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

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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:

- **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.

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[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 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

[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

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[2].

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[3] 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

[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

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[4] 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.[5] 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.

[4] Sections 13Q and 14Z2 of the NHS Act 2006 as amended by the Health and Social Care Act 2012
[5] 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.[6] 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[7] and Managing Public Money.[8] 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.

[6] This requirement is at section 13A(7) of the National Health Service Act 2006.
[7] https://www.gov.uk/government/publications/framework-agreement-between-dh-and-nhs-england
[8] 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'[9] 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.

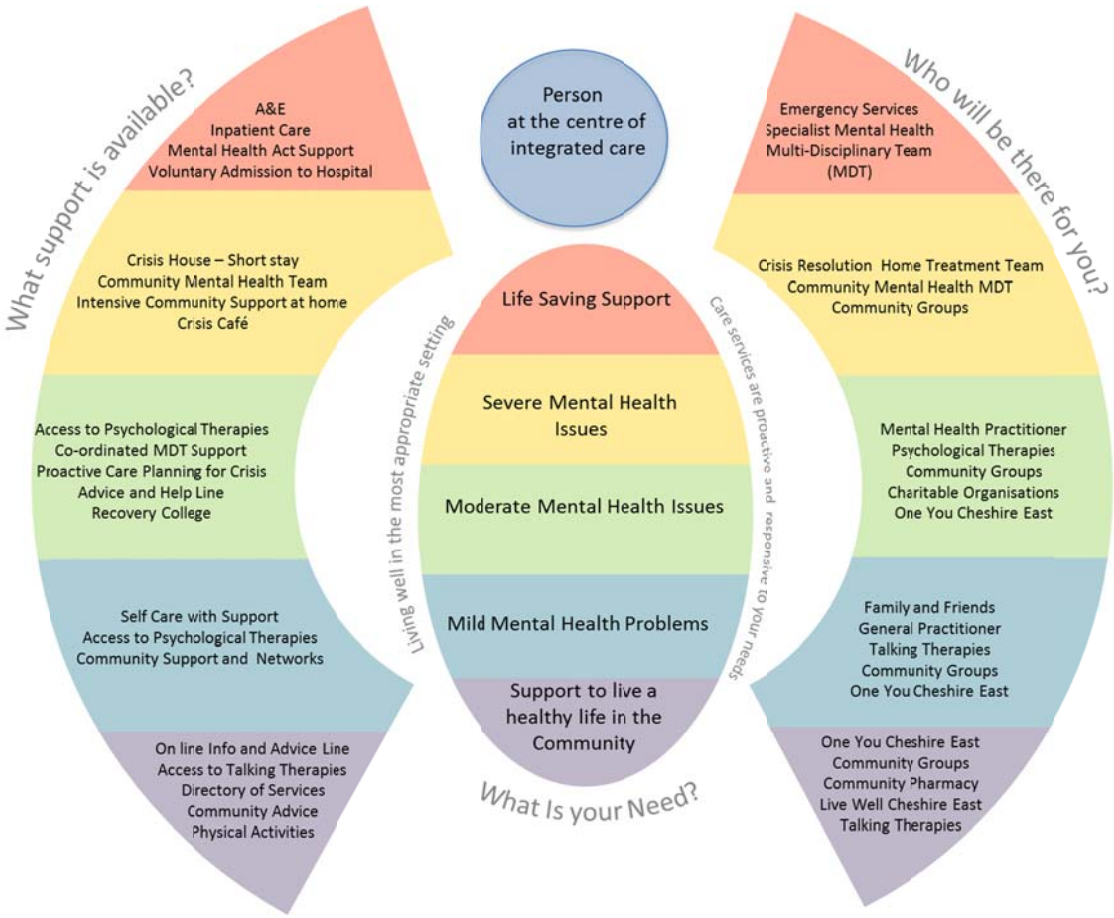
[9] http://www.doyoumind.co.uk/

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 <u>improve patient outcomes</u> 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. NWAS 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 NWAS, 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'*[10] 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

[10] 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.[11]

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.

[11] http://webstore.cwp.nhs.uk/board/agendas/agendanov17.pdf

Adult and Older Peoples Specialist Mental Health Services Redesign

Pre-Consultation Business Case

Contents

1.0 Executive Summary

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

The purpose of this pre-consultation business case is to outline a compelling case for change and present options which will deliver improved mental health outcomes for the registered population of Vale Royal, South and Eastern Cheshire within the financial resources available. Specifically:

- There is rising demand for care and support. 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. The majority of people can be effectively managed in community setting with the right level of support.

- Local evidence shows 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 over 40% of adults and 69% of older people were fit for discharge from hospital but awaiting community support or long term placement

- 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 services of up to 16% which equates to approximately 10 additional beds[2].

- The current model of care and ways of working are not consistent with either national policy and best practice or local transformation plans leaving room to improve patient experience and outcomes of care.

- In patient services are currently provided at a number of sites across Cheshire and Wirral 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 local health and social care system is showing a deteriorating financial position. The cost of the current adult and older people's mental health service configuration

[1] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

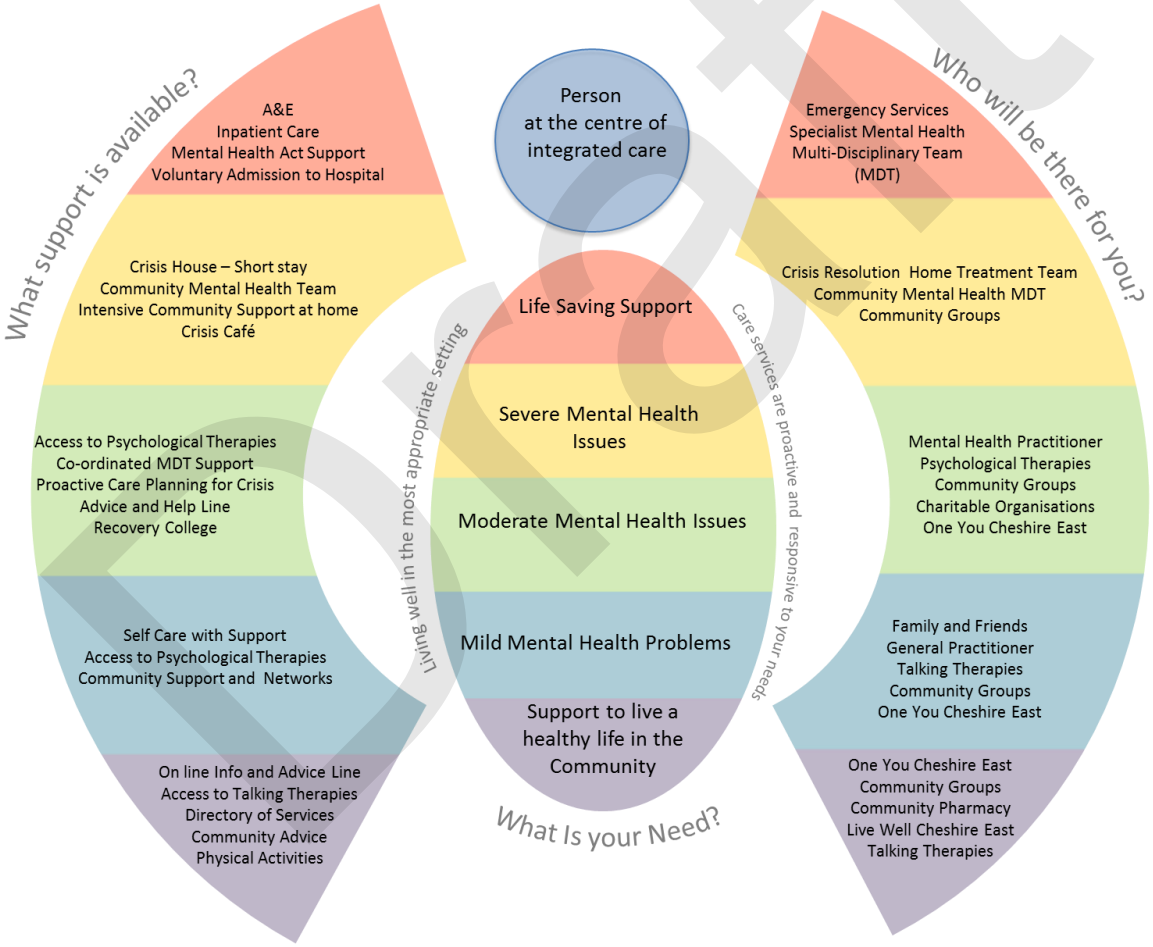
[2] https://docs.wixstatic.com/ugd/0e662e_a93c62b2ba4449f48695ed36b3cb24ab.pdf

exceeds the funding available and change is required for the local NHS to operate within mandated financial controls.

In order to address the issues described above, a programme of redesign was agreed to explore opportunities and options which would deliver improved outcomes for the local population within the operating costs available.

Clinicians from secondary and primary care have developed a new model of secondary mental health care, based on national best practice and consistent with local plans for transformation and are visually represented below within the wider mental health services framework.

Diagram 1**: **A model of care for mental health



Components of the secondary care service model will <u>improve patient outcomes</u> 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.

In the current configuration of services there are potentially 58 beds on the Millbrook site in Macclesfield whereas national evidence, supported by local audit data, shows that for our population only 48 beds would be required if community services and rapid response were enhanced.

The local health and social care system is working within a capped expenditure programme due to the deteriorating financial position. There is an opportunity however, through service redesign to shift resources into the community away from the over reliance on inpatient care, to both improve outcomes 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.

Proposals presented 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.

A number of options were developed at long list which included the use of alternative providers closer to people's homes. 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.

All the options were considered and following a panel decision based on safety, affordability and sustainability, cost, quality and strategic plans the below three proposals will be brought forward for the public to consider:

- **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 care services, in order to maintain, in the longer term, safe 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 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.

During the pre-consultation engagement events there was a consistent concern raised in relation to the travel implications for carers should inpatient care be re-provided at Bowmere in Chester. In addition to a detailed analysis into the logistics of travelling the project team are currently developing a support plan which includes working with the voluntary sector to support carers travel, flexible visiting times and use of technology to maintain contact

This Pre Consultation Business Case (PCBC) will be presented to the Cheshire East Overview and Scrutiny Committee in December 2017 to seek support to commence public consultation for a 12-week period. Analysis of consultation results and reporting will be in June 2017 following which a full business case will be produced for consideration and implementation.

2.0 Introduction and background

Commissioners in Vale Royal, South and Eastern Cheshire are working with local mental health provider; Cheshire and Wirral Partnership NHS Trust, users of the service and Cheshire East Council to review and redesign secondary care adult and older peoples mental health services for those people with severe mental illness (SMI). 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 includes specialised community support, crisis response and inpatient care.

There are 479,000 people living in Vale Royal, South Cheshire and Eastern Cheshire. 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 SMI and require care and support from specialist mental health services, rather than primary mental health services such as GP care and IAPT.

Current services are organised around; functional mental health needs, which relates to the type of illness which has a predominantly psychological cause. It may include conditions such as depression, schizophrenia, mood disorders or anxiety and organic such as dementia.

There are currently in excess of 7,127 people receiving CCG commissioned care and support from the main local provider of specialist mental health Cheshire and Wirral Partnership 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.

2.1 The case for change

- There is rising demand for care and support. 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. The majority of people can be effectively managed in community setting with the right level of support.

- Local evidence shows 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 over 40% of adults and 69% of older people were fit for discharge from hospital but awaiting community support or long term placement

- 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 services of up to 16% which equates to approximately 10 additional beds[3].

- The current model of care and ways of working are not consistent with either national policy and best practice or local transformation plans leaving room to improve patient experience and outcomes of care.

- In patient services are currently provided at a number of sites across Cheshire and Wirral 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 local health and social care system is showing a deteriorating financial position. The cost of the current adult and older people's mental health service configuration exceeds the funding available and change is required for the local NHS to operate within mandated financial controls.

[3] https://docs.wixstatic.com/ugd/0e662e_a93c62b2ba4449f48695ed36b3cb24ab.pdf

In order to address the issues described above a programme of redesign was agreed to explore opportunities and options, which would deliver improved outcomes for the local population within the operating costs available.

2.2 Project scope and process

The scope of this PCBC is Adult and Older people with severe mental illness who are in contact with secondary care specialist services. The table below 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 1: Detailed project scope

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 Post Natal Care
Crisis response: Home Treatment Teams	Liaison psychiatry	
Crisis support:- third sector collaborative	Mental health reablement	
Dementia outreach	Rehabilitation services	
Electro convulsive Therapy (ECT)	GP led Primary mental health	

A joint commissioner/provider project group was established in June 2017. Patient representation and social care partners are key members of the project team. The mandate for the team was to undertake a clinically led, systematic approach to the identification of need and then determine options for care delivery to best meet those needs within the resources available. The project membership can be found at appendix 1.

The approach taken to the management of this programme of work is consistent with NHSE guidance[4] and provides assurance in relation to the four tests for service redesign which are:

1. strong public and patient engagement;
2. consistency with current and prospective need for patient choice;
3. clear, clinical evidence base; and
4. support for proposals from commissioners.

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

2.3 Ensuring strong clinical and user engagement

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. (See appendix 1 for a complete list of members). 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.

During development of these proposals we have demonstrated a commitment to be proactive to seek the views and experiences of our local populations and be accessible and convenient. We have met with various interest groups, undertaken site visits with experts by experience and invited users to share experiences and views in a range of meetings from CCG Annual Fairs and listening events to individual case studies. Partners have used this information alongside carer and staff views and experiences in the development of the Pre-Consultation Business Case; including the options appraisal process.

Patient and carers workshops were held at the Millbrook Unit 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 Cheshire East Healthwatch, Eastern Cheshire Health Voice 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.

More recently listening events were held in September 2017 at Crewe Alexandra FC and Macclesfield Town FC. 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.

The views and experiences of users and carers have informed the development of plans so far and will be referenced throughout. In addition stated priorities have directly informed the development of the long list of options, and appraisal process – specifically informing the public acceptability criteria.

A detailed engagement and communications strategy has been developed to ensure that service users, health care professionals and other key stakeholders have a wide range of opportunities to shape developments as they emerge. This can be seen at appendix 2.

2.4 Needs analysis

Prior to identifying the model of care and the options for service delivery it is 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 relates to registered population rather than resident.

- A number of information sources were used such as projected population statistics and actual activity data as we found limited national benchmarking data was available to check assumptions relating to prevalence vs incidence.
- Professional judgement and local benchmarking 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 and the categories of health need related to dementia, depression, psychosis, bipolar disorder, personality disorder, and anxiety. We then compared this data to current activity using caseload data. The prevalence codes were different to the activity codes requiring professional input to 'map' them accurately across.

Once the core numbers had been signed off by the clinical and information group we used the data to understand the actual needs of patients within each diagnostic code. Previous 'PbR clustering' categories have been used. Diagnostic conditions were grouped into Super Clusters which describe the severity of need rather than condition specific symptoms. Super clusters link to evidence based care pathways which describe the care required from low to highly complex needs which enabled the project team to model the capacity required and the skill mix within the new workforce model. The completed needs analysis can be found at appendix 3.

3.0 Improving Quality and Outcomes

The Five Year Forward View for Mental Health 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.

In the table below is a summary of the key standards to be achieved by 2021 for the services within scope of this programme.

Table 2: Five Year Forward View (5YFV) 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 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.

Learning from other areas show that facilities like crisis café's and places of safety with 24/7 access to crisis support are highly valued by carers and people who use the service. These are now common place in other parts of the country. During the listening events there was strong support for an alternative model for crisis care which should range from overnight placements to day centres and cafes.

A café in a North East Hampshire has helped reduce mental health hospital admissions by a third in seven months by providing an alternative solution for service users[5]. Other examples are evident across the country.

During the planning phase members of the project team alongside experts by experience and carers undertook site visits to existing local facilities and other areas within the current provider footprint. These included inpatient facilities and community and crisis centres.

Initial feedback would suggest crisis beds located in the community and run through a collaboration of third sector organisations and specialist clinical services offer a timely, cost effective and highly valued service to people and carers. Evidence both locally and nationally show that these facilities are well used, length of stay is around 6 days and onward admission to hospital is low.

Underpinning the proposals presented here 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.

Success will be measured by looking at:

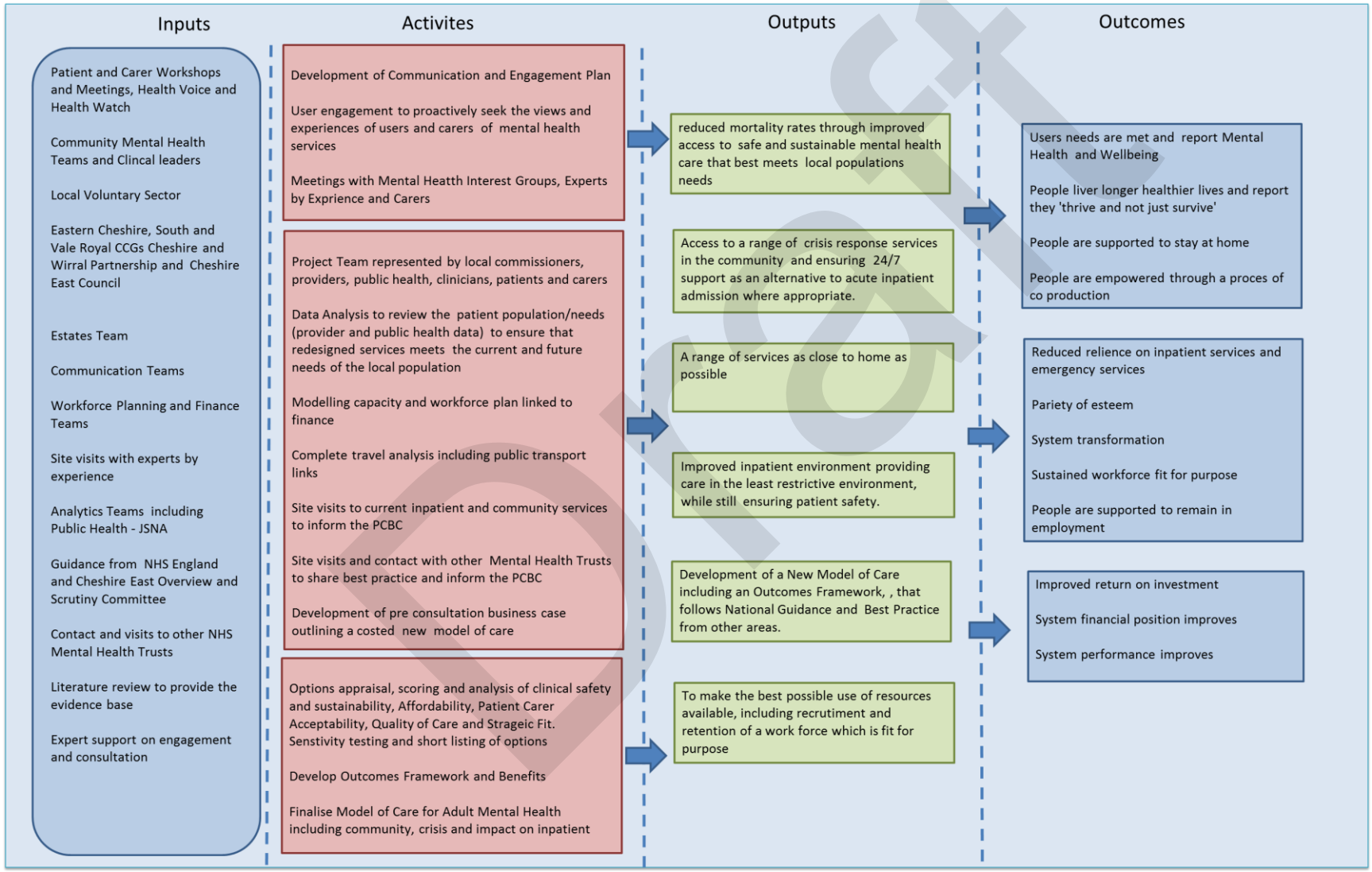
- patient reported outcomes;

[5] www.england.nhs.uk/mental-health/casestudies/aldershot

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

In diagram 2 (below) we describe the development journey taken to deliver plans which, once implemented will achieve and outcomes for service users.

Diagram 2: Achieving improved outcomes for people through service redesign



4.0 Options for delivery of adult and older peoples mental health services

Locally developed transformation plans 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. They represent a system wide commitment to implementing the changes required to deliver a care system that is fit for the 21st century's population needs and is entirely consistent with the national vision for future mental health services described in the 5YFV.

The aim is to develop a new model of care 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 patient outcomes through:

- access to an enhanced multi professional community mental health services;
- timely response to crisis support; and
- improved inpatient experience.

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 a recognition of the importance of managing physical and mental health together in the application of person centred care.

4.1 Enhanced Community Mental Health Teams

People will be supported in their own homes as far as possible by a multi professional team who support the GP as the lead professional where appropriate and deliver integrated care through care communities. Care management plans will be co-produced and people will know what to expect in relation to care, review and medicines management. Patients who have required hospital care should be able to return home as soon as possible and may include a period of increased 'step down' support by community and home treatment teams. The community teams will provide the following key functions:

- a person- centred approach to treatment that supports people to live full and meaningful lives. Treatment approaches will be in line with NICE Clinical Guidelines and encourage personal independence and self-management approaches to maintaining physical and mental wellbeing where appropriate
- a single point of referral. This will be for assessment of need and ongoing management e.g. to crisis support secondary care mental health services where clinically appropriate. Additional community support or an alternate package of care in line with NICE Clinical Guidelines.

4.2 Crisis Support

A range of options will be available to people both in and out of hours. Home treatment teams will provide additional support in the home but will also have access to crisis placements for short stay care and day time community support through crisis cafes. They will provide 'in reach services' for crisis placements to provide alternatives to hospital admission and A&E attendance. The crisis service will be a collaboration between CWP and third sector partners.

For older people with dementia an outreach service will support people in crisis in their own homes to avoid unnecessary admissions to hospital or allow time for a long term placement to be identified.

4.3 Inpatient provision

When a period of very specialised care is needed and there is no appropriate alternative to care, people will be admitted to hospital, where care will be provided in facilities which offer a range of therapeutic interventions options 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.

In the care model below we show how mental health secondary care services will be delivered within a wider, holistic model of care where patients can access services that meet their needs. The development of the 'navigator role' will ensure people can move easily between levels of support combining low level interventions and complex care packages where required.

Diagram 3: A model of care for mental health

In the scenarios below we show how the new model of care will bring benefits to people and demonstrate how professionals, working in partnership with a wider range of options can deliver care closer to home

5 *Case Study 1: A model of care for mental health*

Crisis support

Carol is a 34 year old lady who has suffered from Bipolar Affective Disorder since she had her first child. She has 3 children aged 12, 7, and 3 years old. She lives with them and her partner. When younger she had episodes where she felt elated and hyperactive but these days her illness means that she feels depressed most of the time. She struggles to motivate herself to get out of the house. She is on a lot of medication and worries about the effect this is having on her body. Sometimes her moods become so bad that she feels like killing herself and she has had to be admitted to hospital. However this in infrequent and she had only had two admissions in the last 10 years. Carol is very reliant on the support she gets from the Community Mental Health Team. She has noticed that her community nurse, Peter, and her Consultant psychiatrist both seem much busier these days and she is not able to see them as often as she would like.
In the past few weeks Carol has been feeling very low and has started to think it might be better if she wasn't here

Current -Carol has told Peter how she feels and he has increased his visits to see her. He has asked the Community Home Treatment Team to be involved. Carol feels supported throughout the day but things are much worse at night. She can't sleep and feels she has no-one to turn to when she wakes in the night. She calls the emergency contact number and talks to a nurse on the ward. The nurse listens and is supportive. However carol feels she has to tell her story all over again and she is worried the nurse has other work she should be doing so she hangs up. Things are so bad that she takes an overdose and ends up admitted to hospital

After redesign – As well as support throughout the day there is now a 24 hour Community Home Treatment Team. They give Carol a number to call if she becomes afraid in the night and when she calls the nurse knows about her case and what has been happening recently. She is able to calm Carol and arrange to see her first thing in the morning. Carol feels at the end of her tether and to have a break "from life" she ends up at the local crisis house for a couple of nights. After 2 days she feels well enough to return home and resume her parenting role and continue to be supported by her CMHT.

Carol is given the number for a Talking Therapies, Crisis Café and Recovery College that she can visit for additional group support.

Case Study 2: A model of care for mental health

Dementia outreach service

Mr Joseph is a 75 years old elderly gentleman with a diagnosis of an Alzheimer's Dementia of moderate severity (known to Memory Clinic). He has deteriorated rapidly in his mental state and has become agitated and aggressive towards others (family) especially on intervention. His wife contacts the GP stressing that she requires extra support but desperately wishes to keep him at home for as long as possible.

Currently: Due to the degree of his acute presentation he is admitted to an inpatient ward. He becomes more distressed due to the change in environment and change in people who he is not familiar with. We establish that his abdomen is heavily distended and he is acutely constipated. He is treated successfully and has a good bowel movement in the next 24-48 hours. His presentation settles. No further agitation / aggression is reported, however he ends up developing Pneumonia and spends some time on the medical ward. He has a fall and sustains a fracture to his wrist. He is eventually discharged home with a care package 3 months later.

After redesign: With the development of the Dementia Outreach Service – professionals will be able to visit him in his own home and complete a thorough assessment. They can liaise with the GP and work with the multi-disciplinary team in managing his relapse. They treat his underlying constipation and he settles. The above medical complications can be avoided by simply having this service – where staff from the dementia outreach service are going out to see him in his own familiar surroundings.

4.4 Options for service delivery

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 we considered:

- 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 patients in response to user feedback

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

In Options 4a, 4b, 5, 6 and 7 the Millbrook unit would close and in patient services re -provided elsewhere

Once complete, a stakeholder panel undertook an options appraisal exercise to identify the pros and con of each long listed option. In doing this we considered the:

- need to deliver clinically safe and sustainable services;
- need to offer services that are acceptable to users;
- ambition to improve clinical outcomes;
- need to reduce the system cost pressure whilst enhancing services available;
- potential to utilise existing provider estates;
- use of alternative providers to reduce travelling for patients and carers; and
- need to increase choice through a range of service and treatment options.

In order to assess each option a set of criteria were developed against which people could score against the set benefit with 1 being the lowest and 5 the highest. The patient acceptability criteria was developed using feedback from the patient engagement events whereas clinicians determined the quality, sustainability and safety criteria.

The full pack (scoring sheet and long list of options) can be seen at appendix 4. 47 scoring packs were sent out to clinicians, managers and the project team and 26 completed sets were returned. Of the 26 returned there was an even split between clinical and non- clinical responses. The results of the scoring can be seen in the table below

Table 3: Results of the non- financial scoring of options

Option	Non-Financial Criteria Scores
Option 1	493
Option 2	516
Option 3	964
Option 4a	1,074
Option 4b	979
Option 5	832
Option 6	860
Option 7	824

4.5 Financial gateway

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

The results of this assessment was that only options 1, 4a and 4b passed the financial gateway.

Therefore the project group determined that the options to take forward to consultation are as follows

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 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.

However it is recognised that whilst option 1 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 care services, in order to maintain, in the longer term, safe services.

4.6 Sensitivity test

While both the weighting applied to each benefit and the scores attributed were determined by stakeholders, it is recognised that the concerns of stakeholders vary significantly. It was agreed that sensitivity testing should be undertaken. This is a means of scrutinising what the effect would be of applying different weights to the benefits and will determine the level of confidence the project team has in the ranking of options.

It was agreed that the sensitivity test should include;

- **Sensitivity Test 1:** Applying an equal weight to all options. This removes any possibility that weighting favoured particular benefit disproportionately. Thus each weight is given an equal score of 2.

