NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group Governing Body
Paper Summary Sheet
Date of Meeting: 26 July 2016

For: PUBLIC session ☒ **PRIVATE Session** ☐

For: Decision ☒ **Discussion** ☐ **Noting** ☐

Agenda Item and title:	**GOV/16/07/10** Mental Health Workstream – Funding Requests
Author:	Meuthia Endrojono-Ellis
Lead Director/GP from CCG:	Ted Wilson/ Dr. D.Beale
Executive summary:	To request an increase of investment in Mental Health Service lines in 16/17. The increase of investment is a combination of recurrent and non-recurrent monies: • An operationally safe and effective provision within Wiltshire • The continuity of the right type of service for Wiltshire Community • Equity of access into services, Ensuring parity of esteem of Mental Health Services across Wiltshire Community
Evidence in support of arguments:	AWP Contract Activity Reports Street Triage Evaluation – UWE EIP National Model Workforce Calculator
Who has been involved/contributed:	MH & Disability Joint Commissioning Team MH & Disability Joint Commissioning Board EMT Out of Hospital Board
Cross Reference to Strategic Objectives:	Sustainable Transformation Plan – Planned Care Workstream Wiltshire Joint Mental Health & Well Being Strategy
Engagement and Involvement:	Incorporating & imbedding recommendations and commitment identified within Wiltshire Joint Mental Health strategy which was co-produced with Wiltshire Community
Communications Issues:	n/a

Financial Implications:	£146,100.00 (year 1)
Review arrangements:	Each service line will be reviewed on a 6 monthly basis via the AWP contract management and performance governance arrangement
Risk Management:	Non effective delivery of service
National Policy/ Legislation:	Five Year Forward View – Mental Health, Parity of Esteem CCG Improvement & Assessment Framework
Equality & Diversity:	Meeting the requirements of the Equality Bill under access
Other External Assessment:	n/a
What specific action re. the paper do you wish the Governing Body to take at the meeting?	Approve Funding

NHS
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July 2016

MENTAL HEALTH WORK STREAM – FUNDING REQUEST

1.0 Purpose of the document

This paper summarises to Out of Hospital Board the 4 business cases that have been endorsed by the Mental Health & Learning Disabilities Joint Commissioning Board & EMT & Out of Hospital Board for an increase of funding for 4 service provisions within 16/17 financial year.

The request has been made by the Joint Commissioning Team to ensure there is:

- An operationally safe and effective provision within Wiltshire
- The continuity of the right type of service for Wiltshire Community
- Equity of access into services

The total funding increase across the 4 service line that is being requested in 16/17 Financial year is £146,100.00

2.0 Business Case/Progress Report Summaries

2.1 ADHD – additional investment of £185k recurrent (17/18)

The Adult ADHD Service for Wiltshire commenced on 1st July 2014 with funding of £120k having been identified for the first year's activity; anticipated to be 80 new referrals plus transitions and follow ups. The service model proved to be unsustainable and the funding insufficient after 180 referrals were received during the first 6 months of the contract. This, combined with serious issues on the provider side, led to the collapse of the contract within one year. The request for an additional investment of £185k recurrently (increasing the ADHD funding envelope to a recurrent £305,000k per annum) is to enable the service to resume with a revised service model and care pathway. Ensuring that this service continues with a revised service model and care pathway is essential to protect some 133 patients already on medication (amphetamines) and to mitigate the clinical risk for those GPs who are already prescribing. It is anticipated that the new contract would be in place by April 2017.

The source of the funding for the proposed investment would be the existing MH growth monies for 2016/17, held in Reserves.

	£000s						
Option	FY Total ADHD Rec Funding Requirement	Existing ADHD Rec Funding in 1617 Envelope	**Additional FY Rec Funding Requirement**	1617 PY Addt'l Requirement*	1718 FY Addt'l Rec Requirement**	Proposed Source of Funding	
B	305	120	**185**	0	185	MH Growth Funds	Preferred Option

* It is assumed that the new ADHD service will not be in place until April 2017.
It should be noted that there is a likely cost pressure of c£50k in 1617 relating to new patients being accepted into the existing service. New patients are not covered by the 1617 block arrangement with AWP.

** Costs for 1718 are quoted at 1617 rates.

For full business case, please refer to Appendix 1

2.2 IAPT – SilverCloud – additional investment of £18k non-recurrent (16/17)

One of the recommendations within the IAPT Service Review which was approved by the Mental Health & Disabilities JCB in September 2015 was for the provider to make use of an online CBT

programme as an alternative therapy option. In light of the requirement for the provider to achieve the National Recovery Rate target of 50%, funding is now requested in the non-recurrent sum of £18k for 2016/17 to enable a trial for up to 500 patients in the use of the SilverCloud programme. NHS England are requiring the CCG to report on a monthly basis as to how the Recovery Rate is improving and whilst the most recent data indicates that the service is meeting the required trajectory and is on target to achieve 50% by the end of October, implementation of this additional therapy option would support aim. Post-October, it is hoped that this will enable the service to maintain this 50%. It is envisaged that this funding requirement would become recurrent thereafter and may increase if the take-up of this option exceeds the initial 500 patients.
The source of the funding for the proposed investment would be from within the £200k reduction in the original IAPT funding envelope, held in reserves.

	£000s				
Option	FY Non-Rec Funding Requirement as detailed in bus. case	1617 PY NR Requirement*	1718 PY NR Requirement**	Proposed Source of Funding	
n/a	18.1	18.1	0.0	Ex-IAPT Funds	Preferred (& Only) Option

* This pilot would run for 12 months covering up to 500 patients. Payment for 500 treatments would need to be made at the start of the service.
** Costs for 1718 depend on the outcome of the pilot evaluation.

For full business case, please refer to Appendix 2

2.2 Street Triage - additional investment of £49k non-recurrent (16/17)

Following a National Directive from DoH in 15/16, extra non recurrent funding was made available for Mental Health Services to ensure appropriate and rapid response can be conducted across the health and criminal justice system to support Section 136 detainment and assessment. The chosen model for Wiltshire, in partnership with Swindon, was Control Room Based Street Triage which has been funded on a 6 month only pilot basis with AWP. An initial assessment of this pilot has provided very positive results with the majority of service users being discharged. Commissioners are now seeking a further £49k non-recurrent to enable the pilot to run for a further 6 months forming part of the Wiltshire CCG contribution of the pilot commissioned jointly with Swindon CCG & Wiltshire Constabulary.
The source of the funding for the proposed investment would be the existing MH growth monies for 2016/17, held in Reserves.

	£000s				
Option	FY Non-Rec Funding Requirement as detailed in bus. case	1617 PY NR Requirement*	1718 FY NR Requirement**	Proposed Source of Funding	
n/a	n/a	49.0	0.0	MH Growth Funds	Preferred (& Only) Option

* Part year assumption is for a 6 month pilot running in 1617
** Costs for 1718 depend on the outcome of the pilot evaluation.

For full Progress Report, please refer to Appendix 3 & 3a

2.3 Early Interventions for Psychosis (AWP) – additional investment of £78,652 2016/2017 and £309,304 recurrent from 17/18

Based on recommendations from NICE guidance and quality standards, which simultaneously address parity of esteem in provision of mental health support for psychosis, NHS E and DoH have specified national service provision standards for EIP. New service standards not only feature specific standards and targets for delivery of therapeutic interventions, but also extend the remit of EIP service to work with an extended age group, moving from 14-35 to 14-65, also to work with those who are deemed at risk of developing psychosis, and to offer an extended period of allocation to the team of up to 5 years where clinically appropriate (original period of support being 3 years). Wiltshire already commissions a well-established EIP service, however to meet the new RTT and intervention standards, and manage a larger caseload workforce development is required. Additional investment is requested: £78,652 2016/2017 (part year cost), £309,304 recurrent from 17/18. Regular reviews would take place during the initial 12 months of implementation to ensure national targets are met and service capacity is sufficient.
The source of the funding for the proposed investment would be the existing MH growth monies for 2016/17, held in Reserves.

	£000s				
Option	FY Rec Funding Requirement as detailed in Option	1617 PY Funding Requirement*	1718 FY Rec Funding Requirement**	Proposed Source of Funding	
2	309	79	309	MH Growth Funds	Preferred Option

* Part year 1617 cost assumption assumes a start date of October 2016.
Part year cost for 6 months would be £155k however the £79k as quoted includes a non-rec deduction of £76k for 1516 PoE funds being held in credit by AWP.

** Costs for 1718 are quoted at 1617 rates.

For full business case, please refer to Appendix 4

3.0 DECISION

The Joint Commissioning Team are seeking endorsement from the Out of Hospital Board for the 4 funding request that has been endorsed by MH&LD Joint Commissioning Board, to ensure there is:

- An operationally safe and effective provision within Wiltshire
- The continuity of the right type of service for Wiltshire Community

(report ends)

Author(s): MEE/MT
Endorsed: TW
MH&LD JCB (27.06.2016)
EMT (04.07.2016)

NHS
Wiltshire
Clinical Commissioning Group

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)
BUSINESS CASE FOR REVISED WILTSHIRE SERVICE

Version:	1.0
Date:	31 May 2016
Author:	Miriam Turner Mental Health Commissioning
Sponsoring Director:	Meuthia Endrojono-Ellis Interim Associate Director Mental Health Commissioning
Sponsoring GPs:	Dr Debbie Beale Wiltshire CCG Mental Health – GP Lead

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Additional Paper

1 "ADHD: Making the invisible visible. Expert White Paper on attention-deficit hyperactivity disorder (ADHD): policy solutions to address the societal impact, costs and long-term outcomes, in support of affected individuals". Presented to the European Parliament in 2013. **Recommended Reading:**

ADHD Making the invisible visible

1.0 Executive Summary

The BMC Psychiatry describes ADHD as "a common childhood onset mental health disorder that persists into adulthood in two thirds of cases….the symptoms lead to impairments in academic, occupational and social functioning as well as comorbid disorders including anxiety, depression, personality disorder, antisocial behaviour and substance misuse disorders". It is a neuro-behavioural condition which makes it exceptionally hard for those affected to sit still or concentrate on important tasks. The disorder has a substantially negative impact on day to day life as well as on education and employment prospects. These symptoms often respond well to appropriate treatment which can be transformative. It can be treated by medication and therapy; either independently or a combination of both.

The Avon & Wiltshire Mental Health Partnership NHS Trust (AWP) Adult ADHD Clinic currently provides ADHD services to all the CCGs within the AWP Trust area – North Somerset, Bristol, South Gloucestershire on a block funded basis, B&NES and Swindon on a spot purchase basis. Prior to 2014, Wiltshire also spot purchased with referrals coming into the CCG's Exceptions Team for review at panel. The service is provided against a single specification and all patients are seen in Bristol.

The Wiltshire Adult ADHD Service Contract commenced on 1st July 2014. The service provider is AWP and the service is provided from their ADHD Clinic in Bristol. One of the key aims of this contract was to provide an alternative to travelling to Bristol for Wiltshire patients enabling them to be seen at Savernake Hospital with an intention to expand the service to be provided from at least one other Wiltshire location as the contract progressed.

Significant issues with the Wiltshire contract became apparent during its first year of operation; primarily arising from poor management on the part of the Consultant Lead and the service's Business Manager. Following their suspension by AWP during March 2015, the quality of the data they had been providing was examined and it became apparent that whilst activity levels were increasing, the contract itself was under-performing. It also came to light that the service model was not what the Mental Health GP Leads believed they had signed up to. In December 2015, the Mental Health GP Leads elected to cancel the contract when it came to an end at 31st March 2016.

