

# Report to Cheshire East Health and Adult Social Care and Communities Overview and Scrutiny Committee



**07 December 2017**

Report Title	Redesign of Adult and Older Peoples Specialist Mental Health Services: Pre-Consultation Business Case		
Report Author	Contributors		
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Purpose of report			
To inform members of the Committee on the draft proposals for the redesign of adult and older people’s specialist mental health services in Eastern Cheshire, South Cheshire and Vale Royal, as outlined within the Pre-Consultation Business Case (PCBC).			
Recommendations			
The Committee is asked to:			
<ul style="list-style-type: none"><li>• NOTE and provide comment on the information contained within the Pre-Consultation Business Case</li><li>• ENDORSE the intent of the Clinical Commissioning Groups to commence a 12 week public consultation in early 2018</li><li>• NOTE the next steps.</li></ul>			
Appendices	Appendix A: Full Pre-Consultation Business Case (197 pages) Appendix B: New model of care case studies (1 page) Appendix C: Travel analysis (1 page) Appendix D: Capacity and Workforce Plan (1 page) Appendix E: Communications and Engagement Strategy Summary (2 pages)		

# Redesign of Adult and Older Peoples Specialist Mental Health Services: Pre-Consultation Business Case

## 1. Executive Summary

- 1.1 The Five Year Forward View for Mental Health<sup>1</sup> 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 Clinical Commissioning Group (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 patient experience and outcomes of care. As a consequence of the limited community resources the level of service for adult and older peoples specialist mental health services in Vale Royal, South Cheshire and Eastern Cheshire has more of a focus on inpatient (hospital based) services when compared with the model of care delivery in the Wirral and in Western Cheshire.
- 1.3 In patient services are currently provided at a number of sites across Cheshire and Wirral by Cheshire and Wirral partnership NHS Foundation Trust (CWP) including the Millbrook unit in Macclesfield which is part of the East Cheshire NHS Trust estate. The facilities at Millbrook are in need of significant refurbishment to comply with CQC standards and due to the layout of the unit, require a disproportionately higher staffing model to maintain clinical safety. The Millbrook Unit is CWP's least good inpatient environment and results in additional costs being incurred to ensure safe services.
- 1.4 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. Based on national prevalence data we would expect to see around 119,750 people locally (Eastern, South, Vale Royal) with a diagnosable mental health problem, but of these people only 10,778 will have Severe Mental Illness (SMI) and require care and support from specialist mental health services, rather than primary mental health services such as GP care and IAPT. There are currently in excess of 7,127 people receiving CCG commissioned care and support from CWP - the main local provider of specialist mental health - via the community mental health teams. Others are accessing care via other commissioners such as NHS England and Cheshire East Council and through third sector and other mental health providers.
- 1.5 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 based 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 who had accessed in-patient hospital based

<sup>1</sup> <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>

services were fit for discharge from hospital but awaiting community support or long term placement.

- 1.6 Service users and carers state there is limited choice and access to care for patients 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 patients 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<sup>2</sup>.
- 1.7 The local health and social care system is working within a capped expenditure programme due to their deteriorating financial position, and the current service model in Vale Royal, South Cheshire and Eastern Cheshire, is financially unsustainable. The cost of the current adult and older people's specialist mental health service configuration exceeds the funding provided by local commissioners and change is required for local NHS organisations to operate within their financial controls, deliver locally the Governments Mandate<sup>3</sup> requirement for the NHS to balance its books, whilst maintaining delivery of quality patient care.
- 1.8 There is an opportunity however, through service redesign to shift resources so as to enhance community and crisis care and move away from the over reliance on inpatient care. This will both improve outcomes and choice for adult and older people with severe mental health needs and significantly reduce the system cost pressure resulting from services operating in excess of funds available. This will also help close the financial gap through a redirection of existing funding.
- 1.9 In order to address the issues described, a programme of redesign was agreed between the three CCGs and CWP to explore opportunities and options which would deliver improved outcomes for the local population within the operating costs available. This programme of redesign has been strongly influenced by the involvement and leadership of a variety of clinical professionals including public health, consultant psychiatrists, therapy staff and GPs, as well as involvement and support from service users, patient groups and carers. A multi-disciplinary clinical advisory group led the care model development and the identification of options for delivery. The scoring of options created an opportunity to extend the clinical input into the development process, as did workshops which enabled GPs to identify across the three CCGs how plans could be shaped to align with local transformation plans.
- 1.10 The shortlisted options are underpinned by a robust and innovative approach to needs analysis against which capacity has been modelled and workforce plans built. The needs analysis looks at both numbers of people but also at the level of care required; recognising that within any diagnostic group there will be people with low level needs and some with very complex needs. Capacity planning has taken account of the individual and used evidence based care pathways to determine the care the person will need.
- 1.11 The work of the Programme Redesign Group has resulted in the development of a **Pre-Consultation Business Case (PCBC)** (**Appendix A** of this report). The purpose of the PCBC is to not only outline the compelling case for change to improve local adult and older peoples specialist mental health services but also to inform on the most viable options