- **Sensitivity Test 2:** Lowering the weight applied to weighting applied to affordability by one point from 3 to 2, and increasing the weighting applied to patient acceptability from 2 to 3. This is to demonstrate that the exercise is not finance led and that the views of patients have been taken into consideration.

The sensitivity test does not alter the overall outcome of the evaluation of options. Both sensitivity test 1 and 2 both result in Option 4a scoring the highest followed by Option 4b.

4.7 Impact of options 4a and 4b on Travel for patients and carers

With the development of highly specialised services such as stroke, cardiac and trauma, the development of networked services aims to provide access 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.

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.

There are currently approximately 305 patients who would need to travel further to get to Bowmere than if travelling to Macclesfield shown below by CCG:

Table 4: Table showing number of patients travelling further	
Name of CCG	**Number of People**
NHS EASTERN CHESHIRE CCG	176
NHS SOUTH CHESHIRE CCG	118
NHS VALE ROYAL CCG	11
Grand Total	305

For these patients and their carers this will mean additional travel as outlined below

Table 5: Table showing the additional miles if services move to Bowmere			
Town	**Distance (miles) to Macclesfield**	**Distance (miles) to Chester**	**Additional miles**
Macclesfield	1	41.9	40.90
Crewe	20.7	26.5	5.80

The project team undertook further work in response to patient and public concerns looking at the logistics of traveling to Bowmere particularly in relation to public transport and is summarised in the table below.

Table 6: Table showing the available modes of transport if services move to Bowmere			
From and To	**Mode of Transport**	**Time (one way)**	**Approx cost return**
Macclesfield to Chester	Bus	3.30 minutes	£5.50
Crewe to Chester	Bus	1.30	£5.50
Macclesfield to Chester	Train	1.30	£12 – 21

Crewe to Chester	Train	23 minutes	£7 – 12
Macclesfield to Chester	Car	51 minutes	£12 - 20
Crewe to Chester	Car	36 minutes	£8 - 12

In the majority of cases if travelling from towns in Cheshire East it isn't possible to do the whole journey by bus in the same day if existing visiting hours remain later in the day.

Plans are being developed to minimise impact for patients and carers include:

- 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

A more detailed travel analysis is available in appendix 5

4.8 NHS System Impact

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. 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.

The system partners across Vale Royal, South 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.

4.9 Patient transport and place of safety

NWAS state when services are provided out of Cheshire to busy towns, cities and hospitals, this reduces the number of vehicles able to respond to 999 calls within the Cheshire footprint

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. NWAS also provide Urgent Care Services for planned work between hospitals. Patient Transfer Services are commissioned through West Midland Ambulance Service.

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 NWAS, 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 of 'places of safety' supported by competent and timely assessment and treatment.

5.0 Capacity and Workforce plan

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.

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 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.

We believe 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.

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 services. This would be managed through existing HR processes and procedures.

5.1 Modelling capacity and workforce plan linked to finance

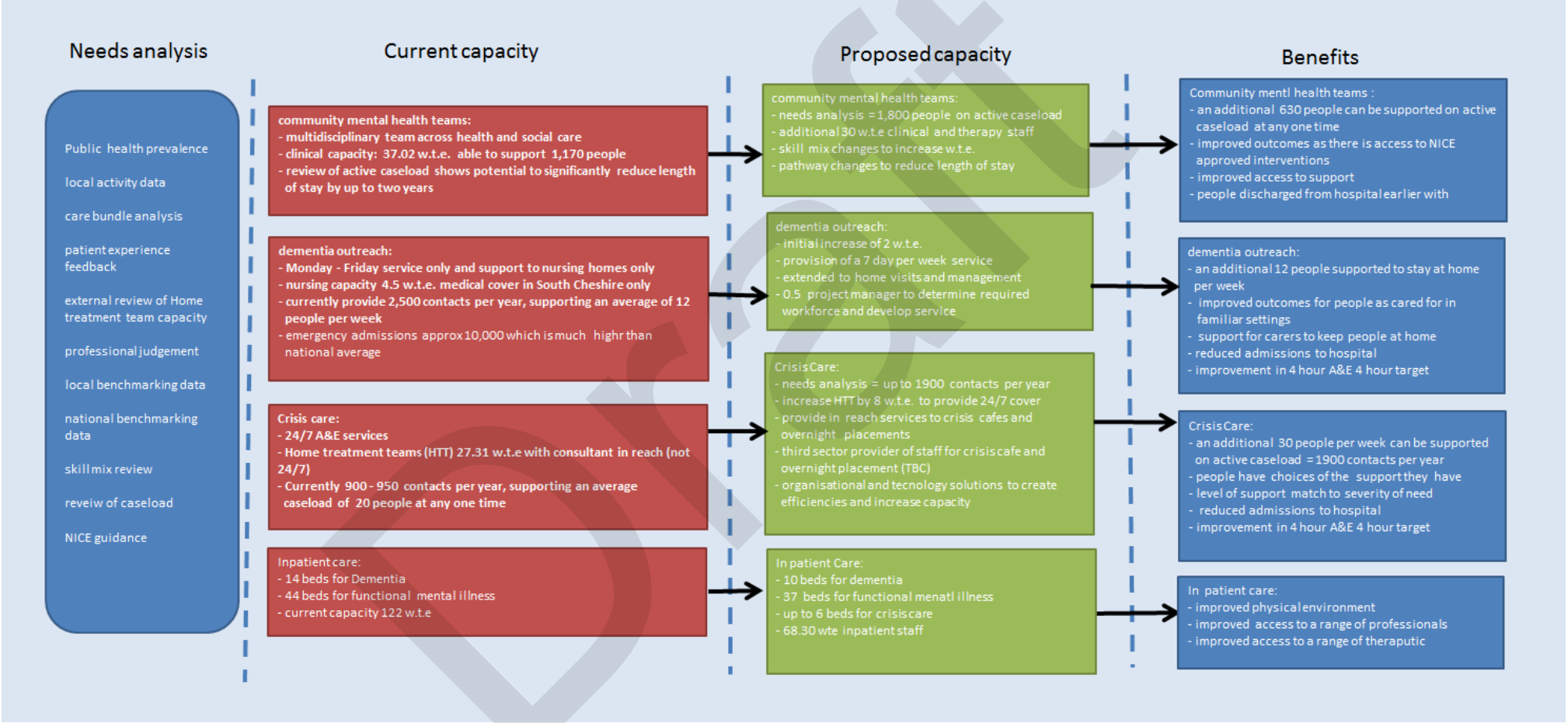
Using the needs analysis as a baseline in relation to numbers and evidenced based pathways of care to determine what people needed in relation to care and support, capacity requirements were modelled. The skill mix of staff was determined by patient needs for a safe and effective service. The cost modelling work was undertaken in parallel and determined by the skill mix and numbers required. The workforce plan is presented in summary in Diagram 4 below and in detail at appendix 6

The results represent a starting position against which future developments can be delivered. It describes the community and crisis response which will deliver improved outcomes for patients and reduce the over reliance on inpatient services.

According to national 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 review of working practices shows that people can stay on active caseload for up to two years longer than required and should be discharged back into the care of the GP.

Diagram 4 shows the link to demand and the difference in capacity generated by new ways of working and enhancement. It describes how changes will deliver improved outcomes for patients and carers.

Diagram 4: Capacity and workforce plan



6.0 Finance

The local health and social care system is showing a deteriorating financial position. The cost of the current adult and older peoples mental health service configuration exceeds the funding available and change is required for the local NHS to operate within mandated financial controls.

As a consequence of the limited community resources the level of service in Vale Royal South and Eastern Cheshire has more of a focus on inpatient services when compared with CWP's model on the Wirral and in Western Cheshire. Additionally the Millbrook facility is CWP's least good inpatient environment and results in additional costs being incurred to ensure safe services.

Both the current service model in Vale Royal, South and Eastern Cheshire, and the financial position, are unsustainable.

In the current financial environment it is not expected that new funding will be identified to meet the shortfall identified or provide funding for community services. The aim of this redesign programme is to both enhance the community and crisis care provision and help close the financial gap through a redirection of existing funding

Without the proposed redirected investment in community services the dependency on the current bed configuration will continue and the service delivery and financial risks associated with these services will continue to grow.

From a financial perspective, the optimal option, 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 the Five Year Forward View and the surplus expected by regulators. A detailed cost analysis on long listed options is available at appendix 7

7.0 Risks and mitigation plan

Table 7: Risk mitigation plan			
	Risks	**Impact**	**Mitigation**
Consultation	There is a risk that the Pre Consultation Business case won't be approved.	• Impact the ability to deliver the strategic changes required as set out by the Mental Health 5 year forward view.	• Engagement with OSC and organisational Boards/Governing Bodies throughout the process. • Pre consultation engagement events to inform preferred options • Follow NHSE process for service redesign • CWP to evoke business continuity plans pending decisions on next steps •
Patient Acceptability	Lack of public support for options	• Options 4a and 4b would result in some people having to travel further should a period of inpatient care be necessary	• Work with third sector organisations to provide short term support for travel • Agree flexible visiting times to enable people to visit during the day • Use of technology to support contact e.g. skype, face time • Minimise length of stay in hospital through enhanced community services
Delay in Consultation	There is a risk that the consultation process may be delayed if the Pre Consultation Business case is not approved	• Impact on staffing numbers. • Clinical risks not addressed • Recruitment continues to be difficult during period of uncertainty • Sustainability of services •	• CWP to evoke business continuity plans. • Regular communication with staff • Clinical leadership across system to identify measures to maintain quality of care • Monitoring of key safety indicators to highlight increasing risks • Continue active recruitment to all vacant posts

Clinical Risks	There is a risk to service sustainability during the planning and consultation phase	• Unable to recruit and retain staff due to uncertainty • Increase in un-planned staff absences • Increase in caseloads in community teams • Longer response and waiting times in the community • Occurrence of out of area admissions to other Trusts • Increase in avoidable harm incidents	• CWP to evoke business continuity plans. • Regular communication with staff • Clinical leadership across system to identify measures to maintain quality of care. • Monitoring of key safety indicators to highlight increasing risks
Reputational and Organisational	There is a risk to the project from Negative media coverage.	• Public consultation outcome influenced by negative coverage	• Development of a communications and engagement strategy • Fully engage public in pre consultation and consultation events • Engagement with media to establish relationship

8.0 Next Steps

8.1 Public consultation strategy

The public consultation will be for a 12-week period and will be a comprehensive process involving six public meetings across the major towns in Eastern Cheshire, South Cheshire and Vale Royal.

In addition offers will be made to attend local community meetings such as mental health forums, Age UK, Alzheimer's Society etc.

A comprehensive Equality Impact Assessment has been conducted that will guide our approach to formal consultation, ensuring that we target groups that will be directly and indirectly affected by the proposals – and that we produce information in different formats and made available in different places that are convenient and accessible for different people, including those with protected characteristics.

To enable people to understand the rationale for change and give full consideration to the options, information will be shared via a number of channels, these include:

- A public consultation booklet in plain language that clearly sets out the reasons for change and the options the public are being asked to comment on, including details of public meetings and ways to find out more information and feedback views. It will feature a freepost survey to complete and return;
- An online version of this booklet will also enable people to share their views via a simple online survey;
- Further hard copy information including posters and flyers signposting people to the public meetings and website, distributed widely in:
    - CWP services, including the Millbrook Unit where volunteers will support an information hub throughout the 12-week consultation period;
    - GP surgeries;
    - Macclesfield and Leighton general hospitals;
    - Other NHS and public sector premises, including libraries; and
    - Voluntary sector premises
- Where possible the use of messages on information screens in hospital and GP surgeries will also be utilised;
- There will be a dedicated website page to act as a hub of online information;
- We will seek to engage with local media outlets (local newspapers and radio) as well sharing information via NHS and local authority websites and social media channels;
- Dedicated staff events and drop-in sessions in Eastern Cheshire, South Cheshire and Vale Royal will continue during the formal consultation period;
- All CWP members and staff in Eastern Cheshire, South Cheshire and Vale Royal will be invited to give their views;
- A dedicated phone number will be available throughout the 12 week period for people with any queries about public meetings or getting copies of the consultation document; and

- In addition, the Patient Advice and Liaison Service at commissioners and CWP will support service users and carers with specific concerns raised as a result of the consultation during this time.

We will engage an independent organisation to receive feedback and conduct analysis of findings in order for the partnership to fully consider views put forward, before making a decision on next steps.

Any personal details provided will be treated in accordance with the Data Protection Act and will not be used for any other purpose. We will also establish robust methods of recording stakeholder comment directed at partners during this period, to ensure we can channel all feedback into the final report.

8.2 Reporting and decision-making

The independent analysis of feedback on the consultation will be reviewed by a range of organisations before any decisions are made on the way forwards:

- CWP's Trust Board;
- Eastern Cheshire CCG's Governing Body;
- South Cheshire and Vale Royal CCG's Governing Body;
- Cheshire East Council's Adult Health and Social Care Overview and Scrutiny Committee; and
- NHS England's Assurance Process.

The partners are committed to communicating the outcome of the consultation and what will happen next and ensure the continued involvement of service users, carers, staff and partners during implementation of any changes.

Appendix 1

Membership Groups

Adult Mental Health Project Team	
Ian Hulme	GP Mental Health Clinical Lead
Jacki Wilkes	Sponsor
Suzanne Edwards	Service Director CWP
Sadia Ahmed	Consultant CWP
Sally Sanderson	Service lead CWP
Marie Ward	Transformation Project Manager
Elizabeth Insley	Finance Lead
Robert Walker	Expert by Experience
Jamaila Tausif	South Cheshire Lead
Nicola Glover Edge	Director, Cheshire East Council
John Loughlin	Project Manager CWP
Katherine Wright	Comms and Engagement CWP
Scott Maull	Finance Lead CWP
Charles Malkin	Comms and Engagement ECCCG
Amanda Graham	ECCCG PMO
Clinical Advisory Group	
Kate Chapman	Matron CWP
Jane Tyrer	Therapy Lead CWP
Sabu Oomman	Consultant CWP
Sadia Ahmed	Consultant CWP
Anushta Sivananthan	Medical Director CWP
Teresa Strefford	GP Mental Health Clinical Lead
Philip Goodwin	GP Mental Health Clinical Lead
Ian Hulme	GP Mental Health Clinical Team
Zoe Ball	Clinical pychologist
Options Appraisal Scoring - additional support	
Andrew Smith	Cheshire Police Mental Health Liason
Carol Robertson	NWAS - East Cheshire
Julia Cottier	Service Director CWP
Tracy Parker Priest	Director Vale Royal and South CCG
Julia Huddart	GP
James Milligan	GP
Mike Clark	GP
Julie Sin	PH consultant
Site Visits	
Phil Jarrold	Expert by Experience
Mike Heald	Expert by Experience
Robert Walker	Expert by Experience
Marie Ward	Transformation Project Manager
John Loughlin	CWP Estates

Appendix 2

Communication and Engagement Strategy

Eastern Cheshire, South Cheshire and Vale Royal Adult Mental Health Services

Communications & Engagement Strategy to Support Pre-Consultation and Consultation

Dated 17th November 2017

Version 1.9

Version	Comments	Date
1.0	First draft of document shared with NHS Eastern Cheshire CCG and Cheshire & Wirral Partnership Foundation Trust (CWP) for comments and amends.	10/10/2017
1.1	Amends and comments received from Eastern Cheshire CCG and CWP, further draft updated and shared within CSU teams for further work and development.	11/10/2017
1.2	Further draft updated and shared within CSU teams for further work and development.	12/10/2017
1.3	Amends completed and shared with NHS Eastern Cheshire CCG, CWP, NHS South Cheshire CCG and Vale Royal CCG for comments and amends.	23/10/2017
1.4	Amends completed and shared with NHS Eastern Cheshire CCG, CWP, NHS South Cheshire CCG and Vale Royal CCG for comments and amends.	31/10/2017
1.5	Amends completed and shared with NHS Eastern Cheshire CCG, CWP, NHS South Cheshire CCG and Vale Royal CCG for comments and further amends.	9/11/2017
1.6	Amends completed and shared with NHS Eastern Cheshire CCG, CWP and NHS South Cheshire and Vale Royal CCGs for comments and amends.	10/11/2017
1.7	Amends completed and shared with NHS Eastern Cheshire CCG, CWP, NHS South Cheshire CCG and Vale Royal CCG	13/11/2017
1.8	Amends completed and shared with NHS Eastern Cheshire CCG, CWP, NHS South Cheshire CCG and Vale Royal CCG	14/11/2017
1.9	Amends completed and shared with NHS Eastern Cheshire CCG, CWP, NHS South Cheshire CCG and Vale Royal CCG	17.11.17

Contributing partners include; Cheshire and Wirral Partnership NHS Foundation Trust, NHS Eastern Cheshire Clinical Commissioning Group, NHS South Cheshire Clinical Commissioning Group and NHS Vale Royal Clinical Commissioning Group

Contents

1.0 Introduction

This document sets out the approach to the communications and engagement supporting the Adult Mental Health Services Consultation for Eastern Cheshire, South Cheshire and Vale Royal. The partners involved in the re-configuration are:

- Cheshire and Wirral Partnership NHS Foundation Trust (CWP)
- NHS Eastern Cheshire Clinical Commissioning Group
- NHS South Cheshire Clinical Commissioning Group
- NHS Vale Royal Clinical Commissioning Group

It is recognised that the population served by the Adult Mental Health Services falls within the two Council footprints of Cheshire East and Cheshire West and Chester and that they are a key stakeholder to be addressed in the development of this work.

2.0 Background

Thousands of people of all ages with acute or long term chronic mental health conditions are supported each year in Cheshire within hospitals and outpatient clinics, as well as in people's homes.

Most people access mental health services in the community, either via primary mental health services e.g. Improving Access to Psychological Therapies services (IAPT) or specialist community mental health services.

Specialist community mental health services include:

- Adult community mental health services
- Older adult community services
- Early intervention team
- A home treatment team which operates daily between 8am and 9pm
- Street triage
- Recovery colleges
- Liaison Psychiatry within local hospital NHS trusts
- Mental health rehabilitation services

CWP is the main NHS mental health provider in Cheshire. In the most recent inspection by the Care Quality Commission (CQC), CWP was rated as an organisation as 'good' overall and 'outstanding' for caring. CWP provides inpatient mental health services for adults and older people in three locations in Cheshire and Wirral – Bowmere Hospital, Chester; Springview Hospital, Wirral; and the Millbrook Unit, Macclesfield, as well as the range of community services described above (with the exception of IAPT services in Eastern Cheshire, which are provided by another service provider).

Inpatient services for residents in Eastern Cheshire, South Cheshire are currently delivered at the Millbrook Unit which provides 44 inpatient beds for people with mental illness and 14 beds for people living with dementia. Inpatient recovery and assessment services are delivered from nearby Limewalk House, Macclesfield. For residents who live in the Vale Royal area, inpatient services are delivered at Bowmere Hospital.

2.1 The Challenge

The NHS is committed to improving services for people with mental ill-health in Eastern Cheshire, South Cheshire and Vale Royal.

In order to do this we face two main challenges:

- to improve outcomes in the face of increasing demand for mental health services; *and*
- to achieve this within available financial resources.

In order to improve overall outcomes for people we aim to improve four key areas in line with the Mental Health Five-Year Forward View and local best practice:

- Community mental health services.
- The inpatient environment.
- Access to psychiatric intensive care.
- Physical health outcomes.

3.0 Communications, Engagement and Consultation

Section 14 (Z2) and 13 (Q) of the Health and Social Care Act require the involvement and engagement of the public and stakeholders in the formulation and planning of service change proposals. Section 244 of the NHS Act 2006 also includes the duty to consult the relevant local authority in its health scrutiny capacity.

NHS England provide guidance on how to fulfill the statutory requirements surrounding service change in their publication: “Planning and delivering service changes for patients – a good practice guide for commisioners on the development of proposals for major service changes and reconfigurations”. They also provide further guidance on ensuring appropriate involvement of patients and the public in service change: ‘Transforming Participation in Health and Care’ and the recent ‘Engaging Local People in Sustainability and Transformation Plans’.

Our approach to pre-consultation and planning for full public consulation has been based on this guidance. Central to an effective strategy is to ensure that service change communications are appropriate and accessible to meet the needs of diverse communities; and that patients and the public are involved throughout the development, planning and decision making of proposals. This includes early involvement with local Healthwatch organisations and the local voluntary sector.

Involvement activity around developing and presenting our proposals aims to:

- Be proactive to local populations
- Be accessible and convenient
- Take into account different information and communication needs;

and

- Be clinically led, to ensure that clinicians are driving any changes for the benefit of service users and carers.

3.1 How we will communicate and engage

Our guiding principles are to ensure that the communications and engagement relating to potential service change, is both within statutory requirements and allows the public to understand the changes being proposed, are to:

- Provide honest, simple and accessible information at appropriate stages of the process to enable people to influence plans;
- Establish clear messages on why change is needed, what the process for change is, and what that change will involve at each significant milestone;

- Deliver messages consistently and tackle mis-information quickly and effectively;
- Ensure that relevant stakeholders are engaged and reach out to groups with protected characteristics to ensure they have equal opportunity to influence change and are informed about any change to services and how to access them.

3.2 Communication Aims and Objectives

We will deliver a consultation based on best practice principles, which is founded on the commitment to inform and listen. We will work with our stakeholders to deliver key consultation work and to analyse the results to ensure an objective outcome. We will use a mix of qualitative and quantitative methodologies to allow for both volume and richness of response.

To help us achieve this, we have the following three high-level objectives:

- To ensure that the consultation process is transparent and that it meets its statutory requirements through sufficient inclusiveness, breadth and depth.
- To provide sufficient opportunity for existing and former service users, and their carers, to have their say in shaping options for consultation by delivering pre-consultation events in an open and honest manner.
- To create a significant and meaningful amount of engagement with local stakeholders, and to provide evidence of this.

3.3 Stakeholders

The following provides a list of key stakeholders from which the communications and engagement can be planned. This list will be continuously reviewed and added to, as and when new stakeholders are identified.

Type	**Stakeholders**
Clinical Commissioning Group (CCG)	NHS Eastern Cheshire CCG NHS South Cheshire CCG NHS Vale Royal CCG
Clinical	GP Practices GP Alliances and Federations Secondary care clinicians Mental health clinicians
Councillors	Cheshire East Council
Health and wellbeing board	Cheshire East Health & Wellbeing Board
Local Authority	Cheshire East Cheshire West and Chester (for information purposes re Vale Royal) Social services Police Fire & Rescue Service
Media	Local and regional media outlets – please see Appendix E for full details
MPs	Cheshire East MP for Vale Royal area
OSC	Cheshire East OSC
PALS, Complaints and FOIs	NHS Eastern Cheshire CCG NHS South Cheshire CCG Vale Royal CCG

	CWP East Cheshire NHS Trust Mid Cheshire Hospitals NHS Foundation Trust
Staff	CCGs CWP
Trusts	CWP East Cheshire NHS Trust Mid Cheshire Hospitals NHS Foundation Trust
Voluntary and third sector	For example Healthwatch, Eastern Cheshire HealthVoice, local charity groups, community groups etc. For full list of stakeholders, please see Appendix D

4.0 The Approach

4.1 Pre-consultation Engagement

Service user, carers and staff views have been integral to development of the Pre-Consultation Business Case; including the options appraisal process.

Engagement has taken place from 2016 up until October 2017 as outlined below.

4.1.1 CWP Initial engagement (2016)

CWP held patient and carers workshops at the Millbrook Unit and the Macclesfield Recovery College, as well as a series of briefings and drop-in sessions for frontline staff towards the end of 2016. At this time CWP also engaged with Healthwatch Cheshire East, Cheshire East Health Voice 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.

The main themes from CWP's pre-consultation engagement were:

- Ensuring that community services were sufficiently resourced to support people earlier on to enable early intervention, prevention and thereby preventing unnecessary inpatient admissions
- Concerns about the travel implications of any potential relocation of inpatient services for people who access services and their carers - particularly the older population
- An awareness of the challenging financial conditions
- Queries regarding why a new inpatient facility could not be built
- Acknowledgement among people accessing services that the Millbrook Unit does not meet the environmental standards required for modern mental health practice
- Recognition for the care provided by the mental health teams at the Millbrook Unit despite the building limitations
- More support is needed with rehabilitation, housing and finding a job.

4.1.2 NHS South Cheshire CCG and NHS Vale Royal CCG Engagement (2016)

NHS South Cheshire CCG and NHS Vale Royal CCG have engaged over the last 12 months with their population in regard to the 5 Year Forward View as well as the future of mental health services.

Jointly with CWP from Jan-June they held a number of workshops around early intervention models through a newly developed Mental Health gateway service.
They also have patient feedback from the provider through contract meetings, and, through

their clinical commissioning executive and GP membership meeting they gained further feedback from GPs.

Over the past 12 months, engagement work saw over 100 service users and carers, CWP staff, and providers from across the local health and social economy including third sector agencies, involved with events and surveys, with the majority of responses focused largely on secondary care services.

The process of engagement included the following;

- Information about proposals for the mental health gateway, discussions around access to services, choice and the process of assessment
- a mental health focused questionnaire included in the 'Cheshire Chat' event and
- A focus on mental health crisis services.

From this engagement, the following themes were identified under the headings – what works well, what could be improved and how does crisis care work;

- Concerns around communication i.e between providers and patients, friends and family etc
- Concerns around access to services i.e wanting services and support closer to home, meeting thresholds, access to appointments out of office hours
- Concerns around attitudes and knowledge i.e a stigma and lack of awareness in primary care
- The following were listed as some of the top 3 priorities for crisis care;
    - Support for carers and family, especially providing support for people at home
    - Access to treatment quickly and
    - Consistent follow up appointments after a crisis event.

This feedback has helped inform the Pre-Consultation Business Case. For full report on this activity, please see Appendix F.

4.1.3 Engagement by the Joint Project Team: Second Phase Pre-engagement (2017)

Having accepted CWP's case for change, commissioners have led the partnership project to produce a pre-consultation business case since the Spring of 2017. As a partnership, commissioners and CWP held listening events in September 2017 at Crewe Alexandra FC and Macclesfield Town FC. Approximately 50 people attended the events, the majority of whom were service users and carers. A full summary of the event workshop is outlined in Appendix A and further information is provided below

4.1.4 Event Aim & Objectives

Aim

To gather feedback from service users, carers and other stakeholders which can be used to inform the development of a new service model and the options appraisal process.

Objectives

- To understand users' and carers' experiences of adult mental health services across the Eastern Cheshire, South Cheshire and Vale Royal areas. What has worked well, what has not worked well; what we can do differently and better.

- To understand the perception and experiences of key stakeholders who are familiar and/or work with adult mental health services across the Eastern Cheshire, South Cheshire and Vale Royal areas.
- To gauge understanding of and appreciation for the case for change
- To explore views and opinions to shape the development of a new service model (Community Care, Crisis Care and Inpatient Care). Specifically what should it look like? What is missing? How can it be improved?

To understand what is important to service users and carers (in the broadest sense of the term including wider stakeholders) when producing a shortlist of proposals.

Table-based discussions gave participants an opportunity to describe what had worked well for them, what had not worked well and how services might be improved.

The event was structured and feedback was provided on the following areas:

- Experiences of using mental health services.
- Understanding of the importance of the reasons for change
- Views on the future of mental health services around the specific areas of: crisis care, inpatient care and community care.
- Rating the criteria which will inform the possible scenarios for mental health services.

Feedback was provided within each of these areas through a mix of both qualitative and quantitative feedback.

4.1.5 Analysis of Findings: Summary

The main themes from the events were as follows (a full analysis of the event is available in appendix B):

- Support for the case to change
- Calling for more 'personalised' care
- Calling for more support in community
- Local services were important to people
- Travel times for carers were important
- Calling for more support when in crisis – specifically:
    - One point of contact for services / clear access points
    - Care available quickly e.g. 24/7 care which is not A&E
    - Support available at different places: home setting/ safe houses/ day centre.

