NHS
Yorkshire and the Humber
Clinical Senate

Clinical Senate Review

for

Mental Health Services at Bassetlaw Hospital

On behalf of

NHS Bassetlaw CCG & Nottinghamshire Healthcare NHS Trust

Version 1.0

December 2020

Clinical Senate Reviews are designed to ensure that proposals for large scale change and reconfiguration are sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

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Yorkshire and the Humber Clinical Senate
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Date of Publication:

Version Control

Document Version	Date	Comments	Drafted by
Draft version 0.1	November 2020	Initial draft following panel and commissioner discussion	J Poole
Final Draft	November 2020	Amended to incorporate panel comments and improve formatting	J Poole
Final Draft	December 2020	Amended to include 2 points of accuracy from the commissioners	J Poole
Version 1.0	December 2020		J Poole

1. Chair's Foreword

The Yorkshire and the Humber Clinical Senate thanks NHS Bassetlaw Clinical Commissioning Group (CCG) and Nottinghamshire Healthcare NHS Trust (NHCT) for involving the Senate in the review of their proposals for mental health services for working age adults and older people. These proposals include enhancing the community model and the move of the inpatient services from Worksop to Mansfield.

We fully support your case for change for the provision of inpatient beds due to the serious environmental and safety concerns related to the quality of that provision. We agree that there is opportunity here to significantly enhance the quality of the inpatient care provided. We also welcome the range of improvements you are proposing to the community services. There are however a few areas which need further development as you move forward with your proposals and I hope that this advice will prove helpful to you. We would be delighted to review any further work as your proposals develop.

I would also like to take this opportunity to thank the panel of clinical and lay experts who assisted with this review. I very much appreciate their enthusiasm and diligence in reviewing the detailed evidence provided to us.

Chris Welsh, Senate Chair

2. Summary of Key Recommendations

Our key recommendations are:

1. To consider the design of the Millbrook facility to address the mixed sex nature of the current ward proposals.

2. To gain a greater understanding of the impact of the 28% of patients who will need to travel further to access the inpatient service and to develop a robust long-term plan to address their disadvantage in access.

3. To further consider the impact of the change in inpatient provision on the Health Based Place of Safety and to clearly address these issues in your documentation.

4. To investigate further the reasons for the reduction in the referrals to community mental health and ensure these are addressed in your new community offer.

5. To develop a robust workforce plan to address the issues arising from the relocation of inpatient services and the changes to the community offer. To include within this plan the implications for the training of students.

6. To co-produce your service model with service users and to engage widely with the public and your partner organisations in your service development.

3. Background

3.1 The CCG and provider Trust are proposing to enhance the community mental health services in Bassetlaw in line with the Mental Health Long Term Plan. This endeavours to integrate services and enhance service models to be able to meet the access and outcomes detailed in the national plan.

3.2 The proposals presented to the Senate detail the planned enhancements to the community model and include the proposals to move the inpatient services (which includes 2 wards) from Worksop to Mansfield. The planned changes to the inpatient services are due to the concerns related to the quality of the inpatient estate and these proposals are presented as an opportunity to significantly enhance the quality of the inpatient care provided.

3.3 The impact for people using the inpatient services relates to approximately 109 admissions a year for adults and older people with mental illness, who have an average length of stay of 48 days. The distance between the current and the

proposed sites for re-provision are approximately 15.97 miles (adult mental health) and 17.38 miles (mental health services for older people).

Role of the Senate

3.4 The CCG and NHCT are working with the regional NHS England/ Improvement (NHSE/I) team on the assurance process for the proposed service changes. The Strategic Sense Check meeting has taken place which included a request from NHSE/I for a review by the Clinical Senate before the next stage (Stage 2) of the assurance process, to provide assurance on the clinical model and that it is in line with best practice and the evidence base.

3.5 The Clinical Senate advice will be used to provide an independent evaluation to enhance the plans, guide onward assessment and evaluation and inform the assurance process for both the CCG and the Healthcare Trust. It will also be used to advise the Nottinghamshire Health Scrutiny Committee as part of the engagement process.

