NHS
Yorkshire and the Humber
Clinical Senate

Clinical Senate Review

for

Harrogate and Rural District CCG on Mental Health Services

Final Version

October 2018

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.

Clinical Senates are independent non statutory advisory bodies hosted by NHS England. Implementation of the guidance is the responsibility of local commissioners, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of access. Nothing in the review should be interpreted in a way which would be inconsistent with compliance with those duties.

Yorkshire and the Humber Clinical Senate
England.yhsenate@nhs.net

Date of Publication: October 2018

Version Control

Document Version	Date	Comments	Drafted by
Draft Version 0.1	September 2018	Initial draft report incorporating Expert Panel comments	J Poole
Draft Version 0.2	September 2018	Revised draft incorporating panel and Council comments	J Poole
Final Version 1.0	October 2018	Revised following commissioner comment on accuracy	J Poole
Final Version 2.0	December 2018	Revised following minor comment from the Senate Council	J Poole

1. Chair's Foreword

1.1 The Yorkshire and the Humber Clinical Senate thanks Harrogate and Rural District CCG for involving the Senate in the review of their mental health services for working age adults and older people. I would like to thank the expert clinicians and lay members who have worked with us on this review.

1.2 We have focussed our report on the few clinical areas which we consider need further development, however, we agree that the proposed model is in line with best practice.

2. Summary of Key Recommendations

2.1 The proposed model from Harrogate and Rural District Clinical Commissioning Group (HaRD CCG) for increased focus on community based provision, reduced admissions, length of stay and increased support to help people stay at home is in line with best practice. We very much welcome the whole systems approach from prevention through to recovery and rehabilitation.

2.2 Our recommendations are:

i. That you continue to develop your proposals for the integration of mental health services across primary care, secondary care, social care services (particularly with regard to dementia services and housing) and explore further opportunities for working with the voluntary sector.
ii. To provide further detail on the patient preferences for the in-patient service.
iii. To demonstrate that the York facility has the capacity for the Harrogate population and to provide information on how the bed requirements for the Harrogate population have been calculated.
iv. To provide further detail on the pathways for the patient if the York facility is full.
v. To further describe how you will ensure the holistic approach between physical and mental health.
vi. To demonstrate that solutions to the issue of Suite 136, the place of safety for detaining patients under the Mental Health Act, are being developed.

3. Background

Clinical Area

3.1 HaRD CCG are reconfiguring their mental health service for working age adults and older people in the Harrogate and Rural District area. The present in-patient mental health unit is in the Briary Unit on the acute hospital site, Harrogate District

Foundation Trust (HDFT). The unit is not considered by the Care Quality Commission (CQC) as fit for purpose and benchmarking and analysis of local data shows that admission rates and lengths of stay are longer than other areas where their provider Tees, Esk and Wear Valley Foundation Trust (TEWV) provides adult or older peoples inpatient care.

3.2 The CCG have undertaken significant pre-engagement with the local population, including service users and carers, which has emphasised the need to:

- Keep people in their own homes for as long as possible
- Provide care closer to home, particularly in times of crisis
- Improve community services by extending the skills and experience of community staff with extended working hours

3.3 In response to this the CCG have developed proposals to extend and enhance their community provision and provide their in-patient care at the newly provided unit at Haxby Road in York. This work is intended to provide a comprehensive mental health offer to the population of HaRD for working age adults and older people.

Role of the Senate

3.4 The CCG has stated that the advice from the Clinical Senate will feed into the work led by HaRD CCG to allow their governing bodies to make the decision to move to public consultation. Our advice will specifically feed into the NHS England's second sense check at the start of October 2018.

3.5 In their discussions the Senate has focused on providing a response to the following questions:

- Is the proposed model, and preferred solution description, in line with best practice?
- Can the Senate identify any clinical concerns about the proposed model, and the preferred solution description?

Process of the Review

3.6 The Terms of Reference were agreed in July 2018 and are available at Appendix 3. The supporting documentation was received by the Senate at the end of July and then distributed to the Expert Panel. During August and September the Senate panel shared comments on the documents by email and supplemented this with 2 clinical discussions by teleconference and a teleconference with the providers and commissioners to provide opportunity to further improve our understanding of the proposals. This report has been approved by all members of the panel.