Views expressed have directly informed the development of the long list of options, and the options appraisal process – specifically informing the public acceptability criteria and also feeding into further thinking on options development and appraisal.

4.2 Public Consultation Strategy

The public consultation will be for a 12-week period and will be a comprehensive process involving six public meetings across the major towns in Eastern Cheshire, South Cheshire and Vale Royal, held at different and accessible times for the local community.

In addition offers will be made to attend local community meetings such as mental health forums, Age UK, Alzheimer's Society etc.

A comprehensive Equality Impact Assessment has been conducted that will guide our approach to formal consultation, ensuring that we target groups that will be directly and indirectly affected by the proposals – and that we produce information in different formats and made available in different places that are convenient and accessible for different people, including those with protected characteristics.

To enable people to understand the rationale for change and give full consideration to the options, information will be shared via a number of channels, these include:

- A public consultation booklet in plain language that clearly sets out the reasons for change and the options the public are being asked to comment on, including details of public meetings and ways to find out more information and feedback views. It will feature a freepost survey to complete and return;
- An online version of this booklet will also enable people to share their views via a simple online survey;
- Further hard copy information including posters and flyers signposting people to the public meetings and website, distributed widely in:
    - CWP services, including the Millbrook Unit where volunteers will support an information hub throughout the 12-week consultation period;
    - GP surgeries;
    - Macclesfield and Leighton general hospitals;
    - Other NHS and public sector premises, including libraries;
    - Voluntary sector premises.
- Where possible the use of messages on information screens in hospital and GP surgeries will also be utilised;
- There will be a dedicated website page to act as a hub of online information;
- We will seek to engage with local media outlets (local newspapers and radio) as well sharing information via NHS and local authority websites and social media channels;
- Dedicated staff events and drop-in sessions in Eastern Cheshire, South Cheshire and Vale Royal will continue during the formal consultation period;
- All CWP members and staff in Eastern Cheshire, South Cheshire and Vale Royal will be invited to give their views;
- A dedicated phone number will be available throughout the 12 week period for people with any queries about public meetings or getting copies of the consultation document;
- In addition, the Patient Advice and Liaison Service at commissioners and CWP will support service users and carers with specific concerns raised as a result of the consultation during this time;
- Communication to GP Practices will take place within the CCG areas via bulletins and newsletters.

We will engage an independent organisation to receive feedback and conduct analysis of findings in order for the partnership to fully consider views put forward, before making a decision on next steps.

Any personal details provided will be treated in accordance with the Data Protection Act and will not be used for any other purpose. We will also establish robust methods of recording stakeholder comments directed at partners during this period, to ensure we can channel all feedback into the final report.

4.2.1 Stakeholder Communication

We will engage with stakeholders in advance of the consultation go live date; to inform them of the rationale and options to be presented to patients and public audiences, and the channels that will be used.

Communication will take place via the following methods:

Clinical Communications

- Briefing note to GP Alliance leads
- Briefing via GP newsletters to GP Practices
- Letter to all GP practices from the Lead Commissioner
- Briefing to secondary care clinicians, including regular briefings for CWP staff both face-to-face and written briefings.

Acute Care

Letter from the Lead Commissioner to Chief Executives outlining the consultation background and approach and commencement date.

Health Overview & Scrutiny Committees

Engagement will take place via face to face briefings and presentation at OSC meetings.

Councillors

Briefings will be provided to councillors across the Cheshire footprint, in advance of the consultation commencing.

Health & Wellbeing Boards

The Lead Commissioner and appropriate CCG will brief the H&WB Boards at a face to face meeting.

PALS and Complaints Teams

A briefing will be provided to CCG and Acute Trust PALS and Complaints / FOI teams to enable them to effectively respond to queries or to direct queries to the Lead Commissioner.

Neighbouring CCGs

A briefing will be provided to neighbouring CCGs to inform them of the consultation process and the appraoch to be taken, with timelines and channels to be used.

Voluntary & Third Sector

Briefings will be provided to relevant voluntary and third sector organisations in advance of the consultation start date.

A local campaign group ‘Do You Mind’ is running an online petition which has gathered the support of 2,805 people calling for a number of actions around mental health, including retaining inpatient services in Macclesfield and increased funding for mental health.

The project team has met with the group during pre-consultation and has 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.

4.3 Reporting and decision-making

The independent analysis of feedback on the consultation will be reviewed by a range of organisations before any decisions are made on the way forwards:

- CWP's Trust Board
- NHS Eastern Cheshire CCG's Governing Body
- NHS South Cheshire CCG's Governing Body
- NHS Vale Royal CCG's Governing Body
- Cheshire East Council's Adult Health and Social Care Overview and Scrutiny Committee
- NHS England's Assurance Process

The partners are committed to communicating the outcome of the consultation and what will happen next and ensure the continued involvement of service users, carers, staff and partners during implementation of any changes.

5.0 Media

Local media interest is high with the result that some inaccurate articles have been printed. Media lines to take are agreed (see Appendix C) and will be revised throughout the process. All partners will take a proactive approach to working with the local media to inform and engage on the stages of the consultation process and will operate within a joint protocol adhering to SMART principles.

It is recognised that the media are a key communications channel for the local population and that the messages need to be correct in order to reduce incorrect articles which lead to confusion and inaccuracy. With that in mind, a media planner will be implemented to support the consultation process

5.1 Proactive communications

The proposed consultation survey and public events will be promoted across partners' external communications channels at the earliest opportunity and again at periodic intervals, as appropriate, throughout the consultation process.

Consultation findings and consequent actions will also be communicated proactively. Channels will include print and broadcast media, websites and social media. News releases will be complemented by paid-for advertising and by posters, flyers and an animation. Partners will use media monitoring software to measure advertising value equivalency, audience reach and sentiment and all coverage will be collated within a joint report.

5.2 Reactive communications

It is probable that the media, members of the public and key stakeholders including MPs and councilors will request information at various stages of the consultation process and during the period following consultation and preceding implementation of decisions. Every effort will be made to provide information to meet information request deadlines.

Any such requests will be responded to adhering to the joint media protocol. Requests for information under the Freedom of Information Act 2000 will be met by the relevant team of the partner receiving the request. Responses will be drafted in collaboration with the communications team of the recipient partner. Responses will be published in compliance with legislation.

5.3 Values

All communications, both proactive and reactive, will demonstrate transparency, openness, honesty and integrity.

5.4 Joint protocol

All communications will be authored by the communications and engagement teams of NHS Eastern Cheshire CCG, Cheshire and Wirral Partnership NHS Foundation Trust, NHS South Cheshire CCG and NHS Vale Royal CCGs, and quality assured by Midlands and Lancashire Commissioning Support Unit. A joint protocol is in place to guide approval of documents.

Appendices

Appendix A: Pre-Consultation Workshops

The workshops were designed to encourage interaction and engagement with the audience. An initial ice breaker 'quiz' which is based on mental health services acts as a warm up and also provides information on the services. The project lead then provided a presentation outlining the purpose of the event and then led into the interactive workshops, as follows:

Presentation from senior CCG lead and lead facilitator covering the following.

- What is a CCG and what are its responsibilities
- What the CCG is trying to achieve around adult mental health
- Where this event sits within the consultation process
- How the event is going to run/structure/governance

Workshop 1 – Your experiences

- Introductions at the table, who participants are sat with and the role of the facilitator
- Participant demographic profiling questionnaire.
- First activity explores their experiences of mental health services – specifically what's been good/strengths and what's been bad/weaknesses and challenges.

Workshop 2 – the case for change

- Conduct a case for change quiz. For each reason outlined in the case for change a simple multiple choice question was designed. Each question had 4 possible answers (A, B, C and D).
- Each table was asked to guess the correct answer and the lead facilitator then provided the correct answer
- At the end of this round a clinical expert from the CCG described the case for change in more detail.
- Each participant completed a questionnaire where they were asked 'to what extent do you understand the 'insert reason' from the case for change between 1 and 4 where 1 is understand and 4 is do not understand'.

Workshop 3 – the model for change

- Senior clinician/CCG member presented the model for change
- Each table discussed the model and each element of the model in turn. Their feedback will be used to feed into the options list.
- They were asked to think about how the model can be implemented. What should this look like, what is missing, how can it be improved.
- Each part of the model was the focus of a separate flipchart sheet (Community Care, Crisis Care and Inpatient Care).

Workshop 4 – how do we evaluate the options that we put together to implement the model

- Participants were given a list of the factors used to evaluate the options.
- They were discussed and explained.
- Participants were asked to rank them in terms of importance, both individually and as a table

Workshop 5 – Q&A

- Throughout the session participants were invited to post-it note questions on a large piece of flipchart paper.
- At the end of the session the clinical lead/CCG lead fielded the common questions.

Appendix B: Analysis of findings from Pre-Consultation Workshops

Please click below for PDF of findings

Appendix C: Media – key messages during pre-consultation

1. **Why is the NHS reviewing local adult mental health services?**
   NHS England has published a Mental Health Five-Year Forward View that challenges commissioners and providers of services to work together to redesign services so that people get high-quality, responsive care that allows them to get better quickly. There is evidence that timely support reduces the number of people experiencing crisis and requiring hospital care. By designing services in line with existing and projected demand, the aim is to provide affordable care that meets people's needs. The project involves NHS Eastern Cheshire Clinical Commissioning Group (CCG) NHS South Cheshire CCG, NHS Vale Royal CCG, Cheshire East Council and Cheshire and Wirral Partnership (CWP) NHS Foundation Trust, as main provider of the area's mental health services.

2. **Is it true that the Millbrook Unit is closing?**
   At this time, there are no proposals for the Millbrook Unit or any other element of adult mental healthcare in the area. Options for consultation will be informed by the needs of service users and carers as expressed during pre-consultation, and by clinical evidence, data on use of current services and financial information. A three-month public consultation is expected to start early in 2018 and will include an online survey and public events that give people plenty of chance to have their say. No decisions will be made until after the consultation has ended.

3. **What was the purpose of the pre-consultation events?**
   The listening events in Crewe and Macclesfield gave current and former service users, and their carers, an opportunity to express their needs and wishes. Interactive discussions encouraged participants to say what worked well, what did not work well, and how services might be improved. The events were attended by more than 40 service users and carers in total.

4. **Is this process all about saving money?**
   No. The aim is to ensure high quality and sustainable care that meets demand in a way that enables service users to get well quickly and then stay well.

5. **What happens next?**
   Workshop findings are informing the development of consultation options which will require approval by NHS England; Cheshire East Council's Health, Adult Social Care and Communities Overview and Scrutiny Committee; the Governing Bodies of NHS Eastern Cheshire CCG, NHS South Cheshire CCG and NHS Vale Royal CCG; and the CWP Board. A public consultation will then commence in the New Year for a three-month period. The findings of the consultation will be presented back to the above groups before any changes are implemented.
   ENDS

Appendix D – Third and Voluntary sector stakeholder list

Type	Name
Sport Groups	A variety of sports and community groups in the local area
Older people	Age UK Cheshire East
Voluntary	Always There Homecare
Condition Specific Group	Alzheimer Society
Community & Voluntary	Big Life Group
Condition Specific Group	British red cross
Misc	Buddies women's group
Misc	CAB - Congleton, Crewe, Knutsford, Macclesfield, Nantwich (mental health advocate)
Carers	Carers Trust
Carers	Carers Trust 4 all
Misc	CEC Parent Partnership
CEC Public Health	CEC Public Health
CEC	CEC Youth Service
Condition Specific Group	Central Cheshire Alcohol Services
Misc	ChAPS
Carers	Cheshire Carers Centre
Condition Specific Group	Cheshire Disability Federation
Carers	Cheshire East Parent Carer Forum
Condition Specific Group	Cheshire West Eating Support Team
SC & VR GP Alliances	Chief Executive of East Cheshire Hospice/ and managers Alliance
Misc	Crewe Women's Aid
Community & Voluntary	CVS Cheshire East
CWaC Parent Partnership	CWaC Parent Partnership
CWaC Public Health	CWaC Public Health
Forum	Do You Mind
Social Care	Director of Adult Social Care and Independent Living
Misc	East Cheshire Advocacy Service
SC & VR GP Alliances	GP - Ashfields Primary Care Centre - Sandbach
Voluntary organisation	Healthwatch
Forum	Eastern Cheshire Mental Health forum
Voluntary organisation	Eastern Cheshire HealthVoice
Misc	Homestart West Cheshire-Northwich
Condition Specific Group	Knutford GROW
Condition Specific Group	MENCAP Mid Cheshire
Condition Specific Group	Mental Health Re-ablement South
Condition Specific Group	MIND - Macclesfield, Winsford
Forum	Open Minds Forum
Community & Voluntary	Richmond Fellowship
Voluntary organisation	Samaritans Macclesfield
Community & Voluntary	SMILE
Misc	The Rossendale Trust
Misc	The Wishing Well Project

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Community & Voluntary	Travellers Voice
LBGT	UTOPIA @ The Hub Youth Support Service Crewe
Young people	Visyon
Misc	YMCA

Appendix E – Media list

Type	Outlet
Print	Cheshire Independent Chester Chronicle Congleton Chronicle (also Alsager and Sandbach titles) Crewe Chronicle Knutsford Guardian Macclesfield Express Norwich Guardian Wilmslow Guardian
Online	Alderley Edge and Wilmslow community websites So Cheshire Community website
Radio	BBC Radio Manchester BB Radio Stoke Canalside Radio Imagine FM Signal Radio Silk FM
TV	North West News

Appendix F –South Cheshire/Vale Royal Mental Health Gateway Engagement Report

Joint Report Template - MH Gatev

Appendix 3

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
National Benchmarking data

Mental Health Benchmarking.pdf

Dementia Diagnostic Rate Workbook
https://www.england.nhs.uk/publication/dementia-diagnosis-rate-workbook/
Public Health Data
Public Health Profiles

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%	

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	%age
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 Disorder secondary care activity only	Eastern Cheshire CCG	98	10,096	0.97%
	South Cheshire CCG	141	8,717	1.62%
	Vale Royal CCG	41	4,981	0.82%
Depressive	Eastern Cheshire	279	5,647	4.94%

Disorder secondary care activity only	CCG			
	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 patients' 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 to show needs analysis data mapped to 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 4

Final Scoring Options

1) Scoring Options Template (example)

2) Scoring Options Overview

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		
Description: In this option 58 beds are retained on the Millbrook Unit 44 for adults and 14 for older people. There would be no upgrading of the current facility and no enhancement of the community services or crisis care. ECT inpatient and day case would continue on the Millbrook site		
Benefit	**Pros**	**Cons**
Clinical safety and sustainability	Adequate inpatient capacity	Community teams unable to meet the needs of the local population with existing capacity and current service model Unable to provide a 24/7 response in the community for people experiencing crisis. Limited community response for people with complex needs. No onsite access to PICU resulting in service users not having timely access to the least restrictive environment.
Affordability		The cost of providing services from the Millbrook unit have been assessed by the provider as being £2,000,000 higher than that being recovered from the commissioners. Higher spend on inpatient compared to community with fewer people benefiting from inpatient care compared to community services. Higher levels of staff are required at a greater cost compared to other more fit for purpose mental health inpatient facilities. Net impact is system cost pressure of £2,000,000
Patient acceptability	No additional travelling for patients and carers	Lack of community support leads to unnecessary admissions and extended length of stay of up to 50% (local clinical snapshot audit). Shared bedrooms in Millbrook would continue to impact on individuals privacy and dignity. Users and carers have limited choice to the type of response to support them in a crisis.

Quality of care		Increased risk of breaching CQC requirements for mixed sex and single bedroom accommodation NICE guidance cannot be fully implemented within existing staff skill mix.
Strategic fit		The existing model of care is historical and not consistent with either national policy (five year forward view) or local integration plans as described in Connecting Care and Caring Together There is a lack of choice for crisis intervention and inadequate community capacity to support care closer to home

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)		
Description: In this option 58 beds are retained on the Millbrook Unit 44 for adults and 14 for older people. The unit would be upgraded to comply with CQC standards. There would be no enhancement of community or crisis services. ECT inpatient and day case would continue on the Millbrook site		
Benefit	**Pros**	**Cons**
Clinical safety and sustainability	Adequate inpatient capacity	Community teams unable to meet the needs of the local population with existing capacity and current service model Unable to provide a 24/7 response in the community for people experiencing crisis. Limited community response for people with complex needs. No onsite access to PICU resulting in service users not having timely access to the least restrictive environment. Refurbishment would result in a reduction in bed numbers without the enhancement of community services to offset the loss.
Affordability		The cost of providing services from the

		Millbrook unit have been assessed by the provider as being £2,000,000 higher than that being recovered from the commissioners. The capital cost of refurbishment is £14,000,000 paid at £560,800 per annum. Higher levels of staff are required at a greater cost compared to other more fit for purpose mental health inpatient facilities. Net impact would be system cost pressure of £2,500,000
Patient acceptability	No additional travelling for patients and carers Improved environment for service users	Lack of community support leads to unnecessary admissions and extended length of stay of up to 50% (local clinical snapshot audit) Users and carers have limited choice to the type of response to support them in a crisis.
Quality of care	Facility does comply with building guidance and the provision of single sex rooms with en-suite facilities	NICE guidance cannot be fully implemented within existing staff skill mix.
Strategic fit		The existing model of care is historical and not consistent with either national policy (five year forward view) or local integration plans as described in Connecting Care and Caring Together There is a lack of choice for crisis intervention and inadequate community capacity to support care closer to home

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)

Description: In this option 58 beds are retained on the Millbrook Unit. This would mean 44 for adults and 14 for older people. Community mental health teams would deliver interventions to enable safe care and have the appropriate skill mix to do so community teams would be able to provide a timely response to the current level of demand. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with overnight placement support and day time crisis cafe.

Benefit	Pros	Cons
Clinical safety and sustainability	Adequate inpatient capacity Increased community support	No onsite access to PICU resulting in service users not having timely access to the least restrictive environment.

	leads to reduced admissions and length of stay of up to 50% (local clinical snapshot audit). Staffing levels within community services mapped to meet the current level of demand Able to provide a range of responses in the community for people experiencing crisis. Community response for people with complex needs.	
Affordability		The cost of providing services from the Millbrook unit have been assessed by the provider as being £2,000,000 higher than that being recovered from the commissioners. The predicted reduction in admissions is likely to lead to under use of bedstock by a minimum of 17%. The estimated cost of enhancing Community/Crisis services is £1,170,000 The Net Impact would be system cost pressure of £3,170,000
Patient acceptability	No additional travelling for patients and carers Users and carers will have access to a range of crisis responses.	
Quality of care		Increased risk of breaching CQC requirements for mixed sex and single bedroom accommodation
Strategic fit	The new model of care is partially consistent with both national policy (five year forward view) and local integration plans. There is increased choice for crisis intervention and community capacity to support care closer to home.	

Option 4a: Enhanced community and home treatment teams. Crisis care services established including up to 6 local short stay beds. Re-provide inpatient care from Millbrook to other facilities within current provider footprint with older people services at Lime Walk House Macclesfield, and adults functional services at Bowmere , Chester (47 + circa 6 beds)		
Description: In this option 22 beds would be provided at Lime Walk; 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. 22 beds would be provided at Bowmere and 3 at Wirral for adults. Central and East patients would be admitted to Bowmere. Rehabilitation services currently delivered at Lime Walk would be re-provided at the Soss Moss site in Nether Alderley. In patient ECT would be delivered at the specialist ward in Bowmere. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café.		
Benefit	**Pros**	**Cons**
Clinical safety and sustainability	Adequate inpatient capacity. Staffing levels within community services mapped to meet the current level of demand. Increased community support leads to reduced admissions and length of stay of up to 50% (local clinical snapshot audit) Able to provide a range of responses in the community for people experiencing crisis. Community response for people with complex needs.	
Affordability	Shift of resources to the community, with more people benefiting from community care compared to inpatient services The cost of expanding the community resource is offset by cash release from unnecessary inpatient costs	Ability to deliver interventions in line with NICE guidance will not be achievable for all mental health conditions, however services will be safe and effective. Re-provision of inpatient services would result in net financial impact of £670,000 remaining cost pressure to the system.
Patient acceptability	Improved environment for service users Timely alternatives to hospital	Additional travelling for some patients and carers.

	admission are available Length of stay are reduced with additional support offered in the community Users and carers will have access to appropriate crisis support 24/7	
Quality of care	Improved environment for service users within facilities that comply with HBN and CQC requirements.	
Strategic fit	The new model of care is consistent with both national policy (five year forward view) and local integration plans. There is increased choice for crisis intervention and community capacity to support care closer to home	

Option 4b: Enhanced community and home treatment teams. Crisis care services established including up to 6 local short stay beds. Re-provide inpatient care from Millbrook to other facilities within current provider footprint with older people services at Bowmere, Chester and adults functional services at Lime Walk House Macclesfield, (47 + circa 6 beds)		
Description: In this option 22 beds would be provided at Lime Walk for adults. 22 beds would be provided at Bowmere, 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. There will be 3 beds at Wirral for adults. Central and East patients would be admitted to Bowmere. Rehabilitation services currently delivered at Lime Walk would be re-provided at the Soss Moss site in Nether Alderley. In patient ECT would be delivered at the specialist ward in Bowmere. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café.		
Benefit	**Pros**	**Cons**
Clinical safety and sustainability	Adequate inpatient capacity. Staffing levels within community services mapped to meet the current level of demand.	

	Increased community support leads to reduced admissions and length of stay of up to 50% (local clinical snapshot audit) Able to provide a range of responses in the community for people experiencing crisis. Community response for people with complex needs.	
Affordability	Shift of resources to the community, with more people benefiting from community care compared to inpatient services The cost of expanding the community resource is offset by cash release from unnecessary inpatient costs	Ability to deliver interventions in line with NICE guidance will not be achievable for all mental health conditions, however services will be safe and effective. Net impact is as for Option 4a (£670,000 remaining system cost pressure).
Patient acceptability	Improved environment for service users Timely alternatives to hospital admission are available Length of stay are reduced with additional support offered in the community Users and carers will have access to appropriate crisis support 24/7	Additional travelling for some patients and carers. Previous engagement feedback indicated this would be more problematic for an older population.
Quality of care	Improved environment for service users within facilities that comply with HBN and CQC requirements.	
Strategic fit	The new model of care is consistent with both national policy (five year forward view) and local integration plans. There is increased choice for crisis intervention and community capacity to support care closer to home.	

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

Description: In this option 12 beds would be provided at Lime Walk for older adults and adults with functional mental health problems. 22 beds would be provided at Bowmere. 10 beds for older people with functional problems would be procured from the private sector and 3 beds at Wirral. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café. ECT services will be provided at the specialist unit in Bowmere.

Benefit	Pros	Cons
Clinical safety and sustainability	Increased community support and crisis services leads to reduced admissions and length of stay of up to 50% (local clinical snapshot audit) Staffing levels within community services mapped to meet the current level of demand. Able to provide a range of responses in the community for people experiencing crisis. Community response for people with complex needs.	Lack of capacity and capability within the care home market to support the model. High risk of increased acute hospital DTOC due to lack of capacity
Affordability	The cost of expanding the community resource is partially offset by cash release from unnecessary inpatient costs	Ability to deliver interventions in line with NICE guidance will not be achievable for all mental health conditions, however services will be safe and effective. Increased cost of private sector provision will negate value for money benefits when compared to other inpatient facilities. Net impact would be remaining system cost pressure of £1,450,000.
Patient acceptability	Improved environment for service users Timely alternatives to hospital admission are available Length of stay are reduced with additional support offered in the community	Additional travelling for patients and carers using adult services Unpredictable travel times for patients and carers of older peoples services

	Users and carers will have access to appropriate crisis support 24/7	
Quality of care	Improved environment for service users within facilities that comply with HBN and CQC requirements	Reduced continuity of care Risk of extended lengths of acute hospital stay due to none availability of private sector placement. Varied quality across the care home provider sector evidenced by CQC.
Strategic fit	The new model of care is consistent with both national policy (five year forward view) and local integration plans. There is increased choice for crisis intervention and community capacity to support care closer to home.	

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

Description: In this option12 beds would be provided at Lime Walk for older adults with functional problems and 10 for older people's services. In Patient services would be delivered by alternate providers in North Staffordshire and Stockport approx 25 beds. There is no additional capacity available in South Manchester. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café. ECT services will be provided at the specialist units in multiple providers.

Benefit	**Pros**	**Cons**
Clinical safety and sustainability	Inpatient capacity matched to predicted demand Increased community support and crisis services leads to reduced admissions and length of stay of up to 50% (local clinical snapshot audit). Staffing levels within community services mapped to meet the current level of demand.	Fragmented care and potential delays due to repatriation processes. Higher risk of avoidable harm occurring when multiple providers are involved in complex care packages and discharge planning. Level of complexity due to cross boundary working required with the local authority. Variable CQC rating across alternative providers.