1.1 Decisions Required

On the basis of the options presented below, the two key decisions are:

1) to accept the new service model

AND

2) to increase the funding envelope in line with Option A, A1, B, C and D

NOTE: NONE OF THE COSTINGS PROVIDED INCLUDE MEDICATION (See Section 9.0)

1.2 Options

Option	Description	Benefits	Risks	Funding Required £000 pa	Total Funding – 2 years £000 pa	Additional Funding £000 pa
A – **DO NOTHING**	Maintenance ADHD service within existing financial envelope. This would exclude any new referrals or transitions and the current waiting list of 20 patients would be discharged (this does not include the 120 or so patients already removed and potentially awaiting re-referral).Providing a maintenance service for existing patients would mean that work around the shared care protocol would need to continue but that the clinical risk associated with approximately 130 patients currently on amphetamine based drugs would be mitigated against. Additionally, GPs would still have access to specialist advice for their patients.	1) This level of service would mitigate against the risks related to medication	1) AWP would not be in a position to provide additional resources which would mean that it could two years to clear the backlog alone. 2) This is currently not a user friendly service and not patient led. There is anecdotal evidence that patient's may go to the specialist centre and not return so may be assessed but follow a treatment plan. 3) Service model provided is too inflexible to be effective 2) Without a full shared care protocol being agreed and in use by Wiltshire GPs, the ongoing follow up position would mean that the funding position would be continually compromised 3) It would not be possible to continue to hold clinics in Wiltshire and some patients may not be able to travel to Bristol which would impact on their need for medication	120	240	N/A

			4 This group of patients are at high risk of drug abuse (self management of symptoms); unemployment; imprisonment due to harm to self and others as well as poor parenting; more at risk of being the perpetrators of domestic abuse and involved in child safeguarding issues 5) GP's at clinical governance risk because NICE Guidelines states that a GP cannot stop prescribing or initiate or change prescribing of medication for the treatment of ADHD without the support from secondary care			

NB: ALL COSTS ARE RECURRENT

Option A1	Description	Benefits	Risks	Funding Required £000 pa	Total Funding – 2 years £000	Additional Funding £000 pa
1	The need for additional funding having already been recognised and This would enable the backlog to be cleared and some new referrals to be seen but a decision would have to be made on a cap for this service. (See comparison with Bristol ADHD Service currently operating within same financial envelope – Section 7.3)	1) This level of service would mitigate against the risks related to medication 2) The additional funding would enable additional new patients to be seen (number unknown)	1) GPs and patients would become frustrated by the lack of availability of new appointments as numbers would have to be capped. It is known that the service will again not meet demand 2) If capped, all the risks from Option A will also occur for this group of patients. This would then be an equality of access issue which would not reflect well on the CCG and leave the organisation at risk of litigation as potentially complex cases will not be picked up. These carry the risk of self-harm and harm to others; as well as the risk of criminal behaviour and use of unlicensed medication from the internet 3) In addition, capping could lead to the need for a prioritisation process which again, would potentially impact on the most complex who will drift away if they are not seen quickly 4 This group of patients are at high risk of drug abuse (self	240,000	480,000	120,000

			management of symptoms); unemployment; imprisonment due to harm to self and others as well as poor parenting; more at risk of being the perpetrators of domestic abuse and involved in child safeguarding issues 5) GP's at clinical governance risk because NICE Guidelines states that a GP cannot stop prescribing or initiate or change prescribing of medication for the treatment of ADHD without the support from secondary care			

NB: ALL COSTS ARE RECURRENT

<table>
<tr><th>Option</th><th>Description</th><th>Benefits</th><th>Risks</th><th>Funding Required £000 pa</th><th>Total Funding – 2 years £000</th><th>Additional Funding £000 pa</th></tr>
<tr><td>B</td><td>Move to the new service model taking into account the increase in referrals over and above the activity levels previously contracted for as previously described. Costings are from the new proposals:
<table>
<tr><th></th><th>14/15 Activity</th><th>Actual Referrals</th><th>Accepted into Package</th><th>Cost per Person</th><th>Totals £000</th></tr>
<tr><td>New</td><td>80</td><td>180</td><td>152*</td><td>£1,570</td><td>282,600</td></tr>
<tr><td>Transition</td><td>40</td><td>33**</td><td>33</td><td>£560</td><td>22,400</td></tr>
<tr><td colspan="5">Cost per annum</td><td>305,000</td></tr>
<tr><td colspan="5">Funding Envelope Required for 2-year Contract:</td><td>610,000</td></tr>
</table>
* AWP have indicated that approximately 65% of referrals are accepted although this will increase in line with increasing referral numbers; however the actuals provided indicate that for 2015 it is nearer an 85% acceptance rate
** Transitions for 14/15 were lower than originally contracted for and allowing for the 5% increase indicated by AWP, the number remains within the 40 previously allowed for and is costed accordingly

NB: ALL COSTS ARE RECURRENT</td><td>1) The service will continue enabling those already on the waiting list to be assessed and where appropriate, receive medication.
2) Those patients no longer eligible for children's services will be transitioned directly into adult services.
3) The 2-year block contract will provide AWP with the ability to more adequately resource the service going forward with a view to achieving ensuring services are delivered within the maximum 18 week time period
2) As neighbouring CCGs are also now looking at this service model and the possibility of increased funding, this would ensure that Wiltshire is on a par with other counties</td><td>1) This proposal represents the minimum improvement level required and does not allow for any expansion in the service over the period of the contract which would lead to an increase in waiting times.
2) This group of patients are at high risk of drug abuse (self management of symptoms); unemployment; imprisonment due to harm to self and others as well as poor parenting; more at risk of being the perpetrators of domestic abuse and involved in child safeguarding issues
3) GP's at clinical governance risk because NICE Guidelines states that a GP cannot stop prescribing or initiate or change prescribing of medication for the treatment of ADHD without the support from secondary care</td><td>305,000</td><td>610,000</td><td>185,000</td></tr>
</table>

<table>
<tr><th>Option</th><th>Description</th><th>Benefits</th><th>Risks</th><th>Funding Required £000 pa</th><th>Total Funding – 2 years £000</th><th>Additional Funding £000 pa</th></tr>
<tr><td>C</td><td>Between 2014 and 2015 there has been an increase in referrals of 21% and it is expected that as ADHD continues to be accepted as a diagnosis, this will continue as it has done for neighbouring CCGs. For example, Bristol have experienced a year on year increase of approximately 13% and AWP do not anticipate this being any different over 2016/17. Accepting the new proposal on this basis, the activity and funding would be as shown below:
<table>
<tr><th></th><th>14/15 Actual referrals</th><th>Including 20% increase</th><th>Accepted into Package</th><th>Cost per Person</th><th>Totals £000</th></tr>
<tr><td>New</td><td>180</td><td>216</td><td>192*</td><td>1,570</td><td>339,120</td></tr>
<tr><td>Transition</td><td>33</td><td>40</td><td>40</td><td>560</td><td>22,400</td></tr>
<tr><td colspan="5">Cost per annum</td><td>361,520</td></tr>
<tr><td colspan="5">Funding Envelope Required for 2-year Contract:</td><td>723,040</td></tr>
</table>
* Based on acceptance rate of 85%</td><td>1) The proposed new service model and increased funding would allow the ADHD Service to become properly established and bespoke as originally intended, providing a flexible service for the residents of Wiltshire with a choice of location
2) This option would enable Wiltshire to comply with NICE Guidelines as referred to in Section 2.1
3) This would greatly reduce the risk of complex patients not receiving the level of service and specialist support they require
4) Block contract</td><td>1) Not providing this level of service means that it will still be inflexible
2) This option still does not fully allow this service to become community and patient focussed
3) Relationships with other organisations such as prisons, offending services, social services will not be developed as fully as is needed
4) This is a growing group of patients and it is likely that there will be a future need to return to this option, potentially after year one of contract</td><td>361,520</td><td>723,040</td><td>241,520</td></tr>
</table>

<table>
<tr><th>Option</th><th>Description</th><th>Benefits</th><th>Risks</th><th>Additional Funding required £000 pa</th><th>Total Funding £000</th></tr>
<tr><td>D</td><td>Whilst developing the options, the possibility of additional community support was considered. The aim of this would be move patients more quickly into shared care and annual reviews and reduce the number of specialist interventions. It has been recognised that 1:1 coaching can assist in this but acknowledged that further research and development of this proposal is required. AWP have kindly provided an indicative cost on the basis of a one to one consultation during which a coaching assessment exercise is completed and goals set. The goals are then followed up by telephone calls and further goal settings as required.
<table>
<tr><th>1:1 Coaching Cost per person</th><th>Patient Numbers</th><th>Option B</th><th>Option C</th></tr>
<tr><td></td><td></td><td>£610,000</td><td>£723,040</td></tr>
<tr><td>420.00</td><td>152</td><td>£ 63,840</td><td></td></tr>
<tr><td>420.00</td><td>192</td><td></td><td>£80,640</td></tr>
<tr><td colspan="2">Revised Funding Envelope for Options B and C</td><td>£673,840</td><td>£803,680</td></tr>
</table></td><td>1) Adding this 1:1 coaching into the specification would potentially reduce the number of specialist reviews individuals require enabling them to be managed under shared care arrangements more effectively
2) Provision of this element could be incorporated into Options B and C as part of the already indicated funding providing a fully comprehensive service
3) Looking ahead, this element could become one part of a structured community support service reducing the need for expensive specialist input
4) Block contract</td><td>1) Non-provision could mean that more patients end up on the more complex package increasing the cost of the service and resulting in fewer patients being seen overall
2) Relationships with other organisations such as prisons, offending services, social services will not be developed as fully as is needed</td><td>Option B – 63,840

Option C – 80,640</td><td>Option B – 673,840

Option C – 803,680</td></tr>
</table>

NB: THESE COSTS WOULD BE RECURRENT

1.3 Recommendation

The recommendation is that Option B at a total cost of £305,000 per annum, block contract basis, should be considered as a desirable option in terms of mitigation of clinical risk and flexibility of service and that Option C, costed at £361,000 per annum be viewed as a preferred option which may be attainable as the service is developed. Option D should be looked at as something to develop as part of the planned integrated pathway and community development work and not necessarily as an additional cost.

2.0 Strategic context

High Quality Care for All - NHS Next State Review Final Report was published in June 2008. It set out how the NHS should move from centrally driven, target based management to one of empowered local services focused on quality as well as activity.

No health without mental health: a cross-government mental health outcomes strategy for people of all ages (February 2011).

The overall aims of this strategy are to improve the mental health and wellbeing of the population to keep people well and improve outcomes for people with mental health problems through high-quality services that are equally accessible to all. The document especially highlights the need to meet some principles of high quality care including:

- equal and timely access to appropriate services
- single assessments to ensure continuity of care and adopting the ask once methodology
- co-ordinated interventions planned around outcomes agreed by the user of the service

Mental Health Clustering Booklet (V4.0) (2015/16). Annex 7c of the '2015/16 National Tariff Payment System: A Consultation Notice'. NHSE Official Documentation.

Mental Health and the Productivity Challenge (2010) described the actions that providers and commissioners may consider taking in order to improve productivity and make best use of savings. This explicitly states the need to improve the assessment process and reconfigures community teams of life, including improvements in employment, accommodation and social relationships**.**

The NHS plan (2000) set out a vision of a service designed around the patient and set the foundations for rapidly improved access to care. Service standards were clarified in the NHS Improvement Plan (2004), with a maximum wait of 18 weeks for assessment. As of 1st April, the maximum wait of 18 weeks now applies to mental health services.

NHS South West's Framework Improving Health (2008) set specific service standards for accessing assessment and treatment from NHS mental health providers, within which a requirement for the reasonable and appropriate management of referrals, appointments, treatment interventions and discharge/onward referral.

NHS South West's Management of Scheduled Care sets out the guiding principles for a standardised approach to access to care within agreed timescales, building on Department of Health guidance.

3.0 Current position

Since notifying AWP of the CCG's intention to cancel the ADHD contract, the CCG has been attempting to seek alternative service provision, particularly for those patients on medication who represented a significant clinical risk to both AWP and CCG. A Prior Information Notice (PIN) placed during January/February resulted in no expressions of interest being returned.

In February 2016, the Mental Health GP Leads decided that negotiations with AWP should be reinstated. The contract is currently working under a 6 month extension which allows for existing patients only to be seen and suspending immediate concerns relating to clinical risk. In addition to existing patients, transitions and any referrals considered by the ADHD GP Lead and the Bristol ADHD Team to be very urgent are being spot purchased. To date, this is an additional cost to the contract of some £8,000.

At a Mental Health & Disabilities JCB held on 25th April, the principles of this business case were discussed and the Mental Health GP Leads present agreed that the new service model was acceptable and that Option C would remain the preferred option whilst recognising that this may not be attainable at this time.

4.0 2014/15 Local Service Model

Until 2014, ADHD assessments had only been made available on an ad-hoc basis via WCCG's Exceptions Process, with individuals having to travel to Bristol in order to be assessed and receive appropriate treatment. The aim of this Contract was to remove the necessity to travel and provide flexible, appropriate care within Wiltshire.