<sup>2</sup> [https://docs.wixstatic.com/ugd/0e662e\\_a93c62b2ba4449f48695ed36b3cb24ab.pdf](https://docs.wixstatic.com/ugd/0e662e_a93c62b2ba4449f48695ed36b3cb24ab.pdf)

<sup>3</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/601188/NHS\\_Mandate\\_2017-18\\_A.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/601188/NHS_Mandate_2017-18_A.pdf)

available, which if implemented, could either continue to deliver the existing service model or deliver a new model of care within available financial resources. The PCBC also provides the case for undertaking the need for a formal consultation with the public, service users and stakeholders.

## 2. Recommendation(s):

### 2.1 The Committee is asked to:

- **NOTE** and provide comment on the information contained within the Pre-Consultation Business Case
- **ENDORSE** the intent of the Clinical Commissioning Groups to commence a 12 week public consultation in early 2018.
- **NOTE** the next steps.

## 3. Ward Area / Town Area Affected

### 3.1 All ward/town areas within Cheshire East.

## 4. Population affected

4.1 All of the 479,000 population of Eastern Cheshire, South Cheshire and Vale Royal. Based on national prevalence data we would expect to see around 119,750 people across the three areas with a diagnosable mental health problem, but of these people only 10,778 will have Severe Mental Illness (SMI) and require care and support from specialist mental health services, rather than primary mental health services such as GP care and IAPT.

4.2 There are currently in excess of 7,127 people receiving CCG commissioned care and support from CWP via the community mental health teams. Others are accessing care via other commissioners such as NHS England and Cheshire East Council and through third sector and other mental health providers.

## 5. Services in scope

5.1 The scope of the PCBC is Adult and Older people with severe mental illness who are in contact with secondary care specialist services. **Table A** shows the scope in more detail and outlines where future pathway development will need to establish links to other services in order to response to user and clinician feedback.

**Table A**

In scope services	Linked services	Out of scope
Adult functional	Health and wellbeing: IAPT step 1	Children's services
Older peoples functional	Talking therapies IAPT step 2 & 4	Complex secure services
Dementia	Specialist IAPT step 4	Specialist Mental Health Pre and Postnatal care
Crisis response: Home Treatment Teams	Liaison psychiatry	
Crisis support:- third sector collaborative	Mental health reablement	
Dementia outreach	Rehabilitation services	
Electro convulsive Therapy	GP led Primary mental health	

## 6. Finance

- 6.1 The local health and social care system is showing a deteriorating financial position. The local commissioners (CCGs) are reporting a combined projected year end deficit of c£38m.
- 6.2 The cost of the current adult and older people's specialist mental health service configuration exceeds the funding currently provided by commissioners, with CWP operating the delivery of the existing service model at a cost of around £2.5m more than income received. Change is required for the local NHS to operate within available funding and within the mandated financial controls.
- 6.3 In the current financial environment it is not expected that new funding can be identified to meet the shortfall identified in currently delivering the existing model of inpatient care or to provide additional funding for community services. The facilities at Millbrook Unit are in need of significant financial investment (c£14million) to bring the facility up to a CQC compliant facility for such services. Capital funding for this investment would need to be financed by a Private Finance Initiative.
- 6.4 Appendix Seven of the PCBC provides a cost analysis of each of the options considered. Each option was assessed against a defined affordability gateway set on the current cost of the delivering the existing adults and older peoples specialist mental health service configuration – the 'do nothing' option. Where the cost of an option exceeded the current cost of service provision it was excluded.
- 6.5 Within the pre-consultation business case, the preferred option identified whilst reducing the deficit in this area does not completely eliminate the financial challenge facing these services and is still some way short of the level of investment required for delivery of the Five Year Forward View, and the surplus expected to be delivered by providers and commissioners by their NHS regulators.

