit Terms of Reference

Title: Clinical Review of the proposals to redesign the Adults & Older Peoples Specialist Mental Health Services

Sponsoring Commissioning Organisation: NHS Eastern Cheshire Clinical Commissioning Group

Lead Clinical Senate: Cheshire & Merseyside Clinical Senat

Terms of reference agreed by: Roy McLachlan, (Chair) and Jacki Wilkes, Associate Director Panel Chair: Roy McLachlan, Independent Chair

Citizen Representative(s): Ian Linford, Cheshire & Merseyside Senate Council Member

Clinical Senate Review Team Members:

- Dr Kalakala Prasad, Consultant Psychiatrist in Liaison Psychiatry, North West Boroughs
- Mehran Javeed, Consultant in Old Age Psychiatry & Clinical Lead Primary Care Services
- Phil McEvoy, Managing Director, Six Degrees Social Enterprise

Aims and Objectives of the Clinical Review:

To undertake an independent clinical review of the proposals to redesign the Adults and Older Peoples Specialist Mental Health Services

Main Objectives of the Clinical Review:

- Will the redesign proposals described deliver improved outcomes for adults and older people with specialist mental health needs?
- Will the redesign proposals described address the issues raised in the case for change?

- Does the draft Decision Making Business Case adequately take account of the findings of the public consultation?
- Will the redesign proposals address future demand on adult and older people's specialist mental health?
    - Do the redesign proposals align with the CCG's strategic direction?
    - Are the proposals modelled on demand?
    - Are the proposed models clinically sustainable identifying the potential workforce implications?
    - Do the proposals provide opportunities for growth?
    - Do the proposals provide the appropriate balance of proactive and reactive support?

Background Information

The CCG partners have concluded a formal 12 week public consultation and have received the independent review of findings, given them conscientious consideration and agreed how they will be used to shape the Decision Making Business Case due for completion in November 2018

The Clinical Senate has previously undertaken a table top exercise on proposals during the pre- consultation phase and are now requested to revisit and provide a more detailed appraisal of plans, taking account of how the consultation partners have responded to the findings of the public consultation.

The population covers the three CCG areas of Eastern Cheshire, South Cheshire and Vale Royal. It specifically relates to specialist mental health services for adults and older people both organic and nonorganic mental health needs

In Scope

The scope of the Senate review is to provide a more details appraisal of plans, taking account of how the consultant partners have responded to the findings of the public consultation.

The service(s) in scope of this review therefore are:

- Adults and Older Peoples Specialist Mental Health Services

Timeline: October to November 2018 Reporting Arrangements

The review panel will be led by Dr Cecil Kullu, Chair of the Cheshire & Merseyside Clinical Senate. The panel will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the media handling of the report and subsequent publication of findings will be agreed within 3 months of delivery.

Methodology

The methodology for this review will comprise of a desktop review of paperwork, face to face conversations with key clinical and managerial colleagues and site visits of two sites within scope.

Key Process and Milestones

PROCESS	TIMESCALE
Information for formal review submitted by Commissioner and distributed to review panel	1st October 2018
Review Panel meeting/teleconference for initial thoughts, emerging key lines of enquiry and requests for clarification and/or further information from Commissioners	15th October 2018
Formal Review panel site visits – Millbrook Unit and Bowmere	30th & 31st October 2018
Draft findings report sent to commissioner	2nd November 2018
First draft of the report sent to review panel members for final checks and corrections	9th November 2018
Review panel submit any final edits	16th November 2018
Final draft report sent to commissioners for accuracy checks and feedback – response by the 26th November 2018	21st November 2018
Final report completed and remote ratified by Clinical Senate Council	27th November 2018

REPORT

A draft clinical senate findings report will be available to the commissioner on the 2nd November 2018 with the final report completed and ratified by the Clinical Senate Council on the 27th November 2018

COMMUNICATION AND MEDIA HANDLING

The Clinical Senate aims to be open and transparent in the work that it does. The Clinical Senate would request that the sponsoring commissioning organisation publish any clinical advice and recommendations made.