The Wiltshire service was designed to operate as a 'spoke' of the Bristol Adult ADHD service with additional staff employed specifically to provide clinics within Wiltshire. The advantages of being part of the Bristol service is that it supports the development of specialist expertise while keeping costs down as the team will have a single administrative base with access to local delivery points. It was originally anticipated that AWP would run a clinic for two to three days per month within Wiltshire at Savernake Hospital. The intention was to increase these clinics as more funding became available and to operate from more than one location.

It was anticipated that the service capacity would very quickly be taken up by the ongoing caseload. Therefore, AWP would need to work with Wilts CCG to establish shared care for patients who were stabilised on medication and also to agree how to manage the additional in-year demand over and above the commissioned capacity.

4.1 Initial basis for contract

In setting up this contract, it was made very clear to AWP that funding for the service could not exceed £120k (excluding the cost of medication). AWP were essentially asked how much activity could they provide within that funding envelope. The basis of the contract then became how much activity could be provided by the planned staff complement as shown on the following page.

Table A

Cost	w.t.e.	Cost per wte	Total (£)
Consultant	0.22	130,000	28,600
Band 7	1.00	43,323	43,323
Band 4	1.00	24,834	24,834
Non pay	n/a	n/a	5,805
Contribution to central costs	n/a	n/a	17,436
Total			119,998

ACTIVITY CONTRACTED FOR ON THE BASIS OF THE ABOVE COSTINGS	
Contracted Activity	Total (Patients)
Full/New Assessments	80
Transitions	40
Follow ups	320

Had the contract been based around a cost per person model, the actual cost of the service model as developed would have been £216,800 (excluding medication):

Table B

2014/15 Block Contract Value £120k			
Contracted Activity	Numbers	Cost per person £000	Total Value £000
Full/New Assessments	80	1,634	130,720
Transitions	40	560	22,400
Follow ups	320	199	63,680
TOTAL			216,800

The service model within the 2014/15 contract involved a year long package of assessment, treatment, stabilisation and reviews. This model was to be underpinned by a shared care protocol which Wiltshire CCG was to put in place. Patients would then be transferred to share care with their respective GPs as soon as they were stable on their medication. AWP already had a shared care protocol with B&NES, North Somerset and South Gloucestershire and the intention was to adapt that protocol to include Wiltshire.

Prevalence data/anticipated activity: This was all provided by the since removed ADHD Consultant and his Business Manager with apparently no additional research undertaken.

4.2 Issues arising

- The AWP management team were slow to recruit the staffing as shown in Table A and failed to inform the CCG that they were encountering any issues or that this was impacting on their ability to deliver against the contract
- Agreement with the three formularies was not pursued with regard to the shared care protocol and, although AWP have managed to achieve a shared care position on behalf of 18 patients, this has been done by asking GPs to sign a form rather than a protocol. The majority of Wiltshire GPs have been reluctant to enter into such an arrangement to prescribe the red top drugs involved and may well still be resistant to any share care arrangements when the drugs have been reduced to amber.
- Referral levels were significantly higher than contracted for which meant that the ADHD Team in place would never have been able to cope with demand. The impact of this was that there were also more follow up appointments needed and insufficient capacity place to respond to the need.
- In March 2015, the CCG were advised that both the Consultant Lead and the Business Manager had been suspended from their posts and that another Consultant had been put in place from within AWP.
- Following this event and the changes in the ADHD Team, some urgent review work was done to establish what the exact position was. AWP were found to be underperforming against the contract and remedial measures were put in place. However, all the review work was later found to be flawed as it was still based on original data from the then suspended members of staff.

5.0 Evidence to support need

Prevalence Rates

There is currently very little UK specific data particularly in relation to adults with ADHD and this is confirmed by the numerous websites visited in researching this subject.

"The prevalence rates in children, adolescents and adults can vary depending on a number of factors such as: age, gender, presentation of ADHD and comorbidities. Mean worldwide prevalence of ADHD is estimated at between 5.29% and 7.1% in children and adolescents, and at 3.4% (range 1.2–7.3%) in adults. Reported prevalence rates may also be affected by population characteristics; methodological, environmental and cultural differences; and variability in identification and diagnostic guideline tools employed in studies." [1]

Approximately 9% of children and 4% of the adult population in the UK have ADHD. Wiltshire Population 2015 data taken from www.pansi.org.uk[2] provides an estimated population of 484,400 suggesting that around 18,243 children and 11,268 adults could be affected by ADHD. Whilst some children do outgrow the symptoms of ADHD, it is estimated that between 50% and 66% of individuals have symptoms which persist into adulthood (to age 55 and beyond) requiring ongoing support and/or treatment.

In 2008 the National Institute of Clinical Excellence (NICE) completed a full review of the diagnosis and treatment of ADHD across the lifespan, and published guidelines for the diagnosis and management of ADHD in childhood, adolescence and adulthood. These guidelines were a significant stimulus for the development of improved service provision for ADHD in the UK. Similar guidelines published in Germany (DGKJP, 2007) and Canada (CADDRA, 2011) had comparable effects in their respective countries (Seixas et al., 2012). A further detailed review and European consensus statement was also published by the European Network of Adult ADHD (ENAA), (Kooij et al., 2010). Despite this increased interest there is still a scarcity of services, particularly adult services, for those with ADHD.

The proportion of the population receiving treatment for ADHD in the UK and other Western countries is far lower than the estimated population prevalence of the disorder. A great number of patients who would benefit from treatment for ADHD, both children and adults, are never identified or treated (Gustavsson et al., 2011; Wittchen et al., 2011). In view of the current under-provision of services it remains important that ADHD continues to be considered a field for expansion of service provision.

5.1 NICE Guidance

The NICE guideline on ADHD highlights that people with ADHD need integrated care that addresses a wide range of personal, social educational and occupational needs. Commissioning services for children, young people and adults with ADHD is therefore likely to involve close working between healthcare and social care commissioners and social care, education, children's services, mental health services, adults ADHD services and the third sector to provide multidisciplinary care for people with ADHD.

"…teams and clinics should have expertise in the diagnosis and management of ADHD and should: provide diagnostic, treatment and consultation services for people with ADHD who have complex needs or where general psychiatric services are in doubt about the diagnosis and/or management of ADHD" and "produce local protocols for shared care arrangements with primary care providers and ensure that clear lines of communication between primary and secondary care are maintained".

The guidance is also clear that "adults presenting with symptoms of ADHD in primary care or general adult psychiatric services who do not have a childhood diagnosis should be referred for assessment by a mental health specialist trained in the diagnosis and treatment of ADHD". [3]

5.2 IMPACT

- **Socio-Economic**

UK data on the economic cost of ADHD is limited; In 2010, Healthcare costs associated with treating adolescents with ADHD was reported as £670m in the UK with education and NHS resources accounting for approximately 76% and 24% of spending respectively. The mean cost per person with ADHD was £5494 in terms of NHS, social care and education.

Failure to treat adults with ADHD is costly to society. Untreated ADHD results in increased rates of unemployment (I) (Halmoy et al., 2009) and sickness absence (I) (de Graaf et al., 2008). There are associations with illicit drug use and alcohol addiction (Ia), lack of academic achievement (I) and higher rates of poor social adjustment and family or marital conflict (II) (Biederman et al., 2006; Fried et al., 2013; Kaye et al., 2013; Wymbs et al., 2008). Recently, a large epidemiological study from Sweden showed an approximately four-fold increase in criminal convictions associated with ADHD, that was reduced during periods of targeted treatment for ADHD (Lichtenstein et al., 2012) (II). In addition, untreated ADHD can have a detrimental effect on the relatives of patients and their carers (Cadman et al., 2012)"

Consensus points

1. The proportion of the population receiving treatment for ADHD in the UK and other Western countries is still lower than the estimated population prevalence of the disorder.
2. Untreated ADHD is costly to society. It produces increased rates of unemployment; it associates with illicit drug use and alcohol addiction, poor academic outcomes, higher rates of marital conflict and increased criminality. [4]

Recommended Reading: In 2013, an "Expert White Paper on attention-deficit hyperactivity disorder (ADHD): policy solutions to address the societal impact, costs and long-term outcomes, in support of affected individuals" was published and a copy of this paper is attached at Appendix One. The three main authors were: Susan Young, King's College London, Institute of Psychiatry; Michael Fitzgerald,Trinity College, Dublin, Ireland and Maarten J Postma, University of Groningen, the Netherlands.

This paper was presented to policymakers and key stakeholders in Brussels on 23rd April 2013. The Expert White Paper, based on patient-informed research and independent expert opinion, demonstrates the substantial impact ADHD can have on an individual from childhood into adulthood, in addition to the broader impact on families, welfare systems and national budgets and sets out a framework for action. The paper includes a number of studies, reaching a variety of conclusions and made some key recommendations:

- Increase Informed awareness of ADHD in schools, workplace, criminal justice system and broader society
- Improve access to earlier and accurate diagnosis of ADHD
- Improve access to ADHD services ensuring timely access to appropriate, integrated and cost-effective treatment and care
- Involve and support patient organisations
- Encourage a patient centered research agenda

- **Transition to adult services**

In 2010, a study by Consultants in South Yorkshire set out to identify the ongoing service needs of young people with attention-deficit hyperactivity disorder (ADHD). 139 young people aged 14 years and over on 1 September

2007 with a diagnosis of ADHD were identified from ADHD service user databases at a centre in Sheffield. Of these 139 patients:

- 102 were on medication for ADHD and just over 50% had well controlled ADHD
- 71% had at least one co-morbid condition
- 46 patients had had intervention from child and adolescent mental health services
- 17% had offended
- 37% were likely to need transition to adult mental health services as soon as they left paediatric services
- 36% would benefit from the expertise of a clinical nurse specialist, either to support a general practitioner (GP) or adult mental health professionals.

The then recent National Institute for Health and Clinical Excellence guidelines highlighted the need to provide transition services for young people with ADHD who have continuing impairment. The need for services for adults with ADHD was also recognised. The study concluded that the data confirmed and refined the nature of this need in the local population. Young people with mental health problems in addition to their ADHD will need support from adult mental health services. However, a significant group of young adults are likely to be managed well by specialist nurses working with GPs in a primary care setting or adult mental health.[5]

- **Adult ADHD in the workplace and its consequences**

In 2008, as part of a WHO World Mental Health Survey Initiative, an ADHD screen was administered to 7075 adults aged between 18 and 44 in ten countries. The response rate was between 45.9 and 87.7% across the ten countries. The results of this survey found that an average of 3.5% of workers met the DSM-IV criteria for adult ADHD and that it was more common amongst non-professional males than other groups. ADHD was associated with a statistically significant 22.1 annual days of excess lost role performance compared to otherwise similar respondents without ADHD. No difference in the magnitude of this effect was found by occupation, education, age, gender or partner status. Although only a small minority of workers with ADHD ever received treatment for this condition, higher proportions were treated for comorbid mental/substance disorders.[6]

- **ADHD and Crime**

    - People with ADHD are twice as likely to commit crime
    - People with ADHD commit three times as many offences as those without the disorder
    - People with ADHD are more susceptible to problematic drug use
    - People with ADHD are more likely to attempt to take their own life

Offences such as criminal damage and violence are prevalent in this cohort, whereby typically the offender is inappropriately egged on to commit crime by peers, and they go on to do the act to curry favour and seek lifts in personal esteem. People with ADHD are nearly three times more likely to commit arson.

The key challenges for the criminal justice agencies is to focus on improving services for this population, and it is a key population that both deserves and requires improvement. Recent research suggests that up to 25% of the UK prison population has some form of mental health disorder, typically ADHD, and this disproportionality with general population figures should be a cause for concern.

The costs to the criminal justice system for people with ADHD are immense when compared to those without the disorder, rising from £200 in a control study to £20K plus for the ADHD cohort.[7]

- **Medication**

In 2006, the total annual cost of prescribed stimulants and other drugs for ADHD in England was roughly £29 million, comprising a 20% increase from the previous year [8]. This increase in cost is attributed in part to the increased numbers of individuals being treated, and in part to a shift in prescribing towards more expensive MR formulations. Schlander (2007) estimated that, in 2012, the ADHD pharmacotherapy expenditures for children and young people may exceed £78 million in England, owing to an increase in the number of diagnosed cases, growing acceptance and intensity of pharmacotherapy, and higher unit costs of medications.