## 8. Equality

- 8.1 Equality impact assessments have been undertaken for options 4a and 4b as outlined within the Appendices of the PCBC.

## 9. Legal

- 9.1 CCGs have a statutory duty<sup>4</sup> to involve service users in the development of proposals around service re-configuration.
- 9.2 NHS bodies have a legal duty to consult local authority Overview and Scrutiny Committees.<sup>5</sup> Although it is strongly advised that local authority scrutiny functions are involved throughout development, commissioners should hold a separate formal discussion on the final set of proposals on which they intend to consult. This is referred to as 'pre-consultation'.
- 9.3 CCGs also have to take into account the duties placed upon them under the Equality Act 2010 regarding reducing health inequalities, and duties under the Health and Social Care Act 2012. Service design and communications should be appropriate and accessible to meet the needs of diverse communities.

<sup>4</sup> Sections 13Q and 14Z2 of the NHS Act 2006 as amended by the Health and Social Care Act 2012

<sup>5</sup> [www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf)



9.4 NHS England is legally required to seek to achieve the objectives, and comply with the requirements in the NHS Mandate.<sup>6</sup> In doing so, NHS England is required to comply with its responsibilities and delegated authorities as set out in the Framework Agreement between the Department of Health and NHS England<sup>7</sup> and Managing Public Money.<sup>8</sup> In turn, NHS England is expected to ensure CCGs play their part in delivering the mandate.

9.5 Within the NHS Mandate there are a number of key objectives, namely:

- **OBJECTIVE 3: To balance the NHS budget and improve efficiency and productivity.** NHS England to ensure overall financial balance in the NHS, working with NHS Improvement (which has statutory responsibility for trust financial control) to support local areas in developing credible, financially balanced operational plans, which build on, and align with, STPs. NHS England is tasked by Government to ensure that aggregate spending by commissioners does not exceed mandate funding, that appropriate contingency funding is maintained and to make sure that commissioners discharge their duties in a way which enables all parts of the system (commissioners and providers) to meet their control totals.
- **OBJECTIVE 6: To improve out-of-hospital care.** The Government wishes to see more services provided out of hospitals, a larger primary care workforce and greater integration with social care, so that care is more joined up to meet people's physical health, mental health and social care needs. People with mental health problems should receive better quality care at all times, accessing the right support and treatment throughout all stages of life. Overall there should be measurable progress towards the parity of esteem for mental health enshrined in the NHS Constitution, particularly for those in vulnerable situations. A key deliverable for the NHS in 2017-18 is to develop and implement a 5 year improvement programme for crisis and acute mental health care, including investing in liaison psychiatry and crisis resolution and home treatment teams as part of seven-day services, as well as continuing to collaborate with partners to support the ongoing work to improve care for people detained under s.136 of the Mental Health Act, including provision of health based places of safety

## 10. Quality and Patient Experience

10.1 Underpinning the proposals presented within the PCBC is a collective ambition for improved user outcomes of mental health services which is to:

- improve clinical outcomes for people with SMI;
- meet people's health and well-being needs
- ensure people live longer healthier lives
- support people as close to home as possible in the least restrictive environment; and
- empower users and their carers through choice and co – production.

10.2 Success will be measured by looking at:

- patient reported outcomes
- mortality/morbidity data
- patient experience and satisfaction
- access and waiting times; and
- referral data and activity.

<sup>6</sup> This requirement is at section 13A(7) of the National Health Service Act 2006.

<sup>7</sup> <https://www.gov.uk/government/publications/framework-agreement-between-dh-and-nhs-england>

<sup>8</sup> <https://www.gov.uk/government/publications/managing-public-money>

- 10.3 A quality impact assessment has been undertaken and can be found within the PCBC Appendices.