3.6 The Senate was asked to consider the following three questions:

Does the Senate support the case for change for the provision of inpatient beds for Bassetlaw patients?

Is the proposed model, and suggested solution for the provision of inpatient beds for Bassetlaw patients, in line with best practice?

Does the Senate have any clinical concerns about the proposed model?

Process of the Review

3.7 The Terms of Reference for this review were agreed in November 2020 and are available at Appendix 3 to this report. The supporting documentation was received by the Senate and distributed to the clinical panel in mid-October. A full list of the documentation provided to the panel is contained in Appendix 2. The Senate expert panel shared comments on the documents through discussions by teleconference and email and as a result of these discussions the panel requested further clarification on a number of points from NHS Bassetlaw CCG and Nottinghamshire Healthcare NHS Trust. A teleconference was held on 23rd November to provide opportunity for a robust clinical discussion and to further improve our understanding of the proposals. Once consensus was reached by the panel on the draft report it was sent to the commissioner for comment on 2nd December 2020.

3.8 The commissioners and hospital Trust are given 10 working days to respond with any comments on the accuracy of the report. The report is to be ratified by the Senate Council at their January meeting and published within 8 weeks of ratification unless there are reasons to delay this to tie in with planned public engagement.

4. Recommendations

4.1 The recommendations are grouped to address the questions asked of the Senate:

Does the Senate support the case for change for the provision of inpatient beds for Bassetlaw patients?

4.2 Inpatient mental health provision within Bassetlaw currently consists of a 39 bedded inpatient facility located within the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust at the Bassetlaw Hospital site, Worksop. It comprises of 2 wards which serve the population of Bassetlaw district and provide inpatient services for both male and female Adult Mental Health (AMH) and Mental Health Services for Older People (MHSOP). B2 is a 24 bedded ward for adults primarily under 65 and B1 is a 15 bedded ward for older people with a split to accommodate patients with organic and functional illness. There are currently over 100 admissions of Bassetlaw patients with a combined total of 5287 occupied bed days to the two wards.

4.3 The panel were all in agreement that the case for change had been clearly articulated and agreed that the acute inpatient services are delivered in environments that are no longer fit for purpose. The evidence in support of the change to the inpatient provision was conclusive. The concerns with the current provision, that were highlighted by the panel, included:

- The dormitory style accommodation which breaches national quality guidance
- Both wards are mixed gender which is not recommended in quality and safeguarding guidance
- The MHSOP ward houses both organic and functional patients on the same wards
- The lack of direct access to outside space
- Both ward designs offer poor lines of sight for safe and effective observation of patients
- Neither wards have access to de-escalation or seclusion facilities on the site
- The lack of space for therapeutic activities
- The lack of space to facilitate visits safely

4.4 The Senate is fully supportive of the case for change for the provision of inpatient beds for Bassetlaw patients.

Is the proposed model, and suggested solution for the provision of inpatient beds for Bassetlaw patients, in line with best practice? Does the Senate have any clinical concerns about the proposed model?

4.5 The panel was in agreement that the suggested solution for the provision of inpatient beds for Bassetlaw patients is in line with best practice and provides an opportunity to significantly improve upon the current service. The Senate advises commissioners,

however, to take into account the following clinical concerns with the proposed model and address these issues as you further develop your proposals.