3.7 Commissioners 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 November meeting.

4. Recommendations

4.1 Our recommendations first focus on the following part of the question:

Is the proposed model and preferred solution description in line with best practice?

4.2 The Senate agrees that the proposed model and preferred solution are in line with best practice.

4.3 Formed in March 2015, the independent Mental Health Taskforce brought together health and care leaders, people who use services and experts in the field to create a Five Year Forward View for Mental Health for the NHS in England.[1] This national strategy, which covers care and support for all ages, was published in February 2016 and signifies the first time there has been a strategic approach to improving mental health outcomes across the health and care system, in partnership with the health arm's length bodies. Their recommendations include that the NHS should expand proven community-based services for people of all ages with severe mental health problems who need support to live safely as close to home as possible. Recommendation 17 also states that by 2020/21 NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission'.

4.4 The proposed model from HaRD CCG for increased focus on community based provision, reduced admissions, length of stay and increased support to help people stay at home, is in line with best practice. The principles for care which are designed around effective clinical pathways as close to as home as possible, delivered to support recovery and resilience and achieve sustainability are also in line with best practice. These are commendable principles of care. We very much welcome the whole systems approach from prevention through to recovery and rehabilitation.

4.5 The commissioners have developed a very detailed case for change which is well thought through. There has been very wide consultation, and the ideas have remained very sensitive to the needs and wishes of service users.

4.6 It is evident that the Briary site is not providing facilities which are gender specific and which respect patient privacy and dignity. The commissioners are faced with a tension between having adequately staffed, state of the art in-patient facilities, that are large enough to provide excellent services with the patient numbers to sustain that service, and the need to have community in-patient facilities near patients'

[1] The Five Year Forward View for Mental Health, A report from the Independent Mental Health Taskforce to the NHS in England, February 2016.

homes. This is a tension that exists in all aspects of health care and the Senate understands and supports the reasoning which led to the pause on the decision to build a new in-patient facility in Harrogate. We agree that you are likely to struggle to recruit to a small Harrogate based service and will be unable to provide the full range of specialist care and that it will be difficult to maintain this financially.

4.7 The Senate agrees that continuing 'as is' in solution 1 is not workable as it limits the choices people have about their care. Solution 2, retaining local in-patient facilities, also does not seem to address the challenges and concerns but moves them at considerable cost somewhere else. The Senate agrees that solution 3 does seem to be the best option to explore however the presentation of those options could be more balanced. Solutions 1 and 2 don't detail the improved therapeutic care that could still be offered despite the financial constraints. In reality there is probably no reason why benefits like use of new technology, or improved working with social care couldn't be implemented with any of the options. The list of "cons" for the preferred option 3 are also not fully explored. The risk of loss of relationship between physical and mental health by moving in-patient services to another site outside the area needs to be included.

4.8 In our response to the second part of the question to "**identify any clinical concerns about the proposed model and preferred solution description",** we have highlighted some clinical issues which need further consideration.

Community Services

Integration with Primary Care

4.9 In the review of the proposals the Senate were in full agreement that the investment in community, recovery, resilience, early intervention and prevention is the right way forward. We explored the integration of the teams further with you in discussion to understand how staff currently working within primary care will be trained to work with people with mental health issues, delivering care in a psychologically minded way. For the community services to be effective it will be essential for clinical teams to think as one system with seamless pathways between integrated primary care teams and specialist support and we emphasise to you the importance of strengthening the offer in primary care to support prevention.

4.10 In discussions you have been clear that the proposals need to be seen alongside the detailed on-going work in HaRD around primary care through Your Community, Your Care which is linked with the Vanguard in Harrogate and the pilot work that TEWV did to integrate mental health workers into different teams. We understand that you have looked at mental health as part of an overall system and that services for preventative primary community care are integrated alongside specialist mental health services. You also acknowledge that there is still further work to ensure that the pathway is cohesive.

4.11 We understand that this model will have 4 integrated community hubs across the CCG geography and a TEWV support hub which will be staffed by a Band 7 mental health role to act as a trainer and advisor around patient needs and act as a conduit

to secondary services. The aim is to have the right level of support in primary care to reduce referrals in to secondary services and you are aware of the need to have experienced staff in post to correctly assess and signpost patients to the appropriate services.