## **11. Pre-Consultation and Engagement (Public/Patient/Carer/Clinical/Staff)**

- 11.1 There has been significant engagement with stakeholders in advance of the publication of the PCBC; to inform them of the rationale and options to be presented to patients and public audiences, and the channels that will be used.
- 11.2 This work has been strongly influenced by the involvement and leadership of a variety of clinical professionals including public health, consultant psychiatrists, therapy staff and GPs. A multi-disciplinary clinical advisory group led the care model development and the identification of options for delivery. The scoring of options created an opportunity to extend the clinical input into the development process, as did workshops which enabled GPs to identify across the three CCGs how plans could be shaped to align with local transformation plans.
- 11.3 Patient and carers workshops were held at the Millbrook Unit in Macclesfield and the Recovery Colleges, as well as a series of briefings and drop-in sessions for frontline staff towards the end of 2016. At this time there was engagement with Healthwatch Cheshire East, Eastern Cheshire HealthVoice and Cheshire East Council's Adult Health and Social Care Overview and Scrutiny Committee. This included providing a site-visit for Scrutiny committee members to CWP services.
- 11.4 More recently listening events were held in September 2017 at Crewe Alexandra Football Club and Macclesfield Town Football Club. 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. In addition an online survey was also made available to those who couldn't attend the sessions. Information gathered was used to inform the public acceptability criteria in the scoring of options.
- 11.5 A local campaign group 'Do You Mind'<sup>9</sup> has been running an online petition which has gathered the support of over 2,800 people calling for a number of actions around mental health, including retaining inpatient services in Macclesfield and increased funding for mental health. The service redesign project team has met with the group during pre-consultation and has had a constructive ongoing dialogue with them. A key objective during the public consultation will be to ensure that service users, carers and the wider public are fully aware of the case for change and the proposed future service model.
- 11.6 A number of briefing sessions have been undertaken with and/or briefing materials provided to the local media and local politicians.

## **12. Programme Redesign and Options**

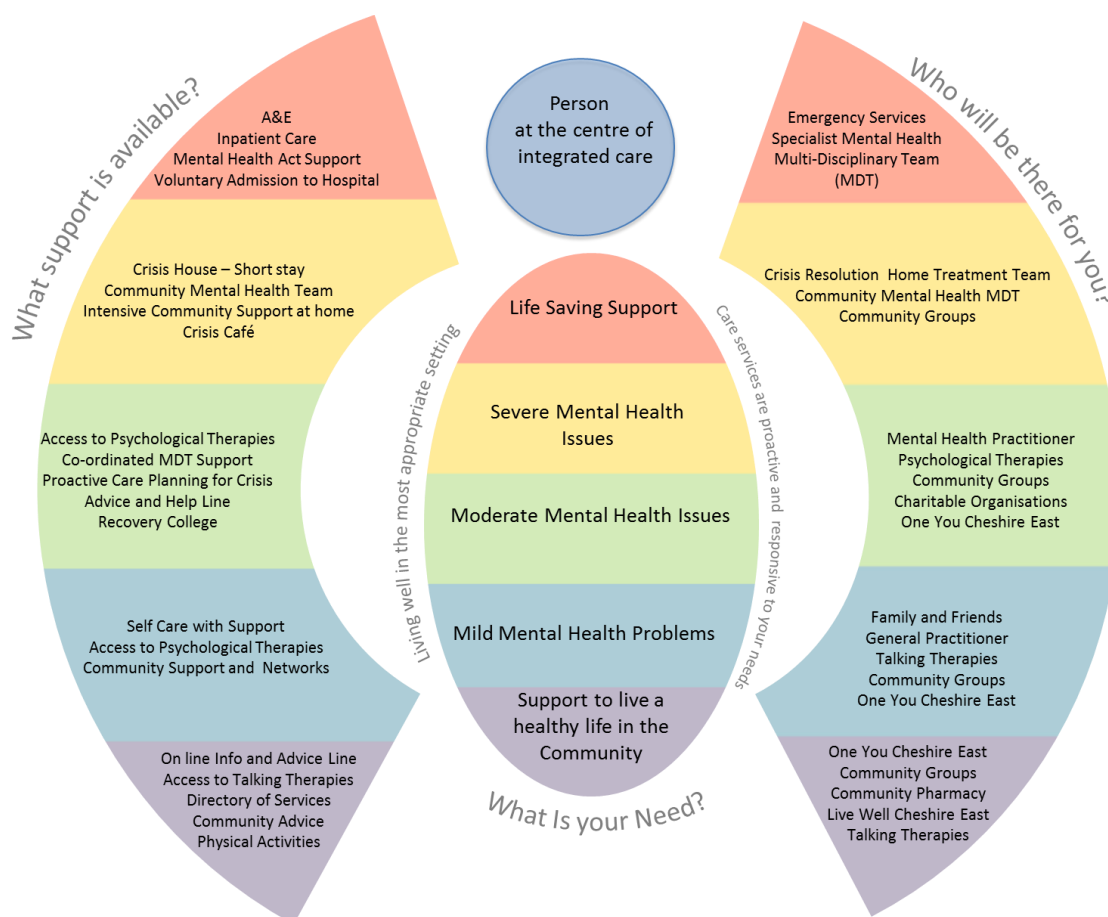
- 12.1 In order to address the issues described regarding the configuration of existing Adult and Older Peoples Specialist Mental Health provision, a programme of redesign was agreed between the three CCGs and CWP so as to explore opportunities and options which would deliver improved outcomes for the local population within the operating costs available.

