NHS
Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

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*Via email to:*
Corrine McDonald
Mental Health Commissioning Manager
Calderdale CCG

26th October 2017

Dear Corinne

**Senate Review of Mental Health Recovery and Rehabilitation Proposals in Calderdale**

Thank you for the opportunity to review your proposals for Mental Health Recovery and Rehabilitation in Calderdale.

The objectives of the clinical review are to provide the CCG with an independent clinical view of the proposed model prior to the formal public consultation. This will allow time for any amendments to the model to be reflected in the consultation documents. The Senate review is part of the assurance process. The members of the clinical review panel who reviewed the proposals through email and teleconference discussion are listed within the Terms of Reference enclosed with this letter.

The questions you asked us to consider are

- Is the proposed model in line with best practice?
- Does the Senate have any clinical concerns about the proposed model?

In response to the initial documentation the Senate requested more information on the demographics and the service users, the activity both in the community and inpatient provision, the linkages with the wider pathway of care and the staffing and skill mix of the specialist community team. In response to these questions a more detailed summary document was provided to us which helped considerably with our understanding of the model. This was supplemented with a helpful discussion with you on 17th October.

I hope this letter provides a constructive summary of our comments and advice.

**Is the proposed model in line with best practice?**

The review panel are very supportive of the principles and vision of this model. Resourcing community rehabilitation to provide more choice and support for the patient and thereby reducing the inpatient admissions and the length of stay in these facilities has our full support.

The Senate welcomes the close working relationship between the Local Authority, the Mental Health Trust and the CCG who we are informed are all committed to this service model. Their collaboration and joined up approach to offer a combined health and social care solution should result in a much improved service for these patients.

The documentation makes reference to 2 guidance documents and although one is recent the Royal College of Psychiatrists paper is from 2009 and other more recent work could be referenced, potentially from organisations working on the personalisation agenda (Helen Sanderson's work). We would also recommend reference to the following guidance and to exemplify within your documentation how your model fits with the guidance.

CQC guidelines
https://www.cqc.org.uk/sites/default/files/201608b_briefguide-rehabilitation.pdf

Royal College of Psychiatrists
https://www.rcpsych.ac.uk/pdf/Rehab%20Standards%203rd%20Edition%20Final.pdf

NHS England commissioning guidelines (broader than Mental Health)
https://www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf

**Clinical concerns about the proposed model:**

Our clinical concerns on the model were mainly addressed during the discussion with you. A summary of the concerns raised and the responses are detailed below.

***The assumptions on inpatient provision and out of area placements***

The Senate understands the vision to provide an alternative to inpatient care for patients through the active case management of the dedicated community team and the increased housing solutions through the partnership with Local Authority. Given this model we questioned why there is only a slight reduction in the bed provision between the current and proposed model and the expected continuation of a small number of out of area placements. You confirmed that the new model aims to use resources more efficiently resulting in reduced use of inpatient facilities, reduced length of stay and reduced out of area placements through offering less restrictive community options for the patient. We confirmed that the savings from the inpatient provision will all be reinvested back into the community mental health services.

We discussed the proportion of people placed in out of area placements who currently cannot receive care locally as the current service does not have the skill set to offer the dedicated in reach support. We understand that there is a wider piece of work ongoing, working closely with social care, to provide new tenancies and more supported living options for patients with Personality Disorder, for example, who need longer term placements.

The multi-agency mental health panel will provide an important role in the oversight and governance of Out of Area Placements (OAP). Our understanding is that any application for OAP has to be approved by the panel who will scrutinise the rationale and ensure that there is a clear support plan in place. The panel will hold clinicians to account to ensure that the patient's stay out of area is as short as possible and will provide real rigour over the pathway.

***The Users of this Service***

The documentation we received categorises patients into a number of clusters in order to provide a high level overview of service users. It was clarified in discussion that this service is available for any patient who requires the level of rehabilitation offered.

In discussion it was acknowledged that there is currently a high use of Mental Health Act admissions and an acknowledgement that cultural practice may play a part in this in combination with the lack of available intensive services. You agreed that whilst this model may address part of the issue there is further work to undertake on this area to address the clinical culture.

***The relationship of this model with other services.***

The Senate panel questioned how this model will impact on the admission and discharge into the general mental health services and questioned how the service will escalate service users who are becoming increasingly unwell while they are in their own homes.

In discussion it was confirmed that the specialist rehabilitation team is surrounded by the generic service and will therefore have access to all the wider services as patients are stepped into the community. Once the patient is transferred back to their community team the support from the specialist rehabilitation team will continue. For those patients in their own home there is an integrated community offer and patients are allocated individuals who are rostered on for contact and support. The Senate panel was assured of the fit of this model with the wider services.

***The skill mix across the different teams and facilities***

Within the documentation there is little information on the skill mix of the community intensive team and their capacity to support the patient to have care in the least restrictive setting possible. The success of this model is dependent on the specialist community team being adequately staffed and having the right skill mix within the team and the Senate advises that this needs to be set out in more detail.