	Able to provide a range of responses in the community for people experiencing crisis. Community response for people with complex needs.	
Affordability	The cost of expanding the community resource is partially offset by cash release from unnecessary inpatient costs	Ability to deliver interventions in line with NICE guidance will not be achievable for all mental health conditions, however services will be safe and effective. The cost of multiple contracts with other providers will result in increased costs for inpatient services. Loss of income to existing provider requiring further efficiencies to be made. Initial quotes from alternative providers demonstrate 50% increase on bed day rates. Net impact would be system cost pressure of £2,870,000.
Patient acceptability	Less travelling for some patients and carers. Timely alternatives to hospital admission are available Length of stay are reduced with additional support offered in the community Users and carers will have access to appropriate crisis support 24/7	Capacity constraints in alternative providers may render this option non-viable. (Please score option 6 and 7 as if they are viable) Patients in the catchment area for South Manchester are unable to access services in South Manchester.
Quality of care		Unable to guarantee improved environment for service users within facilities that comply with HBN and CQC requirements. Potential impact on continuity of care
Strategic fit	The new model of care is consistent with both national policy (five year forward view) and local integration plans. There is increased choice for crisis intervention and community capacity to support	

	care closer to home	

Option 7: Transfer some community, crisis care (6 local beds) and inpatient services (45 beds) to alternative providers closer to the users home. Re-provide older peoples services at Lime Walk site in Macclesfield. Total 53 beds.		
Description: In this option the entire care for patients would transfer to alternative providers including North Staffordshire and Stockport. In this option 12 beds would be provided at Lime Walk for older adults with dementia and 10 for older people's services.		
Benefit	**Pros**	**Cons**
Clinical safety and sustainability	For some patients: Inpatient capacity matched to predicted demand. For some patients: Increased community support and crisis services leads to reduced admissions and length of stay of up to 50% (local clinical snapshot audit). For some patients: Staffing levels within community services mapped to meet the current level of demand. For some patients: Able to provide a range of responses in the community for people experiencing crisis. For some patients: Community response for people with complex needs.	Variable CQC rating across alternative providers. Local service provisions for the remaining population may become non-viable due economies of scale.
Affordability		The cost of multiple contracts with other providers will result in increased costs for inpatient services. Loss of income to existing provider requiring further efficiencies to be made. Initial quotes from alternative providers demonstrate 50% increase on bed day rates. Net impact would be in the region of

		£1,700,000 without including consequences of unpicking services currently shared between commissioners which may increase costs further.
Patient acceptability	Improved environment for service users Timely alternatives to hospital admission are available Length of stay are reduced with additional support offered in the community Less travelling for some patients and carers Users and carers will have access to appropriate crisis support 24/7	Capacity constraints in alternative providers may render this option non-viable. (Please score option 6 and 7 as if they are viable) Patients in the catchment area for South Manchester are unable to access services in South Manchester.
Quality of care		Unable to guarantee improved environment for service users within facilities that comply with HBN and CQC requirements. Potential impact on continuity of care
Strategic fit	The new model of care is consistent with both national policy (five year forward view) and local integration plans. There is increased choice for crisis intervention and community capacity to support care closer to home	

Scoring Options for Adult Mental Health Redesign

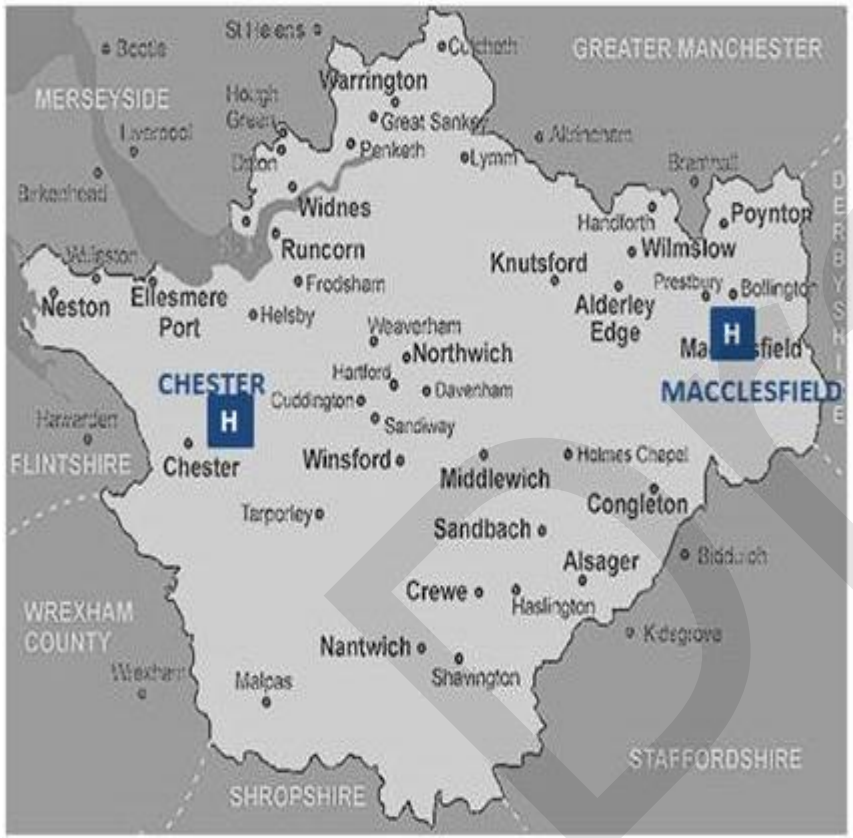
Option 1: Do nothing: No enhancement of community care and no crisis care placements provided. No enhancement in Home treatment teams or dementia outreach developed. Retain all inpatient care (58 beds) on the Millbrook

Grouping	Factor	Score					Your Score (user input) 1-5
		1	2	3	4	5	
Clinical safety and sustainability section							
Clinical safety and sustainability	Adequate staffing across community, crisis and inpatient relative to care needs (ratio).	Provides inadequate staffing across community, crisis and inpatient relative to care needs	Provides limited staffing needs across community, crisis and inpatient relative to care needs	Provides some of the staffing needs across community, crisis and inpatient relative to care needs	Provides majority of the staffing needs across community, crisis and inpatient relative to care needs	Provides adequate staffing across community, crisis and inpatient relative to care needs	
Clinical safety and sustainability	PICU provision within appropriate inpatient service	There is no PICU provision				PICU provision available	
Clinical safety and sustainability	Right staff skill mix	Provides inadequate staffing skill mix	Provides limited staffing skill mix	Provides some of the staffing skills mix	Provides majority of the staffing skills mix	Provides adequate staffing skills mix	
						Subtotal	**0**
Affordability							
Affordability	Value for money - what gives us the best return on investment	Cost more than 10% above CCG funding	Costs between 0.1% and 10% above CCG funding	Cost matches CCG funding	Cost between 0.1% and 5% less than CCG funding	Cost more than 5% less than CCG funding	1
						Subtotal	**1**
Patient/carer acceptability							
Patient/carer acceptability	To be completed as part of pre consultation engagement process	Little choice of services locally which are not personalised. Not 24/7 access	Limited choice of services locally, some personalised not 24/7 access	Some increase in range of services locally, some personalisation and cover extended hours	Provides a range of services locally which is mainly personalised and accessible 24/7	Provides a full range of services locally which is personalised and easily accessed 24/7	
						Subtotal	**0**
Quality of care							
Quality of care	Provides the right care in the right place at the right time	Care needs not met with inadequate access to services across limited facilities	Care needs often unmet with limited access to services across limited facilities	Care needs sometimes met with reasonable access to services in a small range of facilities	Care needs often met with with good access to services in a wide range of facilities	Care needs always met with with good access to services in a wide range of facilities	
						Subtotal	**0**
Strategic fit							
Strategic fit	National - Implementing Five Year Forward View for Mental Health	Major adverse contribution to national strategic plans	Some adverse contribution to national strategic plans	Moderate contribution to national strategic plans	Significant positive contribution to national strategic plans	Major positive contribution to national strategic plans	
Strategic fit	Local - CCG 5 Year Plan, CWP Strategic Plan 5 Year Plan	Major adverse contribution to local strategic plans	Some adverse contribution to local strategic plans	Moderate contribution to local strategic plans	Significant positive contribution to local strategic plans	Major positive contribution to local strategic plans	
						Subtotal	0
						GRAND TOTAL	**1**

Appendix 5

Travel Map and Analysis

Distance to Chester and Patient Numbers



Area	Town	Macclesfield	Chester	Difference in miles between Macc & Chester	Patients Admitted (-16%)
Eastern Cheshire	Bollington	5	46	-41	<10
Eastern Cheshire	Macclesfield	1	42	-41	66
Eastern Cheshire	Disley	11	49	-38	<10
Eastern Cheshire	Congleton	8	46	-38	22
Eastern Cheshire	Poynton	8	43	-35	<10
Eastern Cheshire	Alderley	6	40	-34	<10
Eastern Cheshire	Wilmslow	8	38	-30	13
Eastern Cheshire	Handforth	9	39	-30	<10
Eastern Cheshire	Chelford	7	37	-30	<10
Eastern Cheshire	Holmes Chapel	12	37	-25	<10
South Cheshire	Scholar Green	13	36	-23	<10
South Cheshire	Alsager	15	33	-18	<10
Eastern Cheshire	Knutsford	11	27	-16	13
South Cheshire	Sandbach	15	27	-12	19
Vale Royal	Northwich	18	27	-9	11
South Cheshire	Crewe	21	26	-5	60
South Cheshire	Middlewich	15	21	-6	<10
South Cheshire	Shavington	23	25	-2	<10
South Cheshire	Wistaston	23	23	0	<10
Vale Royal	Winsford	19	19	0	<10
South Cheshire	Audlem	31	31	0	<10
South Cheshire	Nantwich	26	22	4	<10
Vale Royal	Weaverham	23	17	6	<10
South Cheshire	Marbury	34	22	12	<10

<10 denotes between 0 – 9 patients admitted

Appendix 6

Workforce and Capacity Table

Community Mental Health Team

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

- A revised patient journey based upon new ways of working that will increase the time that staff spend providing direct patient 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**. Medical support and senior clinical leadership is provided by the Consultant Psychiatrists that cover inpatient care and community care.	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 1 consultant per 50,000 adult population	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 cancelling other routine pieces of work. The current operational model, its systems and processes are not wholly	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 recovery. This would include: - Releasing senior clinical staff [including medics] from routine tasks to ensure a more responsive and proactive and early intervention approach.	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 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)	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: 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

		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.	- 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	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	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 East footprint and dedicated medical input in only the South Cheshire CCG footprint	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 number of requests for support are currently being managed via the wider older peoples'/ memory team,	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 '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	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 to stay at home per week	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.

			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.		

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 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.	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 **900-950** episodes of care per year which on average is a caseload of 20.	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 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	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 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	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' 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

			full business case		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 patient 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	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	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	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 beds	Improved physical environment resulting in: - Improved patient 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

<table>
<tr>
<td>leaving gaps in the ability to deliver NICE compliant interventions.
Inpatient care is led by Consultant Psychiatrists who traditionally 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.</td>
<td>between B3 and B7<table><tr><td>B7</td><td>4.4</td></tr><tr><td>B6</td><td>11.96</td></tr><tr><td>B5</td><td>49.51</td></tr><tr><td>B4</td><td>3</td></tr><tr><td>B3</td><td>53.21</td></tr></table></td>
<td></td>
<td>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</td>
<td></td>
<td>provision as access to a larger range of community services will be available</td>
</tr>
</table>

Appendix 7

Finance Table

Table XX: 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)	(446)	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**

Supporting Document 1

Equality Impact Assessment 4a

MIDLANDS AND LANCASHIRE COMMISSIONING SUPPORT UNIT

Equality Impact and Risk Assessment Stage 2

Equality Impact and Risk Assessment

Title

Equality & Inclusion Team, Corporate Affairs
For enquiries, support or further information contact
Email: equality.inclusion@nhs.net

EQUALITY IMPACT AND RISK ASSESSMENT TOOL STAGE 2 ALL SECTIONS – MUST BE COMPLETED			
SECTION 1 - DETAILS OF PROJECT			
Organisation: Eastern Cheshire CCG			
Assessment Lead: Mandie Graham / Marie Ward			
Directorate/Team responsible for the assessment: Option 4a: Adult and Older Peoples Mental Health Redesign Project Team			
Responsible Director/CCG Board Member for the assessment : Jacki Wilkes			
Who else will be involved in undertaking the assessment? Marie Ward, Suzanne Edwards, Jamaila Tausif			
Date of commencing the assessment: 13/10/17			
Date for completing the assessment: 09/11/17			
SECTION 2 - EQUALITY IMPACT ASSESSMENT			
Please tick which group(s) this project will or may impact upon?	**Yes**	**No**	**Indirectly**
Patients, service users	☑		
Carers or family	☑		
General Public		☑	
Staff	☑		
Partner organisations	☑		

Background of the project being assessed:

The NHS in Eastern and Central Cheshire are working with users of the service, local mental health provider Cheshire and Wirral Partnership and the local council to review and redesign secondary care adult and older peoples mental health services for people with a severe and enduring mental health need. Secondary care services is the term used to differentiate them from primary mental health services such as GP only care and universal psychological therapies (IAPT) Secondary services includes specialised community support, crisis response and inpatient care which is provided mainly on The Millbrook unit in Macclesfield. The project aims to improve clinical and health and well-being outcomes for service users through a new model of care and redesigned service delivery arrangements to support early intervention and prevention and reduce overall reliance on hospital services

What are the aims and objectives of the project being assessed?

Option 4a: 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)

Description: In this option 22 beds would be provided at Lime Walk; 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. 22 beds would be provided at Bowmere and 3 at Wirral for adults. Central and East patients would be admitted to Bowmere. 6 beds will be available locally

to support short stay care for people in crisis. . Rehabilitation services currently delivered at Lime Walk would be re-provided at the Soss Moss site in Nether Alderley. In patient ECT would be delivered at the specialist ward in Bowmere. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café

Services currently provided in relation to the project:

Community care is provided by Community Mental health Teams (CMHTs) based in Macclesfield for Eastern Cheshire residents and Crewe for Vale Royal and South Cheshire residents. Home Treatment Teams provide access to crisis care and are the gatekeepers to inpatient services. They will also provide in reach services for crisis care. In this option the service would be extended to cover 24/7. In addition a dementia outreach service would provide intensive support to people at home, thereby preventing unnecessary admissions to hospital

Community mental health teams are comprised of a mix of community psychiatric nurses, allied professionals and medical staff provided by CWP whilst Local Authorities provide social work input to these teams: Cheshire East Council for Eastern Cheshire and South Cheshire teams and Cheshire West and Chester to the Vale Royal teams. In patient facilities are provided at both Millbrook in Macclesfield and Bowmere in Chester.

Which equality protected groups (age, disability, sex, sexual orientation, gender reassignment, race, religion and belief, pregnancy and maternity, marriage and civil partnership) and other employees/staff networks do you intend to involve in the equality impact assessment?

Please bring forward any issues highlighted in the Stage 1 screening

In this option it is proposed that 22 beds would be provided at Lime Walk; 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. 22 beds would be provided at Bowmere and 3 at Wirral for adults. Central and East patients would be admitted to Bowmere. Rehabilitation services currently delivered at Lime Walk would be re-provided at the Soss Moss site in Nether Alderley. In patient ECT would continue to be delivered at the specialist ward in Bowmere. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café

In response to the growing body of evidence that demonstrates improved outcomes for people where there are adequate community services and rapid response to support people in crisis. (Kings Fund 2017, FYFV 2016) we are planning to make changes to the way in which services are commissioned and delivered for our population.

Locally developed transformation plans describe a programme of co-design across the health and social care economy where health and care commissioners and providers respond to patient 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 fit for the 21st century's population needs and is entirely consistent with the national vision for future mental health services described in the 5YFV and is the framework we have used for our needs analysis and workforce planning

In early stages of implementation, the aim is 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.

In taking transformation plans forward for people with SMI an improved approach to care has been created by local clinicians and patients. We have segmented the population into groups according to their risk of needing care so that we can develop services to meet their needs and better target services where they have the most impact. We believe that we will be able to dramatically shift the over reliance on reactive, acute hospital care to proactive care closer to home with improved patient experience and outcomes.

Based on the above following sections will consider the impact of this option against the Protected Characteristics.

1. **Gender**

The 2011 census data shows that in East Cheshire approximately 51% of the population are female and 49% are male.

Nationally, when looking at the sex distribution for people who have a severe mental illness, overall rates do not differ significantly between male and female. This is for conditions such as psychotic disorders, bipolar effective disorder and personality disorder.

The table below highlights the admissions to Millbrook, broken down by gender. Slightly more females were admitted between 1st April 2016 to 31st March 2017.

	Female	% Female	Male	% Male	Total Patients
Adelphi Ward - open age inpatient mental health ward caring for older people in East Cheshire.	222	69.16%	99	30.84%	321
Bollin Ward - open age inpatient mental health ward caring for young adults in East Cheshire	217	48.33%	232	51.67%	449
Croft Ward - 14 bed inpatient ward providing specialist treatment for people with dementia in East Cheshire	39	57.35%	29	42.65%	68
Overall	**478**	**57.04%**	**360**	**42.96%**	**838**

It is considered that all genders will be impacted upon as a result of the changes.

Impact of service reconfiguration on Gender as a Protected Characteristics.

Option 4a

All genders will be adversely impacted by this option. All genders will receive their care in the main in Bowmere, Chester. All genders over the age of 64 and/or with greater physical health needs will in the main receive their care in Lime Walk House. Both male and female within this option will be cared for in single, ensuite rooms in buildings that meet the national standards.

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to

visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire. This option is expected to improve service user experience, and provide improved quality of care through improved access to community based services.

Potential Mitigations for option 4a

The relocation of some inpatient services to Bowmere may have an adverse impact on all genders. For all service users requiring an admission to Bowmere CWP will ***continue*** to support their transfer via a mental health practitioner or ambulance.

CWP, CCG and Local Authority would need to ensure that travel options are well published, which would include travelling with NHS patient transport services. Individual difficulties would be reviewed on a case by case basis and every attempt made to support family and carers and patients to remain connected through in patient stay, through flexible visiting, use of technology and local in patient crisis beds.

2. Pregnancy and maternity

In 2009 the general fertility rates for England and Wales was 63.6 (per live 1,000 births), in East Cheshire this rate is 59.8, and therefore slightly lower than the national rate, but is more or less equal to the birth rate in the North West.

Perinatal services are specialist mental health services that support women and their families during pregnancy and following birth.

Impact of service reconfiguration on Pregnancy and Maternity as a Protected Characteristics

Option 4a

There is no proposed change in the provision of Specialist community perinatal services and these are provided via CWP and are across Cheshire and Merseyside. Women in the perinatal period who require admission to a specialist mother and baby unit will continue to access regional units. This is not provided at Millbrook or any of the other inpatient units within CWP.

Women in the perinatal period who wish to remain at home during periods of crisis will be able to receive enhanced community support via the crisis service, therefore increasing the likelihood of the mother being able to stay at home. Access to mother and baby units can take a number of days to secure due to the limited numbers, and therefore at times of need they will require admission to an acute inpatient unit. Bowmere has single on suite rooms, family visiting areas that can be utilised to support mother and baby during periods of visiting. The community specialist perinatal team will ensure that the service user maintains contact with their local midwifery services and arrangements will be put in place for this to continue if admitted to Bowmere. It is believed that this option will improve service user experience and supports person centred care.

Potential Mitigations to option 4a

The relocation of some inpatient services to Bowmere will have no adverse impact on women during the perinatal period. For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner, ambulance or other means based on individual choice.

CWP, CCG and Local Authority would need to ensure that travel options are well published, which would include travelling with NHS patient transport services. The use of technology and flexible visiting hours to

maintain contact with family and friends will be explored.

3. Impact of service reconfiguration on Age as a Protected Characteristic

Since the 2001 census there has been a 26% increase in the number of residents 65 and older, which is a larger increase than in the North West (15%) and England and Wales (20%). There has been a 35% increase in the number of residents 85 years and older, which again is a larger increase than the North West (205) and England and Wales (24%). There has been a decrease in the number of children by 4% and those of approximate working age have increased by 4% in line with trends in the North West and England and Wales. There are fewer people in all age groups under 40 than England and Wales, and the median age of residents in 2001 was 40.6 years and by 2011 this has increased to 43.6 years.

Population of East Cheshire by Age

Age All categories: Age - 370,127	Number	% of population
Under 16	65,753	17.9%
16-29	55,282	14.90%
29-64	177,720	48%
65+	71,372	19.30%

Admissions to Millbrook by age (2016/2017)

	Aged 16-29	% 16-29	Aged 30-64	% 30-64	Aged 65 +	% 65+	Total Patients
Adelphi Ward	37	11.53%	163	50.78%	121	37.69 %	321
Bollin Ward	116	25.84%	322	71.71%	11	2.45%	449
Croft Ward	Less than 10	0.00%	Less than 10	10.29%	61	89.71 %	68
Overall	**153**	**18.26%**	**492**	**58.71%**	**193**	**23.03 %**	**838**

Option 4a

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire, and will be enhanced. This option is expected to improve service user experience, and provide improved quality of care through improved access to community based services.

For older adults age 65+ requiring inpatient care, they will experience a positive impact as a result of this option as most service users in this group will receive their care at Limewalk House. Those who require PICU, ECT or specialist intervention for complex presentations will receive their care at Bowmere.

Adults of working age will receive the same enhanced community provision however this group will be admitted to Bowmere if they require inpatient care, and therefore maybe adversely impacted on as a result of this option, as a result of extra travel, but would have a positive impact from the enhanced community care. This cohort during 2016/17 accounted for 0.016% of the total population of Central and Eastern Cheshire.

Potential Mitigations to option 4a

Access to community based crisis services 24/7 will reduce the need for admission to an inpatient unit, and will reduce length of stay by facilitating early discharge

The relocation of some inpatient services to Bowmere may have an adverse impact on adults of working age. For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner or ambulance.

4. **Impact of service reconfiguration on Disability as a Protected Characteristic**

Disability All households - 159,441	Number	% of population
One person in household with a long-term health problem or disability: With dependent children	6,045	3.8%
One person in household with a long-term health problem or disability: No dependent children	33,628	21.1%

Option 4a

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire. This option is expected to improve service user experience, and provide better quality of care through improved access to community based services.

For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner or ambulance.

Potential Mitigations for Option 4a

Ensure that services and locations where community services will be offered from are EQUALITY ACT 2010 compliant

Improve data quality of services for users with a disability to inform further mitigations and equality impact assessments.

Ensure that reasonable adjustments are made, and facilities are suitable.

Ensure that information on the service reconfiguration specially targets disabled groups

Provide clear information in alternative formats and with alterative content targeted at people with different

abilities for wide dissemination (Accessible Information Standard)

Ensuring compliance with safeguarding regulations

Provide staff training on how to actively support members of this community

CWP, CCG and Local Authority would need to ensure that travel options are well published, which would include travelling with NHS patient transport services.

5. Impact of service reconfiguration on Race as a Protected Characteristic

Breakdown from 2011 Census

Ethnicity All categories: Ethnic group - 370,127	Number	% of population
White	357,627	96.7%
Black/African/Caribbean/Black British	1,402	0.4%
Asian/Asian British:Chinese	2,553	0.7%
Asian/Asian British:Bangledeshi/Indian,Pakistani	3,507	0.9%
Mixed/Multiple Ethnic Groups	3,873	1.0%
Gypsy/Traveller/Irish Traveller	313	0.1%
Other Ethnic Group	852	0.2%

Breakdown of Ethnicity for Individuals accessing all services in Central and East Cheshire

Ethnicity	Total
Asian Or Asian British, Bangladeshi	Less than 10
Asian Or Asian British, Indian	15
Asian Or Asian British, Other	28
Asian Or Asian British, Pakistani	10
Black Or Black British, African	18
Black Or Black British, British Caribbean	27
Black Or Black British, Other	Less than 10
Mixed, Other	20
Mixed, White & Asian	13
Mixed, White & Black African	Less than 10
Mixed, White & Black Caribbean	16
Not Stated	41
Other Ethnic Groups, Chinese	Less than 10

Other Ethnic Groups, Other	18
Unknown	929
White, British	9359
White, Irish	55
White, Other	133
Total	**10704**

Option 4a

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire. This option is expected to improve service user experience, and provide better quality of care through improved access to community based services and crisis beds.

For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner or ambulance.

Potential mitigations for option 4a

The mitigations would be:

- Providing information in alternative languages;
- Ensuring all staff have appropriate training in cultural diversity
- Ensuring effective and timely interpretation services are made available and staff understand the requirements and system for providing this
- All CWP staff work within the Equality, Diversity and Human Rights policy, and regardless of the outcome of the consultation everyone will be offered a person centred approach.
- All CWP inpatient units provide access to multi-faith rooms, facilitate support from faith leaders and promote and support individuals to continue to access faith based community support whilst receiving inpatient care.

6. Impact of service reconfiguration on Gender reassignment as a Protected Characteristic

Currently CWP do not hold any information on the number of people who have undergone gender reassignment.

At present there is no official estimate of the transgender population. The England/Wales and Scottish Census have not asked if people identify as trans and did not ask the question in the 2011 census. In a Home Office funded study estimated numbers of transgender people in the UK was documented to be between 300,000 – 500,000. This was however described as including anybody who experienced some degree of gender variance.

The absence of public data raises concerns for the completeness of this pre-consultation equality impact assessment.

Despite the lack of data we know that transgender individuals may require services typically associated with a defined gender that they do not identify with, or are accessing services that are seen to promote traditional "family" orientated services. It is acknowledged that individuals may experience anxiety and discomfort when

receiving inpatient care where signage and labels are male and female and they may still be undergoing gender reassignment. CWP will facilitate the gender assignment that the person identifies with, and will provide the appropriate support and adjustments. This issue could be addressed by the provision of single ensuite rooms.

Mitigations

- Single ensuite rooms
- The provision of non-gender bathrooms in community resources.
- Providing staff training and awareness sessions, on how to actively support individuals in the different care settings.
- Work with 3rd sector organisations via the EDS2 framework including Body Positive (LGBT) and a Unique Transgender organisation. Both organisations have provided training and information sessions to CWP staff, with Body Positive sitting on the assessment panel.
- Data collection methodology should be explored on how best this information can be captured.

7. Impact of service reconfiguration on Marriage and civil partnerships as a Protected Characteristic

Marital & civil partnership All categories: Marital and civil partnership status - 304,374	Number	% of population
Single (never married or never registered a same-sex civil partnership)	86,618	28.5%
Married	158,540	52.1%
In a registered same-sex civil partnership	563	0.2%
Separated (but still legally married or still legally in a same-sex civil partnership)	6,708	2.2%
Divorced or formerly in a same-sex civil partnership which is now legally dissolved	28,426	9.3%
Widowed or surviving partner from a same-sex civil partnership	23,519	7.7%

Breakdown of marital status for individuals receiving CWP services

Marital Status	Total
Cohabiting	186
Divorced	438
Married	2916
Not Disclosed	14
Not Known	1084
Separated	139

It is acknowledged the role that partners play in caring for their loved ones. A separate section of this EIA will address the impact that the proposed option will have on carers.

It is however not anticipated that individuals who are married or in a civil partnership will be disproportionally affected on either of the options described in this pre-consultation business case.

8. Impact of service reconfiguration on Religion and belief as a Protected Characteristic

Access to and the provision of services is not provided on the grounds of religion. All CWP inpatient units

provide access to multi-faith rooms, facilitate support from faith leaders and promote and support individuals to continue to access faith based community support whilst receiving inpatient care. The EDS2 stakeholder assessment will monitor the actions in relation to this protected group and ensure that there are no unintended consequences as a result of the agreed option following consultation. Both options put forward will be expected to impact all religious beliefs equally.

Religion All categories: Religion - 370,127	Number	% of population
Christian	254,940	68.9%
Buddhist	882	0.2%
Hindu	1328	0.4%
Jewish	581	0.2%
Muslim	2438	0.7%
Sikh	279	0.1%
Other religion	1065	0.3%
No religion	83,973	22.7%
Religion not stated	24,641	6.7%

Baptist	Less than 10
Buddhist	16
Christian	2515
Christian Science	11
Church Of England	1586
Church Of Scotland	Less than 10
Church Of Wales	Less than 10
Declined To Disclose	15
Hindu	14
Jehovah's Witness	32
Jewish	Less than 10
Lutheran	Less than 10
Methodist	69
Muslim	29
None	383
Not Specified	3368
Orthodox	Less than 10
Other	581
Pagan	Less than 10
Pentecostal	Less than 10
Roman Catholic	258
Salvation Army	Less than 10

Seventh Day Adv'Tist	Less than 10
Sikh	Less than 10
United Reform Church	Less than 10
Unknown	1780
Total	**10704**

9. Impact of service reconfiguration on sexual orientation as a Protected Characteristic

Currently there is no local data that provides a breakdown of sexual orientation by authority. In 2009, there were approximately 430,000 lesbian and gay people living in the North West.Ref: Ecotec (2009), Improving the Region's knowledge base on LGBT population in the North West.

Breakdown of sexual orientation of individuals in receipt of CWP services

Sexual Orientation	Total
BI-SEXUAL	23
GAY OR LESBIAN	Less than 10
GAY/LESBIAN	33
HETEROSEXUAL	4376
Not Known	6067
NOT STATED	132
OTHER	Less than 10
PERSON ASKED AND DOES NOT KNOW OR IS NOT SURE	Less than 10
PREFER NOT TO ANSWER	63
Total	**10704**

Data collection and the quality of the data will require enhancement to ensure that this can then inform the consultation and this equality impact assessment.

Research suggests that LGBT communities experience considerable health inequalities compared to the population on average which impact on their experience in the healthcare system and health outcomes (Stonewall 2008 Prescription for Change)

In 2014 the JSNA in Cheshire East undertook a consultation with the Third Sector Provider on mental health. One of the findings of this work was that gay farmers are a particularly vulnerable group in rural Cheshire East and they recommended that future service-design should take into account the increased risk of suicide amongst gay farmers. They report on evidence that farmers and farm managers are the occupational group with the fourth highest risk of suicide in England and Wales, and say that there is evidence to suggest this figure is much higher. Added to this is the statistic that one in four gay men will attempt suicide at some stage in their lives. This highlights gay farmers to be a particularly vulnerable group.

A further finding of this group concluded that LGBT people confirmed that Isolation and loneliness around

sexual orientation is an issue, and can lead to depression and the use of substances.

Neither of the options described in the pre-consultation business care are expected to discriminate against LGBT individuals.