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<sup>9</sup> <http://www.doyoumind.co.uk/>

- 12.2 Locally developed transformation plans (Caring Together (Eastern Cheshire) and Connecting care (South Cheshire & Vale Royal)) describe a programme of co-design across the health and social care economy where commissioners and providers respond to patient needs and work together to redesign care services.
- 12.3 Feedback from both users and professionals is that there needs to be better links with primary mental health services to ensure the wider determinants of health are addressed and there is recognition of the importance of managing physical and mental health together in the application of person centred care.
- 12.4 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. Diagram One visually represents this new model of care, centred around the person and included enhanced community mental health teams, crisis support and inpatient provision.

**Diagram One: A model of care for mental health**



- 12.5 Components of the new secondary care service model will improve patient outcomes through:
- **Access to an enhanced multi professional community mental health service:** that will support people to remain in the community, in the least restrictive environment. Care plans will be developed and delivered according to care needs for as long as they are



clinically required. Community teams will also support timely discharge from hospital or transfer from crisis placement.

- **Timely response to crisis support:** overseen by an enhanced home treatment team, who will provide support to a wider range of services including locally provided crisis beds, dementia out-reach services, and enabling people to be supported in their own home, in crisis café's and drop in centres as an alternative to hospital admission and A&E attendance.
- **Improved inpatient experience:** where care will be provided in facilities which offer a range of therapeutic interventions in an environment which is modern and supports privacy and dignity through the provision of single ensuite accommodation. The unit will be staffed appropriately and the length of stay determined by patient need rather than what is available in the community on return to home.

12.6 **Appendix B** to this report provides two case studies which show how the new model of care will bring benefits to people and demonstrate how professionals, working in partnership with a wide range of options, can deliver care closer to home.

12.7 The programme redesign group considered a number of options (eight in total) around the continued and future delivery of adult and older people specialist mental health services, and which included the use of alternative providers closer to people's homes. Options considered included whether to continue the delivery of the existing service model as well as those that would enable the delivery of an alternative model of care.

12.8 The longer list of options were assessed against key criteria such as safety, affordability, sustainability, cost, quality and alignment to strategic plans and national requirements. For many of these options the cost quoted significantly exceeded the cost envelope available and worsened the financial situation for the health economy. There were also concerns in relation to patient safety, continuity of care and the ability to guarantee a level of quality which matched the current provider.

12.9 The review of the eight options against this criterion (outlined in greater detail in Appendix 4 of the PCBC) has resulted in a shortlist of three options, with one being identified by the programme redesign group as the preferred option, and which are being proposed to the CCGs for final consideration to be brought forward for the public to consider. These three options are:

- **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. *(Whilst this is technically defined as do nothing; in accordance with the case for change the consequence of this option being selected would be the need to redirect funding from other current commissioned care services, in order to maintain, in the longer term, safe adult and older persons specialist mental health services).*
- **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 Hospital in Chester. In total these services provide 53 beds. This is the preferred/optimal option.

- **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 Hospital in Chester. In total these services provide 53 beds.