All media enquiries will be handled by the sponsoring organisation. Name of Communication Lead Sponsoring Commissioner: Charles Malkin, Communication Manager

The detailed arrangements for any publication and dissemination of the clinical senate report and associated information will be decided by the sponsoring organisation.

RESOURCES

The clinical senate will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the North Region Clinical Senate accountability and governance structure.

The Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring commissioning organisation.

The sponsoring commissioning organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

FUNCTIONS, RESPONSIBILITIES & ROLES

The sponsoring organisation will:

1. Provide the clinical review panel relevant information, this may include: the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance, specifications. Background information may include, among other things, relevant data and

activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions). The sponsoring organisation will provide any other additional background information required by the clinical review team.

2. Respond within the agreed timescale to the draft report on matter of factual inaccuracy
3. Undertake not to attempt to unduly influence any members of the clinical review team during the review.
4. Submit the final report to NHS England for inclusion in its formal service change assurance process.

Clinical Senate Council and the sponsoring organisation will:

1. Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements
2. Appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member
3. Advise on and endorse the terms of reference, timetable and methodology for the review
4. Consider the review recommendations and report (and may wish to make further recommendations)
5. Provide suitable support to the team
6. Submit the final report to the sponsoring organisation

Clinical review team will:

1. Undertake its review in line with the methodology agreed in the terms of reference
2. Follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies
3. Submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council
4. Keep accurate notes of meetings

Clinical Review team members will undertake to:

1. Commit fully to the review and attend all briefings, meetings, interviews, panels etc that are part of the review (as defined in methodology)
2. Contribute fully to the process and review report
3. Ensure that the report accurately represents the consensus of opinion of the clinical review team
4. Comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare any potential conflicts, to the chair or lead member of the review panel.

Appendix 8 : Option 1 Cost Analysis

Option 1 costs based on the following information

Capital costs of works - £7.4m

Cost of borrowing above amount forecasted over 25 years at a borrowing rate of 6%- £6.6m

Total - £14m (there was no allowance for purchase of asset but we assume this would be a minimal amount)

Detailed breakdown of the £7.4m

Costs based on Taylor Young appraisal report for Millbrook Unit refurbishment dated 2010-11 (construction costs have not been indexed up at this stage)

Assumptions – project completed with appointment of principle supply chain partner under Procure 22.

Costs based on a full refurbishment all in cost of £2663 / m2 inc extensions and refurbishment.

Costs include Contingency sums @ 10%

Costs include all preliminary costs

Costs include M & E

(Costs do not include Fixtures Fittings and equipment)

Adephi Costs:	£k
Demolition and site clearance	75
Extension new build	850
Refurbishment of ward	2,400
Sub total	**3,325**
Bollin Costs:	
Demolition and site clearance (inc above)	
Refurbishment of ward	1,822
New build works	500
Sub total	**2,320**
Croft Costs	
Internal & external refurbishment of Croft ward	**400**
Total Cost	**6,045**
Plus 20% VAT	**7,254**

Professional fees are included in the ‘all in’ Procure 22 rate, however we have allowed for 150k Project management fees.

Therefore total estimation of construction costs = £7.4m

Appendix 9 : Risks and Mitigation

Risks	Relevant option	Description	Impact	Mitigation
Travel Impact (Service users and Carers)***	Option 2 Option 2+	Travel implications for 260 service users and/or visitors with significant time and financial impact for a number of these	• Service users unable to attend appointments • Family/carers unable to visit inpatient facilities	• 3rd sector organisations provide short term support for travel • Agree flexible visiting times to enable people to visit • Use of technology to support contact e.g. skype, facetime • Minimise length of stay via enhancement of community services • **Appendix 10: Travel Analysis**
Rehabilitation ward moving to Chester	Option 2+	Implementation requires the specialist rehabilitation service users currently at Lime Walk House to be transferred to a specialist rehabilitation facility at Chester instead of Soss Moss to allow Lime Walk House development	• Service users currently using rehab inpatient unit will have to be relocated to Chester	• Work is under way to understand where individual service users are in their rehabilitation journey to understand the impact and provide a seamless transition
Access to Capital	Option 2 Option 2+	Capital monies required by provider for renovation of estates to bring in line with national standards and guidance.	• If no capital available, modernisation of estates will not be possible therefore resulting in Option 2+ not being implemented within suggested timescales.	• TBC
Gifting of ward	Option 2+	Implementation of 2+ relies on Eats Cheshire NHS Trust gifting a ward to Cheshire and Wirral Partnership Foundation Trust.	• Implementation of option 2+ will not be possible within suggested timescales or financial envelope specified.	• TBC
Commissionin	Option 2	Funding identified	• Crisis service will	• Scoping of