Carers

Based on this option, carers may be impacted as follows

Option 4a

Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. It is acknowledged that carers will have to travel to visit their loved ones, and this may be a greater distance than they would if their loved one was admitted to Millbrook. This is dependent on where the carer lives in relation to the various inpatient units, and we cannot assume that all carers reside with the individual whom they are caring for and/or related to. Older people will in the main be admitted to Lime Walk House, unless they require PICU or ECT. Based on admission in the previous year, this would equate to circa 370 individuals (admissions that would be admitted to Bowmere if we progressed option 4a). To put this into context there are around 5,300 service users being supported in the community. By making this change we would anticipate that the number of in patient admissions to be reduced due to the enhanced community care provision.

Inpatient mental health care is considered as specialist, and not comparable to physical health care from district general hospitals. It is common for individuals to travel for specialist care, such as cancer, cardiac, paediatrics or neurology. Individuals requiring specialist inpatient mental health care should not be seen any differently from those requiring specialist physical health care. However it is acknowledged that under this option some carers may be disadvantaged compared to the current arrangements.

Mitigations for option 4a

- use of technology to support carers and family to maintain contact
- Flexible visiting hours
- where the family or carers have concerns around in patient placement every attempt will be made to support the patients, carers and family to remain connected.
- Enhanced community provision will reduce the need for hospital admission and facilitate early discharge therefore reducing the number of carers impacted by the changes
- consultation will have a focus on carer engagement and feedback

Summary of the pre-consultation equalities impact assessment

The following provides an overview of whether the proposed options are expected to have a disproportionate effect on any of the 9 protected characteristics.

Protected Group	Options	Expected Impact	Risk	Mitigations
Gender	4a	Neutral	Low	Staff support and training Provision of single ensuite rooms

Disability	4a	Neutral	Low	Ensure that services are compliant with the Equality Act 2010 Ensure reasonable adjustments Staff support and training Support engagement with identified groups via the EDS2
Gender Reassignment	4a	Neutral	Low	Staff support and training Support engagement with identified groups via the EDS2
Marriage and Civil Partnership	4a	Neutral	Low	No specific mitigations identified
Pregnancy and maternity	4a	Neutral	Low	No specific mitigations identified
Race	4a	Neutral	Low	Access to information in a range of languages and formats Staff training and support Access to translation services Single ensuite rooms
Religion and belief	4a	Neutral	Low	Provide adequate faith facilities Facilitate community engagement with faith groups via EDS2 Training and staff support
Sexual orientation	4a	Neutral	Low	Work closely with LGBT groups Support engagement with LGBT community via EDS2 Training and staff support
Age	4a	Neutral for Older People	Medium	Enhanced community provision

How will you involve people from equality/protected groups in the decision making related to the project?

During development of these proposals we have demonstrated a commitment to be proactive to seek the views and experiences of our local populations and be accessible and convenient. We have met with various interest groups, undertaken site visits with experts by experience and invited users to share experiences and views in a range of meetings from CCG Annual Fairs to individual case studies

We have used this information alongside carer and staff views and experiences in the development of the Pre-Consultation Business Case; including the options appraisal process.

Patient and carers workshops were held at the Millbrook Unit 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 Cheshire East Healthwatch, Cheshire East Health Voice 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.

More recently listening events were held in September 2017 at Crewe Alexandra FC and Macclesfield Town FC. Over 60 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 services might be improved. In addition an online survey was also made available to those who couldn't attend the sessions.

Further engagement with people from the different protected characteristic groups, will take place throughout the consultation period.

EVIDENCE USED FOR ASSESSMENT

What evidence have you considered as part of the Equality Impact Assessment?

- **All research evidence base references including NICE guidance and publication – please give full reference**

The table below shows the 5 year forward view mental health standards to be achieved by 2021. This option will help towards meeting these standards. A copy of the full Adult mental health policy is attached.

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.

People recover better in the home environment – find quote

- **Bring over comments from Stage 1 and prior learning (please embed any documents to support this)**

Mitigating actions

The Five Year Forward View recognises the need to address capacity in the community and is a national mandate to improve and modernise mental health services to reflect a proactive, timely response to need. (FYFV)

Underpinned by an appropriately trained workforce, there is a requirement to improve access for Crisis Resolution and Home Treatment Teams (CRHTTs) to ensure that a 24/7 community-based mental health crisis response is available in all areas. These teams must be adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission, in the least restrictive manner and as close to home as possible. There must be evidence of investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder and 'navigators' who are available to people who need specialist care from diagnosis onwards, to guide them through options for their care and ensure they receive appropriate information and support

In this option we will Enhance community services through:

- 24/7 crisis house
- Crisis café
- 22 beds for older people at Soss Moss (10 people aged 65+) 12 beds for adults between aged 18-64
- Increased capacity of mental health teams to enhance home treatment.

ENSURING LEGAL COMPLIANCE		
Think about what you are planning to change; and what impact that will have upon 'your' compliance with the Public Sector Equality Duty (refer to the Guidance Sheet complete with examples where necessary)		
In what way does your current service delivery help to:	How might your proposal affect your capacity to:	How will your mitigate any adverse effects? (You will need to review how effective these measures have been)
End Unlawful Discrimination?	**End Unlawful Discrimination?**	**End Unlawful Discrimination?**
Enhances provision for all protected characteristics	Enhances provision for all protected characteristics	Enhanced community services to all groups
Promote Equality of Opportunity?	**Promote Equality of Opportunity?**	**Promote Equality of Opportunity?**
This change facilitates all members of the community to access information, services, help and support by providing access to all the local community services 24/7.	This change facilitates all members of the community to access information, services, help and support by providing access to all the local community services 24/7.	Enhanced community services to all groups
Foster Good Relations Between People	**Foster Good Relations Between People**	**Foster Good Relations Between People**
The various types of support available through this service help to engage and enable people from different backgrounds to participate in public life	The various types of support available through this service help to engage and enable people from different backgrounds to participate in public life	Investigate use of technology i.e. facetime, skype. Flexible visiting hours

WHAT OUTCOMES ARE EXPECTED/DESIRED FROM THIS PROJECT?

What are the benefits to patients and staff?

Care in community

Evidence shows from other areas that facilities like crisis café's and places of safety with 24/7 access to crisis support are highly valued by carers and people who use the service. These are now common place in other parts of the country.

A café in a North East Hampshire has helped reduce mental health hospital admissions by a third in seven months by providing an alternative solution for service users (NHS England case study) Other

examples are evident across the country including Greater Manchester, Wirral. We want these types of services to be available to our communities too

Enhancing our community support

Benefits will include:

- Consistent access to services
- PICU provision within appropriate inpatient facility
- Enhanced community services
- Responsive, community focussed, personalised care system providing wrap around care.
- Access to specialist services as close to home as possible
- Support for individuals to effectively manage their wellbeing with a focus on empowerment, prevention and resilience
- More patients supported in their own homes
- Access to out of hours support for those in a crisis

How will any outcomes of the project be monitored, reviewed, evaluated and promoted where necessary?

The project will be monitored using the Outcomes framework, IAF framework measures to ensure no adverse impact on care, and also through contractual obligations with CWP

"think about how you can evaluate equality of access to, outcomes of and satisfaction with services by different groups"

- Feedback from users of the service will be captured through the use of the following:
- Friends and family test
- Patient satisfactions survey
- Patient reported outcomes measures
- Patient reported experience measures

EQUALITY IMPACT AND RISK ASSESSMENT

Does the 'project' have the potential to:

- Have a ***positive*** **impact (benefit)** on any of the equality groups?
- Have a ***negative impact / exclude /*** **discriminate** against any person or equality group?
- **Explain** how this was **identified? Evidence/Consultation?**
- Who is most likely to be **affected** by the proposal and **how** (think about barriers, access, effects, outcomes etc.)

- Please include all evidence you have considered as part of your assessment e.g. Population statistics, service user data broken down by equality group/protected group

Please request guidance on Equality Groups/Protected Groups and their issues, this document may help and support your thinking around barriers for the equality groups

Equality Group / Protected Group	Positive effect	Negative effect	Neutral effect	Please explain - MUST BE COMPLETED
Age	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Adults in the age category 65+ would continue to have their care provided locally. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis.
Disability	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis.

Gender Reassignment	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis Mitigation • Taking into regard the persons chosen gender identity, patients would be appropriately placed.
Pregnancy and Maternity	☑			Patients already travel out of area for maternal mental health.
Race	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis Mitigation • Providing information in alternative languages; • Ensuring all staff have appropriate training

				in cultural diversity • Ensuring effective and timely interpretation services are made available and staff understand the requirements and system for providing this • All CWP staff work within the Equality, Diversity and Human Rights policy, and regardless of the outcome of the consultation everyone will be offered a person centred approach.
Religion or Belief	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Providing information in alternative languages; • Ensuring all staff have appropriate training in cultural diversity • Ensuring effective and timely interpretation services are made available and staff understand the requirements and system for providing this • All CWP staff work within the Equality, Diversity and Human Rights policy, and regardless of the outcome of the consultation everyone will be offered a person centred approach. • All CWP inpatient units provide access to

				multi-faith rooms, facilitate support from faith leaders and promote and support individuals to continue to access faith based community support whilst receiving inpatient care.
Sex (Gender)	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis Mitigation • Staff support and training • Provision of single ensuite rooms
Sexual Orientation	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis.

				Mitigation • Work closely with LGBT groups • Support engagement with LGBT community via EDS2 • Training and staff support
Marriage and Civil Partnership N.B. Marriage & Civil Partnership is only a protected characteristic in terms of work-related activities and NOT service provision	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis.
Carers	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. It is acknowledged that carers will have to travel to visit their loved ones, and in some cases this may be a greater distance than they would if their loved one was admitted to Millbrook. This is dependent on where the carer lives in relation to the various inpatient units, and we cannot assume that all carers reside with the individual whom they are caring for and/or related to. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation

				• Flexible visiting hours • Explore the use of technology for Virtual visiting i.e. Skype, Facetime etc
Deprived Communities	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis Mitigation • Flexible visiting hours • Virtual visiting. I.e. Skype, Facetime etc. • Prioritise local beds based on patient and carer need • Appropriate package of care on discharge from hospital.
Vulnerable Groups e.g. Homeless, Sex Workers, Military Veterans	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults of working age who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation

				• Flexible visiting hours • Virtual visiting. I.e. Skype, Facetime etc. • Prioritise local beds based on patient and carer need • Appropriate package of care on discharge from hospital.

SECTION 3 - COMMUNITY COHESION & FUNDING IMPLICATIONS

Does the 'project' raise any issues for Community Cohesion?

N/A

What effect will this have on the relationship between these groups? Please state how will you manage this relationship?

N/A

What is the overall cost of implementing the 'project'?

Potential additional cost of providing free transport for those admitted to Bowmere for those in the protected characteristics.

Please state: Cost & Source(s) of funding:

This is the end of the Equality Impact section, please use the embedded checklist to ensure and reflect that you have included all the relevant information

EI&RA checklist_V1.0_11091

SECTION 4 - HUMAN RIGHTS ASSESSMENT

If the Stage 1 Equality Impact and Risk Assessment highlighted that you are required to complete a Stage 2 Human Rights assessment (please request a stage 2 Human Rights Assessment from the Equality and Inclusion Team), please bring the issues over from the screening into this section and expand further using the Human Rights full assessment toolkit then embed into this section.

SECTION 5 - PRIVACY IMPACT ASSESSMENT

If the Stage 1 Equality Impact and Risk Assessment highlighted that you are required to complete a Stage 2 Privacy Impact Assessment, please request a stage 2 Privacy Impact Assessment either from the Equality and Inclusion Team or the Information Governance Team, email your completed stage 2 to your Information Governance Support Officer either at the CCG or CSU.

SECTION 6 – RISK ASSESSMENT

Please identity any possible risk for patients and / or the Clinical Commissioning Group if the project is implemented without amendment. All risks will be monitored for trends and provided to the project author when the project is due to be reviewed

IMPLEMENTATION RISK: CONSEQUENCE SCORE

DOMAIN	INSIGNIFICANT	MINOR	MODERATE	MAJOR	CATASTROPHIC
Impact on the safety of patients, staff or public (physical / psychological harm	Minimal injury requiring no / minimal intervention or treatment	Minor injury or illness, requiring minor intervention	Moderate injury requiring professional intervention RIDDOR / agency reportable incident, an event which impacts on a small number of patients	Major injury leading to long-term incapacity / disability. Mismanagement of patient care with long-term effects	Incident leading to death. An event which impacts on a large number of patients
Complaints / Audit	Informal complaint / inquiry	Formal complaint (Stage 1) Local resolution Single failure to meet internal standards Reduced performance rating if unresolved	Formal complaint (Stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards	Multiple complaints / independent review Low performance rating Critical report	Inquest / Ombudsman inquiry Gross failure to meet national standards Severely critical report
Statutory Duty / Inspections	No or minimal impact or breech of guidance / statutory duty For example: Unsatisfactory patient experience which is not directly related to patient care. No action required	Breech of statutory legislation. Reduced performance rating if unresolved. For example: a minor impact on people with a protected characteristic has been identified that was agreed to be accepted within the scope of the project. No action required.	Single breech in statutory duty. Challenging external recommendations / improvement notice. For example: a moderate impact on people with a protected characteristic has been identified. This can be resolved by making amendments to the project or providing an objective justification for not amending the project (This must be published with the EIA)	Multiple breeches in statutory duty. Enforcement action Low performance rating report For example: a major impact on people with a protected characteristic has been identified. Consideration	Multiple breeches in statutory duty. Prosecution Zero performance rating Severely critical report. For example: a catastrophic impact on people with a protected characteristic has been identified that may lead to litigation or impact on patient safety. The project should be stopped immediately

				should be given to and review the project immediately. Q. Can we make amendments to the project or provide objective justifications? If yes, this must be published the EIA.	
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage short-term reduction in public confidence. Elements of public expectation not being met	Local media coverage. Long-term reduction in public confidence	National media coverage <3 days service well below reasonable public expectation	National media coverage > 3 days MP concerned (questions in the House) Total loss of public confidence
Business Objectives / Projects	Insignificant cost increase No impact on objectives	<5 per cent over project budget Minor impact on delivery of objectives	5 – 10 per cent over project budget	Non-compliance with national 10 – 25 per cent over budget Major impact on delivery of strategic objectives	Incident leading > 25 per cent over project budget Failure of strategic objectives impacting on delivery of business plan
Finance Including Claims	Small loss risk of claim remote	Loss of 0.1 – 0.25 per cent of budget Claim less than £10,000	Loss of 0.25 – 0.5 per cent of budget Claims (s) between £10,000 and £100,000	Loss of 0.5 – 1.0 per cent of budget Claim(s) between £100,000 and £1	Loss of >1 per cent of budget Claim(s) > £1 million

				million	
IMPLEMENTATION RISK: LIKELIHOOD SCORE					
Frequency: How often might it / does it happen?	Not expected to occur for years	Expected to occur annually	Expected to occur monthly	Expected to occur weekly	Expected to occur daily
Probability	<1%	1.5%	6-20%	21-50%	>50%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not occur

RISK MATRIX					
	RARE	**UNLIKELY**	**POSSIBLE**	**LIKELY**	**ALMOST CERTAIN**
Insignificant	**1**	**2**	**3**	**4**	**5**
Minor	**2**	**4**	**6**	**8**	**10**
Moderate	**3**	**6**	**9**	**12**	**15**
Major	**4**	**8**	**12**	**16**	**20**
Catastrophic	**5**	**10**	**15**	**20**	**25**

RISK SCORE ON DRAFT PROJECT	**RISK SCORE ON FINALISED PROJECT**
5	**5**

WHAT ARE THE KEY REASONS FOR THE CHANGE IN THE RISK SCORE?
N/A

EQUALITY IMPACT AND RISK ASSESSMENT AND ACTION PLAN

Risk identified	Actions required to reduce / eliminate the negative impact	Resources required* (see guidance below)	Who will lead on the action?	Target completion date
Negative media coverage has a detrimental impact on public consultation outcome	Communication and Engagement Plan to support proactive approach to local media. Consistent message from partners in communicating case for change. Joint approach to communication to wider statutory bodies. Clear governance process to obtain sign off from all partners for communication plan. Fully engage public in pre consultation process and consultation process (health voice, health watch, general public, 3rd sector organisations)	**Comms and Enagagement team**	**Katherine Wright, Charles Malkin**	**Ongoing throughout life of project**
Service sustainability during the planning and consultation phase	CWP to evoke Business Continuity plans. Regular communication with staff. Clinical	**CWP**	**Suzanne Edward**	**Post Consultation**

	Leadership across system to identify measures to maintain quality of care.		**s**	
Potential delays in delivering the programme within the timescales	Develop project plan with clear time lines to deliver the work plan and navigate governance process including NHSE sign off. Project Meetings bi weekly to monitor delivery against plan. Escalate project slippage to SRO.	**Project Sponsor**	**Jacqui Wilkes**	**Throughout the life of the project**
The decision making process following consultation period is challenged	Project process to follow NHS England best practice guidance recruit consultation expert to support pre-consultation engagement and the consultation itself. Ensure project documentation fully up to date and take clear and transparent approach to process and decision making. Take legal advice on consultation documentation. Independent review by Chester University within consultation timeline	**Project Sponsor**	**Jacqui Wilkes**	**Throughout the life of the project**
The new care model may exceed the financial envelope available and cannot be fully implemented.	To ensure clinical engagement in the redesign process. Highlighting efficiency measures that deliver savings whilst not compromising patient safety.			

'Resources required' is asking for a summary of the costs that are needed to implement the changes to mitigate the negative impacts identified

SECTION 7 – ONGOING MONITORING AND REVIEW OF EQUALITY IMPACT ASSESSMENTS AND ACTION PLANS

Please describe briefly, how the equality action plans will be monitored through internal CCG governance processes?

Using the IAF framework, and project highlight reports to Programme executive and organisational boards.

Date of the next review of the Equality Impact Assessment section and action plan? (Please note: if this is a project or pilot reviews need to be built in to the project/pilot plan)

Date: End of consultation
Which CCG Committee will be responsible for monitoring the action plan progress? Caring Together Board, Connecting Care
Who will be the responsible person in the organisation to ensure the action plan is monitored? Jacki Wilkes and Jamaila Tausif
FINAL SECTION **SECTION 8**
Date sent to Equality & Inclusion (E&I) Team for quality check: **09-11-2017**
Date quality checked by Equality and Inclusion Business Partner: **09-11-2017**
Date of final sign off by Equality and Inclusion Business Partner: **09-11-2017**
Signature Equality and Inclusion Business Partner: *Q Hussain*
CCG Committee Name and sign off date:

This is the end of the Equality Impact and Risk Assessment process: By now you should be able to clearly demonstrate and evidence your thinking and decision(s).
To meet publishing requirements this document SHOULD NOW BE PUBLISHED ON YOUR ORGANISATIONS WEBSITE.

- Save this document for your own records
- Send this document and copies of your completed Privacy Impact Assessment and Human Rights Screening to equality.inclusion@nhs.net

Supporting Document 2

Equality Impact Assessment 4b

MIDLANDS AND LANCASHIRE
COMMISSIONING SUPPORT UNIT

Equality Impact and Risk Assessment Stage 2

Equality Impact and Risk Assessment

Title

Equality & Inclusion Team, Corporate Affairs
For enquiries, support or further information contact
Email: equality.inclusion@nhs.net

EQUALITY IMPACT AND RISK ASSESSMENT TOOL STAGE 2 ALL SECTIONS – MUST BE COMPLETED			
SECTION 1 - DETAILS OF PROJECT			
Organisation: Eastern Cheshire CCG			
Assessment Lead: Mandie Graham / Marie Ward			
Directorate/Team responsible for the assessment: Option 4b: Adult Mental Health Redesign Project Team			
Responsible Director/CCG Board Member for the assessment: Jacki Wilkes			
Who else will be involved in undertaking the assessment? Marie Ward, Suzanne Edwards, Jamaila Tausif			
Date of commencing the assessment: 13/10/17			
Date for completing the assessment: 03/11/17			
SECTION 2 - EQUALITY IMPACT ASSESSMENT			
Please tick which group(s) this project will or may impact upon?	**Yes**	**No**	**Indirectly**
Patients, service users	☑		
Carers or family	☑		
General Public		☑	
Staff	☑		
Partner organisations	☑		

Background of the project being assessed:
The NHS in Eastern and Central Cheshire are working with local mental health provider Cheshire and Wirral Partnership and the local council to review and redesign secondary care adult and older peoples mental health services for those residents with a severe and enduring mental health need. Secondary care services is the term used to differentiate them from primary mental health services such as GP only care and universal psychological therapies (IAPT) Secondary services includes specialised community support, crisis response and inpatient care which is provided mainly on The Millbrook unit in Macclesfield. The project aims to improve clinical and health and well-being outcomes for service users through a new model of care and redesigned service delivery arrangements to support early intervention and prevention and reduce overall reliance on hospital services.

What are the aims and objectives of the project being assessed?
The purpose of this project is to deliver improved mental services for the registered population of Vale Royal South and Eastern Cheshire.

Option 4b: 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)

Description: In this option 22 beds would be provided at Lime Walk for adults. 22 beds would be provided at Bowmere, 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. There will be 3 beds at Wirral for adults. Central and East patients would be admitted to Bowmere. Rehabilitation services currently delivered at Lime Walk would be re-provided at the Soss Moss site in Nether Alderley. In patient ECT would be delivered at the specialist ward in Bowmere. 6 beds will be available locally to support short stay care for people in crisis. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café.

Services currently provided in relation to the project:

Community care is provided by Community Mental health Teams (CMHTs) based in Macclesfield for Eastern Cheshire residents and Crewe for Vale Royal and South Cheshire residents. Home Treatment Teams provide access to crisis care and are the gatekeepers to inpatient services. They will also provide in reach services for crisis care. In this option the service would be extended to cover 24/7. In addition a dementia outreach service would provide intensive support to people at home, thereby preventing unnecessary admissions to hospital.

Community mental health teams are comprised of a mix of community psychiatric nurses, allied professionals and medical staff provided by CWP whilst Local Authorities provide social work input to these teams: Cheshire East Council for Eastern Cheshire and South Cheshire teams and Cheshire West and Chester to the Vale Royal teams. In patient facilities are provided at Millbrook in Macclesfield and Bowmere in Chester.

Which equality protected groups (age, disability, sex, sexual orientation, gender reassignment, race, religion and belief, pregnancy and maternity, marriage and civil partnership) and other employees/staff networks do you intend to involve in the equality impact assessment?

Please bring forward any issues highlighted in the Stage 1 screening

In this option 22 beds would be provided at Lime Walk for adults. 22 beds would be provided at Bowmere, 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. There will be 3 beds at Wirral for adults. Central and East patients would be admitted to Bowmere. Rehabilitation services currently delivered at Lime Walk would be re-provided at the Soss Moss site in Nether Alderley. In patient ECT would be delivered at the specialist ward in Bowmere. Community mental health teams would deliver interventions to allow safe care and have the appropriate skill mix to do so. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café.

In response to the growing body of evidence that demonstrates improved outcomes for people where there are adequate community services and rapid response to support people in crisis. (Kings Fund 2017, FYFV 2016) we are planning to make changes to the way in which services are commissioned and delivered for our population.

Locally developed transformation plans describe a programme of co-design across the health and social care

economy where health and care commissioners and providers respond to patient 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 fit for the 21st century's population needs and is entirely consistent with the national vision for future mental health services described in the 5YFV and is the framework we have used for our needs analysis and workforce planning

In early stages of implementation, the aim is 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.

In taking transformation plans forward for people with SMI an improved approach to care has been created by local clinicians and patients. We have segmented the population into groups according to their risk of needing care so that we can develop services to meet their needs and better target services where they have the most impact. We believe that we will be able to dramatically shift the over reliance on reactive, acute hospital care to proactive care closer to home with improved patient experience and outcomes.

Based on the above options the following sections will consider the impact of each of the options against the Protected Characteristics.

1. Gender

The 2011 census data shows that in East Cheshire approximately 51% of the population are female and 49% are male.

Nationally, when looking at the sex distribution for people who have a severe mental illness, overall rates do not differ significantly between male and female. This is for conditions such as psychotic disorders, bipolar effective disorder and personality disorder.

The table below highlights the admissions to Millbrook, broken down by gender. Slightly more females were admitted between 1st April 2016 to 31st March 2017.

	Female	% Female	Male	% Male	Total Patients
Adelphi Ward - open age inpatient mental health ward caring for older people in East Cheshire.	222	69.16%	99	30.84%	321
Bollin Ward - open age inpatient mental health ward caring for young adults in East Cheshire	217	48.33%	232	51.67%	449
Croft Ward - 14 bed inpatient ward providing specialist	39	57.35%	29	42.65%	68

treatment for people with dementia in East Cheshire					
Overall	**478**	**57.04%**	**360**	**42.96%**	**838**

It is considered that all genders will be impacted upon as a result of the changes.

Impact of service reconfiguration on Gender as a Protected Characteristics.

All genders will be adversely impacted by this option. All genders will receive their care in the main in Bowmere, Chester. All genders over the age of 65 and/or with greater physical health needs will in the main receive their care in Bowmere. Both male and female within this option will be cared for in single, en-suite rooms in buildings that meet the national standards.

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire. This option is expected to improve service user experience, and provide improved quality of care through improved access to community based services.

Potential Mitigations for Option 4b

The relocation of some inpatient services to Bowmere may have an adverse impact on all genders. For all service users requiring an admission to Bowmere CWP will ***continue*** to support their transfer via a mental health practitioner or ambulance.

CWP, CCG and Local Authority would need to ensure that travel options are well published, which would include travelling with NHS patient transport services. Individual difficulties would be reviewed on a case by case basis and every attempt made to support family and carers and patients to remain connected through in patient stay, through flexible visiting, use of technology and local in patient crisis beds.

2. **Pregnancy and maternity**

In 2009 the general fertility rates for England and Wales was 63.6 (per live 1,000 births), in East Cheshire this rate is 59.8, and therefore slightly lower than the national rate, but is more or less equal to the birth rate in the North West.

Perinatal services are specialist mental health services that support women and their families during pregnancy and following birth.

Impact of service reconfiguration on Pregnancy and Maternity as a Protected Characteristics

There is no proposed change in the provision of Specialist community perinatal services and these are provided via CWP and are across Cheshire and Merseyside. Women in the perinatal period who require admission to a specialist mother and baby unit will continue to access regional units. This is not provided at Millbrook or any of the other inpatient units within CWP.

Women in the perinatal period who wish to remain at home during periods of crisis will be able to receive

enhanced community support via the crisis service, therefore increasing the likelihood of the mother being able to stay at home. Access to mother and baby units can take a number of days to secure due to the limited numbers, and therefore at times of need they will require admission to an acute inpatient unit. Bowmere has single ensuite rooms, family visiting areas that can be utilised to support mother and baby during periods of visiting. The community specialist perinatal team will ensure that the service user maintains contact with their local midwifery services and arrangements will be put in place for this to continue if admitted to Bowmere. It is believed that this option will improve service user experience and supports person centred care.

Potential Mitigations

The relocation of some inpatient services to Limewalk will have no adverse impact on women during the perinatal period. For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner, ambulance or other means based on individual choice.

CWP, CCG and Local Authority would need to ensure that travel options are well published, which would include travelling with NHS patient transport services. The use of technology and flexible visiting hours to maintain contact with family and friends will be explored.

3. Impact of service reconfiguration on Age as a Protected Characteristic

Since the 2001 census there has been a 26% increase in the number of residents 65 and older, which is a larger increase than in the North West (15%) and England and Wales (20%). There has been a 35% increase in the number of residents 85 years and older, which again is a larger increase than the North West (205) and England and Wales (24%). There has been a decrease in the number of children by 4% and those of approximate working age have increased by 4% in line with trends in the North West and England and Wales. There are fewer people in all age groups under 40 than England and Wales, and the median age of residents in 2001 was 40.6 years and by 2011 this has increased to 43.6 years.