Nevertheless, the current £29 million annual cost of prescribed drugs for ADHD in England is low compared with annual costs of drugs prescribed for other chronic conditions such as depression (£292 million) and diabetes (£562 million).[6]

The taking of some unlawful substances, such as cannabis, amphetamines, cocaine and heroin is more common amongst those with ADHD and whereas for the 'norm' this would produce a 'high', for the ADHD cohort this produces a more normal state, where the user is less hyperactive, able to focus and concentrate and to pause before acting on impulse. In short, this act of 'self-medication' brings about a more normal state and behavioural acceptance amongst society.[9]

The current medication cost to Wiltshire CCG is in the region of £50k per annum. See Section 9.0.

- **Case Study provided by Dr Debbie Beale**

S was diagnosed with ADH at the age of 10. He had problems with attention in class, very fidgety and difficulty with coping with change. He had no friends and found noise very irritating. He was referred to the Sirona service and diagnosed with ADH. He was on Concerta until he left school at 16. He then went onto college for a life skill course and had some work placements in light industry and a building project. While on the Concerta he felt calmer and could remain in a class room, tolerating the other students. He completed his college course with a literacy certificate and some building related NVQs. He was planning to join the family building/decorating business. He had a few friends and was generally contented. His family supported him and he lived at home. He enjoyed working on painting projects and carpentry. He cycled with a local club. He did not gain GCSES and was socially awkward, but enjoyed his life with the aim to save for a car.

At 18 he was discharged from the community paediatrics service and was monitored by his GP, who continued to prescribe his medication. He left college and the support that he found there. The family moved area and the new practice felt unable to prescribe medication. He could not cope with the change of practice and would not make further appointments. He became aware of increased restlessness and irritability, falling out with his few friends and his family. He left the family home and business. He found a room in a flat and worked sweeping at a local factory. His work mates introduced him to cannabis, which relieved a lot of his restlessness and irritability. He became popular with a group of young men because they realised the level of his naivety and persuaded him to collect and buy the cannabis for them. He was eventually caught by police and although not charged, lost his job.

He was now homeless and unable to buy cannabis. Eventually he was picked up by the police for "drunk and disorderly behaviour" and put in a holding cell. He had always found it difficult to cope with enclosed spaces and became very agitated and aggressive. He was assessed by a mental health team and thought to be psychotic and needed a secure unit. There was no facility available in Wiltshire. He was sectioned and admitted to a hospital in Stevenage for 3 month. He was eventually transferred to green lane and then home with intensive support. He is

Currently taking Quetiapine. He does not like the doped up feeling it gives him and will stop medication for a while. He tries to control his symptoms of hyperactivity by cycling 50-60 miles a day, often during the night.

6.0 Integration with/development of and with other service pathways

In developing this business case, it is recognised that the integrated care pathways referred to by NICE have not been developed locally. The urgent need to revisit this service has not allowed sufficient time for all pathways to be reviewed at the same time. However, two specific areas have immediately been identified:

- Discussions with Wiltshire CCG's new Children's Commissioner have begun with a view to ensuring that the transition pathway is improved and better understood. The Children's Commissioner has been asked to look at the numbers of children with ADHD likely to be transitioning over the next few years with a view to better planning – in terms of pathway, capacity and financial. Additionally, the nature of the discharge information sent to GPs is under scrutiny and the new provider of Children's Services, Virgin, have been requested to provide audit data specifically relating to ADHD during the first year of their contract which can then be used to inform the new service as it moves forward enabling improved planning for the transition element of the contract
- Wiltshire also has a an Autism Assessment and Diagnosis service which is provided on an Any Qualified Provider basis by three providers – AWP, Autism Development and Research Council (ADRC) in Southampton and SEQOL in Swindon. It is widely acknowledged that there is a similarity between the symptoms of ASD and ADHD and professionals, not infrequently, refer into the incorrect service. There is an increasing interest in bringing the two services together into one centre. Additionally, the Oxford ADHD Centre now has children and adult services under one roof to smooth the transition pathway

These areas, together with community support pathways, should be considered in more detail over the coming year. This would include the idea of a mentoring support service being available at community level with a view to reducing the number of follow-ups required by individuals. This should, subject to their level of medication stability, reduce reviews to an annual basis.

7.0 Data

Having agreed a contract extension from 31st March, AWP were asked to undertake a number of actions in terms of providing assurance for moving forward. The CCG had undertaken a review of the data that had been received over the course of the contract to date and found that the original business manager had taken the activity contracted for and extrapolated it down because the contract was on a 42-week basis. Additionally, performance data that had been provided could not be reconciled. AWP were then required to undertake a thorough data cleansing exercise and the now confirmed activity data is shown on the following page. It should be noted that prior to 2014/15, referrals were via the CCG exceptions process only.

The data received from AWP demonstrated three emerging trends:

- Referrals - the referral rate has gone up considerably in the last 4 years and that this is in common with Bristol. On average, over a 4 year period, 61% of all referrals get to the stage of being offered an assessment package. For 2015/16, this has been demonstrated as being 85% for Wiltshire patients.

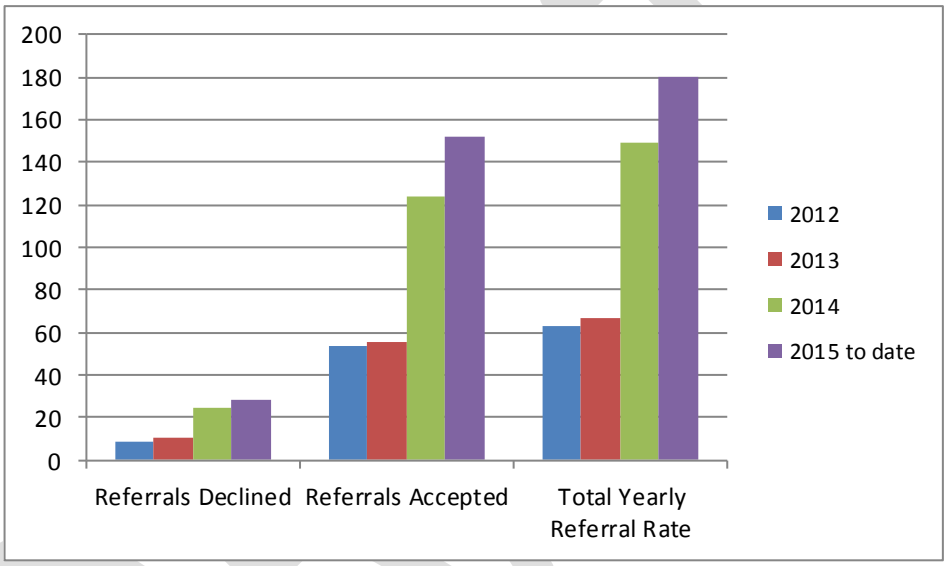
- Activity - regarding the ADHD caseload, there has been a change from service users on 'In-package' care being the majority of caseload to service users on 'On-going' or out of package care being the majority.

- Output – There have been small increases in service users on shared care and static discharge data.

These three trends highlight a service that will inevitably start struggling to keep up with incoming demand and its own subsequent caseload demand. It is receiving more service users into the service, with more service users remaining in the service, while shared care and general discharges are not increasing at an equal rate to accommodate for this demand.

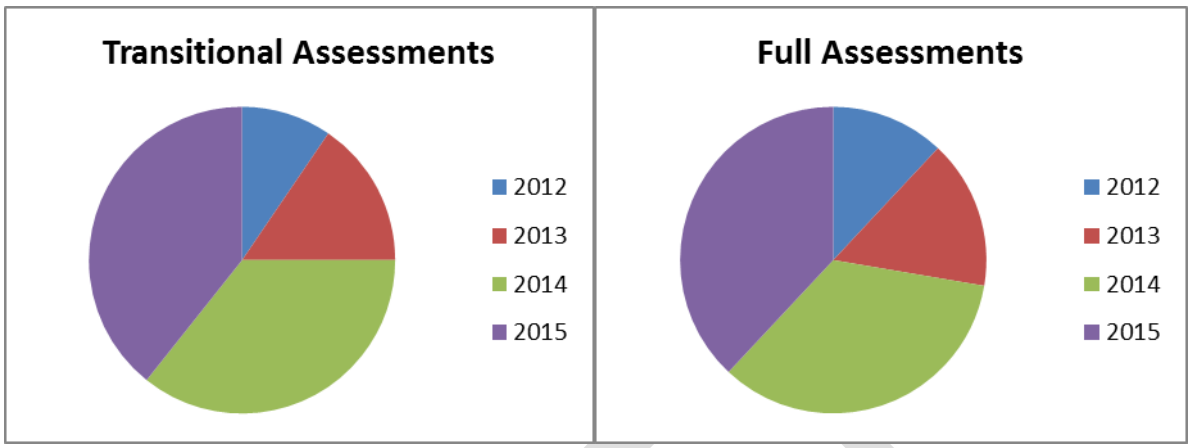
7.1 Referrals

Chart 1 demonstrates the steady increase in referral numbers within Wiltshire since 2012 and it is understood that this is a familiar picture across the AWP Trust area i.e. Bristol, B&NES, S.Glos, North Somerset and Swindon (unfortunately, at this time, only data from Bristol has been made available but it is very pertinent to this case. See Section 7.3).



	2012	2013	2014	2015/16
Referrals Declined	9	11	25	28
Referrals Accepted	54	56	124	152
Total Yearly Referrals	63	67	149	180

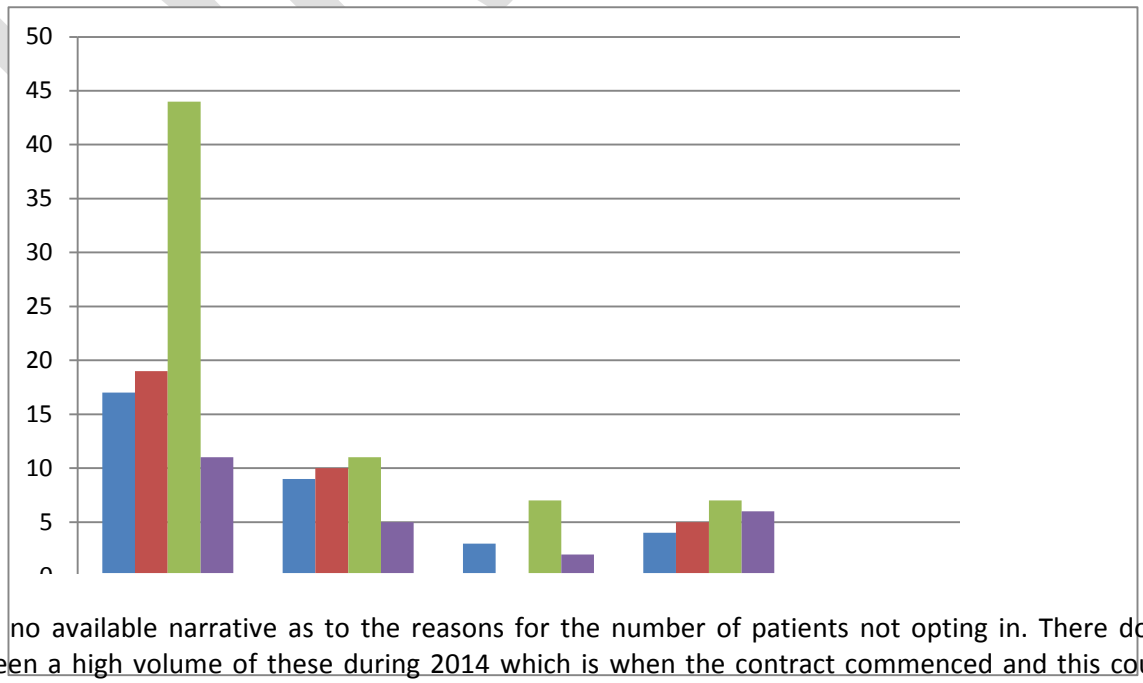
7.2 **Chart 2** shows the breakdown between transitional and full/new referrals can be seen below(not necessarily accepted/seen):



	2012	2013	2014	2015
Transitional Assessments	8	13	30	33
Full Assessments	29	38	83	92

Referrals for transitional assessments have shown a small increase over the past year although it is likely that this is not a true picture of the number of young people needing to transfer. During the first year (2016/17) of the new Children's Services Contract, an audit will be undertaken to assess the actual position in terms of numbers likely to be referred into the Adult ADHD Service with a view to informing future activity.