g of Crisis Café	Option 2+	for the Crisis service currently only delivers the short term crisi beds. Additional funding is required to facilitate the implementation of the wider Crisis Service vision.	not deliver the full vision as described within the PCBC and consultation document.	partnership opportunities with key stakeholders (Cheshire East, Community and Voluntary Sector) to utilise existing community assets.
Double running costs during implementation phase	Option 2 and 2 plus	There will be a period of double running where community and crisis services are put in place in advance of wards being closed	• Funding not available to ensure continuity of service provision during the implementation of the new model of care	• High level implementation plan developed by CWP • Pump priming and releasing funding being organised
Rehabilitation patients may decide to relocate to Chester	Option 2 plus	The small number of service users who will be receiving rehabilitation services in Chester, may decide to relocate to Chester on discharge	• Increase 117 costs for Cheshire West local authority	• Local authority colleagues are discussing an informal agreement that 117 costs are not transferred between the two local authorities • CWP aim to ensure that the latter stages of a service users rehabilitation pathway will occur in Macclesfield

Appendix 10 : Travel Analysis

Option 2

The people most impacted upon by the implementation of option 2 would be those from Eastern Cheshire. The highest number of admissions was from Macclesfield which had the second to larges impact regarding distance travelled (40.9 miles). For individuals in Eastern Cheshire, the majority of postcodes do not have rail or bus (none or more than 3 changes) routes to Chester. For those that live in South and Vale Royal CCGs there is more access to bus and train links. The table below shows the areas with the highest number of admissions and the access to public transport.

Table 2: Public Transport accessibility from postcode with highest number of admissions

Postcode	Admissions*	Access to transport
SK10	63	Not possible to reach by public transport
SK11	75	Not possible to reach by public transport
SK12	18	Not possible to reach by public transport
SK9	47	Not possible to reach by public transport
CW1	76	Requires at least 2 trains/buses. Travel time: Approx. 1hr-2hr
CW2	20	Requires at least 2 trains/buses. Travel time: Approx. 1hr-2hr
ST7	8	Not possible to reach by public transport
CW5	10	Requires at least 2 trains/buses. Travel time: Approx. 1hr-2hr
CW9	7	Requires at least 2 trains/buses. Travel time: Approx. 1hr-2hr
CW10	8	Not possible to reach by public transport
CW11	15	Not possible to reach by public transport
CW12	48	Not possible to reach by public transport
WA16	35	Requires at least 2 trains/buses. Travel time: Approx. 1hr-2hr
CW7	4	Not possible to reach by public transport

* Admission in year previous to Preconsultation Business Case completion

Table 3: Option 2 Travel Analysis

Area	Town	Number of Admissions Adults	Number of service users Adults	Macclesfield	Chester	Difference in miles between travel to Macc & Chester
Eastern Cheshire	Macclesfield	100	79	1	41.9	40.90
Eastern Cheshire	Congleton	33	26	8.4	46	37.60
Eastern Cheshire	Holmes Chapel	<10	<10	11.8	37.3	25.50
Eastern Cheshire	Knutsford	16	16	11.2	26.8	15.60
Eastern Cheshire	Bollington	<10	<10	4.5	46	41.50
Eastern Cheshire	Disley	<10	<10	10.6	49	38.40