Population of East Cheshire by Age

Age All categories: Age - 370,127	Number	% of population
Under 16	65,753	17.9%
16-29	55,282	14.90%
29-64	177,720	48%
65+	71,372	19.30%

Admissions to Millbrook by age (2016/2017)

	Aged 16-29	% 16-29	Aged 30-64	% 30-64	Aged 65 +	% 65+	Total Patients
Adelphi Ward	37	11.53%	163	50.78%	121	37.69 %	321
Bollin Ward	116	25.84%	322	71.71%	11	2.45%	449
Croft Ward	Less than 10	0.00%	Less than 10	10.29%	61	89.71 %	68

Overall	**153**	**18.26%**	**492**	**58.71%**	**193**	**23.03 %**	**838**

Option 4b

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire and will be enhanced. This option is expected to improve service user experience, and provide improved quality of care through improved access to community based services.

For older adults age 65+ requiring inpatient care, they will receive their care at Bowmere, balancing additional travel and quality of specialist care. Those who require PICU, ECT or specialist intervention for complex presentations will also receive their care at Bowmere.

Adults of working age will receive the same enhanced community provision, this group will be admitted to Limewalk if they require inpatient care, and therefore are not adversely impacted on as a result of this option. This cohort during 2016/17 accounted for 0.016% of the total population of Central and Eastern Cheshire.

Potential Mitigations

Access to community based crisis services 24/7 will reduce the need for admission to an inpatient unit, and will reduce length of stay by facilitating early discharge

For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner or ambulance.

4. **Impact of service reconfiguration on Disability as a Protected Characteristic**

Disability All households - 159,441	Number	% of population
One person in household with a long-term health problem or disability: With dependent children	6,045	3.8%
One person in household with a long-term health problem or disability: No dependent children	33,628	21.1%

Option 4b

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire. This option is expected to improve service user experience, and provide better quality of care through improved access to community based services.

For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner or ambulance.

Potential Mitigations for Option 4b

Ensure that services and locations where community services will be offered from are EQUALITY ACT 2010 compliant

Improve data quality of services users with a disability to inform further mitigations and equality impact assessments.

Ensure that reasonable adjustments are made, and facilities are suitable.

Ensure that information on the service reconfiguration specially targets disabled groups

Provide clear information in alternative formats and with alterative content targeted at people with different abilities for wide dissemination (Accessible Information Standard)

Ensuring compliance with safeguarding regulations

Provide staff training on how to actively support members of this community

CWP, CCG and Local Authority would need to ensure that travel options are well published, which would include travelling with NHS patient transport services.

5. **Impact of service reconfiguration on Race as a Protected Characteristic**

Breakdown from 2011 Census

Ethnicity All categories: Ethnic group - 370,127	Number	% of population
White	357,627	96.7%
Black/African/Caribbean/Black British	1,402	0.4%
Asian/Asian British:Chinese	2,553	0.7%
Asian/Asian British:Bangledeshi/Indian,Pakistani	3,507	0.9%
Mixed/Multiple Ethnic Groups	3,873	1.0%
Gypsy/Traveller/Irish Traveller	313	0.1%
Other Ethnic Group	852	0.2%

Breakdown of Ethnicity for Individuals accessing all services in Central and East Cheshire

Ethnicity	Total
Asian Or Asian British, Bangladeshi	Less than 10
Asian Or Asian British, Indian	15
Asian Or Asian British, Other	28

Asian Or Asian British, Pakistani	10
Black Or Black British, African	18
Black Or Black British, British Caribbean	27
Black Or Black British, Other	Less than 10
Mixed, Other	20
Mixed, White & Asian	13
Mixed, White & Black African	Less than 10
Mixed, White & Black Caribbean	16
Not Stated	41
Other Ethnic Groups, Chinese	Less than 10
Other Ethnic Groups, Other	18
Unknown	929
White, British	9359
White, Irish	55
White, Other	133
Total	**10704**

Option 4b

Enhanced community services will be provided closer to home and support will be offered 24/7 for those experiencing a crisis. For those who are unable to attend community based clinics, practitioners will be able to visit at home or venue of choice to provide the appropriate support, therefore negating the need for additional travel. Community provision will remain in Central and East Cheshire. This option is expected to improve service user experience, and provide better quality of care through improved access to community based services and crisis beds.

For all service users requiring an admission to Bowmere CWP will continue to support their transfer via a mental health practitioner or ambulance.

Potential mitigations for Option 4b

The mitigations would be:

- Providing information in alternative languages;
- Ensuring all staff have appropriate training in cultural diversity
- Ensuring effective and timely interpretation services are made available and staff understand the requirements and system for providing this
- All CWP staff work within the Equality, Diversity and Human Rights policy, and regardless of the outcome of the consultation everyone will be offered a person centred approach.
- All CWP inpatient units provide access to multi-faith rooms, facilitate support from faith leaders and promote and support individuals to continue to access faith based community support whilst receiving inpatient care.

6. Impact of service reconfiguration on Gender reassignment as a Protected Characteristic

Currently CWP do not hold any information on the number of people who have undergone gender reassignment.

At present there is no official estimate of the transgender population. The England/Wales and Scottish Census have not asked if people identify as transgender and did not ask the question in the 2011 census. In a Home Office funded study estimated numbers of trans people in the UK was documented to be between 300,000 – 500,000. This was however described as including anybody who experienced some degree of gender variance.

The absence of public data raises concerns for the completeness of this pre-consultation equality impact assessment.

Despite the lack of data we know that transgender individuals may require services typically associated with a defined gender that they do not identify with, or are accessing services that are seen to promote traditional "family" orientated services. It is acknowledged that individuals may experience anxiety and discomfort when receiving inpatient care where signage and labels are male and female and they may still be undergoing gender reassignment. CWP will facilitate the gender assignment that the person identifies with, and will provide the appropriate support and adjustments. This issue could be addressed by the provision of single en-suite rooms.

Mitigations

- Single en-suite rooms
- The provision of non-gender bathrooms in community resources.
- Providing staff training and awareness sessions, on how to actively support individuals in the different care settings.
- Work with 3rd sector organisations via the EDS2 framework including Body Positive (LGBT) and a Unique Transgender organisation. Both organisations have provided training and information sessions to CWP staff, with Body Positive sitting on the assessment panel.
- Data collection methodology should be explored on how best this information can be captured.

7. Impact of service reconfiguration on Marriage and civil partnerships as a Protected Characteristic

Marital & civil partnership All categories: Marital and civil partnership status - 304,374	Number	% of population
Single (never married or never registered a same-sex civil partnership)	86,618	28.5%
Married	158,540	52.1%
In a registered same-sex civil partnership	563	0.2%
Separated (but still legally married or still legally in a same-sex civil partnership)	6,708	2.2%
Divorced or formerly in a same-sex civil partnership which is now legally dissolved	28,426	9.3%
Widowed or surviving partner from a same-sex civil partnership	23,519	7.7%

Breakdown of marital status for individuals receiving CWP services

Marital Status	Total

Cohabiting	186
Divorced	438
Married	2916
Not Disclosed	14
Not Known	1084
Separated	139

It is acknowledged the role that partners play in caring for their loved ones. A separate section of the EIA will address the impact that the proposed options will have on carers.

It is however not anticipated that individuals who are married or in a civil partnership will be disproportionally affected on either of the options described in this pre-consultation business case.

8. Impact of service reconfiguration on Religion and belief as a Protected Characteristic

Access to and the provision of services is not provided on the grounds of religion. All CWP inpatient units provide access to multi-faith rooms, facilitate support from faith leaders and promote and support individuals to continue to access faith based community support whilst receiving inpatient care. The EDS2 stakeholder assessment will monitor the actions in relation to this protected group and ensure that there are no unintended consequences as a result of the agreed option following consultation. Both options put forward will be expected to impact all religious beliefs equally.

Religion All categories: Religion - 370,127	Number	% of population
Christian	254,940	68.9%
Buddhist	882	0.2%
Hindu	1328	0.4%
Jewish	581	0.2%
Muslim	2438	0.7%
Sikh	279	0.1%
Other religion	1065	0.3%
No religion	83,973	22.7%
Religion not stated	24,641	6.7%

Baptist	Less than 10
Buddhist	16
Christian	2515
Christian Science	11
Church Of England	1586

Church Of Scotland	Less than 10
Church Of Wales	Less than 10
Declined To Disclose	15
Hindu	14
Jehovah's Witness	32
Jewish	Less than 10
Lutheran	Less than 10
Methodist	69
Muslim	29
None	383
Not Specified	3368
Orthodox	Less than 10
Other	581
Pagan	Less than 10
Pentecostal	Less than 10
Roman Catholic	258
Salvation Army	Less than 10
Seventh Day Adv'Tist	Less than 10
Sikh	Less than 10
United Reform Church	Less than 10
Unknown	1780
Total	**10704**

9. Impact of service reconfiguration on sexual orientation as a Protected Characteristic

Currently there is not local data that provides a breakdown of sexual orientation by authority. In 2009, there were approximately 430,000 lesbian and gay people living in the North West.Ref: Ecotec (2009), Improving the Region's knowledge base on LGBT population in the North West.

Breakdown of sexual orientation of individuals in receipt of CWP services

Sexual Orientation	Total
BI-SEXUAL	23
GAY OR LESBIAN	Less than 10
GAY/LESBIAN	33
HETEROSEXUAL	4376
Not Known	6067
NOT STATED	132
OTHER	Less than 10
PERSON ASKED AND DOES NOT KNOW OR IS NOT SURE	Less than 10

PREFER NOT TO ANSWER	63
Total	**10704**

Data collection and the quality of the data will require enhancement to ensure that this can then inform the consultation and this equality impact assessment.

Research suggests that LGBT communities experience considerable health inequalities compared to the population on average which impact on their experience in the healthcare system and health outcomes (Stonewall 2008 Prescription for Change)

In 2014 the JSNA in Cheshire East undertook a consultation with the Third Sector Provider on mental health. One of the findings of this work was that gay farmers are a particularly vulnerable group in rural Cheshire East and they recommended that future service-design should take into account the increased risk of suicide amongst gay farmers. They report on evidence that farmers and farm managers are the occupational group with the fourth highest risk of suicide in England and Wales, and say that there is evidence to suggest this figure is much higher. Added to this is the statistic that one in four gay men will attempt suicide at some stage in their lives. This highlights gay farmers to be a particularly vulnerable group.

A further finding of this group concluded that LGBT people confirmed that Isolation and loneliness around sexual orientation is an issue, and can lead to depression and the use of substances.

Neither of the options described in the pre-consultation business care are expected to discriminate against LGBT individuals.

Carers

Based on this option, carers may be impacted as follows

Option 4b

Older people, age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. It is acknowledged that carers will have to travel to visit their loved ones, and this may be a greater distance than they would if their loved one was admitted to Millbrook. This is dependent on where the carer lives in relation to the various inpatient units, and we cannot assume that all carers reside with the individual whom they are caring for and/or related to. Based on admission in the previous year, this would equate to circa 41 individuals (that would be potentially be admitted to Bowmere if we progressed option 4b). To put this into context there are around 5,300 service users being supported in the community. By making this change we would anticipate that the number of in patient admissions to be reduced due to the enhanced community care provision.

Adults of a working age will in the main be admitted to Lime Walk House, unless they require PICU, ECT or have complex needs. Inpatient mental health care is considered as specialist, and not comparable to physical health care from district general hospitals. It is common for individuals to travel for specialist care, such as cancer, cardiac, paediatrics or neurology. Individuals requiring specialist inpatient mental health care should not be seen any differently from those requiring specialist physical health care. However it is acknowledged that under this option some carers may be disadvantaged compared to the current

arrangements

Mitigations for option 4b

- use of technology to support carers and family to maintain contact
- Flexible visiting hours
- where the family or carers have concerns around in patient placement every attempt will be made to support the patients, carers and family to remain connected.
- Enhanced community provision will reduce the need for hospital admission and facilitate early discharge therefore reducing the number of carers impacted by the changes
- consultation will have a focus on carer engagement and feedback

Summary of the pre-consultation equalities impact assessment

The following provides an overview of whether the proposed options are expected to have a disproportionate effect on any of the 9 protected characteristics.

Protected Group	Expected Impact	Risk	Mitigations
Gender	Neutral	Low	Staff support and training Provision of single ensuite rooms
Disability	Neutral	Low	Ensure that services are compliant with the Equality Act 2010 Ensure reasonable adjustments Staff support and training Support engagement with identified groups via the EDS2
Gender Reassignment	Neutral	Low	Staff support and training Support engagement with identified groups via the EDS2
Marriage and Civil Partnership	Neutral	Low	No specific mitigations identified
Pregnancy and maternity	Neutral	Low	No specific mitigations identified
Race	Neutral	Low	Access to information in a range of languages and formats Staff training and support Access to translation services

			Single ensuite rooms
Religion and belief	Neutral	Low	Provide adequate faith facilities Facilitate community engagement with faith groups via EDS2 Training and staff support
Sexual orientation	Neutral	Low	Work closely with LGBT groups Support engagement with LGBT community via EDS2 Training and staff support
Age	Neutral for Adults	Medium	Enhanced community provision

How will you involve people from equality/protected groups in the decision making related to the project?

During development of these proposals we have demonstrated a commitment to be proactive to seek the views and experiences of our local populations and be accessible and convenient. We have met with various interest groups, undertaken site visits with experts by experience and invited users to share experiences and views in a range of meetings from CCG Annual Fairs to individual case studies

We have used this information alongside carer and staff views and experiences in the development of the Pre-Consultation Business Case; including the options appraisal process.

Patient and carers workshops were held at the Millbrook Unit 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 Cheshire East Healthwatch, Cheshire East Health Voice 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.

More recently listening events were held in September 2017 at Crewe Alexandra FC and Macclesfield Town FC. Over 60 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 services might be improved. In addition an online survey was also made available to those who couldn't attend the sessions.

Further engagement with people from the different protected characteristic groups, will take place throughout the consultation period.

EVIDENCE USED FOR ASSESSMENT

What evidence have you considered as part of the Equality Impact Assessment?

- **All research evidence base references including NICE guidance and publication – please give full reference**

The table below shows the 5 year forward view mental health standards to be achieved by 2021. This option will help towards meeting these standards. A copy of the full Adult mental health policy is attached.

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.

- **Bring over comments from Stage 1 and prior learning (please embed any documents to support this)**

Mitigating actions

The Five Year Forward View recognises the need to address capacity in the community and is a national mandate to improve and modernise mental health services to reflect a proactive, timely response to need. (FYFV)

Underpinned by an appropriately trained workforce, there is a requirement to improve access for Crisis Resolution and Home Treatment Teams (CRHTTs) to ensure that a 24/7 community-based mental health crisis response is available in all areas. These teams must be adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission, in the least restrictive manner and as close to home as possible. There must be evidence of investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder and 'navigators' who are available to people who need specialist care from diagnosis onwards, to guide them through options for their care and ensure they receive appropriate information and support

In this option we will Enhance community services through:

- 24/7 crisis house
- Crisis café
- 22 beds would be provided at Lime Walk for adults. 22 beds would be provided at Bowmere, 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. There will be 3 beds at Wirral for adults.
- Increased capacity of mental health teams to enhance home treatment.

ENSURING LEGAL COMPLIANCE		
Think about what you are planning to change; and what impact that will have upon 'your' compliance with the Public Sector Equality Duty (refer to the Guidance Sheet complete with examples where necessary)		
In what way does your current service delivery help to:	How might your proposal affect your capacity to:	How will your mitigate any adverse effects? (You will need to review how effective these measures have been)
End Unlawful Discrimination?	**End Unlawful Discrimination?**	**End Unlawful Discrimination?**
Enhances provision for all protected characteristics	Enhances provision for all protected characteristics	Enhanced community services to all groups
Promote Equality of Opportunity?	**Promote Equality of Opportunity?**	**Promote Equality of Opportunity?**
This change facilitates all members of the community to access information, services, help and support by providing access to all the local community services 24/7.	This change facilitates all members of the community to access information, services, help and support by providing access to all the local community services 24/7.	Enhanced community services to all groups

Foster Good Relations Between People	Foster Good Relations Between People	Foster Good Relations Between People
The various types of support available through this service help to engage and enable people from different backgrounds to participate in public life	The various types of support available through this service help to engage and enable people from different backgrounds to participate in public life	Investigate use of technology i.e. facetime, skype. Flexible visiting hours

WHAT OUTCOMES ARE EXPECTED/DESIRED FROM THIS PROJECT?

What are the benefits to patients and staff?

Care in community

Evidence shows from other areas that facilities like crisis café's and places of safety with 24/7 access to crisis support are highly valued by carers and people who use the service. These are now common place in other parts of the country.

A café in a North East Hampshire has helped reduce mental health hospital admissions by a third in seven months by providing an alternative solution for service users (NHS England case study) Other examples are evident across the country including Greater Manchester, Wirral. We want these types of services to be available to our communities too

Enhancing our community support

Benefits will include:

- Consistent access to services
- PICU provision within appropriate inpatient facility
- Enhanced community services
- Responsive, community focussed, personalised care system providing wrap around care.
- Access to specialist services as close to home as possible
- Support for individuals to effectively manage their wellbeing with a focus on empowerment, prevention and resilience
- More patients supported in their own homes
- Access to out of hours support for those in a crisis

How will any outcomes of the project be monitored, reviewed, evaluated and promoted where necessary?

The project will be monitored using the Outcomes framework, IAF framework measures to ensure no adverse impact on care, and also through contractual obligations with CWP

"think about how you can evaluate equality of access to, outcomes of and satisfaction with services by different groups"

- Feedback from users of the service will be captured through the use of the following:
- Friends and family test
- Patient satisfactions survey

- Patient reported outcomes measures
- Patient reported experience measures

EQUALITY IMPACT AND RISK ASSESSMENT

Does the 'project' have the potential to:

- Have a ***positive*** **impact (benefit)** on any of the equality groups?
- Have a ***negative impact / exclude /*** **discriminate** against any person or equality group?
- **Explain** how this was **identified? Evidence/Consultation?**
- Who is most likely to be **affected** by the proposal and **how** (think about barriers, access, effects, outcomes etc.)
- Please include all evidence you have considered as part of your assessment e.g. Population statistics, service user data broken down by equality group/protected group

Please request guidance on Equality Groups/Protected Groups and their issues, this document may help and support your thinking around barriers for the equality groups

Equality Group / Protected Group	Positive effect	Negative effect	Neutral effect	Please explain - MUST BE COMPLETED
Age	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Adults in the age category 18-64 would continue to have their care provided locally. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis..
Disability	☑	☑		Positive impact - With the changes proposed in this model the Services users

				will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis.
Gender Reassignment	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Taking into regard the persons chosen gender identity, patients would be appropriately placed.
Pregnancy and Maternity	☑			Patients already travel out of area for maternal mental health.
Race	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed,

				therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Providing information in alternative languages. • Ensuring all staff have appropriate training in cultural diversity. • Ensuring effective and timely interpretation services are made available and staff understand the requirements and system for providing this. • All CWP staff work within the Equality, Diversity and Human Rights policy, and regardless of the outcome of the consultation everyone will be offered a person centred approach.
Religion or Belief	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact –Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case

				basis. Mitigation • Providing information in alternative languages; • Ensuring all staff have appropriate training in cultural diversity • Ensuring effective and timely interpretation services are made available and staff understand the requirements and system for providing this • All CWP staff work within the Equality, Diversity and Human Rights policy, and regardless of the outcome of the consultation everyone will be offered a person centred approach. • All CWP inpatient units provide access to multi-faith rooms, facilitate support from faith leaders and promote and support individuals to continue to access faith based community support whilst receiving inpatient care.
Sex (Gender)	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Staff support and training

				• Provision of single ensuite rooms
Sexual Orientation	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Work closely with LGBT groups • Support engagement with LGBT community via EDS2 • Training and staff support
Marriage and Civil Partnership N.B. Marriage & Civil Partnership is only a protected characteristic in terms of work-related activities and NOT service provision	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis.
Carers	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7

				crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. It is acknowledged that carers will have to travel to visit their loved ones, and this may be a greater distance than they would if their loved one was admitted to Millbrook. This is dependent on where the carer lives in relation to the various inpatient units, and we cannot assume that all carers reside with the individual whom they are caring for and/or related to. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Flexible visiting hours • Virtual visiting. I.e. Skype, Facetime etc.
Deprived Communities	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Flexible visiting hours • Virtual visiting. I.e. Skype, Facetime etc. • Prioritise local beds based on patient and carer need • Appropriate package of care on

				discharge from hospital.
Vulnerable Groups e.g. Homeless, Sex Workers, Military Veterans	☑	☑		Positive impact - With the changes proposed in this model the Services users will have the opportunity to access a 24/7 crisis service, which should ensure access to help at the point at which it is most needed, therefore preventing the need for hospitalisation. Enables earlier supported discharge. Potential negative impact – Adults age 65+ who require an acute inpatient bed, ECT or PICU provision will be admitted to Bowmere. This may be a greater distance than if they were admitted to Millbrook. In some cases the in-patient facility may be closer to the patients home than the one based in Macclesfield. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Mitigation • Flexible visiting hours • Virtual visiting. I.e. Skype, Facetime etc. • Prioritise local beds based on patient and carer need • Appropriate package of care on discharge from hospital.

SECTION 3 - COMMUNITY COHESION & FUNDING IMPLICATIONS

Does the 'project' raise any issues for Community Cohesion?

N/A

What effect will this have on the relationship between these groups? Please state how will you manage this relationship?

N/A

What is the overall cost of implementing the 'project'?

Please state: Cost & Source(s) of funding:

This is the end of the Equality Impact section, please use the embedded checklist to ensure and reflect that you have included all the relevant information

EI&RA checklist_V1.0_11091

SECTION 4 - HUMAN RIGHTS ASSESSMENT

If the Stage 1 Equality Impact and Risk Assessment highlighted that you are required to complete a Stage 2 Human Rights assessment (please request a stage 2 Human Rights Assessment from the Equality and Inclusion Team), please bring the issues over from the screening into this section and expand further using the Human Rights full assessment toolkit then embed into this section.

SECTION 5 - PRIVACY IMPACT ASSESSMENT

If the Stage 1 Equality Impact and Risk Assessment highlighted that you are required to complete a Stage 2 Privacy Impact Assessment, please request a stage 2 Privacy Impact Assessment either from the Equality and Inclusion Team or the Information Governance Team, email your completed stage 2 to your Information Governance Support Officer either at the CCG or CSU.

A separate document has been completed for the Privacy Impact Assessment.

SECTION 6 – RISK ASSESSMENT

Please identity any possible risk for patients and / or the Clinical Commissioning Group if the project is implemented without amendment. All risks will be monitored for trends and provided to the project author when the project is due to be reviewed

IMPLEMENTATION RISK: CONSEQUENCE SCORE

DOMAIN	INSIGNIFICANT	MINOR	MODERATE	MAJOR	CATASTROPHIC
Impact on the safety of patients, staff or public (physical / psychological harm	Minimal injury requiring no / minimal intervention or treatment	Minor injury or illness, requiring minor intervention	Moderate injury requiring professional intervention RIDDOR / agency reportable incident, an event which impacts on a small number of patients	Major injury leading to long-term incapacity / disability. Mismanagement of patient care with long-term effects	Incident leading to death. An event which impacts on a large number of patients
Complaints / Audit	Informal complaint / inquiry	Formal complaint (Stage 1) Local resolution Single failure to meet internal standards Reduced performance rating if unresolved	Formal complaint (Stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards	Multiple complaints / independent review Low performance rating Critical report	Inquest / Ombudsman inquiry Gross failure to meet national standards Severely critical report
Statutory Duty / Inspections	No or minimal impact or breech of guidance / statutory duty For example: Unsatisfactory	Breech of statutory legislation. Reduced performance rating if unresolved. For	Single breech in statutory duty. Challenging external recommendations / improvement notice.	Multiple breeches in statutory duty. Enforcement action Low	Multiple breeches in statutory duty. Prosecution Zero performance rating Severely critical report.

	patient experience which is not directly related to patient care. No action required	example: a minor impact on people with a protected characteristic has been identified that was agreed to be accepted within the scope of the project. No action required.	For example: a moderate impact on people with a protected characteristic has been identified. This can be resolved by making amendments to the project or providing an objective justification for not amending the project (This must be published with the EIA)	performance rating report For example: a major impact on people with a protected characteristic has been identified. Consideration should be given to and review the project immediately. Q. Can we make amendments to the project or provide objective justifications ? If yes, this must be published the EIA.	For example: a catastrophic impact on people with a protected characteristic has been identified that may lead to litigation or impact on patient safety. The project should be stopped immediately
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage short-term reduction in public confidence. Elements of public expectation not being met	Local media coverage. Long-term reduction in public confidence	National media coverage <3 days service well below reasonable public expectation	National media coverage > 3 days MP concerned (questions in the House) Total loss of public confidence
Business Objectives / Projects	Insignificant cost increase No impact on objectives	<5 per cent over project budget Minor impact on delivery of objectives	5 – 10 per cent over project budget	Non-compliance with national 10 – 25 per cent over budget Major impact on delivery of strategic objectives	Incident leading > 25 per cent over project budget Failure of strategic objectives impacting on delivery of business plan
Finance Including Claims	Small loss risk of claim remote	Loss of 0.1 – 0.25 per cent of budget Claim less than £10,000	Loss of 0.25 – 0.5 per cent of budget Claims (s) between £10,000 and £100,000	Loss of 0.5 – 1.0 per cent of budget Claim(s) between £100,000 and £1 million	Loss of >1 per cent of budget Claim(s) > £1 million
IMPLEMENTATION RISK: LIKELIHOOD SCORE					
Frequency: How often	Not expected to occur for years	Expected to occur annually	Expected to occur monthly	Expected to occur weekly	Expected to occur daily

might it / does it happen?					
Probability	<1%	1.5%	6-20%	21-50%	>50%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not occur

RISK MATRIX					
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
Insignificant	1	2	3	4	5
Minor	2	4	6	8	10
Moderate	3	6	9	12	15
Major	4	8	12	16	20
Catastrophic	5	10	15	20	25

RISK SCORE ON DRAFT PROJECT	RISK SCORE ON FINALISED PROJECT
5	5

WHAT ARE THE KEY REASONS FOR THE CHANGE IN THE RISK SCORE?

EQUALITY IMPACT AND RISK ASSESSMENT AND ACTION PLAN

Risk identified	Actions required to reduce / eliminate the negative impact	Resources required* (see guidance below)	Who will lead on the action?	Target completion date
Negative media coverage has a detrimental impact on public consultation outcome	Communication and Engagement Plan to support proactive approach to local media. Consistent message from partners in communicating case for change. Joint approach to communication to wider statutory bodies. Clear governance process to obtain sign off from all partners for communication plan. Fully engage public in pre consultation process and consultation process (health voice, health watch, general public, 3rd sector organisations)	**Comms and Enagagement team**	**Katherine Wright, Charles Malkin**	**Ongoing throughout life of project**
Service sustainability during the planning and consultation phase	CWP to evoke Business Continuity plans. Regular communication with staff. Clinical Leadership across system to identify measures to maintain quality of care.	**CWP**	**Suzanne Edwards**	**Post Consultation**

Potential delays in delivering the programme within the timescales	Develop project plan with clear time lines to deliver the work plan and navigate governance process including NHSE sign off. Project Meetings bi weekly to monitor delivery against plan. Escalate project slippage to SRO.	**Project Sponsor**	**Jacqui Wilkes**	**Throughout the life of the project**
The decision making process following consultation period is challenged	Project process to follow NHS England best practice guidance recruit consultation expert to support pre-consultation engagement and the consultation itself. Ensure project documentation fully up to date and take clear and transparent approach to process and decision making. Take legal advice on consultation documentation. Independent review by Chester University within consultation timeline	**Project Sponsor**	**Jacqui Wilkes**	**Throughout the life of the project**
The new care model may exceed the financial envelope available and cannot be fully implemented.	To ensure clinical engagement in the redesign process. Highlighting efficiency measures that deliver savings whilst not compromising patient safety.	**Project Sponsor, Finance Rep**	**Jacki Wilkes, Scott Maull, Elizabeth Insley**	

'Resources required' is asking for a summary of the costs that are needed to implement the changes to mitigate the negative impacts identified

SECTION 7 – ONGOING MONITORING AND REVIEW OF EQUALITY IMPACT ASSESSMENTS AND ACTION PLANS

Please describe briefly, how the equality action plans will be monitored through internal CCG governance processes?