Model of Inpatient Services

4.6 Your preferred option is to move the inpatient provision to identified sites in the Mansfield locality at Millbrook and Sherwood Oaks. The distance between the current and the proposed sites for re-provision are approximately 15.97 miles (adult mental health) and 17.38 miles (mental health services for older people). If that is the case the provision would be:

Sherwood Oaks Hospital	**Bed Numbers**
Female Ward 1	17 single en-suite rooms
Female ward 2	17 Single en-suite rooms (4 designed to deliver enhanced care)
Male Ward 1	18 single en-suite rooms
Male Ward 2	18 single en-suite rooms

Millbrook Unit	**Bed numbers**
Functional ward	18 single en-suite rooms
Dementia ward	18 single en-suite rooms
Enhanced care unit	10 single en-suite rooms

4.7 It was noted that the provision for older adults at Millbrook is not delineated by gender, although they are all single occupancy rooms with en suite, and you are yet to define how you will operate those wards. You also advised the panel that there will be separate lounge areas for male and female and the wards will have zoned areas. The panel agreed however that there is opportunity to consider the design of the Millbrook facility now rather than in the longer term as you suggested. You may want to consider wards not separated by age in order to address the mixed sex nature of the MHSOP ones.

Recommendation: *to consider the design of the Millbrook facility to address the mixed sex nature of the current ward proposals.*

4.8 We questioned how much of the new service design had been conducted with Nottinghamshire Healthcare to ensure a good fit with their wider service provision. You confirmed that all the mental health teams sit under one division with a good history of joint working and you see this service redesign as a real opportunity to enhance and improve those services.

The distance to the new inpatient facility

4.9 The main negative impact of the proposed move of inpatient wards are the increased travel for your population. Travel distance is an important marker, but a greater issue is the time of journeys by public transport and we understand that these can be complex and long. You confirmed that from the 360 patients using the ward from August 2019 to August 2020, 101 patients will incur increased travel ranging from 1 to 13.5 additional miles. That is 28% of your patients who will be travelling more.

This also impacts on the ability of friends and family to visit their loved ones. We discussed with you whether you have sufficient understanding of that 28% which is comprised of individuals and families who may all struggle with this arrangement. We asked if you understood the demographics and inequalities which may be hidden in this number and therefore the disproportionate impact this may have on disadvantaged communities or groups of people. We understand that you have data via the E-Health scope platform and more understanding is developing through your maturing PCNs (Primary Care Networks). Whilst you acknowledge that travel is an issue, the panel view however, is that at this stage there does not seem to be a fully developed plan to address this.

4.10 You do have several actions proposed including:

- potential for subsidised or supported travel options from Bassetlaw hospital site to new hospital sites
- potential for partnership arrangement with local transport providers to increase public transport options and frequency to the site
- potential for partnership working with other local businesses to consider mutually beneficial transport solutions
- potential liaison with local council to support improvements in accessibility in terms of road safety and proximity to public transport

4.11 We welcome these discussions and advise that you need a robust long-term plan to address the disadvantage in access for this section of your population.

Recommendation: *To gain a greater understanding of the impact of the 28% of patients who will need to travel further to access the inpatient service and to develop a robust long-term plan to address their disadvantage in access*

4.12 Within our discussion on the inpatient provision it was noted that it is commonplace for the significant majority of B2 beds to be occupied by patients from outside of Bassetlaw and for 50% or more of the B1 beds to be used by non-Bassetlaw residents. We therefore discussed the impact on the change in location of the inpatient beds on the other inpatient units in the area. Within the numbers of non-Bassetlaw residents, we understand that the majority of these are accessing the service from Nottinghamshire and therefore will be closer to the new site. There are 10 admissions from Doncaster and Lincolnshire CCGs each year, however, and you acknowledged that you have further work to do to understand if this is due to patient choice or due to bed demands elsewhere. You agreed to address this point as you further develop your proposals.

Health Based Place of Safety

4.13 In discussion, you confirmed that currently there are 2 health-based places of safety and that this service will relocate to the new inpatient hospital site in 2 separate rooms. Your view is that this will improve the environment of these places of safety. The AMP service will also be located in the grounds of the new site and the crisis referral team will also be on site which you hope to lead to much improvement in the current provision.