Chart 3 shows the breakdown of activity related to those referred but not seen:



There is currently no available narrative as to the reasons for the number of patients not opting in. There does appear to have been a high volume of these during 2014 which is when the contract commenced and this could have been the result of an initial flurry of activity resulting in higher than usual inappropriate referrals.

Chart 4 reveals the number of patients currently in shared care and how this has been steadily increasing. However, a number of these have been individual agreements with GPs and not necessarily on the basis of a signed up to shared care protocol. It does however demonstrate that there is some willingness amongst Wiltshire GPs to enter into such an arrangement subject to specialist support also being available.

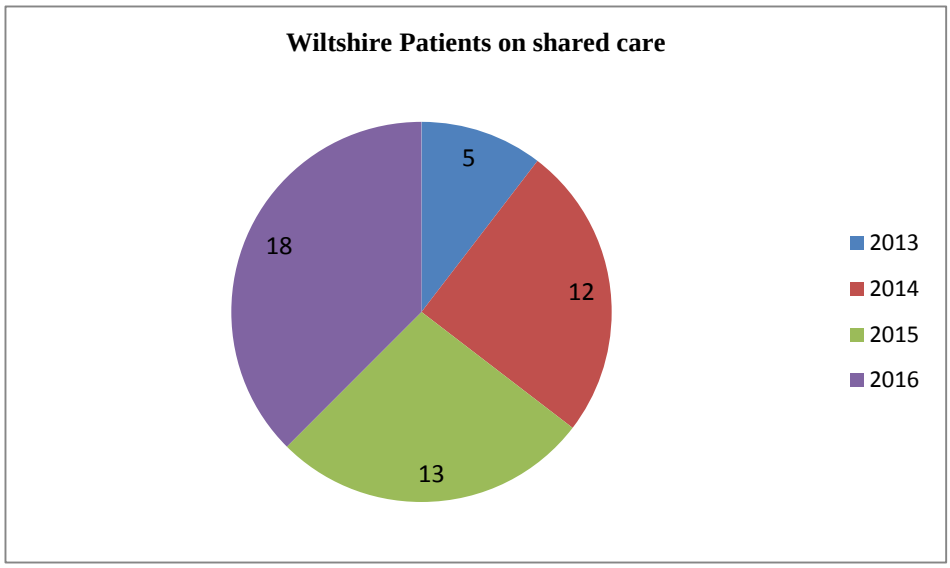
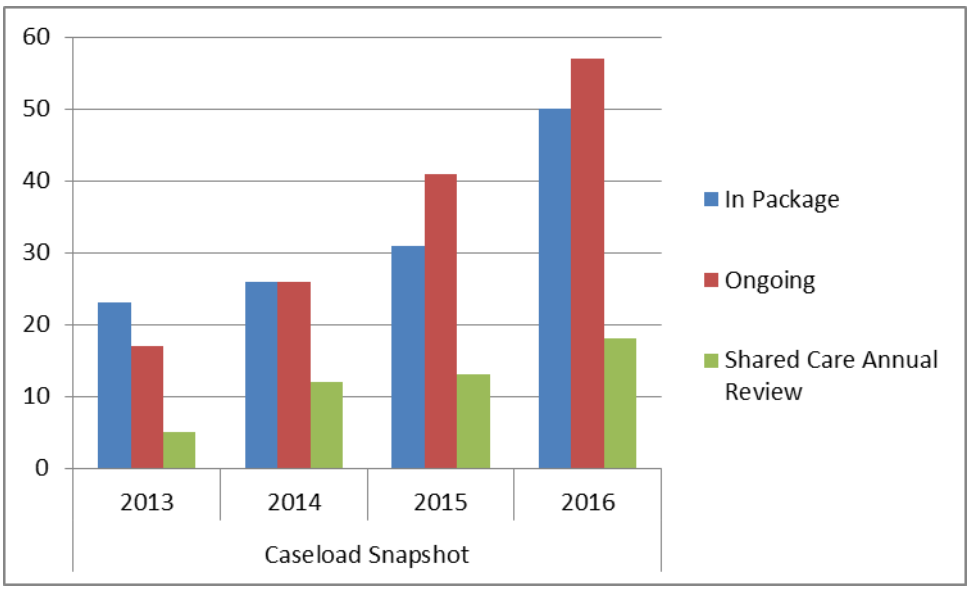


Chart 5 provides a "snapshot" of activity



- An analysis of this data demonstrates a small increase in the percentage of service users on 'Shared Care' from the overall caseload with 11% in 2013 up to 14% in 2016.

- Service users in 'On-going' care have seen that largest increase of caseload percentage with 37% in 2013 increasing to 45% in 2016.

- The number of 'In package' service users have decreased from 51% of the caseload in 2013 down to 40% in 2016.

7.3 Bristol CCG - Comparison

Bristol CCG has been commissioning an Adult ADHD service for the last few years. This is a block contract with AWP with a funding envelope of £241,870 (Option 1B in this business case) for 15/16. There is a similar population base - www.pansi.uk.org 2015 data 484,400 (Wiltshire 477,733). Bristol CCG provided there Q2 ADHD Report which was based on activity up to 26 October 2015.

Referrals	2010-11	2011-12	2012-13	2013-14	2014-15	2015 – End Oct
Bristol	135	142	200	224	320	153
Wiltshire	N/A	N/A	63*	67*	149	180

* These would have been via the Prior Approval's Process

As can be seen, over the first two years of their contract Bristol experienced a 5.1% increase in referrals. By comparison, Wiltshire has had an increase of 20.8%. Understanding and acceptance of ADHD as a recognised disorder has increased since 2010. However, between 2013/14 and 2014/15 Bristol's referrals increased by 42.8%. Bristol CCG have also pointed out that they have a high University population which may not be providing a true reflection of the Bristol population. Bristol are using the same service model as Wiltshire originally contracted for.

As has been predicted in Wiltshire, Bristol have been experiencing an exponential increase in the number of follow ups and the data provided reports that there are currently 261 clients needing 833 follow up appointments in 2015/16 at a cost of £165,767.

Therefore, of the £241,870 funded capacity, £165,767 is required for the on-going caseload, leaving £76,103 for new assessments.

"Since April 2015, AWP have undertaken 32 Full Assessments and 5 Transitional Assessments at a total cost of £55,338 which leaves a total of £20,765 for further assessments. 17 Full Assessments and 6 Transitional Assessments are scheduled in October and November at a total cost of £31,438. This is a planned over-commitment on the commissioned service because a proportion of the estimated follow ups will not take place due to service users dropping out or moving away from the area. However, AWP are very much at the limits of our commissioned activity and need to agree with commissioners how to manage referrals and the waiting list for the remainder of the year."[8]

Bristol CCG are currently awaiting the Q3 Report from AWP and are already considering moving to the new service model (as proposed within this case) and a review of current funding.

8.0 Future Proposed Service Model

In February 2016, AWP were requested to review their previous proposals whilst taking on board the views of the CCG. This was on the basis that the current funding level would not be changing i.e. £120k.

The revised proposal from AWP divides the service into three packages with an associated cost per person within that package. The new model is underpinned by having a shared care protocol in place across Wiltshire. All of these costings are exclusive of medication costs.

Clinical Activity	Cost per person £
Assessment Only (i.e diagnosis not confirmed)	800.00
The Assessment and Treatment Package for Full/New Referrals	1,570.00
The Assessment and Treatment Package for Transition Referrals	560.00
The Complex Package	980.00

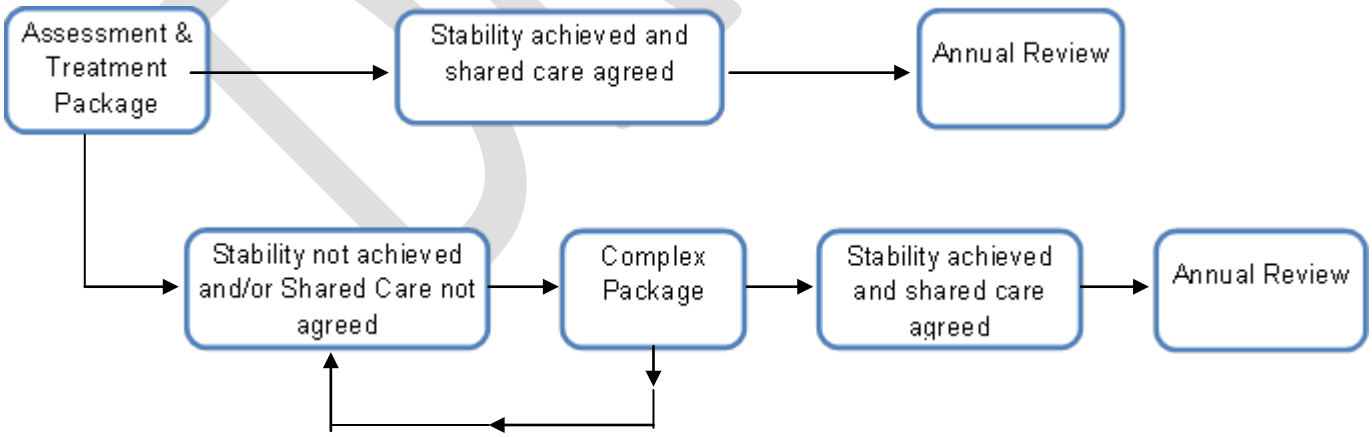
8.1 Referral Pathway

Referrals into the proposed service would need to come via GPs and can be made as described by the GP Referral Support Template provided by AWP. Self-referrals will not be accepted. Each referral should be accompanied by a completed ADHD Self-Assessment form. Both of these templates are embedded here for information:

GP Referral Support Template

ADHD Self-Assessment

A summary of the proposed service model can be shown as:



8.2 Assessment and Treatment Package for Full/New Referrals

This package is essentially the same was previously but with a significantly shorter timeline of 22 weeks. It includes an initial 3 hour MDT assessment, 3 x telephone reviews, 1 x one hour face to face clinical review, inter-professional liaison, attendance at 5 x 90 minute sessions. At week 9, an assessment will be undertaken and if medication and/or psychosocial functioning is not stable, the CCG will be approached with a request for the patient to move into the complex package of care.

8.3 Assessment and Treatment Package for Transition Referrals

Originally the assessment session for a transitioning individual was the same as that for a new referral which the CCG considered unnecessary given that a diagnosis had already been confirmed. Under the new proposal, the session time has been reduced to 2 hours and the subsequent package is for four weeks underpinned by a shared care protocol. Again, if the patient's ADHD is found to be of a more complex nature which may not be managed via the shared care protocol, then moving into the complex package will need to be considered.

9.0 Medication and Shared Care Protocol

Medicines Management were asked to provide the current 12 month spend on ADHD drugs for adults only. They were able to provide a figure of approximately £50k as having been spent on the four main drugs prescribed: Atomexitine, Methylphenidate, Dexamfetamine and Lisdexamfetamine. They were unable to strip out any of these drugs which might have been prescribed for narcolepsy rather than ADHD which is why this can only be an approximate sum. At this time only Methylphenidate is approved under the shared care protocol.

In order to achieve a full shared care protocol, agreement needs to be reached firstly on which drugs the CCG agree should be being prescribed and secondly, on reducing the status of those drugs from Red to Amber enabling GPs to prescribe as necessary. As red top drugs are prescribed by secondary care and amber by primary care, once the shared care protocol is put in place, the budget for the drugs involved should transfer from AWP to CCG.

In the past few months, a shared care protocol has been agreed for Methylphenidate and discussions are now underway with regard to Atomexitine. The Dexamfetamine and Lisdexamfetamine are not drugs the CCG are likely to agree the use of and discussions around these are ongoing.

Many GPs are likely to be concerned about prescribing these drugs even under a shared care protocol which provides them with ongoing specialist support. This is recognised and there is an intention for a Mental Health GP Lead and a commissioner to attend Exec and Locality Meetings are required in order to explain the process and the merits of working under a shared care protocol. It is important that this an accepted part of the service delivery as without it in place, the proposed service model will not be sustainable.

NB: It is currently understood that there is significant push back from Wiltshire GPs to taking on any more responsibility, especially any they see as the role of secondary care. If the follow ups and medication reviews for ADHD patients cannot be shared with primary care, provision of this service becomes unviable.