Eastern Cheshire	Poynton	13	12	7.6	43.4	35.80
Eastern Cheshire	Wilmslow	18	16	7.8	38.3	30.50
Eastern Cheshire	Chelford	<10	<10	6.6	36.7	30.10
Eastern Cheshire	Alderley	<10	<10	5.6	39.6	34.00
Eastern Cheshire	Handforth	12	11	9.1	39.3	30.20
Vale Royal	Northwich	14	13	17.9	26.9	9.00
Vale Royal	Winsford	<10	<10	19.2	19.2	0.00
Vale Royal	Weaverham	<10	<10	22.6	17.4	-5.20
Chester	Chester			37	1.5	-35.50
South Cheshire	Marbury	<10	<10	34.1	21.9	-12.20
South Cheshire	Wistaston	<10	<10	22.6	23.4	0.80
South Cheshire	Crewe	88	71	20.7	26.5	5.80
South Cheshire	Sandbach	29	23	15.3	27.5	12.20
South Cheshire	Middlewich	14	11	15.5	20.8	5.30
South Cheshire	Alsager	12	<10	15.3	32.9	17.60
South Cheshire	Audlem	<10	<10	31.5	30.9	-0.60
South Cheshire	Scholar Green	<10	<10	13.1	35.7	22.60
South Cheshire	Nantwich	22	20	26.4	21.8	-4.60
South Cheshire	Shavington	<10	<10	23.2	25.3	2.10

Option 2 Plus

The travel impact of Option 2 Plus is significantly less than for Option 2 due to the majority of beds remaining in Macclesfield. The main impact will be on those individuals within rehabilitation beds that will move to Chester. As mentioned in the main document, 13 beds rehabilitation beds are commissioned with a length of stay of 12-18 months. The ability of family and carers to visit these individuals will be affected.

A number of people with complex needs will receive treatment in Chester however this is also current practice so the impact of travel will be limited.

Table 4: Option 2 plus Travel Analysis

Area	Town	Number of Admissions Adults	Number of service users Adults	Number of miles to Macclesfield
Eastern Cheshire	Macclesfield	100	79	0
Eastern Cheshire	Congleton	33	26	8.4
Eastern Cheshire	Holmes Chapel	<10	<10	11.8
Eastern Cheshire	Knutsford	16	16	11.2
Eastern Cheshire	Bollington	<10	<10	4.5
Eastern Cheshire	Disley	<10	<10	10.6
Eastern Cheshire	Poynton	13	12	7.6
Eastern Cheshire	Wilmslow	18	16	7.8
Eastern Cheshire	Chelford	<10	<10	6.6
Eastern Cheshire	Alderley	<10	<10	5.6
Eastern Cheshire	Handforth	12	11	9.1
Vale Royal	Northwich	14	13	17.9
Vale Royal	Winsford	<10	<10	19.2
Vale Royal	Weaverham	<10	<10	22.6
Chester	Chester			37
South Cheshire	Marbury	<10	<10	34.1
South Cheshire	Wistaston	<10	<10	22.6
South Cheshire	Crewe	88	71	20.7
South Cheshire	Sandbach	29	23	15.3
South Cheshire	Middlewich	14	11	15.5
South Cheshire	Alsager	12	<10	15.3
South Cheshire	Audlem	<10	<10	31.5
South Cheshire	Scholar Green	<10	<10	13.1
South Cheshire	Nantwich	22	20	26.4
South Cheshire	Shavington	<10	<10	23.2

Travel risk mitigation options

The following information provides examples of patient transport solutions implemented by CCGs across the UK to mitigate travel impact as a result of service redesign. In the majority of cases, service users are offered the standard Patient Transport Service. These services tend to offer support to those travelling short distances within the local community. A number of other CCGs have invested in shuttle bus services when there has been hospital service reconfiguration. The maximum journey identified for such a service is 30 miles. In some cases these services were free and in others a £5 charge was applied for each journey.