4.12 The work with primary care is still ongoing but we are assured that you are sighted on the issues

Integration with Secondary Mental Health Care

4.13 We discussed with you how you are working to ensure that the pathway will offer a seamless service between primary and secondary care. There are currently high levels of mental health secondary care activity but relatively low levels of severe and enduring mental illness. We discussed whether the high number of admissions may be a reflection of the current lack of alternatives in community care, and the gaps in wider primary care to address mental health issues at an earlier stage, or a cultural issue. Your views were that this is due to the lack of supporting community services.

4.14 You will need to have clear arrangements with community services for following the person up in hospital; keeping admission length of stay as short as possible and then integrating back home again. This is more difficult with community staff in Harrogate and in-patient services in York. We're also not clear what links there will be with crisis support and the Intensive Home Treatment Team.

Integration with Social Care and the Voluntary Sector

4.15 In our discussion on the integration with social care you acknowledged that it is more difficult to achieve an integrated approach when the in-patient service is further away from people's home. You are in the process of developing plans with social care colleagues for alternative ways of caring for older/dementia patients and you are looking at working with Dementia Forward on how this could be done locally. In discussion you confirmed that you have a planned visit with York County Council to Dementia Forwards and discussions are ongoing about the extra care facilities available in Yorkshire to keep admissions local with those with dementia. You agreed that further discussion with social care services is required.

4.16 The documentation does not provide much information about the connections with the voluntary sector and we advise that the CCG need to look at developing these connections more widely. Alcohol and self-harm for example are areas for third sector help and transport volunteering could be a good focus in this rural area.

Recommendation: *That you continue to develop your proposals for the integration of mental health services across primary care, secondary care, social care services (particularly with regard to dementia services and housing) and explore further opportunities for working with the voluntary sector.*

Hours of Operation

4.17 The new model of care offers services for adults of working age 9am until 7pm and older people from 9am until 5 pm. Whilst understanding the resource reasons for this, it often puts pressure on emergency services if the "routine" services do not cover the time of GP surgeries. In discussion you confirmed that TEWV have completed some changes in Hambleton & Richmond and found that there is not much demand after 5pm. You have therefore proposed a Rapid Response Intermediate Care (RRICE) Team which operates extended hours in Harrogate which will run alongside the crisis service. RRICE picks up people with organic needs and GPs use this service as well. The discussion has addressed our concerns on this.

In Patient Facility

4.18 We agree with your proposal to have your in-patient provision linked in with a larger geography but this does bring with it a number of issues that need to be addressed:

The Location

4.19 The proposal is to include bed provision for Harrogate and Rural District in the new 72 bedded in-patient facility being built at Haxby Road in York.

4.20 We questioned the patients' views on the location of the in-patient service. We needed to consider whether the proposed York location was a decision based on the preference to keep services within the TEWV footprint without fully considering whether there was a more natural flow of patients to a facility outside of the TEWV footprint (Leeds for example). There is a diverse and rural community within the Harrogate catchment that need to be considered. Train travel between Harrogate and York is expensive. We explored this patient flow in discussion with you and understand that there is a strong culture of quality improvement in TEWV and the development of standard practice across the footprint, so linking Harrogate with York will have the advantage of shared management processes of referral, interventions and discharge. There are also strong clinical relationships.

4.21 You also confirmed that there is no historic flow of people with mental health needs to services in Leeds and in all consultation events the preference from service users and carers is to flow in to a North Yorkshire based service, including people in the Wetherby area. The information provided shows that there are mixed views around the location You confirmed in discussion that York do have the capacity to meet the Harrogate population needs within this facility and you will work closely with York clinical colleagues to develop that. This information is not within the documentation we have received, and was not part of the capacity planning at the time the Senate worked with York on their in-patient proposals. We recommend that more evidence of this agreement is required before progressing in the assurance process. This evidence should also demonstrate how the bed requirements for the Harrogate population have been calculated. of the beds with 'some people wanting all inpatient services to stay in the immediate area, some suggesting that only older peoples inpatient services stay local and some people wanting to receive their inpatient care from a more specialist environment and not minding if it is out of the immediate area

so long as their admission is short and they can return home as soon as possible'. The paper doesn't say the proportions of people wanting each and it is not clear that having in-patient care provided elsewhere in TEWV is the most popular view. We recommend that commissioners provide more detail on the numbers behind the preferences for this in-patient solution.