4.14 We recognise your consideration of this service but we are not clear how much engagement you have had with the police on this issue. This is to ensure that the police understand the impact of residents from Bassetlaw having to be transported to the new health-based place of safety on their operational management. We are also unsure of whether there is an acute hospital close to site as some of these patients may require to be physically checked. If not, commissioners will need to consider what alternative arrangements would be put in place (for example for paramedics to review the patients prior to transfer to the new health-based place of safety)

Recommendation: *To further consider the impact of the change in inpatient provision on the Health Based Place of Safety and to clearly address these issues in your documentation*

Under 18s and Transition

4.15 We were grateful for your confirmation, in discussion, that you have no proposals to admit under 18s in this new inpatient provision and they will continue to be cared for at the dedicated facility in Nottingham. We also broadened this to discuss if you will be using this opportunity to improve services for young people transitioning to adult services, and to ensure there is a comprehensive, inclusive local pathway for 18 – 25-year olds across both community and in-patient services. You agreed that this age group is a key consideration and that the Children and Adolescent Mental health Services (CAMHS) and adult mental health teams are working together and reviewing the pathways. We also welcomed the confirmation that these patients have an identified link worker to support transition from CAMHS to adult care. We noted that you have a Personality Disorder Transition post currently out to recruit which will cover both Nottinghamshire and Bassetlaw and that your eating disorders service also has a transition team.

Digital Innovation

4.16 We welcome your consideration of digital innovation to support alternative means of involvement and the role it can play in maintaining social relationships between service users and carers. As a mitigation against the change in inpatient provision, this digital access does have its limitations. The panel discussed how the elderly profile of the population you are trying to support are less likely to cope well with digital innovation. In discussion, you recognise that 10-15% of the population are vulnerable to digital exclusion and that you need a hybrid model. Your working group is analysing this exclusion and how to reduce it. We are all agreed of the need not to be over reliant on digital solutions in your model of care. You may wish to scope partnership working with local/national agencies (Age UK for example) to provide education/technical assistance to the population that is expected to be excluded. This could be part of the crisis café remit. Age UK have successfully piloted a similar piece of work.

Model of Community Services

4.17 The information you provided to us in your documentation was very helpful in setting out your current model of community mental health services and the changes you propose to this offer as part of your service redesign. You recognise that the distance of the new ward bases from Bassetlaw community services could have a potential detrimental impact on continuity of care, discharge planning and length of stay for the inpatients from the Bassetlaw area and you are working to address this within your model of care.

4.18 We discussed the additional £500k that the CCG will invest in transformation funding for urgent and emergency mental health care between 2021-2023. For this, the local community will see 24/7 community crisis home treatment services and psychiatric liaison services. This will include expanding crisis services including the development of alternatives to crisis such as crisis cafes/sanctuaries. We understand that you currently have 13 QI projects across a diverse programme of work.

4.19 You also propose improvements to the severe mental illness pathway which will provide an opportunity for more focused support in a range of areas. For the dementia pathway, there will be an enhanced multi-disciplinary support for older adults which includes nursing, clinical psychology, occupational therapy, physiotherapy and psychiatry and an additional resource allocated to the dementia outreach service so that an extended offer can be made to the care and nursing homes across Bassetlaw.

4.20 We welcomed the 7 day model of delivery in the Intensive Home Treatment teams which will support people living with dementia in their own homes to remain well at home with intensive support from a multi-disciplinary team. The intensive home treatment team will also work to facilitate hospital discharges and provide daily review and recovery interventions.

4.21 We also welcomed your intention to develop a Mental Health Single Point of Access (SPA) to provide joint assessment and timely access to services. The SPA will provide support and advice to other healthcare professionals to discuss referrals and advise on care plans that are in place. This 'no wrong door' principle aims to ensure that services are integrated and aligned to provide the right support at the earliest point of someone's pathway.

4.22 You confirmed that it is your intention to develop the detail of the community model further next year and agree how you can meet the ambitions of the Long-Term Plan as a system.