10.0 Benefits of a local service

The benefits of commissioning a local service include:

- The service will be provided locally within Wiltshire ensuring that Wiltshire patients receive a high quality, fit for purpose service with a choice of locations enabling easy access
- The development of shared care with Wiltshire GPs will reduce reliance on the specialist service and support the appropriate targeting of its capacity. It will also enable more patients to be seen within the specialist service as a result of GPs sharing follow up responsibility for their patients
- The development of improved links with local mental health and primary care services to assist with management across care pathways
- Opportunities to develop additional local services to support adults with ADHD such as talking therapies and psycho-educational groups

- Opportunities to develop a bespoke service to meet the emerging needs of the Wiltshire population and to work with the provider to become a centre of excellence due to the lack of other ADHD service provider availability

- The development of closer links between Commissioner and provider underpinned by quarterly activity/ performance reports enabling the CCG to ensure that the service is providing a quality, value for money service which is delivering against an outcome based contract.

11.0 Outcomes Based Contract

The original contract could not be set up as an outcome based contract due to the lack of available data to support the outcomes proposed. The intention was that during the first year of the contract, AWP would begin to build up the data required in order to have a basis for the contract going forward. Three specific areas were to be focused on:

1. Employment: Eligible patients: All patients who are unemployed at assessment, with the main suspected cause of unemployment being untreated ADHD. The Five Year Forward View for Mental Health report to NHS England (February 2016) highlights the need to support employment and that it "should be consistently recognised as a crucial health outcome".

2. Crime: Eligible patients: All patients who have received a conviction for crime in the 6 months prior to assessment, where the nature of the crime (impulsive, acquisitive/violent) is attributable to untreated ADHD. See case study provided with this business case.

3. General wellbeing: Eligible patients: all. Use of a nationally recognised recovery and wellbeing measure- the recovery star. AWP have adapted the recovery star to make a simple rating scale which is already used in their clinic.

It is understood that some of the above data has been collected but would need to be reviewed if it were to be used moving forward. The intention would be to ensure that any contractual agreement for 2016-2018 would also be outcome based although the exact nature of those outcomes would require further development as part of the contract negotiations.

11.1 In addition to the above, the following outcomes should also be expected in conjunction with the development of integrated pathways and increased community support:

- Improved medication management and understanding of ADHD
- Individual coping strategies for symptom management and psychological distress
- Increased independence; develop and learn functional skills
- Improved relationships and social networks
- Access to external support agencies; education, employment, housing, service user and carer networks

12.0 Conclusion

The initial desire to establish a bespoke ADHD service for Wiltshire appears to have come about as a result of the spot purchase arrangements being identified as a cost pressure. At the time, however, only limited funding of £120k could be identified. The data supporting the contract was provided by AWP staff who subsequently proved unreliable and are no longer in post. This effectively caused the contract to collapse and whilst remedial action was taken in July 2015, it was not possible to put matters back on track.

It is difficult to demonstrate value for money in this case due to the lack of UK specific data but the impact of ADHD on life at home, at school, and in the workplace, together with the increased risk of criminal activity and the illegal use of medication has been described. The case study clearly demonstrates how situations can escalate when the actions of those with ADHD are misunderstood and lead to completely inappropriate outcomes for the individuals concerned.

Given the number of referrals and the interest in the service, cancelling it is not an option. The take up means that some 130 patients are currently being prescribed medication by AWP and with only 18 currently being cared for under a shared care protocol cancellation removes patient access to the medication they require. The risk of highly complex cases going undiagnosed and the resultant possibility of illegal drug use and physical harm to both themselves and others is not acceptable.

When it was announced that the service would not be available from 31st March 2016, numerous complaints were received by AWP, PALs, Health Watch and GPs and continue to be received. Patients currently waiting for non-urgent appointments are anxious and many applications talk about the need to get stable and get on with their lives. The provision of a fit for purpose ADHD service would enable them to do that, reducing the risk of an escalation in their behaviour and the subsequent impact on their families and society in general.

There is now an opportunity to provide Wiltshire residents with a bespoke service which will be flexible enough to support demand and enable further community based pathway development.

13.0 References

1 www.shirepharmaceuticals.co.uk. The information used in Section 4.1 was extracted from the website of Shire, a specialty biopharmaceutical company who claim that their knowledge, gained over many years, has led to the understanding that ADHD is a diverse disorder and that those with ADHD have widely different needs. They have collated data from European and American studies (2010) – the sources of which are too numerous to list here but do include NICE and the World Health Organisation

2 www.pansi.org.uk. An Institute of Public Care Service (IPC) which projects the needs of the UK adult population and provides population data by age band, gender, ethnic group, and by disability living allowance, incapacity benefits, and guardianship for English local authorities.

3 www.nice.org.uk/guidance/qs39/resources/support-for-commissioning-for-attention-deficit-hyperactivity-disorder

4 Evidence-based guidelines for the pharmacological management of attention deficit hyperactivity disorder: Update on recommendations from the British Association for Psychopharmacology.
Authors: Blanca Bolea-Alamañac1, David J Nutt2, Marios Adamou3, Phillip Asherson4, Stephen Bazire5, David Coghill6, David Heal7, Ulrich Müller8, John Nash9, Paramalah Santosh10, Kapil Sayal11, Edmund Sonuga- Barke12 and Susan J Young2 for the Consensus Group

5 First published in BMJ 2010: Authors Naomi Taylor[1], Amy Fauset[2], Val Harpin[2] + Author Affiliations
1. [1]University of Sheffield Medical School, Sheffield, South Yorkshire, UK
2. [2]Paediatric Neurodisability, Ryegate Children's Centre, Sheffield, South Yorkshire, UK

6 Article published in the BMJ 2008: Author Dr Ron de Graaf, Institute of Mental Health & Addiction, Netherlands

7 http://www.adhdandjustice.co.uk/badge/adhd-and-crime-generally.aspx

8 NHS Health and Social Care Information Centre, 2006; NHS Information Centre, 2007

9 The Information Centre, 2006.

Mental Health and Disabilities Joint Commissioning Board (MH&D JCB)

Cover Sheet

Title:	Wiltshire IAPT Service - Use of SilverCloud On-Line Treatment
Author(s):	Lindsay George and Susan Shallis
Lead Director:	Ted Wilson
Contributors:	Miriam Turner, Mental Health Commissioning
Date of Mental Health and Disabilities JCB Meeting:	Monday 27th June 2016
Paper is for:	Decision

Wiltshire IAPT Service – Use of SilverCloud

1.0 Executive Summary

During 2015, a full IAPT service review was undertaken and, as well as a completely revised service model, one of the options put forward was to introduce on-line therapies in the form of SilverCloud. The Mental Health GP Leads agreed that this would be an acceptable approach at a Mental Health & Disabilities JCB in September 2015. The subsequent reduction in funding envelope meant that the Wiltshire IAPT Service was unable to proceed with this service development. The revised service model commenced on 1st April 2016.

The predicted 'drop' against the national Recovery Rate Target (50%) began to occur at the end of 2015 reaching a low of 29% in April 2016. This decline has generated significant concern from NHS England who now require monthly reporting from the commissioners. Wiltshire IAPT Service has produced an improvement plan for NHS England and agreed an SDIP to ensure they achieve the national 50% recovery rate for IAPT service users by the end of October 2016. The volume of demand on the service (average 900 referrals per month) alongside national and locally agreed targets and a reduction in funding is expected to increase pressure and waits for treatment along with potential reduction in patient choice for therapy options. Procurement of Silvercloud, an online therapy programme which can be tailored to meet individual need and difficulties of service users would alleviate these pressures and increase flexibility in accessing treatment and optimise clinical availability.

Cost of treatment per individual is less than delivery of face to face treatment and can be accessed 24/7 on computer, tablet or smartphone therefore increasing access for those in more rural areas of the county and at times other than those the Service is available in GP surgeries.

Decision: The service is requesting funding which will enable it to purchase 500 therapy episodes over the next 12 months at a non-recurrent cost of £18,100 for one year which will include setup costs. If the trial period proves successful, this would then become a recurrent cost. It is possible that the 500 therapy episodes will prove to be insufficient at which point, the costs would increase as shown in Section 5.0 although the cost per person would decrease. The aim would be to support the drive to improve recovery rates, reduce wait times for treatment and maximise options for access to Psychological Therapy for the population of Wiltshire. It is proposed that this trial would be funded from the cost reduction made to the main IAPT contract for 2016/17.

2.0 Proposals to Support Improvement in Recovery Rate

There has been a recent surge of interest in the use of on-line IAPT therapies and it is understood that the Mental Health Taskforce recently created within NHS England will be placing some emphasis on the use of CBT on line. Provider and Commissioner have been looking at the SilverCloud On-Line Therapy Programme with a view to trialling this for those clients requiring Step 2 interventions. This service is the result of 10+ years of clinical and academic research and has been developed in conjunction with a number of partners including the NHS, Kings College and the MoD.

The programme currently provides a suite of courses related to anxiety, depression, chronic illness, stress and eating issues. New courses due for implementation relate to OCD, health anxieties, social anxieties, GAD and panic. Silver Cloud Health are also working on a PTSD programme in conjunction with the MoD and new programmes for Long Term Conditions such as CHD (beta) and Diabetes IAPT which they hope will be available in a few months' time. The company has also been asked to look at a programme for carers and medically unexplained symptoms. Silver Cloud are currently reporting a 60% engagement rate, 50-60% recovery rates based on trial in the Isle of Wight, Berkshire and Nottingham. Some 23 NHS Trusts have now signed up together with the MoD and 8 Universities.

Use of the system on a trial basis for the next 12 months would enable the service to evaluate the impact on service provision for Wiltshire, with a view to mitigating against the impact on National Targets which has arisen due to the transition of the service from a social model to a clinical pure IAPT model. It will interact with IAPTUS, which is the patient record system in use by the service and enable improved access in line with the declared increase in access

rate targets over the coming years (15% to 25% by 2020). If successful, it is proposed that funding be included in future funding provision .

A reduction in funding as of 1st April 2016, resulted in a corresponding reduction in workforce which has limited the capacity for 1:1 provision and although the service is meeting its wait time targets currently, there is a concern that this may not be sustained as we drive to deliver treatment sessions at a frequency recommended by NICE guidelines. This means reducing the number of bookable appointments to free up capacity for treatment sessions and creating potential for increased wait times both for assessment and treatment. SilverCloud offers a therapy option outside of 1:1 and course provision and allows greater equity in access to services across the county.

SilverCloud can be supported as described in Section 3.0 from within the current workforce and skill mix and will increase availability within surgeries for those who prefer or require face to face interventions.

Wiltshire IAPT Service is committed to delivering on its targets and has brought appointment bookings in house; reduced the number of courses available (in range, frequency and venue) and proportionally increased availability for 1:1 treatment options.

On average, 612 people enter 1:1 treatment per month. There are currently 438 people waiting entry into treatment and they have waited an average 34 days thus far. This wait is expected to increase over time.

In order to improve recovery rates, the focus will be on treating those for whom IAPT is proven to benefit with the right type of therapeutic interventions, in the right quantity at the appropriate intervals and by suitably trained staff. In order to achieve this, the service is committed to:

- Reduce opt in ethos to only first 2 sessions in any episode and book further treatment sessions in advance to ensure adherence to 1-2 week wait between treatment sessions and take account of patient choice.
- Introduce more rigid DNA and cancellation policies allowing only 14 days to re-engage and ensuring appointments are utilised to maximum capacity.
- Increase frequency and level of record management checks to ensure adherence to service model and policies
- Regular case management supervision for all practitioners in addition to clinical skills supervision and line management to support and guide practitioners through change and ensure adherence to new model
- Ongoing recruitment is for IAPT trained or CBT trained staff.
- Ongoing monitoring of wait times in surgeries to ensure resources allocated across service in most efficient and effective way.
- Assign and strategically locate Assistant Psychology Practitioners to clusters and surgeries to supplement and support surgery interventions with 1:1 manualised interventions (around core course subjects) to alleviate pressure.
- Ensure all cases are brought to case management supervision at start of treatment to ensure, appropriateness of intervention, prior treatment has been consolidated or issues presented for treatment within 6 month period of last episode are not duplicated.