4.22 If the facility in York is full we discussed where patients would access their in-patient care and whether this would be to the nearest in-patient facility rather than one within the TEWV area. For patients it is all the NHS and we need to avoid creating confusing boundaries and sending patients further from their home than necessary. Our advice is that this needs further discussion.

Recommendation: *To provide further detail on the patient preferences for the in-patient service.*

Recommendation: *To demonstrate that the York facility has the capacity for the Harrogate population and to provide information on how the bed requirements for the Harrogate population have been calculated.*

Recommendation: *To provide further detail on the pathways for the patient if the York facility is full*

Holistic Approach to Mental and Physical Health

4.22 You have an ageing population to manage and therefore ensuring that you have a holistic approach across mental and physical health is even more important. With an in-patient mental health service at some distance away the Senate is concerned as to how you will arrange services with the physical health care providers. In particular the:

- Mental health assessment of those in district hospital
- Physical health of people admitted in mental health in-patient services outside the area
- Continuity of care with specialists involved in those with co-morbid physical and mental health problems who are in hospital.

4.23 We are not clear on the model that will provide that seamless care between physical and mental health. In discussion you confirmed that TEWV have a good Allied Health Professions structure with in-house therapy to be able to meet different care needs. When there are continuing physical care needs you expect that the community service will be accessible by all and will be picked up in the in-patient services. For people with long-term conditions you expect that physical health care needs will be negotiated with health partners across the system to ensure continuity. You also referenced how the in-patient length of stay will be kept as short as possible for their mental health care, with an emphasis for returning back home and back to care under their specialist consultant.

4.24 The Senate is unsure how developed some of these conversations are to really work through the detail of this and recommends that further detail is required to evidence the solutions to ensure the holistic approach between physical and mental health.

Recommendation: *to provide further information on how you will ensure the holistic approach between physical and mental health.*

Section 136

4.25 The preferred option 3 has implications for the provision of Suite 136. We understand that there are plans to reduce the four 136 suites in the North Yorkshire TEWV footprint (at York, Scarborough, Northallerton and Harrogate) to two (at York and Scarborough) due to the very low usage on the other sites. This facility provides very important crisis care and low usage should not be the only consideration. You are considering the development of street triage in Harrogate to help address the removal of Suite 136 from there but your discussions with Police and Ambulance services are in the very early stages and there is no identified funding for this. Our advice is that the work on this needs to be accelerated. We have clinical concerns about this proposed closure and the lack of any developed services to mitigate against this, with the resulting potential increase risk of people with mental health problems being placed in police cells.

Recommendation: *To demonstrate that solutions to the issue of Suite 136 are being developed.*

Staffing

4.26 The staff are the main asset within this service and ensuring their health and wellbeing in this service change needs to be a priority for the commissioners. With the move from acute/in-patient focus to community there can be the assumption that staff will re-locate to community without adequately considering the support that they will need for this transition. There are practicalities to consider as to whether people can actually work in a 7 day service further from home, is there accommodation to locate the staff in the community and whether staff can afford the costs of travelling further. There are also their training needs to address.

4.27 In discussion you provided confirmation that these issues are being progressed and confirmed that staff engagement has been good. There is general agreement amongst staff to the proposals to increase community provision to enable a more recovery and prevention focus. You confirmed that staff working in the in-patient unit will be given the opportunity to be matched into community posts.

4.28 We understand that your staff retention is good but that recruitment can be difficult and you confirmed that you have a range of measures in place to grow the nursing workforce locally which include:

- Established apprenticeship models,
- A workforce development plan across the Trust,
- The development of talent management;
- Good preceptorship for nurses;
- An established rotation to help newly qualified staff build up their skills and move into areas they would like to go.

4.29 You are also engaging with Health Education England about the changes that will be required to the medical and junior doctor workforce.

4.30 You confirmed that the £500,000 funding which will be released from the in-patient service for investment in the community will be used to recruit to 12 posts over a range of grades, with investment in skill mix, community, support and peer development workers. Our only observation on this is that the demands on this funding are high and it will be challenging to ensure that this enables the recruitment of sufficient numbers on the ground to make the difference you anticipate.

5. Summary and Conclusions

5.1 In conclusion the Senate advises that your proposed model for increased focus on community based provision, reduced admissions, length of stay and increased support to help people stay at home is in line with best practice. We very much welcome the whole systems approach from prevention through to recovery and rehabilitation.