Using the IAF framework, and project highlight reports to Programme executive and organisational boards.

Date of the next review of the Equality Impact Assessment section and action plan? (Please note: if this is a project or pilot reviews need to be built in to the project/pilot plan)

Date: End of the consultation

Which CCG Committee will be responsible for monitoring the action plan progress?
Caring Together Board, Connecting Care

Who will be the responsible person in the organisation to ensure the action plan is monitored? Jacki Wilkes and Jamaila Tausif
FINAL SECTION **SECTION 8**
Date sent to Equality & Inclusion (E&I) Team for quality check: **09-11-2017**
Date quality checked by Equality and Inclusion Business Partner: **09-11-2017**
Date of final sign off by Equality and Inclusion Business Partner: **09-11-2017**
Signature Equality and Inclusion Business Partner: Q Hussain
CCG Committee Name and sign off date:

This is the end of the Equality Impact and Risk Assessment process: By now you should be able to clearly demonstrate and evidence your thinking and decision(s).
To meet publishing requirements this document SHOULD NOW BE PUBLISHED ON YOUR ORGANISATIONS WEBSITE.

- Save this document for your own records
- Send this document and copies of your completed Privacy Impact Assessment and Human Rights Screening to equality.inclusion@nhs.net

Supporting Document 3

Quality Impact Assessment 4a

Eastern Cheshire Clinical Commissioning Group: Quality Impact Assessment Tool

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score. A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

Quality is described in 7 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than a score of 8 this indicates that a more detailed assessment is required in this area, to be completed within stage 2.

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Definitions for grading

Risk Assessment Matrix								
Risk Assessment		Circle consequence, likelihood and total score e.g. 2 x 3 = 6			SCORE			
		LIKELIHOOD/PROBABILITY OF REPEAT						
INCIDENT CONSEQUENCES or POTENTIAL CONSEQUENCES		Rare	Unlikely	Possible	Highly Likely	Almost Certain		
		1	*2*	*3*	*4*	*5*		
1	Negligible	1	2	3	4	5		
2	Minor	2	4	6	8	10		
3	Moderate	3	6	9	12	15		
4	Major	4	8	12	16	20		
5	Extreme	5	10	15	20	25		

Green	(score 5 or less)	Low risk	Low priority	Manage situation by routine procedures
Amber	(score 6 to 15)	Medium risk	Medium priority	Management responsibility and action must be specified
Red	(score 16 to 25) Or any incident recorded as extreme regardless of the likelihood/probability of repeat	High risk	High Priority	Immediate action – Senior Management attention required. 16+ Senior Management to consider informing the Board.

Measures of Likelihood

LEVEL	DESCRIPTOR	PROBABILITY
1	Rare	The event may only happen in exceptional circumstances
2	Unlikely	The event could occur (recur) at some time
3	Possible	The event may well occur (recur) at some time
4	Highly likely	The event will occur (recur) in most circumstances
5	Almost Certain	The event is expected to occur (recur) in most circumstances

Stage 1 – Initial Risk Assessment 6th Month Review Date – 12-June-2017

Title: Adult Mental Health Redesign Option 4a

Lead for scheme: Jacki Wilkes Associate Director of Commissioning

Brief description of scheme:
Commissioners in Vale Royal, South and Eastern Cheshire are working with local mental health provider; Cheshire and Wirral Partnership, users of the service and Cheshire East Council to review and redesign secondary care adult and older peoples mental health services for those people with severe mental illness (SMI).

A Pre Consultation Business Case (PCBC) will outline a compelling case for change and present options which will deliver redesigned services for improved outcomes for the registered population of Vale Royal, South and Eastern Cheshire in line with national Five Year Forward View (FYFV) for Mental Health.

The FYFV for mental health sets out an ambitious programme of improvement to be achieved by 2021 setting standards for access and guidelines for care including 24/7 access to care, early intervention (proactive care) and prevention. The proposals presented are done so within a context of rising demands for services, increasing financial constraints across the health and social care system and national drivers to improve access to a

range of services not currently commissioned.

This QIA is for Option 4a outlined below:

Option 4a: Enhanced community and crisis care service and re-provide inpatient care from Millbrook to other facilities within current provider footprint (older people Lime Walk House, Macclesfield and adults Bowmere in Chester)

Description: In this option 22 beds would be provided at Lime Walk House; 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. 22 beds would be provided at Bowmere and 3 at Wirral for adults. Central and Eastern Cheshire patients would be given priority admission to Bowmere. Rehabilitation services currently delivered at Lime Walk House would be re-provided at the Soss Moss site in Nether Alderley. In patient ECT would be delivered at the specialist ward in Bowmere. Community mental health teams would deliver evidenced based interventions to support people in their own homes and have the appropriate skills to do so. A new model of crisis care will be introduced which would see the home treatment team providing 24/7 care in conjunction with, overnight placement support and day time crisis café

Answer positive/negative (+ / -) in each area. If N; score the impact, likelihood and total in the appropriate box. If score > 8 insert Y for full assessment

Area of Quality	Impact question	+ / -	Impact	Likely-hood	Score	Full Assessment required?
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	positive	**2**	**2**	**4**	**N**
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	Neutral	**2**	**3**	**6**	**N**
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	Positive	**2**	**2**	**4**	**N**
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	Positive	**2**	**2**	**4**	**N**
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	Positive	**2**	**2**	**4**	**N**
Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	Positive	**2**	**2**	**4**	**N**
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing*	Positive	**2**	**2**	**4**	**N**

Completed by:	Designation:	Date:
Marie Ward	Transformation Project Manager	07.11.17

Stage 2 – Full Assessment for identified areas of risk

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
DUTY OF QUALITY	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions?	Continuous improvement in the quality of healthcare will be monitored as part of Mental Health Outcomes Framework, Friends and Family Test and self-reported Experience and Outcomes Assessments.	2	2	4	Monitor and Review
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?	The projects aim is to support the delivery of the Five Year Forward View for Mental Health. To improve quality of care, patient experience and mental health outcomes, whilst ensuring the services are clinically and financially sustainable. The views and experiences of users and carer have informed the development of Pre Consultation Business Case (PCBC)	2	2	4	Monitor and Review
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?	Engagement and communication with Clinical Mental health Specialist including; NHS Mental Health Trust and Community Services and General Practice includes; front line staff drop-in sessions, Clinical Leaderships Meetings, GP Locality	2	2	4	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		and membership meetings to engage views and inform the PCBC and design of new model of care for Adult Mental Health.				
	What is the impact on strategic partnerships and shared risk?	Positive Impact Providers and Commissioners across Eastern Cheshire, South and Vale Royal CCG, Cheshire East Council and Cheshire and Wirral Partnership NHS Foundation Trust, working in partnership to develop the PCBC, North West Ambulances Service and Cheshire Police have been involved in discussion and scoring the options. The project team includes; clinical specialists, patients and carers, commissioners from health and social care and providers of mental health services.	2	2	4	Mitigating Actions Joint /Shared risk log jointly owned across partner organisations
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to CCG Equality Impact Assessment Tool)?	Stage 1 and Stage 2 equality impact and risk assessment have been completed and an action plan has been developed.	2	2	4	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
DUTY OF QUALITY	Are core clinical quality indicators and metrics in place to review impact on quality improvements?	A set of standardised key performance indicator measures aligned to National and Local Outcomes Frameworks have been identified to support completion of a final business case and future commissioning of Adult Mental Health Services.	2	2	4	Monitor and Review
	Will this impact on the organisation's duty to protect children, young people and adults?	There is no perceived negative impact on organisation's duty to protect adults	2	2	4	Monitor and Review
PATIENT EXPERIENCE	What impact is it likely to have on self-reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)	**In option 4a there** is a change in how inpatient beds are provided across Cheshire with 22 beds being provided locally for older people with dementia and more physically vulnerable adults with functional illness, Rehabilitation services would continue to be provided locally. Up to 25 beds would be re provided in Chester and the Wirral. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team, overnight placement support and day time crisis café.	2	3	6	Mitigating Actions Continued engagement with service, users, families and carers to understand solutions for a small proportion of people who will need to travel further for in-patient care and visiting such as flexible visiting times and use of technology e.g. facetime To support for patients, families and carers who will need to travel further. It may be possible to access short term support for families and carers to visit Bowmere, which would be on a case by

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
						case basis and dependent on individual circumstances Monitoring through Friends and Family Test, Patient Reported Outcomes Measures (PROMS), Patient Experience Measures (PREMS)
	How will it impact on choice?	In line with the 5YFV for MH the PCBC is aligned to providing specialist care, at the right time, in the right place. Providing high quality, CQC compliant inpatient care and improving community and crisis resolution home treatment 24/7. Option 4a provides older peoples inpatient care in Macclesfield, Rehabilitation and Crisis Beds. Adult inpatient care will move to Bowmere in Chester which impacts on patients, families and carers travel times.	2	3	6	Mitigating Actions Continued engagement with service, users, families and carers to understand solutions for a small proportion of people who will need to travel further for in-patient care and visiting. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Travel bursaries may be available for low income families Monitoring through Friends and Family Test, Patient Reported Outcomes Measures (PROMS), Patient Experience Measures (PREMS)

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it support the compassionate and personalised care agenda?	Positive Impact additional support will be provided in Community services and crisis resolution home treatment team including Crisis House (short inpatient stay) and Crisis Café. This will achieve the standard of care in the most unrestricted environment. The newly provided Dementia Outreach service will support people to stay safely at home in familiar surroundings	2	2	4	Monitor and Review
PATIENT SAFETY	How will it impact on patient safety?	There is no perceived negative impact to patient safety.	2	2	4	Mitigating Actions Datix Risk Management CQC Reports Audit Outcomes Complaints Reviews Mortality Data
	How will it impact on preventable harm?	There is no perceived negative impact on preventable harm	2	2	4	Mitigating Actions Datix Risk Management CQC Reports Audit Outcomes Complaints Reviews Mortality Data
	Will it maximise reliability of safety systems?	There is no perceived negative impact on safety systems	2	2	4	Mitigating Actions Datix Risk Management CQC Reports Audit Outcomes Complaints Reviews

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
						Mortality Data
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?	There shall be no additional impact on safety systems. As part of STP Prevention Programme additional Antimicrobial Resistance support is being planned, which will impact positively to reduce infection rates. Caring for people in the home where possible will have an impact on hospital acquired infection rates.	2	2	4	Mitigating Actions Datix Risk Management CQC Reports Audit Outcomes Complaints Reviews Mortality Data
	What is the impact on clinical workforce capability care and skills?	A workforce plan will ensure that community and inpatient teams have the right skill mix and capabilities on a rota 24/7 where appropriate to provide high quality patient care and outcomes. The workforce plan has been modelled against patients care needs and will include training on physical and mental health clinical knowledge to support parity of esteem.	2	2	4	Mitigating Actions Mapping existing and future workforce requirements including associated financial implications Development of Work Force Plan
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?	The Pre Consultation Business Case has been developed and based on evidence based best practice, national policy and includes a literature review on achieving	2	2	4	Mitigating Actions Site visits to other Mental Health Units delivering Integrated Community Care and Crisis Models of Care

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		improved outcomes and parity of esteem. Site visits to other Mental Health Trusts have been undertaken with clinicians and experts by experience to look at best practice.				Review of literature
	How will it impact on clinical leadership?	There is no perceived negative impact on clinical leadership	2	2	4	Monitor and Review
	Does it support the full adoption of Better care, Better Value metrics?	The project team has adopted Better Value principles and aligned to Better Care metrics which will be aligned to mental health outcomes framework and future provider contract management	2	2	4	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it reduce/impact on variations in care?	There is a neutral impact on variations in care. Enhanced community and crisis care 24/7 will deliver a proactive approach to community mental health care, with staff being trained to provide intensive home treatment. The new model of care will over time deliver approximately 16% reduction in hospital based activity (Crisp Report) . In patient care will be delivered locally for older people and people requiring short term inpatient care in a crisis. Specialist Mental Health inpatient care for adults and day case Electro Convulsive Therapy will be provided at Bowmere in Chester	2	3	6	Mitigating Actions Where travel is a problem CWP will work with family and carers to find solutions to any transport problems on a case by case basis. Travel bursaries may be available for low income families
	Are systems for monitoring clinical quality supported by good information?	A set of standardised key performance indicator measures aligned to a Mental Health Outcomes Framework will be agreed as part of future provider contract management and monitored via contract and quality assurance	2	2	4	Monitor and Review
	Does it impact on clinical engagement?	As part of the communication and engagement plan, staff are being	2	2	4	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		engaged with through drop-in sessions. The project team include clinical specialists from primary and secondary care. General Practitioners have been engaged with at locality and clinical leadership group meetings.				
PREVENTION	Does it support people to stay well?	The project will encourage people to stay well through supported self-care sign posting to care services though Directory of Services and Single Point of Access. On line information and tools to support people to manage their own health and wellbeing	2	2	4	Monitor and Review
	Does it promote self-care for people with long term conditions?	A key outcome of Mental Health outcomes Framework is Parity of Esteem, which is also a National CQUIN.	2	2	4	Monitor and Review
	Does it tackle health inequalities, focusing resources where they are needed most?	Stage 1 and Stage 2 equality impact and risk assessment have been completed and an action plan has been developed.	2	2	4	Monitor and Review
IVITY & IN	Does it ensure care is delivered in the most clinically and cost effective way?	The proposed service change would cost less overall than current	2	3	6	Mitigating Actions

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		services and contribute to reducing the deficit in NHS mental health services for Central and Eastern Cheshire. Finding an affordable solution is necessary for long-term clinical sustainability and this moves services in the right direction, within the context of severe financial challenge across the Health and Care Economy.				Develop accurate costing model for new model of care to minimise over spend on agreed budget through implementation of new services. Underlying sustainability of the whole economy supported by on-going QIPP/CIP programmes and support from NHSE/I through CEP process Partnership approach to driving out costs Ensure any external contracts procured with value for money at forefront.
	Does it eliminate inefficiency and waste?	The project aim is to reduce inefficiency and waste in the system to enable high quality care, patient experience and improved patient outcomes. Improved access to community teams and crisis resolution home treatment team, which are adequately resourced to	**2**	**2**	**4**	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		offer intensive home treatment as an alternative to acute inpatient admission. Increased access to psychological therapies and access to navigators who are available to people who require specialist care from diagnosis onwards, to guide them through the options for their care and ensure they receive appropriate information and support. Analysis of data highlights that there are currently 58 beds however national and locally modelled data shows that for our population only 45 beds would be required if community services and rapid response was enhanced.				
	Does it support low carbon pathways?	A Travel Assessment has been completed looking at current and future travel to inpatient care and public transport links. There is a neutral impact which will be realised as the service is implemented and benefits are realised in reduced inpatient activity and length of stay.	**2**	**2**	**4**	Monitor and Review
	Will the service innovation achieve large gains in performance?	The new care model design is innovative in supporting people in	**2**	**2**	**4**	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		their own homes or close to home in delivering enhanced Community Care, Crisis Resolution, short stay in-patient care in Crisis House and day time support in Crisis Café with access to Recovery College. Technology will support integrated working across health and social care. A significant gain will be reduction in hospital activity by approximately 16%				
	Does it lead to improvements in care pathway(s)?	The new care model design provides seamless care across the care model, to support people in their own homes or close to home through the delivery of older people inpatient care, increased provision of community care, crisis resolution home treatment and short stay in patient care in Crisis House and day time support in Crisis Cafes	**2**	**2**	**4**	Monitor and Review

Completed by:	Designation:	Date:
Marie Ward Jacki Wilkes	Transformation Project Manager Associate Director of Commissioning Eastern Cheshire	07.11.17

	CCG	

Reviewed and signed off by: Sally Rogers Julia Curtis Pending sign off by CQ&P 13.12.17	Designation: Lead Nurse, Community and Safeguarding Registered Eastern Cheshire CCG Nurse, Governing Body Member Eastern Cheshire CCG Head of Clinical Quality	Date: 09.11.17

Supporting Document 4

Quality Impact Assessment 4b

Eastern Cheshire Clinical Commissioning Group: Quality Impact Assessment Tool

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score. A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

Quality is described in 7 areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is greater than a score of 8 this indicates that a more detailed assessment is required in this area, to be completed within stage 2.

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Definitions for grading

Risk Assessment Matrix								
Risk Assessment		Circle consequence, likelihood and total score e.g. 2 x 3 = 6			SCORE			
		LIKELIHOOD/PROBABILITY OF REPEAT						
INCIDENT CONSEQUENCES or POTENTIAL CONSEQUENCES		Rare	Unlikely	Possible	Highly Likely	Almost Certain		
		1	*2*	*3*	*4*	*5*		
1	Negligible	1	2	3	4	5		
2	Minor	2	4	6	8	10		
3	Moderate	3	6	9	12	15		
4	Major	4	8	12	16	20		
5	Extreme	5	10	15	20	25		

Green	(score 5 or less)	Low risk	Low priority	Manage situation by routine procedures
Amber	(score 6 to 15)	Medium risk	Medium priority	Management responsibility and action must be specified
Red	(score 16 to 25) Or any incident recorded as extreme regardless of the likelihood/probability of repeat	High risk	High Priority	Immediate action – Senior Management attention required. 16+ Senior Management to consider informing the Board.

Measures of Likelihood

LEVEL	DESCRIPTOR	PROBABILITY
1	Rare	The event may only happen in exceptional circumstances
2	Unlikely	The event could occur (recur) at some time
3	Possible	The event may well occur (recur) at some time
4	Highly likely	The event will occur (recur) in most circumstances
5	Almost Certain	The event is expected to occur (recur) in most circumstances

Stage 1 – Initial Risk Assessment 6th Month Review Date – 12-June-2017

Title: Adult Mental Health Redesign Option 4b

Lead for scheme: Jacki Wilkes Associate Director of Commissioning

Brief description of scheme:
Commissioners in Vale Royal, South and Eastern Cheshire are working with local mental health provider; Cheshire and Wirral Partnership, users of the service and Cheshire East Council to review and redesign secondary care adult and older peoples mental health services for those people with severe mental illness (SMI).

A Pre Consultation Business Case (PCBC) will outline a compelling case for change and present options which will deliver redesigned services for improved outcomes for the registered population of Vale Royal, South and Eastern Cheshire in line with national Five Year Forward View (FYFV) for Mental Health.

The FYFV for mental health sets out an ambitious programme of improvement to be achieved by 2021 setting standards for access and guidelines for care including 24/7 access to care, early intervention (proactive care) and prevention. The proposals presented are done so within a context of rising demands for services, increasing financial constraints across the health and social care system and national drivers to improve access to a

range of services not currently commissioned.

This QIA is for Option 4b outlined below:

Option 4b: Expand community and crisis care services and relocate all inpatient care from Millbrook to other facilities within the current provider footprint (Adults Macclesfield site, Older people Bowmere)

Description: In this option 22 beds would be provided at Lime Walk House for adults. 22 beds would be provided at Bowmere and 3 at Wirral for adults. Central and Eastern Cheshire patients would be given priority admission to Bowmere, 10 for older people with dementia and 12 for older or more physically vulnerable adults with functional illness. There will be 3 beds at Wirral for adults. Rehabilitation services currently delivered at Lime Walk House would be re-provided at the Soss Moss site in Nether Alderley. In patient Electro Convulsive Therapy would be delivered at the specialist ward in Bowmere. Community mental health teams would deliver evidenced based interventions to support people in their own homes and have the appropriate skills to do so. A new model of crisis care will be introduced which would see the home treatment team providing 24/7 care in conjunction with, overnight placement support and day time crisis café

Answer positive/negative (+ / -) in each area. If N; score the impact, likelihood and total in the appropriate box. If score > 8 insert Y for full assessment

Area of Quality	Impact question	+ / -	Impact	Likely-hood	Score	Full Assessment required?
Duty of Quality	Could the proposal impact positively or negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	positive	**2**	**2**	**4**	**N**
Patient Experience	Could the proposal impact positively or negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care?	Neutral	**2**	**3**	**6**	**N**
Patient Safety	Could the proposal impact positively or negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	Positive	**2**	**2**	**4**	**N**
Clinical Effectiveness	Could the proposal impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards?	Positive	**2**	**2**	**4**	**N**
Prevention	Could the proposal impact positively or negatively on promotion of self-care and health inequality?	Positive	**2**	**2**	**4**	**N**
Productivity and Innovation	Could the proposal impact positively or negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	Positive	**2**	**2**	**4**	**N**
Resource Impact	Could this proposal impact positively or negatively with regard to estates, IT resource, community equipment service or other agencies or providers e.g. Social care/voluntary sector/District nursing*	Positive	**2**	**2**	**4**	**N**

Completed by:	Designation:	Date:
Marie Ward	Transformation Project Manager	07.11.17

Stage 2 – Full Assessment for identified areas of risk

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
DUTY OF QUALITY	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides and commissions?	Continuous improvement in the quality of healthcare will be monitored as part of Mental Health Outcomes Framework, Friends and Family Test and self-reported Experience and Outcomes Assessments.	2	2	4	Monitor and Review
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?	The projects aim is to support the delivery of the Five Year Forward View for Mental Health. To improve quality of care, patient experience and mental health outcomes, whilst ensuring the services are clinically and financially sustainable. The views and experiences of users and carer have informed the development of Pre Consultation Business Case (PCBC)	2	2	4	Monitor and Review
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?	Engagement and communication with Clinical Mental health Specialist including; NHS Mental Health Trust and Community Services and General Practice includes; front line staff drop-in sessions, Clinical Leaderships Meetings, GP Locality	2	2	4	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		and membership meetings to engage views and inform the PCBC and design of new model of care for Adult Mental Health.				
	What is the impact on strategic partnerships and shared risk?	Positive Impact Providers and Commissioners across Eastern Cheshire, South and Vale Royal CCG, Cheshire East Council and Cheshire and Wirral Partnership NHS Foundation Trust, working in partnership to develop the PCBC, North West Ambulances Service and Cheshire Police have been involved in discussion and scoring the options. The project team includes; clinical specialists, patients and carers, commissioners from health and social care and providers of mental health services.	**2**	**2**	**4**	Mitigating Actions Joint /Shared risk log jointly owned across partner organisations
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual and community health, access to services and experience of using the NHS (Refer to CCG Equality Impact Assessment Tool)?	Stage 1 and Stage 2 equality impact and risk assessment have been completed and an action plan has been developed.	**2**	**2**	**4**	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
DUTY OF QUALITY	Are core clinical quality indicators and metrics in place to review impact on quality improvements?	A set of standardised key performance indicator measures aligned to National and Local Outcomes Frameworks have been identified to support completion of a final business case and future commissioning of Adult Mental Health Services.	2	2	4	Monitor and Review
	Will this impact on the organisation's duty to protect children, young people and adults?	There is no perceived negative impact on organisation's duty to protect adults	2	2	4	Monitor and Review
PATIENT EXPERIENCE	What impact is it likely to have on self-reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)	**In option 4b** there is a change in how inpatient beds are provided across Cheshire with 22 beds being provided locally for adults, Rehabilitation services would continue to be provided locally. Up to 25 beds would be re provided in Chester for older people with dementia and more physically vulnerable adults with functional illness. A new model of crisis care introduced which would see the home treatment team providing 24/7 care in conjunction with an increase in home treatment team providing specialist intensive home treatment,	2	3	6	Mitigating Actions Continued engagement with service, users, families and carers to understand solutions for a small proportion of people who will need to travel further for in-patient care and visiting such as flexible visiting times and use of technology e.g. facetime To support for patients, families and carers who will need to travel further. It may be possible to access short term support for families and carers to visit Bowmere, which would be on a case by

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		overnight placement support and day time crisis café.				case basis and dependent on individual circumstances Monitoring through Friends and Family Test, Patient Reported Outcomes Measures (PROMS), Patient Experience Measures (PREMS)
	How will it impact on choice?	In line with the 5YFV for MH the PCBC is aligned to providing specialist care, at the right time, in the right place. Providing high quality, CQC compliant inpatient care and improving community and crisis resolution home treatment 24/7. Option 4b provides adult inpatient care in Macclesfield, Rehabilitation and Crisis Beds. Older people mental health care will move to Bowmere in Chester which impacts on patients, families and carers travel times.	**2**	**3**	**6**	Mitigating Actions Continued engagement with service, users, families and carers to understand solutions for a small proportion of people who will need to travel further for in-patient care and visiting. With regards to visiting we will work with family and carers to find solutions to any transport problems on a case by case basis. Travel bursaries may be available for low income families Monitoring through Friends and Family Test, Patient Reported Outcomes Measures (PROMS), Patient Experience Measures (PREMS)

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it support the compassionate and personalised care agenda?	Positive Impact - additional support will be provided in Community services and crisis resolution home treatment team including Crisis House (short inpatient stay) and Crisis Café. This will achieve the standard of care in the most unrestricted environment. The newly provided Dementia Outreach service will support people to stay safely at home in familiar surroundings	2	2	4	Monitor and Review
PATIENT SAFETY	How will it impact on patient safety?	There is no perceived negative impact to patient safety.	2	2	4	Mitigating Actions Datix Risk Management CQC reports Audit Outcomes Complaints Reviews Mortality Data
	How will it impact on preventable harm?	There is no perceived negative impact on preventable harm	2	2	4	Mitigating Actions Datix Risk Management CQC reports Audit Outcomes Complaints Reviews Mortality Data
	Will it maximise reliability of safety systems?	There is no perceived negative impact on safety systems	2	2	4	Mitigating Actions Datix Risk Management CQC reports Audit Outcomes Complaints Reviews

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
						Mortality Data
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?	There shall be no additional impact on safety systems. As part of STP Prevention Programme additional Antimicrobial Resistance support is being planned, which will impact positively to reduce infection rates. Caring for people in the home where possible will have an impact on hospital acquired infection rates.	2	2	4	Mitigating Actions Datix Risk Management CQC Reports Audit Outcomes Complaints Reviews Mortality Data
	What is the impact on clinical workforce capability care and skills?	A workforce plan will ensure that community and inpatient teams have the right skill mix and capabilities on a rota 24/7 where appropriate to provide high quality patient care and outcomes. The workforce plan has been modelled against patients care needs and will include training on physical and mental health clinical knowledge to support parity of esteem.	2	2	4	Mitigating Actions Mapping existing and future workforce requirements including associated financial implications Development of Work Force Plan
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?	The Pre Consultation Business Case has been developed and based on evidence based best practice, national policy and includes a literature review on achieving	2	2	4	Mitigating Actions Site visits to other Mental Health Units delivering Integrated Community Care and Crisis Models of Care