The addition of SilverCloud will offer an alternative resource and therapy option for practitioners in surgeries, should alleviate pressures on surgery appointments, maintain and improve access rates and support improvements in recovery rates. Training for staff is included in the cost along with implementation costs

3.0 Description of Proposed Service

The service envisages referrals to Silver Cloud from practitioners and the system will communicate key information to the IAPTUS system through a secure system called PRISM, designed developed and managed by Mayden(IAPTUS providers). Programmes will be tailored to suit an individual's needs across a suite of treatments for both common mental health conditions and Long term health conditions. Each treatment comprises of 8 sessions and review session with a practitioner are programmed at set points to support the individual and to collect scores from within the IAPT minimum data set to monitor progress and outcomes. These scores are transferred to the patients record

within the IAPTUS system through a secure system called PRISM, designed developed and managed by Mayden(IAPTUS providers).

Review sessions can be tailored to an individual's needs and consist of approximately 15 minutes of 'coaching' through the programme.

4.0 Risks/Benefits

Key Benefits	Potential Impact of Implementation
System can be personalised for the region Flexible, accessible 24/7 Breaks down the psychological and physical barriers to accessing therapies Puts the client firmly in control, is interactive with useful tools, exercises and quizzes Personal space for clients to write up diaries, record thoughts/concerns Access for 1 year after course completion to maintain wellbeing Increases patient choice Has proven recovery rates Decreases clinical time required per patient IAPT and NICE compliant Reduced wait times to treatment Personal pathways for clients	Provides an additional "workforce" without the need to physically recruit staff IAPT would be able to review its staff and skill mix and adjust according to the need of those not wanting to use the on-line system Wiltshire IAPT Service is proposing a trial of this delivery method with a view to reducing waiting times for treatment and improving recovery waits. Cost per session is favourable when compared to 1:1 surgery work, 1 treatment (8 sessions) costs £36.20

5.0 Costs

Cost: The cost of this programme based system is based on numbers of patients, reducing as numbers increased i.e. 500 would be charged at £36.20 per user, a total of £18,100.00; 1000 users would be £24.03, a total of £24,030.00 and so on. This would include branding of the system to suit Wiltshire's requirements as well as a full training and implementation programme. An initial one year trial is proposed and if successful against an agreed outcome matrix and demonstrated by a clear increase in recovery rates, the service would be looking for this funding on a recurrent basis. As explained previously, this would be covered by the reduction in cost of the main IAPT contract for 2016/17.

6.0 Conclusion

As already indicated, there is significant pressure on both provider and commissioner to improve and maintain IAPT Recovery Rates against the national target. In order to achieve that whilst maintaining access rates and waiting times, the service is constantly reviewing and fine tuning its processes.

Funding to support the acquisition of 500 treatments on a trial basis over the next 12 months to support improvements in recovery rates using SilverCloud would give the service flexibility and ease the pressure in other areas. Subject to the outcome of the year's trial, the service would be looking to continue use of this on-line therapy and therefore the funding requirement would become recurrent.

NHS
Wiltshire
Clinical Commissioning Group

STREET TRIAGE
PROJECT STATUS REPORT
June 2016

1.0 PURPOSE OF THE REPORT

To provide an update on the progress of Pilot Street Triage and explore next steps, in line with 17/18 commissioning planning round.

2.0 BACKGROUND

In 15/16 National Directive from DOH, extra funding was made available for Mental Health Services to ensure appropriate and rapid response can be conducted across the health and criminal justice system to support the Section 136 detainment and assessment.

As a Wiltshire system, in partnership with Swindon CCG, the chosen model designed by Commissioners which best suited population need was a Control Room Based Street Triage. This is a pilot service that is currently being funded for 6 months only with AWP.

The model consists of a nurse led team based at the Police Control room and provide appropriate advise to the police officers before Section 136 is enacted upon, ensuring this is the best solution for the individual.

3.0 PERFORMANCE TO DATE

According to the Street Triage Evaluation led by University West of England[1]:

The use of a S136 was considered on 126 occasions. Sixty-seven S136 orders were applied, the Swindon & Wiltshire Street Triage Team are recorded as being consulted on 25 (37.3%) of these occasions. Around two-thirds (42 service users; 66.7%) of service users who had a S136 applied came into contact with the Police outside of the Swindon & Wiltshire Street Triage Team's operational hours.

[1] **Evaluation Report Swindon & Wiltshire Street Triage,29th April 2016 – DRAFT attached**

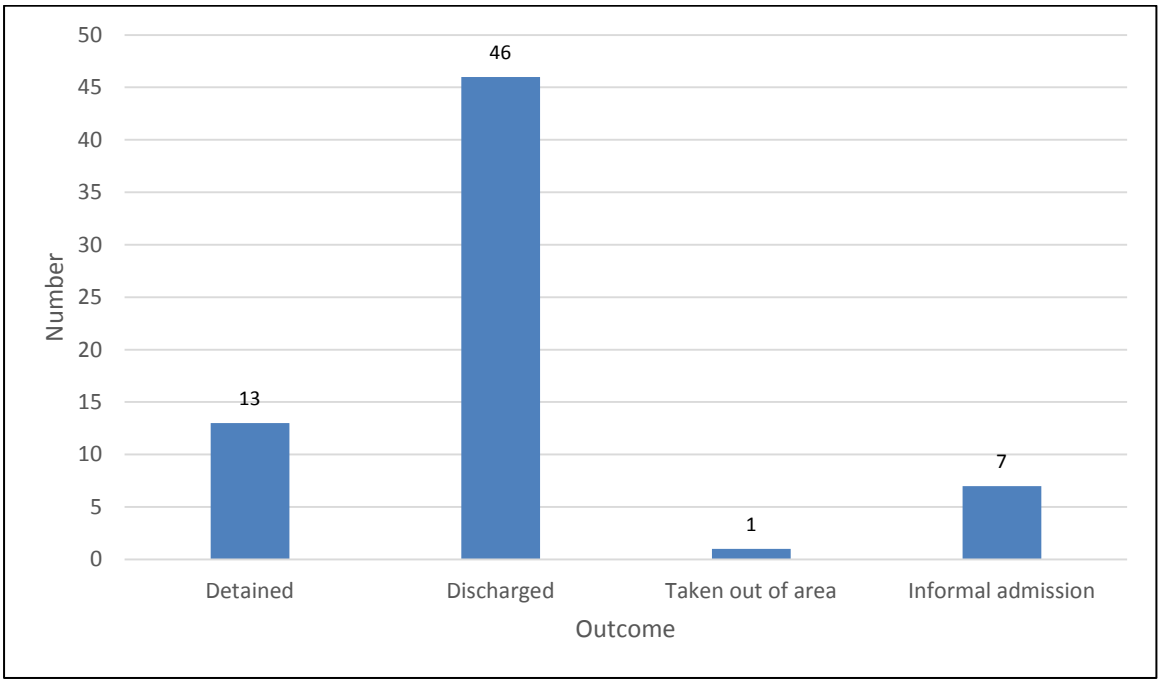
The Swindon & Wiltshire Street Triage Team was operational on the 59 occasions when the use of S136 was considered but not applied.

On three occasions that a S136 was applied when the Swindon & Wiltshire Street Triage Team were operational there was face-to-face contact with the service user; on four occasions there was phone contact between the Swindon & Wiltshire Street Triage Team and the service user. The length of these contacts were recorded on five occasions and ranged from 8 minutes to 2 hours.

The outcome of the Mental Health Assessment (MHA) for those service users where S136 was applied can be seen in Figure 1. The majority (46 services users: 68.7%) were discharged. Of the rest 13 (19.4%) were detained, one was taken from the area and 7 (10.4%) agreed to informal admission.

So, in its most simplistic terms, indicative performance shows, that when individuals are being detained under S136, it is for the right reasons and the majority are being referred and managed more appropriately elsewhere.

Figure 1 Outcome of Mental Health Assessment



4.0 PROPOSED NEXT STEPS

Acknowledging that the 1st evaluation of the pilot is highlighting very positive results, Commissioners are seeking an extension for the pilot to run a further 6 months in

order to understand the full effectiveness of service and to realistically work with AWP to identify key activities that could be mainstreamed into the main block contract going forward (17/18 commissioning intentions).

Commissioners are therefore seeking a further £49k (16/17 non recurrent), which will form part of Wiltshire CCG contribution of the Pilot Services commissioned jointly with Swindon CCG & Wiltshire Constabulary.

5.0 BOARD REQUEST.

For MH&LD Joint Commissioning Board to endorse the request of £49k (non – recurrent) to enable the pilot to run for a further 6 month, until the end of this financial year.

(Report ends)
Author MEE

NHS
Wiltshire
Clinical Commissioning Group

Title	Early Intervention in Psychosis: Workforce Development Business Case
Author:	Georgina Ruddle
Lead Director:	Ted Wilson
Main Contributors: Other contributors:	Phil Harding Wiltshire Early Interventions in Psychosis Manager Sarah Amani (South Region EIP Preparedness Programme Manager) Donna Lynch (Wiltshire CCG) Jo Smith Wiltshire EIP Service Administrator Wiltshire EIP Clinicians Neil Manson EIP service users, carers/family
Date of JCB Meeting:	27/06/2016
Paper is for:	Decision

Early Interventions in Psychosis: Workforce Development Business Case

1.0 Service Background

Wiltshire CCG commissions the Early Interventions in Psychosis Service (EIP) for those aged between 14-65 experiencing their first onset of psychosis or requiring support during their first three years of psychosis. Wiltshire EIP costs £742,758 (full year estimate as per the Month 8 15/16 resource mapping document), service revenue total (with other AWP commissioned CCG activity); £767,628.

EIP are commissioned to provide a community based service, with the flexibility to provide in reach into mental health wards as required. The Wiltshire Early Intervention in Psychosis Service (EIP) provides assessment and interventions for individuals experiencing a first onset of psychosis (during the first 3 years of initial onset). The service was initially commissioned in 2005 to work with those aged 14 to 35; from October 2015 the service extended this to 65 following national guidance recommendations.

EIP work with individuals for up to three years during the 'critical period' to maximise the chances of a symptom and social recovery and is provided by a Multidisciplinary Team. The NICE quality standard for Psychosis and Schizophrenia (2015) in adults recommends extension to five years should a presentation not be stabilised within the three year time period; the Wiltshire EIP team adhere to this recommendation and work flexibly extending allocation periods beyond the 3 year period based on clinical need.

Key Points:
- Extension of age group will require additional work force capacity.

2.0 National EIP Developments

National service delivery targets for EIP service have been set by NHS E and DoH:
50% of those referred to receive NICE compliant treatments by April 2016, increasing to 60% by 2020/21 (MH Taskforce Report, 2016).

Provision of NICE recommended package of care (each area of treatment will have defined targets and parameters for intervention delivery):

- CBT for psychosis
- Physical Health Assessments
- Family Interventions
- Wellbeing support
- Management of clozapine prescribing
- Carer focused education and support
- Education and employment support

The remit of EIP service has also recently been further expanded with provision to those deemed to have an 'at risk mental state'. Characteristically they focus on optimising control and reducing the distress of psychotic symptoms and improving holistic mental wellbeing, providing a range of psychological, family and social interventions and assisting in the personal adjustments arising from the experience of a first episode of psychosis. Early pathway work completed in the south region recommends working with service users assessed as being in the ARMs cohort for up to 6 months, with the main intervention being CBT (as per corresponding NICE guidance), followed by a period of up to 18 months care co-ordination to embed therapeutic coping strategies and to complete a watchful waiting brief.

Key Points:

- Inclusion of ARMs cohort will require additional service capacity.
- Delivery of a NICE compliant service will also require additional workforce capacity and enhanced clinical skills.