5.2 You have developed a very detailed case for change which is well thought through. There has been very wide consultation, and the ideas have remained very sensitive to the needs and wishes of service users.

5.3 We have highlighted some clinical areas which we recommend need further consideration. These include our concerns on the lack of evidence that the York facility can accommodate the in-patient needs of the Harrogate population and how that in-patient need has been calculated. We also recommend the need to consider further the pathways for the patient if the York facility is full. Further detail is also needed on the patient preferences for the in-patient service.

5.4 With regard to the community service we recommend that further information is required on how you will ensure the integration between physical and mental health services, which will be challenging with the in-patient mental health service at some distance away. Your preferred option also impacts on Suite 136 and we recommend that the solutions to this need more urgent discussion.

5.5 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

Council Members

Catherine Wright,
Allied Health Professionals Lead, Bradford District Care Trust (Chair of the Panel)

Stephen Elsmere
Lay representative

Rebecca Bentley
Acting Head of Nursing, Bradford District Care Trust

(Consulted with Kate Yorke, Psychology Director, Humber Teaching NHS FoundationTrust)

Clinicians from Other Senates

Jean Jenkins, Freelance consultant (Previously GP, Associate Specialist in Old Age Psychiatry and Clinical Director for Transformation and Commissioning, NHS South Cheshire CCG)

Nieves Mercadillo, Consultant Psychiatrist. Adult Inpatient Units, Northwest Boroughs Healthcare NHS FT

Kathy Roberts, Chief Executive, Association of Mental Health Providers

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

None declared

Appendix 3

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Mental Health Services on behalf of Harrogate and Rural District CCG

Sponsoring Organisation: Harrogate and Rural District (HaRD) CCG

Terms of reference agreed by: Joanne Crewe HaRD CCG and Joanne Poole, Senate Manager, Yorkshire and the Humber Clinical Senate

Date: 6th July 2018

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Catherine Wright, Allied Health Professionals Lead, Bradford District Care Trust

Citizen Representatives: Stephen Elsmere,

Senate Review Clinical Team Members:

Kathy Roberts
Chief Executive, Association of Mental Health Providers

Jean Jenkins, Freelance Consultant (Previously GP, Associate Specialist in Old Age Psychiatry and Clinical Director for Transformation and Commissioning, NHS South Cheshire CCG)

Dr Nieves Mercadiillo
Consultant Psychiatrist, North West Boroughs Healthcare NHS Foundation Trust

Rebecca Bentley
Acting Head of Nursing, Bradford District Care Trust

2. AIMS AND OBJECTIVES OF THE REVIEW

Question:

Is the proposed model, and preferred solution description, in line with best practice?

Can the Senate identify any clinical concerns that they may have about the proposed model, and preferred solution description.

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

For the Clinical Senate to provide a quality check within the NHS England gateway process regarding the development of the solutions for transformation of mental health services in Harrogate and Rural District CCG to make the decision to proceed to public consultation.

Scope of the review: The Clinical Senate will focus their review on the above 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: by 6th July 2018

Agree the Terms of Reference: by end July 2018

Receive the evidence and distribute to review team: end July 2018

Teleconferences:

The first Clinical Panel discussions 6th August 2018

Teleconference with commissioners 21st August 2018

Second teleconference with the clinical panel 4th September 2018

Draft report submitted to commissioners: 16th September 2018

Commissioner Comments Received: within 10 working days of the draft report being received

Senate Council ratification; at the September Council meeting (or by email if required earlier)

Final report agreed: end October 2018

Publication of the report on the website: 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:

- The case for change, which outlines the reasons for change to the system and the preferred option identified.
- Background data on present use of services
- Mental health Strategy for North Yorkshire
- Joint Health and Wellbeing Strategy
- Pre-engagement report

The review team will review the evidence within this documentation 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

Appendix 4

EVIDENCE PROVIDED FOR THE REVIEW

The CCG provided the following documentation to the Senate for consideration:

- Transforming Adult and Older People's Mental Health Services in Harrogate and Rural District – a case for change. 270718 and the following appendices:
  - Appendix 1 – Proposed Solutions
  - Appendix 2 - Health profile for Harrogate
  - Appendix 3 - Timeline
- Background data on present use of services
- Equality Impact Statement March 2018
- Mental Health Engagement Report Nov 2017
- OSC Mid Cycle Briefing January 2018