These services have contract values of between £33,000 and £90,000 a year and in order to be viable require between 200 and 350 passengers a week. A visitor audit was undertaken by CWP showed there were 64 visitors in a two week period for people with functional illness, those people that would transfer to Chester under Option 2, resulting in 32 visitors a week potentially travelling to Chester. However, a number of these people with have access to their own transport and will not require such a service.

Based on the information from other CCGs, this level of activity would not make a commissioning a bus service a viable option. If a £5 charge was made per trip this would bring an income of £16,640 requiring an investment of C£16,000 from the CCGs.

Richmondshire and Whitby CCG

A free shuttle bus service was introduced as a pilot scheme in October 2014 to transport hospital patients and their families and staff between The Friarage Hospital, Northallerton and James Cook University Hospital, Middlesbrough. The bus travelled between the hospital on average ten times a day, Monday to Friday, a journey of approximately 30 miles. The service was funded by the CCG and operated in partnership with the hospital trust. The service was introduced following service reconfiguration at The Friarage Hospital, namely removal of consultant led maternity services. At the time, there were no commercial bus services in operation. The service has since been decommissioned.

Contract value £90,000 per year.

NHS Doncaster CCG

NHS Doncaster Clinical Commissioning Group (CCG) has commissioned a Patient Transport Service to take eligible Doncaster patients to and from scheduled hospital appointments.

The service is available for patients diagnosed with illnesses such as cancer, and offers a more convenient way of travelling than public transport. Taxiing is available

for patients having to travel between Doncaster and Sheffield's Weston Park Hospital, a journey of approximately 24 miles.

Scarborough & Ryedale CCG

The CCG agreed to fund the cost of a shuttle service between hospitals in Bridlington and Scarborough £63,750, and £127,250 in total. The service charged a £5 return charge for passengers, meaning 350 passengers per week were needed to make the service self-sufficient. Only 140 passengers were using the service per week and so the decision to discontinue the service was made in 2017.

Newark & Sherwood, Mansfield & Ashfield CCG's

The CCG's currently commission a free shuttle bus service which leaves Newark Hospital daily and takes people to King's Mill Hospital, Sutton-in-Ashfield. It currently costs £33,450 a year to run.

The service was decommissioned due to prioritisation of services that meet a direct health need. In 2016, 4,191 passengers used the service, an estimated cost of £16.60 per person for the CCG's. The same route by car would cost £10.70 and by commercial buses, £7.70.

Healthcare Travel Costs Scheme (HTCS)

If a patient is referred to a hospital or other NHS premises for specialist NHS treatment or diagnostic tests by their doctor or primary care health professional there may be the opportunity to claim a refund for reasonable travel costs under the Healthcare Travel Costs Scheme.

In order to qualify, a patient must meet 3 conditions:

1. At the time of the appointment, the patient or their partner (including civil partners) must receive one of the qualifying benefits or allowances listed on this page, or meet the eligibility criteria for the NHS Low Income Scheme.
2. The patient must have a referral from a healthcare professional to a specialist or a hospital for further NHS treatment or tests.
3. The appointment must be on a separate visit to when the referral was made. This applies whether the treatment is provided at a different location (hospital or clinic) or on the same premises as where the GP or another health professional issued the referral.

Travel costs can be claimed for an escort if the health professional deems it to be medically necessary for someone to travel with the patient. Some CCGs may accept claims for help with travel costs if the patient is a parent or guardian of a child under 16 who the patient has to take to the appointment with them.

The HTCS does not provide support to individuals visiting people in hospital however, some local authorities do provide assistance dependent on whether or not the person visiting id in receipt of qualifying benefits. Patients who aren't in receipt of qualifying benefits but are on low income and whose savings are less that £16,000 may be eligible for assistance with their NHS travel expenses via the NHS Low Income Scheme.

The NHS organisation handling the travel claim will base any refund on the basis of the cheapest suitable mode of transport for the patient's circumstances. This can be based on age, medical condition or any other relevant factors such as availability of public transport. If a taxi is the only feasible option, this should be agreed with the hospital or CCG before travel takes place.

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