Increase in Crisis Referrals

4.23 One issue that we wish to highlight from our discussion with you is the increase in crisis referrals. You confirmed that due to the COVID-19 pandemic, there has been a drop in referrals to community teams, in IRIS and older adults especially but crisis

referral has increased significantly. You informed the panel that you are providing a 7 day home treatment offer to dovetail with crisis support in the community with the aim to lower hospital admissions. You have also introduced a triage system to redirect patients to the appropriate service and reduce the number of people going through to service who do not need it. Whilst your response is very welcome, it does not address the reason for an increase in crisis referrals. Simply triaging may result in reduced access and increased mental ill health. Increase in crises is sometimes a sign that community service is not meeting demand or adequately treating the patients it does see. We advise that you focus on the likely reasons for reduced CMHT referrals and encourage increase in access. You will agree that addressing issues early on reduces risk of it becoming a crisis later.

Recommendation: *to investigate further the reasons for the reduction in the referrals to community mental health and ensure these are addressed in your new community offer*

Integration with Physical Health Care

4.24 With an in-patient mental health service at some distance away it makes it more difficult to provide integration with the services provided by the physical health care providers. In particular the:

- mental health assessment of those in district hospital
- physical health of people admitted in mental health inpatient services outside the area
- continuity of care with specialists involved in those with co-morbid physical and mental health problems who are in hospital

4.25 As part of our meeting with you, we discussed the mental health support which will be provided to your emergency department with your new model of care. We note that due to the small size of Bassetlaw hospital you plan to develop an alternative service to CORE 24 that will provide 24/7 access to specialist mental health support. Based on the Bassetlaw Hospital site, the crisis and liaison teams will provide robust admission gatekeeping assessments, intensive home treatment and mental liaison to the emergency department and wards. There will be access to the specialist older adult intensive home treatment team 7 days a week to reduce avoidable admissions. We are pleased that the liaison offer within the Bassetlaw hospital site will be strengthened to provide 24/7 access to a multi-disciplinary mental health team that can respond to patients in the emergency department within 1 hour and to patients on the wards within 24 hours. Peer support workers will be a key part of the team to support patients to access ongoing support services such as substance misuse, IAPT (improving access to psychological therapies) and social prescribing. For people living with dementia who require an urgent response, you propose that the Mental Health Services for Older People (MHSOP) Intensive Home Treatment teams will be able to offer a specialist 7 day service to support patients to receive assessment and treatment at home. There will be a Section 12 doctor in Bassetlaw 24/7 to support the urgent and emergency care pathway. This information addressed the first bullet point and appears to offer a good service to ED. Commissioners may

wish to further develop their documentation to reflect their work to address the other 2 points.

Staffing Impact

4.26 We recognise that as yet you have only had tentative talks with staff on the proposed changes and that you have considerably more work to do as you consider the impact on staff and the mitigations you need to put in place. These challenges are not to be underestimated. Following your initial discussions, we understand that approximately 80% of ward-based staff are happy to relocate. That would still leave a considerable gap in your staffing provision and you may find it very challenging to retain all the staff who are currently agreeable to the change during this process. I am sure you recognise the need to be flexible and to offer staff roles that fit their personal needs and skill sets. You may find it difficult to recruit to these gaps in ward-based staff provision and particularly to recruit to the specialist roles (eating disorders for example) which you have identified in your expanded community services. You will need a robust workforce plan to address these issues and we are not sure how well developed this is currently. Two issues we did not discuss are the impact of the services split across 2 sites for on call rotas and the need to engage with the medical education departments to understand the impact of these changes on the training of students.

Recommendation: *to develop a robust workforce plan to address the issues arising from the relocation of inpatient services and the changes to the community offer. To include within this plan the implications for the training of students.*

Engagement with Service Users and Partner Organisations

4.27 We understand that as yet you have had limited opportunity to discuss your proposals with service users and consequently there is no evidence of a co-produced model. Having well developed service user leadership representatives could bring you considerable benefit. You may also wish to consider bringing in a service user from outside the area with lived experience leadership skills to facilitate that co-production. This absence of expert by experience, service user and carer involvement is a notable gap which would improve the design and implementation of the new services. In discussion, you agreed that there is much more to be done to achieve co-production.