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		improved outcomes and parity of esteem. Site visits to other Mental Health Trusts have been undertaken with clinicians and experts by experience to look at best practice.				Review of literature
	How will it impact on clinical leadership?	There is no perceived negative impact on clinical leadership	2	2	4	Monitor and Review
	Does it support the full adoption of Better care, Better Value metrics?	The project team has adopted Better Value principles and aligned to Better Care metrics which will be aligned to mental health outcomes framework and future provider contract management	2	2	4	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
	Does it reduce/impact on variations in care?	There is a neutral impact on variations in care. Enhanced community and crisis care 24/7 will deliver a proactive approach to community mental health care, with staff being trained to provide intensive home treatment. The new model of care will over time deliver approx 16% reduction in hospital based activity. In patient care will be delivered locally for adults and people requiring short term inpatient care in a crisis. Specialist Mental Health inpatient care for older people and day case Electro Convulsive Therapy will be provided at Bowmere in Chester	2	3	6	Mitigating Actions Where travel is a problem CWP will work with family and carers to find solutions to any transport problems on a case by case basis. Travel bursaries may be available for low income families
	Are systems for monitoring clinical quality supported by good information?	A set of standardised key performance indicator measures aligned to a Mental Health Outcomes Framework will be agreed as part of future provider contract management and monitored via contract and quality assurance	2	2	4	Monitor and Review
	Does it impact on clinical engagement?	As part of the communication and engagement plan, staff are being engaged with through drop-in	2	2	4	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		sessions. The project team include clinical specialists from primary and secondary care. General Practitioners have been engaged with at locality and clinical leadership group meetings.				
PREVENTION	Does it support people to stay well?	The project will encourage people to stay well through supported self-care sign posting to care services though Directory of Services and Single Point of Access. On line information and tools to support people to manage their own health and wellbeing	2	2	4	Monitor and Review
	Does it promote self-care for people with long term conditions?	A key outcome of Mental Health outcomes Framework is Parity of Esteem, which is also a National CQUIN.	2	2	4	Monitor and Review
	Does it tackle health inequalities, focusing resources where they are needed most?	Stage 1 and Stage 2 equality impact and risk assessment have been completed and an action plan has been developed.	2	2	4	Monitor and Review
PRODUCTIVITY & INNOVATION	Does it ensure care is delivered in the most clinically and cost effective way?	The proposed service change would cost less overall than current services and contribute to reducing	2	3	6	Mitigating Actions

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		the deficit in NHS mental health services for Central and Eastern Cheshire. Finding an affordable solution is necessary for long-term clinical sustainability and this moves services in the right direction, within the context of severe financial challenge across the Health and Care Economy.				Develop accurate costing model for new model of care to minimise over spend on agreed budget through implementation of new services. Underlying sustainability of the whole economy supported by on-going QIPP/CIP programmes and support from NHSE/I through CEP process Partnership approach to driving out costs Ensure any external contracts procured with value for money at forefront.
	Does it eliminate inefficiency and waste?	The project aim is to reduce inefficiency and waste in the system to enable high quality care, patient experience and improved patient outcomes. Improved access to community teams and crisis resolution home treatment team, which are adequately resourced to offer intensive home treatment as an	**2**	**2**	**4**	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		alternative to acute inpatient admission. Increased access to psychological therapies and access to navigators who are available to people who require specialist care from diagnosis onwards, to guide them through the options for their care and ensure they receive appropriate information and support. Analysis of data highlights that there are currently 58 beds however national and locally modelled data shows that for our population only 45 beds would be required if community services and rapid response was enhanced.				
	Does it support low carbon pathways?	A Travel Assessment has been completed looking at current and future travel to inpatient care and public transport links. There is a neutral impact which will be realised as the service is implemented and benefits are realised in reduced inpatient activity and length of stay.	**2**	**2**	**4**	Monitor and Review
	Will the service innovation achieve large gains in performance?	The new care model design is innovative in supporting people in their own homes or close to home in	**2**	**2**	**4**	Monitor and Review

Area of quality	Indicators	Description of impact (Positive or negative)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
		delivering enhanced Community Care, Crisis Resolution, short stay in-patient care in Crisis House and day time support in Crisis Café with access to Recovery College. Technology will support integrated working across health and social care. A significant gain will be reduction in hospital activity by approximately 16%				
	Does it lead to improvements in care pathway(s)?	The new care model design provides seamless care across the care model, to support people in their own homes or close to home through the delivery enhanced provision of community care, crisis resolution home treatment including intensive treatment at home, short stay crisis in patient care at Crisis Houses and day time support in Crisis Cafes, and Specialist Mental Health Inpatient Care.	**2**	**2**	**4**	Monitor and Review

Completed by:	Designation:	Date:
Marie Ward	Transformation Project Manager	07.11.17

Jacki Wilkes	Associate Director of Commissioning Eastern Cheshire CCG	

Reviewed and signed off by: Sally Rogers Julia Curtis Pending sign off by CQ&P 13.12.17	Designation: Lead Nurse, Community and Safeguarding Registered Eastern Cheshire CCG Nurse, Governing Body Member Eastern Cheshire CCG Head of Clinical Quality	Date: 09.11.17

Supporting Document 5

Privacy Impact Assessment

Key Information – please be as comprehensive as possible.	
Project Name:	Adult and Older peoples Mental Health Redesign Project
Description of project:	*Explain what the project aims to achieve, what the benefits will be to the organisation, to individuals and to other parties.* *You may find it helpful to link to other relevant documents related to the project, for example a project proposal.* The NHS in Eastern and Central Cheshire are working with local mental health provider Cheshire and Wirral Partnership and the local council to review and redesign secondary care adult and older peoples mental health services for those residents with a severe and enduring mental health need. Secondary care services is the term used to differentiate them from primary mental health services such as GP only care and universal psychological therapies (IAPT) Secondary services includes specialised community support, crisis response and inpatient care which is provided mainly on The Millbrook unit in Macclesfield. For this project there are several options being considered for the redesign. Data will be used to help inform these options and enable the Project Team to score the options and make decisions about those to be taken forward to the Pre Consultation business case.

Will the project involve any data from which individuals could be identified (including pseudonymised data)? **(Yes/No)**	Yes – Admission data and patient numbers for Millbrook and Bowmere will be used to inform where their nearest mental health facility is
IF NO THEN YOU DO NOT NEED TO ANSWER ANY FURTHER QUESTIONS AND A PIA IS NOT REQUIRED.	

Key Contacts	
Project Manager Name & Job Title:	**Jacki Wilkes**
Project Manager Email:	jackiwilkes@nhs.com
Project Manager Phone:	01625 663350
Key Stakeholder Names & Roles:	Suzanne Edwards – CWP, Jamaila Tausif – South and Vale Royal CCG

Screening Questions	YES or NO
Will the project involve the collection of **new** information about individuals?	NO – As admission data is already collected by CWP on Millbrook and Bowmere.
Will the project compel individuals to provide information about themselves?	YES – During pre consultation and consultation events service users, carers and the general public will be asked to provide input into the proposed redesign, during which time patient experiences of using services may be shared
Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	YES – To help inform the options available - High level admission data / patient numbers will be shared with Staffordshire, Pennine and Wythenshawe
Are you using information about individuals for a new purpose or in a new way that is different from any existing use?	YES – The admission data and patient numbers will be used to inform the options that are taken forward to consultation for the redesign of the

	services
Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	NO
Will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services	YES – The project will evaluate several options on how to redesign the services, admission data and patient numbers will potentially help to inform these options so they can be assessed and scored against acceptability criteria
Is the information to be used about individuals' health and/or social wellbeing?	YES – Both data provided by CWP and patient experience info shared at the consultation events will be used to inform the options, score these options against acceptability criteria and shortlist options for the pre consultation business case and consultation.
Will the project require you to contact individuals in ways which they may find intrusive?	YES – During the project patient representatives and carers may be contacted regarding the option to visit mental health facilities elsewhere in the North West, along with members of the project team to help inform the range services available, and how they may fit into the redesign of the services.

If any of the screening questions have been answered "YES", then please continue with the Privacy Impact Assessment Questionnaire (below).

If all questions are "NO", please return the document to the Information Governance Team and **do not** complete a Privacy Impact Assessment. Please email the completed screening to mlcsu.ig@nhs.net

Use of personal information	
Description of data:	*e.g. name, address, date of birth, NHS number, gender, clinical or other health information, ethnicity.* In this project the following data will be requested for Bowmere and Millbrook admissions, all the data requested will be pseudonymised. The fields requested will be: • Speciality description • Admission ward • Admission date • Trust id • Admission type • MHA status • Practice code • CCG • CCG code • Postcode –Outer • Electoral ward • Discharge date time • Gender • Time on ward • Primary diagnosis code • Primary diagnosis • Secondary diagnosis code • Secondary diagnosis • CSU • Year • Month • PICU admission data This data, specifically, admission data for Millbrook (Macclesfield) and Bowmere (Chester) and patient numbers will be used to create tables of data showing information such as : • number of patients/admissions • split between older people and adult admissions/patient numbers

	• towns where they live, • number of patients / admissions from towns • Postcodes and number of patients • travel distance and times • nearest alternative mental health facility to the town in which they live • Average Length of stay of admissions This data will help to inform the options put forward as part of the pre consultation business case, and the options that will be scored against criteria for patient acceptability, safety, financial and strategic criteria. This data will be shared with other CCGs to enable the costing of different options to establish if they are financially viable. Data/information will also be collated at the pre consultation and consultation events based on feedback from service users and carers. The data will not be identifiable to CCG staff. The flat tables of data will show patient numbers / admissions as listed above.
What is the justification for the inclusion of identifiable data rather than using de-identified/anonymised data?	This data will be used to generate the financial costings for services being provided by alternative providers. The number of admissions/patient numbers will be shared with other providers so they have an idea of potentially how many potential patients may be directed to their services. In order to cost this information they will need to know details of numbers of patients, broken down by type of admission. The data will be non identifiable where ever possible, in some cases this may mean only 1 patient from a town. When sharing this data outside the CCG it will be grouped together with other towns but due to low numbers these may still be under five patients.

Will the information be new information as opposed to using existing information in different ways?	The data used for the admission and patient numbers is existing information gathered by CWP. This data will be used to work up options for the pre consultation business case. The patient data gathered from the pre consultation and consultation events will be used to inform the options for the redesign of the services. This will be new information.
What is the legal basis for the processing of identifiable data? **If consent, when and how will this be obtained and recorded?**	*e.g. explicit data subject consent, s251 support, statutory power.* The basis for processing this data is to establish the number of patients who had in-patient treatment during a specific period of time, in order to ensure the appropriate size service is in place when redesigning. When liaising with other CCGs high level data will be shared to enable financial costings to be gathered.
Who will be able to access identifiable data?	*This should include details of any data processors / contractors and sub-contractors and any proposed overseas transfers.* The initial data spreadsheet will be provided by CWP and accessible to the Information team. The spreadsheet of data will be shared with the ECCCG PMO to generate the numbers of patients/admissions per town. This will be pseudonymised data, identifiable only by the trust ID. This data will be analysed by the PMO and shared with key members of the project team to inform the options. A subset of this data may be consolidated and shared with other CCGs (Staffordshire, Pennine and Wythenshawe) to allow costings of potential new services to be carried out. Some high level data may be used in the business case. The pre-consultation and consultation feedback will be consolidated by the communications team and anonymised, sharing only the numbers of people who attended the events

	and high level themes.
Will the data be linked with any other data collections?	*Please specify and provide business reason / information requirement.* There will be no other links into patient identifiable information.
How will this linkage be achieved?	*Who will undertake the linkage and using what identifiers?* N/A
Is there a legal basis for these linkages?	*i.e. is it within the terms of any prior consent? Is it within the scope of any statutory justification?* N/A
What security measures will be used to transfer the data?	The spreadsheet data will be shared with the PMO via NHS email. Only high level tables of data will be shared with Other CCGS. Avoiding any instances where the patient numbers are 1.

What confidentiality and security measures will be used to store the data?	*i.e. contractual arrangements with data processors, contractual arrangements with their staff as well as physical and technical security measures.* Pseudonymised data will be stored in the Adult mental health Project team area of the CCG drive, this drive is only accessible by East Cheshire CCG staff.
How long will the data be retained in identifiable form? And how will it be de-identified? Or destroyed?	*e.g. Data retention, redaction and disposal policy. Include arrangements if the project is withdrawn/ stopped.* The data will be retained for the life of the project.
What governance measures are in place to oversee the confidentiality, security and appropriate use of the data and manage disclosures of data extracts to third parties to ensure identifiable data is not disclosed or is only disclosed with consent or another legal basis?	*e.g. oversight body / committee, security audit and risk review procedures.* *This should also include contingency planning against accidental loss, destruction or damage to personal data.* Pseudonymised data will be stored in the Adult mental health Project team area of the CCG drive, this drive is only accessible by CCG staff.
If holding personal i.e. identifiable data, are procedures in place to provide access to records under the subject access provisions of the DPA? **Is there functionality to respect objections/ withdrawals of consent?**	*This should include how personal data is located and procedures for explaining the information in the record e.g. coded data, to the individual.* *How third party and seriously harmful information will be handled and how grounds for withholding information will be managed.* IT systems and security infrastructure is already in place to support and hold personal identifiable personal information in

	compliance with information governance guidelines.
Are there any plans to allow the information to be used elsewhere either in the CCG, wider NHS or by a third party?	The high level data generated will be shared in a 'flat format' with other CCGs (Staffordshire, Pennine and Wythenshawe) in order for costings to be provided.

Describe the information flows The collection, use and deletion of personal data should be described here and it may also be useful to refer to a flow diagram or another way of explaining data flows.	
Does any data flow in identifiable form? If so, from where, and to where?	Between the service provider CWP and the Project team. High level data between Eastern Cheshire and South CCG and the providers Staffordshire, Pennine and Wythenshawe.
Media used for data flow? **(e.g. email, fax, post, courier, other – please specify all that will be used)**	Email
Consultation requirements Part of any project is consultation with stakeholders and other parties. In addition to those indicated "Key information, above", please list other groups or individuals with whom consultation should take place in relation to the use of person identifiable information. It is the project's responsibility to ensure consultations take place, but IG will advise and guide on any outcomes from such consultations.	
Pre consultation engagement will take place, followed by consultation events once the chosen option has been selected.	

Privacy Risks List any identified risks to privacy and personal information of which the project is currently aware. Risks should also be included on the project risk register.			
Risk Description **(to individuals, to the CCG or to wider compliance)**	**Proposed Risk solution (Mitigation)**	**Is the risk reduced, transferred, or accepted? Please specify.**	**Further detail if required**
Further information Please provide any further information that will help in determining privacy impact.			

Following acceptance of this PIA by Information Governance, a determination will be made regarding the privacy impact and how the impact will be handled. This will fall into three categories:

1. **No action is required by IG excepting the logging of the Screening Questions for recording purposes.**
2. **The questionnaire shows use of personal information but in ways that do not need direct IG involvement – IG may ask to be kept updated at key project milestones.**
3. **The questionnaire shows significant use of personal information requiring IG involvement via a report and/or involvement in the project to ensure compliance.**

It is the intention that IG will advise and guide those projects that require it but at all time will endeavour to ensure that the project moves forward and that IG is not a barrier unless significant risks come to light which cannot be addressed as part of the project development.

Please email entire completed document to mlcsu.ig@nhs.net

Appendix B

New Model of Care Case Studies

Case Study 1: A model of care for mental health

Crisis support

Carol is a 34 year old lady who has suffered from Bipolar Affective Disorder since she had her first child. She has 3 children aged 12, 7, and 3 years old. She lives with them and her partner. When younger she had episodes where she felt elated and hyperactive but these days her illness means that she feels depressed most of the time. She struggles to motivate herself to get out of the house. She is on a lot of medication and worries about the effect this is having on her body. Sometimes her moods become so bad that she feels like killing herself and she has had to be admitted to hospital. However this in infrequent and she had only had two admissions in the last 10 years. Carol is very reliant on the support she gets from the Community Mental Health Team. She has noticed that her community nurse, Peter, and her Consultant psychiatrist both seem much busier these days and she is not able to see them as often as she would like.
In the past few weeks Carol has been feeling very low and has started to think it might be better if she wasn't here

Current -Carol has told Peter how she feels and he has increased his visits to see her. He has asked the Community Home Treatment Team to be involved. Carol feels supported throughout the day but things are much worse at night. She can't sleep and feels she has no-one to turn to when she wakes in the night. She calls the emergency contact number and talks to a nurse on the ward. The nurse listens and is supportive. However carol feels she has to tell her story all over again and she is worried the nurse has other work she should be doing so she hangs up. Things are so bad that she takes an overdose and ends up admitted to hospital

After redesign – As well as support throughout the day there is now a 24 hour Community Home Treatment Team. They give Carol a number to call if she becomes afraid in the night and when she calls the nurse knows about her case and what has been happening recently. She is able to calm Carol and arrange to see her first thing in the morning. Carol feels at the end of her tether and to have a break "from life" she ends up at the local crisis house for a couple of nights. After 2 days she feels well enough to return home and resume her parenting role and continue to be supported by her CMHT.

Carol is given the number for a Talking Therapies, Crisis Café and Recovery College that she can visit for additional group support.

Case Study 2: A model of care for mental health

Dementia outreach service

Mr Joseph is a 75 years old elderly gentleman with a diagnosis of an Alzheimer's Dementia of moderate severity (known to Memory Clinic). He has deteriorated rapidly in his mental state and has become agitated and aggressive towards others (family) especially on intervention. His wife contacts the GP stressing that she requires extra support but desperately wishes to keep him at home for as long as possible.

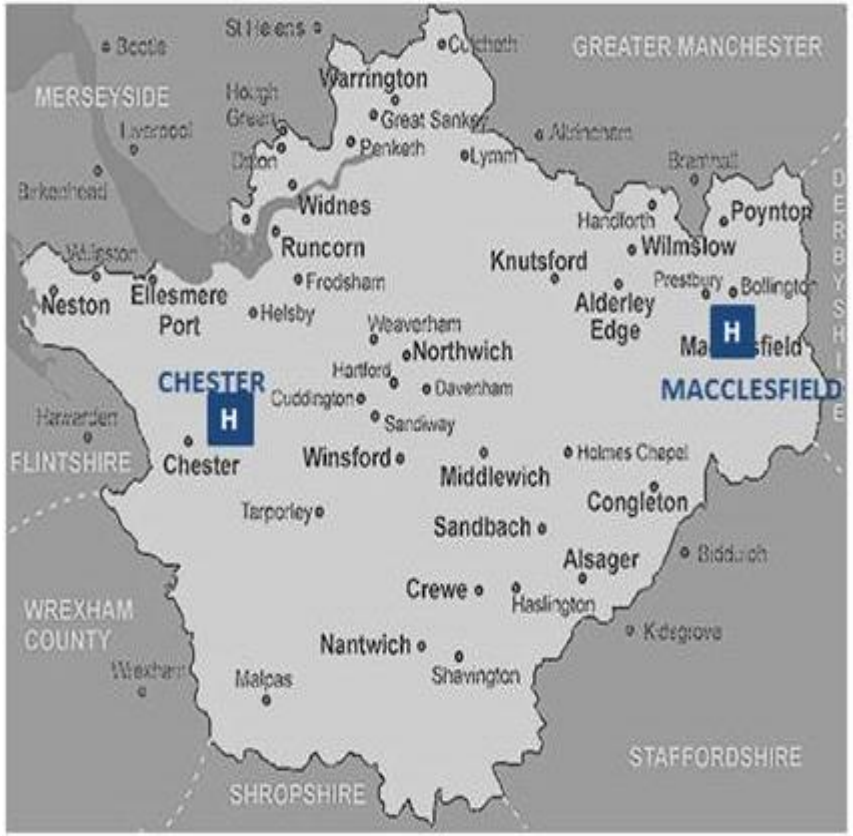
Currently: Due to the degree of his acute presentation he is admitted to an inpatient ward. He becomes more distressed due to the change in environment and change in people who he is not familiar with. We establish that his abdomen is heavily distended and he is acutely constipated. He is treated successfully and has a good bowel movement in the next 24-48 hours. His presentation settles. No further agitation / aggression is reported, however he ends up developing Pneumonia and spends some time on the medical ward. He has a fall and sustains a fracture to his wrist. He is eventually discharged home with a care package 3 months later.

After redesign: With the development of the Dementia Outreach Service – professionals will be able to visit him in his own home and complete a thorough assessment. They can liaise with the GP and work with the multi-disciplinary team in managing his relapse. They treat his underlying constipation and he settles. The above medical complications can be avoided by simply having this service – where staff from the dementia outreach service are going out to see him in his own familiar surroundings.

Appendix C

Travel Map and Analysis

Distance to Chester and Patient Numbers



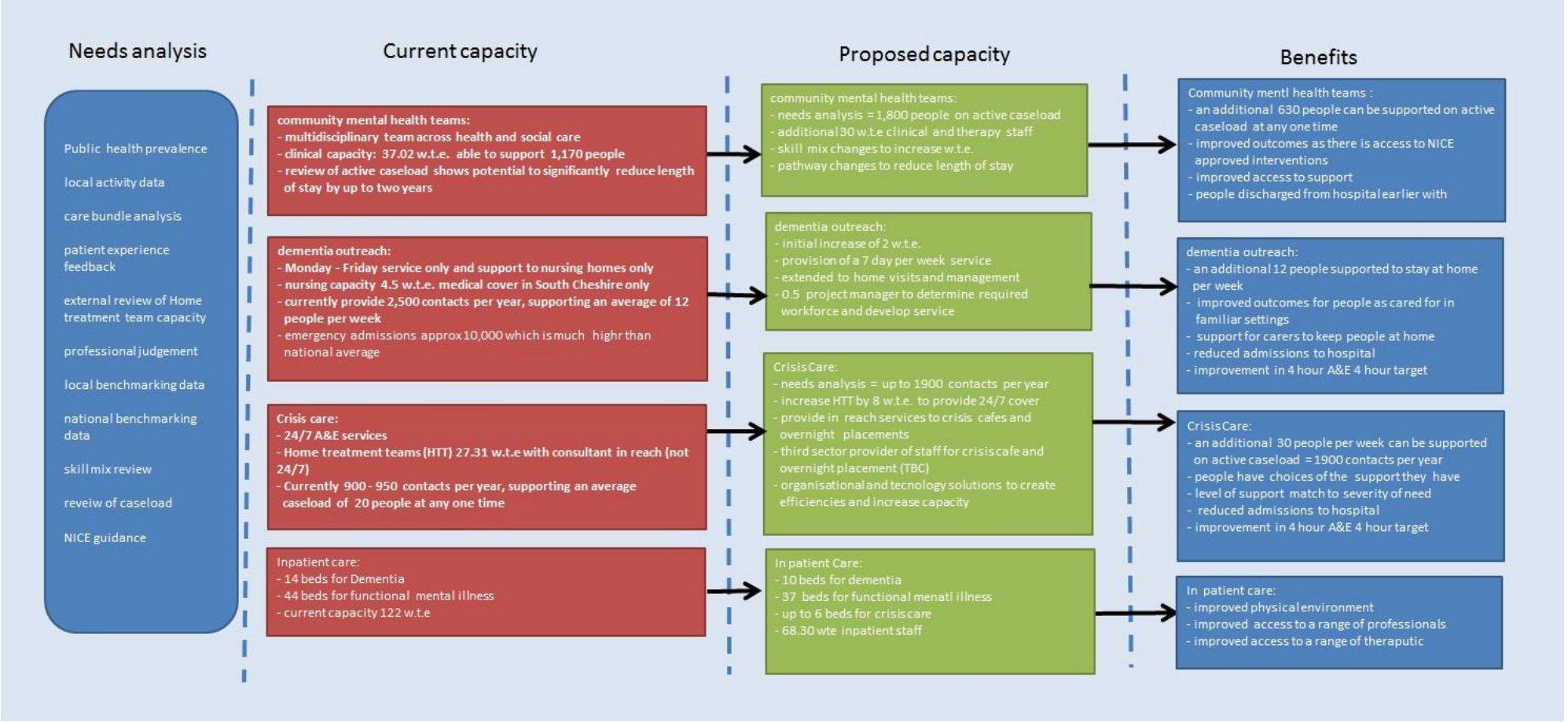
Area	Town	Macclesfield	Chester	Difference in miles between Macc & Chester	Patients Admitted (-16%)
Eastern Cheshire	Bollington	5	46	-41	<10
Eastern Cheshire	Macclesfield	1	42	-41	66
Eastern Cheshire	Disley	11	49	-38	<10
Eastern Cheshire	Congleton	8	46	-38	22
Eastern Cheshire	Poynton	8	43	-35	<10
Eastern Cheshire	Alderley	6	40	-34	<10
Eastern Cheshire	Wilmslow	8	38	-30	13
Eastern Cheshire	Handforth	9	39	-30	<10
Eastern Cheshire	Chelford	7	37	-30	<10
Eastern Cheshire	Holmes Chapel	12	37	-25	<10
South Cheshire	Scholar Green	13	36	-23	<10
South Cheshire	Alsager	15	33	-18	<10
Eastern Cheshire	Knutsford	11	27	-16	13
South Cheshire	Sandbach	15	27	-12	19
Vale Royal	Northwich	18	27	-9	11
South Cheshire	Crewe	21	26	-5	60
South Cheshire	Middlewich	15	21	-6	<10
South Cheshire	Shavington	23	25	-2	<10
South Cheshire	Wistaston	23	23	0	<10
Vale Royal	Winsford	19	19	0	<10
South Cheshire	Audlem	31	31	0	<10
South Cheshire	Nantwich	26	22	4	<10
Vale Royal	Weaverham	23	17	6	<10
South Cheshire	Marbury	34	22	12	<10

<10 denotes between 0 – 9 patients admitted

Appendix D

Capacity and Workforce Plan

Capacity and workforce plan



Appendix E

Communications and Engagement Strategy Summary

Public consultation strategy

The public consultation will be for a 12-week period and will be a comprehensive process involving six public meetings across the major towns in Eastern Cheshire, South Cheshire and Vale Royal.

In addition offers will be made to attend local community meetings such as mental health forums, Age UK, Alzheimer's Society etc.

A comprehensive Equality Impact Assessment has been conducted that will guide our approach to formal consultation, ensuring that we target groups that will be directly and indirectly affected by the proposals – and that we produce information in different formats and made available in different places that are convenient and accessible for different people, including those with protected characteristics.

To enable people to understand the rationale for change and give full consideration to the options, information will be shared via a number of channels, these include:

- A public consultation booklet in plain language that clearly sets out the reasons for change and the options the public are being asked to comment on, including details of public meetings and ways to find out more information and feedback views. It will feature a freepost survey to complete and return;
- An online version of this booklet will also enable people to share their views via a simple online survey;
- Further hard copy information including posters and flyers signposting people to the public meetings and website, distributed widely in:
    - CWP services, including the Millbrook Unit where volunteers will support an information hub throughout the 12-week consultation period;
    - GP surgeries;
    - Macclesfield and Leighton general hospitals;
    - Other NHS and public sector premises, including libraries; and
    - Voluntary sector premises
- Where possible the use of messages on information screens in hospital and GP surgeries will also be utilised;
- There will be a dedicated website page to act as a hub of online information;
- We will seek to engage with local media outlets (local newspapers and radio) as well sharing information via NHS and local authority websites and social media channels;
- Dedicated staff events and drop-in sessions in Eastern Cheshire, South Cheshire and Vale Royal will continue during the formal consultation period;
- All CWP members and staff in Eastern Cheshire, South Cheshire and Vale Royal will be invited to give their views;
- A dedicated phone number will be available throughout the 12 week period for people with any queries about public meetings or getting copies of the consultation document; and
- In addition, the Patient Advice and Liaison Service at commissioners and CWP will support service users and carers with specific concerns raised as a result of the consultation during this time.

We will engage an independent organisation to receive feedback and conduct analysis of findings in order for the partnership to fully consider views put forward, before making a decision on next steps.

Any personal details provided will be treated in accordance with the Data Protection Act and will not be used for any other purpose. We will also establish robust methods of recording stakeholder comment directed at partners during this period, to ensure we can channel all feedback into the final report.

Reporting and decision-making

The independent analysis of feedback on the consultation will be reviewed by a range of organisations before any decisions are made on the way forwards:

- CWP's Trust Board;
- Eastern Cheshire CCG's Governing Body;
- South Cheshire and Vale Royal CCG's Governing Body;
- Cheshire East Council's Adult Health and Social Care Overview and Scrutiny Committee; and
- NHS England's Assurance Process.

The partners are committed to communicating the outcome of the consultation and what will happen next and ensure the continued involvement of service users, carers, staff and partners during implementation of any changes.