12.10 The shortlisted options are underpinned by a robust and innovative approach to needs analysis against which capacity has been modelled and workforce plans built. The needs analysis looks at both numbers of people but also at the level of care required; recognising that within any diagnostic group there will be people with low level needs and some with very complex needs. Capacity planning has taken account of the individual and used evidence based care pathways to determine the care the person will need.

### **13. Impact of Options 4a and 4b on travel for patients and carers**

13.1 With the development of highly specialised services such as stroke, cardiac and trauma, the development of networked services aims to provide access to services at a population level with the growing expectation that for some people this will incur additional travel. Whilst this is similar for mental health services, the enhancement of community services will reduce the need for hospital care by 16% and some crisis bed based care will be locally available.

13.2 During the last year there have already been 12 people from Eastern Cheshire and 57 from South Cheshire and Vale Royal who have received treatment and travelled to Bowmere, and there have been no problems with travel reported.

13.3 If either Option 4a or 4b was implemented, and based on current figures of admission, there would be approx. 305 patients (Eastern Cheshire – 176, South Cheshire – 118, Vale Royal - 11) who would need to travel further to get to Bowmere than if travelling to Macclesfield. The additional travel estimated for patients and carers if from Macclesfield is c40 miles and for those from Crewe c6miles.

13.4 The programme design group has undertaken further work in response to patient and public concern looking at the logistics of travelling to Bowmere in relation to public transport, and which are highlighted within the PCBC.

13.5 On the basis that, following consultation, that either Option 4a or 4b was implemented, the programme design group has been working to identify how best to minimise impact for patients and carers, including:

- working with third sector organisations to provide short term support for travel
- agreeing flexible visiting times to enable people to visit earlier in the day
- use of technology to support contact e.g. skype, face time. In accordance with CWPs enabling technology strategy

13.6 A more detailed travel analysis is available in **Appendix C** to this report and which is included within the PCBC as Appendix 5.

## 14. System Impact

- 14.1 In the options 4a and 4b the existing inpatient facility 'Millbrook' on the Macclesfield Hospital site would be left vacant following the re provision of inpatient care to other facilities with a consequential shift in financial deficit from one system partner to another.
- 14.2 To prevent this scenario a number of options are being considered as part of a strategic approach to estates management and includes:
  - using the site to support the accommodation of new and additional NHS services
  - offer the vacant site for land sale, with proceeds being reinvested into local NHS services.
- 14.3 The system partners across Vale Royal, South Cheshire and Eastern Cheshire will be tasked with undertaking a high level feasibility study on the potential options for the Millbrook site pending a final decision post consultation.
- 14.4 People who have mental health problems, who need a place of safety within the meaning of the Mental Health Act are transported via 'blue light' emergency ambulance, with Cheshire Police accompanying the person. NWSAS also provide Urgent Care Services for planned work between hospitals. Patient Transfer Services are commissioned through West Midland Ambulance Service.
- 14.5 Cheshire Police Mental Health Liaison outlined the importance of adequate provision of 'places of safety' within Cheshire, to enable Police to complete a section within the Mental Health Act, with Approved Mental Health Practitioner (AMP) or Psychiatrist in the interest of the person's mental health and wellbeing. The project team will continue to partner with NWSAS, Cheshire Police Mental Health Liaison and the Pan Cheshire Crisis Care Concordat Board, to develop the model of care for the preferred options that will ensure adequate provision.

## 15. Capacity and Workforce

- 15.1 The national shortage of candidates 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. In a recent NHS Confederation report (July 2017) it highlighted a 12.6% decline of mental health nurses over the last 7 years.
- 15.2 It is necessary therefore to extend our thinking beyond the traditional roles within mental health and capitalise on some of the new and exciting developments that are occurring within the workforce as a whole. It is essential that we 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 health system we recognise 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. For CWP this has been more so in the past twelve months where the future of Millbrook has been under review.

- 15.3 It is believed that the plans outlined in this pre consultation business case 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.
- 15.4 The changes described in the new model of care will also provide existing staff with an opportunity to move into different roles by providing other roles in both inpatient and community
- 15.5 **Appendix D** to this report shows the workforce and capacity plan linked to demand and the differences in capacity generated by new ways of working and enhancement. Greater detail on workforce capacity and the plan is provided in Appendix 6 of the PCBC.