It was noted that there is reference in the papers to staff feeling that they were not able to replicate the Lyndhurst service in the community and a comment about the increased travel time for staff to differing patient locations being a pressure. In response you have confirmed that the provider is very confident of being able to staff the specialist community rehabilitation service with a combination of some of the staff from Lyndhurst, and staff from the wider SWYPFT workforce with the appropriate skills and approach. Those from Lyndhurst who do not move to work in the service will be offered suitable alternatives within the other services that SWYPFT provides. As part of the consultation process, you will be doing some specific work with the Lyndhurst staff to unpick their concerns around a community-based rehabilitation service and to get their suggestions on what could be done to mitigate these concerns. The output from this will be used with the other feedback from the consultation to shape the proposed model further.

***The Voluntary Sector***

We explored the third sector relationship in part with the discussion on the peer support model which we understand is a non-statutory service which will be provided by Healthy Minds. This peer support will be provided for individuals throughout their journey from acute into the

community. The Senate panel is very supportive of this initiative and the CCG will recognise the need to not place too much reliance on peer support from those who are not directed or supervised by statutory mental health provision.

The voluntary sector will provide other support services for the patient, including local self-help groups, and we recommend that the role of the third sector in this service model is set out in more detail.

***Service User Involvement***

The panel commended the CCG for the work they have done to date in involving service users in the design of the service. We questioned the route to gaining the views of minority groups like LGBT and BME and were assured of the role of the engagement champions during the consultation. As the model is focussed on individual care planning it should tailor its response to each person and their needs. In addition working with the carer (with the patient's consent) is part of the specification for the rehabilitation team so as to maximise the support network for the individual. It would be helpful to also consider the 3rd sector support available to the carers.

***Transition***

Our panel questioned the transition arrangements for moving to the new system and how patients will be protected during this process. You confirmed that you are allowing for double running during the implementation period and planning for step down for those patients in Lyndhurst. The housing solutions which are an important aspect of the community model will also take time to achieve. It isn't clear how far down the planning route these housing solutions are and the joint working arrangements in terms of ongoing management of these properties. You acknowledged that transition timescales are not yet clear and commissioners will need to assure the public that you have thought through the need to maintain services until the community provision is established.

**Conclusion**

In summary the Senate is supportive of the model to resource community rehabilitation to provide more choice and support for the patient and thereby reduce the inpatient admissions and the length of stay in inpatient facilities. We agree that the model is in line with best practice of providing support to the patient in the least restrictive setting possible. We recommend that there is opportunity for improving how you exemplify the model's fit with the guidance.

In articulating this model we recommend that commissioners provide more detail on the staffing and skill mix of the specialist community rehabilitation team and set out in more detail the support that the 3rd sector can provide to patients and carers in this model.

The close working with Local Authority and the Mental Health Trust to provide a combined health and social care solution is welcomed and we recognise the importance of improved housing options for the service users to make the community approach a success. All these different elements need consideration in planning the service transition and the public will need to be assured on this.

We also welcome the further work that the CCG will be undertaking on the wider cultural practices

around admissions under the Mental Health Act and recommend that this work continues alongside the development of this model.

Yours sincerely

**Chris Welsh**
**Senate Chair**
**NHS England – North (Yorkshire and the Humber)**

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CLINICAL REVIEW

# TERMS OF REFERENCE

**TITLE: Review of the mental health rehabilitation and recovery model in Calderdale.**

**Sponsoring Organisation:** Calderdale CCG

**Terms of reference agreed by:** Corinne McDonald, Mental Health Commissioning Manager and Joanne Poole, Yorkshire and the Humber Senate Manager

**Date:** October 2017

## 1. CLINICAL REVIEW TEAM MEMBERS

**Clinical Senate Review Chair**: Rebecca Bentley, Nursing Professional Lead & Non-Medical Prescribing Lead, Bradford District Care FT
**Citizen Representative**: Stephen Elsmere and Peter Allen
**Clinical Senate Review Team Members:**
Anne Worrall Davies, Child and Adolescent Psychiatrist
Cathy Wright, Allied Health Professionals Lead for Bradford District Care Trust
John Baker, Professor of Mental Health Nursing
Richard Gurney, Clinical Team Manager, Leeds and York Partnership NHS FT

## 2. AIMS AND OBJECTIVES OF THE REVIEW

**Question:**

Is the proposed model 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):** To provide Calderdale CCG with an independent clinical view of the proposed model prior to the formal public consultation to allow any amendments to the model to be reflected in the consultation documents. The Senate review is part of the assurance process.

**Scope of the review:** The Clinical Senate will focus their review on the above 2 questions based on the information provided in the documentation. The clinical panel will supplement their understanding of the model through discussion with commissioners.

## 3. TIMELINE AND KEY PROCESSES

**Receive the Topic Request form**: 12th September

**Agree the Terms of Reference**: by end September 2017

**Receive the evidence and distribute to review team**: evidence received 25th September. Distributed to the clinical panel 27th September.

**Teleconferences:** 13th October for Working Group discussion and 17th October for discussion with commissioners.

**Draft report submitted to commissioners**: 27th October 2017.

**Commissioner Comments Received**: within 10 working days of receipt

**Senate Council ratification**: 14th November 2017

**Final report agreed:** end of November 2017

**Publication of the report on the website:** Date to be agreed with commissioners.

## 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:

- Mental health Rehabilitation and Recovery in Calderdale, Senate summary paper (revised version received 9th October 2017)

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

**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**