2.1

Table 1: Current Progress against Targets

NICE Quality Standard Outline	Audit descriptor	Additional proposed audit measures	Wiltshire EIP Performance against quality standard
Referral to Treatment Target: • 50% of those referred to receive NICE compliant treatments by April 2016, increasing to 60% by 2020/21 (MH Taskforce Report, 2016).	Evidence commissioning of EIP services. Evidence commissioning for referral pathways for adults with FEP to start treatment in EIP within 2 weeks of referral. Numerator: number in denominator who receive treatment from EIP within 2 weeks. Denominator: number of adults referred with FEP.	• Waiting list monitoring for those exceeding the 2 week RTT.	Referral management duty system introduced November 2015; this enables triaging of referrals, and allocation of initial assessment slot to occur within 72 hours of referral receipt. If a referrals is clearly not FEP onwards signposting takes place. Since November 2015 Wiltshire EIP have sustained exceeded the 50% RTT target. Current service caseload capacity (based on caseloads of 15) is 144. Therefore should the caseload rise to predicted levels approximately 4WTE further staff will be required.
Proportion of adults with psychosis who received CBTp: • Exact standards to be defined, but assumed will be; 16 sessions delivered by an accredited therapist). • Proposed national target 80% (under review)	Numerator: number in the denominator who receive CBTp Denominator the number of adults with psychosis/schizophrenia on caseload.	• Number of service users who have declined the offer of CBTp. • Dropout rate. • Total sessions • DNA rate. • Waiting list (total and lengths of wait). • Clinical pre-post outcome measure(s).	Current CBTp Trained Therapeutic Provision within Service: • 0.6 WTE CBTp trained therapist (Clinical Psychologist) who is seeking professional accreditation. Therapist will complete EMDR training by Dec 2016. • 1 WTE CBT accredited therapist (RMN, band 6). This therapist will complete CBTp training Sept 2016 and will then be eligible for provisional accreditation. Therapist scheduled to complete EMDR training 2017. • 2 further EIP clinicians are scheduled to complete It is estimated that working on the basis of a 42 week year (taking into account Annual Leave, Training and other absences), working at best at 3 CBT slots per day (minus travel, RTT assessment time, Team meetings and paperwork), 1 WTE CBTp therapist will be able to provide 630 CBT sessions

NICE Quality Standard Outline	Audit descriptor	Additional proposed audit measures	Wiltshire EIP Performance against quality standard
			per year (1,890 over 3 years). Working on the 'Gold Standard' of 80% of service users receiving 16 sessions of CBT based on an average caseload of 124, a total of 1,587 sessions of CBT will be required to be delivered over the three years. Should case load rise to projected levels (203) 2600sessions will be required (to deliver CBTp (16 sessions) to 80%). Total CBTp sessions for 1.6 WTE = 3024
Family Interventions • Include su with psychosis/schizophrenia if practical • Duration 3 months-1year • Minimum of 10 sessions • Accommodate preference for single FI or multi-family group intervention • Take account of relationship between main carer and su • Include support, education or treatment function and include	Numerator – number in denominator whose family members receive FI. Denominator – number with psychosis/schizophrenia who live with or are in close contact with family members.	% of service users with a carer identified % of carers assessments completed % of caseload offered Family Interventions % of caseload in receipt of Family Interventions % of caseload received Family Interventions Number received 10 planned sessions. (data to be split by those with psychosis and schizophrenia)	Currently three trained FI clinicians within the team. Three further staff scheduled to attend the training course in September 2016. To manage resource and maintain capacity in the team whilst engaging in FI Care co-ordination visits will cease to take place.

NICE Quality Standard Outline	Audit descriptor	Additional proposed audit measures	Wiltshire EIP Performance against quality standard
negotiated problem solving or crisis management work.			
Clozapine Those who have not responded adequately to treatment with at least 2 antipsychotic drugs (at least 1 of which should be non-clozapine second generation antipsychotic) are offered clozapine.	Numerator: number in the denominator who receive clozapine. Denominator: number of Sus who have not responded to treatment with at least 2 antipsychotic drugs (at least 1 of which should be non-clozapine second generation antipsychotic).		Team Manager is a practicing non-medical prescriber. Capacity to prescribe and review prescriptions within the team is limited. Access to CMHT Consultant Psychiatry can be obtained, however average waiting list is 3-5 weeks.
Assessing Physical Health • Ensure delivery of physical health, initial assessment within first 12 weeks of allocation to EIP, yearly reviews then required.	Numerator: a) Number of Sus in receipt of a physical health assessment within initial 12 wks of allocation to EIP. b) proportion of adults in receipt annual reviews. Denominator: Number of adults on caseload.	Data collected through national CQUIN	Delivery of physical health assessments is completed on a clinic basis at present. 1 CPN leading. Assessments are completed holistically: Physical (15mins) and lifestyle (45mins) 2 further practitioners completing phlebotomy training over next 6 months. CQUIN awarded 2015/2016
Wellbeing : • Provision of physical activity interventions, healthy eating, smoking cessation support.	Proportion of individuals who receive healthy eating and physical activity programmes within last 12 months. Proportions of SUs who smoke who received help to		• Rolling programme of activities groups provided (badminton, pool, walking, football, allotment) enabling engagement, socialising, peer support (IRIS 2012). • Link with smoking cessation nurse.

NICE Quality Standard Outline	Audit descriptor	Additional proposed audit measures	Wiltshire EIP Performance against quality standard
	stop smoking within the past 12 months		
Carer focused education and support programmes: • Carer focused education and support programme to be offered.			Team have educational material in place. Plan to deliver 3 week group on a bi-annual basis. Ongoing informal family/carer support provided through routine visits. Information leaflets re: psychosis provided.
Education and employment Support			Individual Placement Support Service Commissioned. Once IPS worker in reaches into the EIP team 3 days, providing input to 50% EIP current caseload (over 3 year period) working with 10 SUs for 6 months.

3.0 Wiltshire EIP Service need:

Table 2: Estimated incidence of psychosis based upon PHE prevalence data

Population	**The population aged between 16 and 65 served by your team.**	**483,671**
Psychosis incidence / 100,000	The predicted number of new cases per year, by 100,000.	16.9

- Based on a caseload retention rate of 90% at year 1, 80% year 2 and 70% year 3 caseload total is estimated to be 203.
- It should be noted that to date there are no projections for ARMs activity, therefore this remains an undefined pressure upon the team.

Table 3: Wiltshire EIP Workforce Summary and Projected Staffing levels required to deliver a NICE compliant service managing estimated FEP population in Wiltshire.

Staff Role	Current staffing level	Projected NICE Compliant Staff Levels	Variance
Team Leader	1	1.3	-0.3
Medical Time (CAMHS & Adult)	0	1	-1
Care Coordinators	8.6	13	-4.4
CBT Trained Clinicians	1.6	1	+0.6
Family Intervention Therapists	0	0.3	-0.3
Support and Peer Workers	2.8	6.5	-3.7
Administrators	1	2.6	-1.6
Total Number of Clinical Staff	15	25.7	10.7

- Current team care co-ordination capacity is 125. Team caseload for June is 124.
- Table 3 provides the total required workforce to deliver a NICE concordant service with the capacity to manage the projected case load of 203; calculations completed using the EIP Workforce calculator developed by Health Education England.

3.1 Option for consideration:

In order to expand the Wiltshire EIP team to have the capacity to manage extended age group, work with ARMS and deliver a NICE compliant service, additional roles details in table 3 are proposed.

- It should be noted that PHE have not yet provided any modelling which enables estimation of ARMS caseload numbers.

Option 1: Do Nothing

- This option is not perceived as viable as:
  - The EIP service would not have sufficient capacity to support those referred into the service which would place those with complex presentations without appropriate support; meaning those with high risk presentations would be inappropriately supported.
  - It would result in failing to meet national targets set by NHS E.

Table 4: Option 2 Summary and costings

Post description	**WTE**	**Grade**	**Salary WTE (mid band point Agenda for Change)**	**Salary on costs 22.4-25%**	**Pay + on costs per WTE**	**Total salaried staff**	**Non-pay Total (rate per wte £2050 recurrent)**	**10% Overheads charge (£433,571)**	
Consultant Psychiatrist	1	Con	£85,000	£21,250	£106,250	£106,250	£2,050		
Team Manager	0.3	7	£36,378	£8,207	£44,585	£13,376	£615		
Family Intervention Therapist	0.3	6	£30,764	£6,922	£11,185	£11,185	£615		
Clinical Staff	2	6	£30,764	£6,922	£37,686	£75,372	£4,100		
Mental Health Practitioner	2.4	5	£25,186	£5,667	£30,853	£74,046	£4,920		
Community Mental Health Support Worker	3.7	4	£20,838	£4,689	£25,527	£94,450	£7,585		
Administrator	1.6	3	£18,228	£4,101	£22,329	£35,727	£3,280		
Total Costs	11.3		£247,158	£57,758	£278,415	£410,406	£23,165	£43,357	**£476,928**

Year 1 Total part-year cost based on October 2016 start date	£238,464
Adjusted Year 1 cost, after deduction of Parity of Esteem funds already held in credit by AWP	£162,464
Year 2 total cost (recurrent full year cost):	£476,928

- All cost assumptions based on 16/17 agenda for change mid banding point.

Table 5: Option 3 Summary & Costings

Post description	**WTE**	**Grade**	**Pay per WTE**	**Salary on costs 22.4-25%**	**Pay with on costs per WTE**	**Total salaried staff**	**Non-pay Total (rate per wte £2050 recurrent)**	**10% Overheads charge (£281,186)**	
Consultant Psychiatrist	1	Con	£85,000	£21,250	£106,250	£106,250	£2,050		
Clinical Staff	1	6	£30,764	£6,922	£37,686	£37,686	£2,050		
Mental Health Practitioner	2	5	£25,186	£5,667	£30,853	£61,706	£4,100		
Community Mental Health Support Worker	2	4	£20,838	£4,689	£25,527	£51,054	£4,100		
Administrator	0.5	3	£18,228	£4,101	£22,329	£11,165	£1,025		
Total Costs	6.5		£180,016	£42,629	£222,645	£267,861	£13,325	£28,118	**£309,304**

- Option 3 would provide a service which could manage care co-ordination for a total caseload of 164 service users.

Year 1 Total part-year cost based on October 2016 start date: Adjusted Year 1 cost, after deduction of Parity of Esteem funds already held in credit by AWP	(£154,652) £78,652
Year 2 total cost (recurrent full year cost):	£309,304

Preferred Option: Option 3

- Option 3 would enable an initial increase in service capacity which could be reviewed against delivery of targets and management of capacity after 12 months of implementation. It is not expected that EIP caseload will quickly increase to projected numbers, however a steady increase in case load number has been observed with caseload totals moving from 101 August 2015 to 124 June 2016.
    - If the same average increase (2.3 monthly) in caseload continued to occur case load capacity could reach 152 by June 2017).

NHS Wiltshire Clinical Commissioning Group

Equality Impact Analysis – the EIA form

Title of the paper or Scheme:

Mental health Workstream – Funding Request

For the record	
Name of person leading this EIA: **Meuthia Endrojono-Ellis**	Date completed **July 2016**
Names of people involved in consideration of impact:	
Name of director signing EIA**: Ted Wilson**	Date signed **July 2016**

What is the proposal? What outcomes/benefits are you hoping to achieve?

To request an increase of investment in Mental Health Service lines in 16/17. The increase of investment is a combination of recurrent and non-recurrent monies:

- **An operationally safe and effective provision within Wiltshire**
- **The continuity of the right type of service for Wiltshire Community**
- **Equity of access into services,**

Ensuring parity of esteem of Mental Health Services across Wiltshire Community

Who's it for?

Wiltshire Population

How will this proposal meet the equality duties?

By making the services accessible to all for all working age adults and older population under Parity of Esteem for people with Mental Health

What are the barriers to meeting this potential?

None

2 Who's using it?

Wiltshire Community

How can you involve your customers in developing the proposal?

The further investment is for the expansion of known services to ensure parity of esteem of all Mental Health Services, as defined within the Wiltshire Joint Mental Health Strategy which was co-produced with Wiltshire Community

Who is missing? Do you need to fill any gaps in your data? (pause EIA if necessary)

N/A

3 Impact

Using the information in parts 1 & 2 does the proposal:

a) Create an adverse impact which may affect some groups or individuals. Is it clear what this is? How can this be mitigated or justified?

N/A – This is a request for the expansion of services to ensure it is accessible to all of Wiltshire's population

What can be done to change this impact?

N/A

b) Create benefit for a particular group. Is it clear what this is? Can you maximise the benefits for other groups?

This is a request for the expansion of services to ensure it is accessible to all of Wiltshire's population

Does further consultation need to be done? How will assumptions made in this Analysis be tested?

N/A

4 So what?

What changes have you made in the course of this EIA?

The current status has been to seek further investment for the expansion of provision

What will you do now and what will be included in future planning?

Once business cases have been approved, the next steps will be to implement the recommended redesigns to services and this will be defined in 17/18 commissioning intentions

When will this be reviewed?

Progress will be monitored on a monthly basis via AWP contract governance framework

How will success be measured?

Mental Health National Key Performance Indicators
CCG Improvement & Assessment Framework
Quality Indicators & Performance Indicators within the Contract including Friends and Families Test