4.28 With regards to the wider public engagement, we understand that you are meeting with the local Health Scrutiny Committee in December to discuss this further. You will also be aware of the need to bring in your partners in Local Authority and voluntary sector to ensure you also utilise their expertise in your service design.

Recommendation*: to co-produce your service model with service users and to engage widely with the public and your partner organisations in your service development*

5. Summary and Conclusions

5.1 In conclusion, the Senate fully supports your case for change for the provision of inpatient beds due to the serious environmental and safety concerns related to the quality of that provision. We agree that there is opportunity here to significantly enhance the quality of the inpatient care provided. We also welcome the range of improvements which you are proposing to the community services.

5.2 The panel was in agreement that the suggested solution for the provision of inpatient beds for Bassetlaw patients is in line with best practice. With regard to your third question the Senate has highlighted a few areas of clinical concern which need further development as you move forward with your proposals.

5.3 These concerns include the mixed sex nature of the current ward design at Millbrook, the impact of the 28% of patients who will need to travel further to access the inpatient service and the impact of the change in inpatient provision on the Health Based Place of Safety. The panel also raised concerns with the reduction in the referrals to community mental health and the increase in crisis referrals and recommended that this needed further investigation. Your staff are key to the success of your proposals and we recommend the need to develop a robust workforce plan to address the staffing issues arising from these proposed changes. Our final recommendation is to ensure that you utilise the considerable knowledge of your service users, the public and your wider partner organisations in the development of your plans.

5.4 We hope that this report assists commissioners in the further development of your mental health model.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Prof. Chris Welsh, Chair, Yorkshire & the Humber Clinical Senate

Denise White, Senate Assembly Lay Member

Theresa Stearn, Senate Assembly Lay Member

Dr Edward Pepper, Consultant Child and Adolescent Psychiatrist, Leeds Community Healthcare NHS Trust

Pam Rudkin, Mental Health Social Worker, Becton Centre for Children and Young People

Steve Jones, National Service Advisor, CYP Mental Health, NHS England

Shelley Morrison, Lead Nurse for Mental Health, Rotherham, Doncaster & South Humber NHS Foundation Trust

Dr Angela Kennedy, Clinical Lead – Mental Health, North East Clinical Networks

Dr Tolu Olusoga, Consultant Psychiatrist and Deputy Medical Director, Tees, Esk & Wear Valleys NHS Foundation Trust

Appendix 2

Evidence Provided for the Review

- Bassetlaw Mental Health Service Transformation FINAL 23102020
- RD4 Analysis of the Use of Beds by Bassetlaw Inpatients 2013-2018 v2a
- Bassetlaw Service Transformation Inpatient Travel Analysis
- Bassetlaw Service Transformation Equality Impact Assessment
- Bassetlaw Service Transformation Quality Impact Assessment
- NHCT Implementation Plans for the Towards Zero Suicide Strategy 2020-2023
- Bassetlaw Prevention Priorities Report
- South Yorkshire and Bassetlaw Suicide Prevention Plan
- Better Mental Healthcare in Bassetlaw: Bassetlaw Evaluation Strategy
- NHCT Summary of JSNA and population findings for BASSETLAW
- Water Safety incidents Bassetlaw Hospital Wards B1 and B2
- Patient Experience Report
- Inpatient Option Appraisal
- Community Activity and Performance
- Sherwood Oaks Strategic Outline Case submitted to the Board (redacted)
- Sherwood Oaks Unit
- The Community Mental Health Framework for Adults and Older Adults
- Bassetlaw Involvement & Engagement Plan Proposal

Appendix 3

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Review of Mental Health Services at Bassetlaw Hospital

Sponsoring Organisation: NHS Bassetlaw CCG and Nottinghamshire Healthcare NHS Trust

Terms of reference agreed by: Dr Victoria McGregor Riley, Director of Strategy, Deputy Chief Officer, Dr Julie Attfield, Director of Mental Health and Joanne Poole, Senate Manager