## 16. Next steps towards Consultation

- 16.1 In line with national guidance on *'Planning, assuring and delivering service change for patients'*<sup>10</sup> the PCBC is currently being considered by NHS England and the three CCGs will soon receive feedback with regards any amendments to the PCBC and if there is NHS England support for the CCGs to take forward the proposals to the public within their current format.
- 16.2 The Cheshire West and Chester People and Overview Scrutiny Committee have also been engaged to ascertain whether they wish to receive the PCBC for consideration or not. At the time of writing the report a position has not been provided by the Cheshire West and Chester People and Overview Scrutiny Committee.
- 16.3 As commissioners of local adult and older peoples specialist mental health services, the three CCGs need to approve the final draft of the PCBC as do CWP as the current providers of this service and incumbents of the Millbrook Unit, ahead of the PCBC being considered by the Cheshire East Health and Adult Social Care and Communities Overview and Scrutiny Committee (Scrutiny)
- 16.4 Due to the timing of completing the necessary public and clinical engagement to enable completion of final draft of the PCBC, the dates of Governing Body meetings held in public for the three CCGs, and date for presenting to Scrutiny, it has proven logistically challenging for all CCG Governing Bodies and CWP to sign off the PCBC in public before submitting to Scrutiny.
- 16.5 In situations such as this where there are multiple CCGs working together to commission services for which they are responsible, it is common for the CCGs to have a single forum or board where approval of items such as the PCBC can be undertaken. For the three CCGs the only such forum that meets this criteria, and which is meeting within the timeline required, was the Joint Commissioning Committee of the Cheshire CCGs. This Committee

<sup>10</sup> <https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf>

in itself however does not have the delegated authority or remit to make decision on this particular PCBC, however members of that Committee can choose to use such a forum to have the paper discussed with all named CCGs present. Sign off / approval of the PCBC would therefore be done by representatives of the three CCGs in attendance at the Committee, and not the Committee itself.

- 16.6 As such, the Governing Bodies of each of the three CCGs have been requested to delegate authority to the Chief Officer and Clinical Chairs of their respective CCG to sign off/approve the PCBC within the forum of the Joint Committee meeting. CWP are considering the PCBC at the Board meeting on 29 November 2017.<sup>11</sup>
- 16.7 Subject to receiving support to proceed from NHS England and Scrutiny, approval from the three CCGs and CWP, it is intended that a formal 12 week consultation with the public, service users and stakeholders on the proposals outlined within the PCBC will commence early in 2018. **Approval of the PCBC does not mean the start of the Consultation and the PCBC should not be seen as the formal consultation document.**
- 16.8 Prior to the start of the formal public consultation in early 2018, the Governing Bodies of the three CCGs – as the legal consulting bodies - will receive the draft consultation questionnaire / options document, supporting consultation documents and proposed start date for the consultation to approve.
- 16.9 Appendix 2 the PCBC contains the proposed Communications and Engagement Strategy for undertaking the Consultation. A summary of this is provided in **Appendix E** of this report. The Communication and Engagement Strategy articulates how the partners will undertake effective public communication, media handling, plans for reaching interest groups, the involvement of staff and other key stakeholders.

## 17. Post Consultation

- 17.1 Subject to going out to and completing a formal consultation, the Governing Bodies of each CCG will receive a final consultation report which will outline the findings, as analysed by an independent organisation. The findings from the Consultation will inform the PCBC which will reflect the final proposal to be considered by the CCGs, based on the best balance of clinical evidence and evidence gained through public support and consultation. This is then called the decision making business case (DMBC).
- 17.2 The DMBC may need to be further assured by NHS England before final consideration by the three CCG Governing Bodies. Upon the final decision by the Governing Bodies, the three CCGs will formally communicate the decision to the public and stakeholders.
- 17.3 Following the decision on which option to implement, an implementation plan will be made available that sets out how the changes will be taken forward, when and by whom. The partners will continue to involve stakeholders, patients and the public until such time as the changes are in place and considered business as usual. During this time, oversight of the implementation of the preferred option is the duty of the commissioners leading the plans, with support from NHS England, NHS Improvement and other partners.

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<sup>11</sup> <http://webstore.cwp.nhs.uk/board/agendas/agendanov17.pdf>