Date: 18th November 2020

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Chris Welsh, Senate Chair

Citizen Representative: Theresa Stearn and Denise White

Clinical Senate Review Team Members:

Dr Edward Pepper	Consultant Child and Adolescent Psychiatrist	Leeds Community Healthcare NHS Trust
Pam Rudkin	Mental Health Social Worker	Becton Centre for Children & Young People
Steve Jones	National Service Advisor - CYPMH	NHS England
Shelley Morrison	Lead Nurse for Mental Health	Rotherham, Doncaster & South Humber NHS FT
Dr Angela Kennedy	Clinical Lead - Mental Health North East Clinical Networks	Tees, Esk & Wear Valleys NHS FT
Dr Tolu Olusoga	Consultant Psychiatrist and Deputy Medical Director	Tees, Esk & Wear Valleys NHS FT

2. AIMS AND OBJECTIVES OF THE REVIEW

Question:

- Does the Senate support the case for change for the provision of inpatient beds for Bassetlaw patients?
- Is the proposed model, and suggested solution for the provision of inpatient beds for Bassetlaw patients, in line with best practice?
- Does the Senate have any clinical concerns about the proposed model?

Objectives of the clinical review (from the information provided by the commissioning sponsor):

The CCG and provider Trust are proposing to enhance the community mental health services in Bassetlaw in line with the Mental Health Long Term Plan. This endeavours to

integrate services and enhance service models to be able to meet the access and outcomes detailed in the national plan. Alongside enhancing the community model, the proposal also includes the move of the inpatient services (which includes 2 wards) from Worksop to Mansfield.

Scope of the review:

Bassetlaw mental health inpatient and community services.

The Senate will answer the above questions based on the information provided in the documentation and supplementary discussion with the clinical and commissioning leads.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 21st October 2020

Agree the Terms of Reference: by the end of November 2020

Receive the evidence and distribute to review team: 23rd October 2020

Teleconferences: Senate Expert Panel – 11th November 2020 followed by a discussion with commissioners on 23rd November 2020

Draft report submitted to commissioners: 3rd December

Commissioner Comments Received: within 10 days of receiving the report

Senate Council ratification; 20th January

Final report agreed: following Council ratification and commissioner comment

Publication of the report on the website: to be agreed with the commissioner but normally within 8 weeks of the Senate ratification

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the handling of the report and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

- Bassetlaw Mental Health Service Transformation FINAL 23102020
- RD4 Analysis of the Use of Beds by Bassetlaw Inpatients 2013-2018 v2a
- Bassetlaw Service Transformation Inpatient Travel Analysis

- Bassetlaw Service Transformation Equality Impact Assessment
- Bassetlaw Service Transformation Quality Impact Assessment
- NHCT Implementation Plans for the Towards Zero Suicide Strategy 2020-2023
- Bassetlaw Prevention Priorities Report
- South Yorkshire and Bassetlaw Suicide Prevention Plan
- Better Mental Healthcare in Bassetlaw: Bassetlaw Evaluation Strategy
- NHCT Summary of JSNA and population findings for BASSETLAW
- Water Safety incidents Bassetlaw Hospital Wards B1 and B2
- Patient Experience Report
- Inpatient Option Appraisal
- Community Activity and Performance
- Sherwood Oaks Strategic Outline Case submitted to the Board (redacted)
- Sherwood Oaks Unit
- The Community Mental Health Framework for Adults and Older Adults
- Bassetlaw Involvement & Engagement Plan Proposal

The review team will review the evidence within this document and supplement their understanding with a clinical discussion.

6. REPORT

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor, provider, NHS England (if this is an assurance report) and made available on the senate website. Publication will be agreed with the commissioning sponsor.

8. RESOURCES

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

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

9. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

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

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable
v. provide feedback to the Senate on the effectiveness of working with us and to comment on a short case study summarising the work and our impact

Clinical senate council and the **sponsoring organisation** will:

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical senate council will:

i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will:

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.

iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally, they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END