Northern England Clinical Senate – March 2016

Newcastle-Gateshead CCG Deciding Together

1. Introduction

Following an extensive period of listening to patients, carers and the public about their views on current mental health service provision in Newcastle and Gateshead, Newcastle-Gateshead CCG developed a range of clinical scenarios of mental health service configuration as part of the Deciding Together programme. These clinical scenarios formed the basis of a formal statutory 12 week public consultation process which has now concluded.

Newcastle-Gateshead CCG approached the Northern England Clinical Senate to ask for an independent review of these clinical scenarios to help provide assurance to their programme board and governing body as they progress through their management process towards final decision-making.

Clinical senates are non-statutory advisory bodies that exist to provide independent, impartial advice on the clinical aspects of service transformation to commissioners and as such do not take part in the actual decision-making process (where CCG governing bodies consider the senate advice alongside other important information e.g. public and patient views, financial assessments and links to other strategic change programmes).

1.1 Objectives agreed with the CCG

For this review, Newcastle-Gateshead CCG requested that the clinical senate review team:

- Reviewed the CCG assessment of the clinical scenarios of Deciding Together mental health service configuration across Newcastle and Gateshead post-consultation prior to CCG option appraisal and decision-making on the implementation of a preferred option.
- Give views on the CCG's assessment of clinical efficacy, strength of evidence base and activity, capacity and capability assumptions underpinning the clinical scenarios to enable the CCG to make an assessment on the safety and sustainability of the proposed service options prior to implementation.
- Give views on the CCG's identification of clinical interdependencies and plans for ensuring an effective interface between interdependent services

- Give views on clinical and configuration risks that may need to be mitigated before decision-making and/or as part of implementation

1.2 Scope of the services under review

The services “in-scope” for this review are those **provided by Northumberland, Tyne and Wear Mental Health NHS Foundation Trust** for the following areas:

- Community mental health services for adults of working age living in Newcastle and Gateshead
- Community mental health services for older people living in Newcastle
- Inpatient mental health services for adults of working age living in Newcastle and Gateshead (this covers acute care and rehabilitation inpatient services)
- Inpatient mental health services for older people living in Newcastle

The services that were “out-of-scope” of the review were:

- Mental health services provided by GPs, primary care counsellors and therapists, including IAPT services (Improving Access to Psychological Services)
- Community and inpatient mental health services for older people in Gateshead provided by Gateshead Health NHS Foundation Trust
- Other specialist inpatient mental health services (such as psychiatric intensive care, forensic psychiatry etc.)
- Children and young people’s mental health services
- Mental health services provided or commissioned by Newcastle and Gateshead local authorities
- Mental health services provided by the voluntary sector

2. Panel Members

In order to provide an appropriate response to this referral, the Northern England Clinical Senate drew together clinical experts with no links to the services covered by the Deciding Together proposals. The independent senate Review Team was made up of the following experts:

- Kathy Roberts, Chief Executive, National Voluntary Sector MH Provider Forum
- Dr Jean Jenkins, GP and Clinical Director of Mental Health and Transformation, NHS Vale Royal CCG and NHS South Cheshire CCG.
- Dr Nieves Mercadillo, Consultant Psychiatrist, 5 Boroughs Partnership NHS Foundation Trust
- Dr Tolulope Olusoga, Consultant Psychiatrist and Senior Clinical Director MHSOP, Tees, Esk and Wear Valleys NHS Foundation Trust

- Dr Anupam Verma, Consultant Psychiatrist specialising in acute liaison, independent consultant.
- Dr Mike Dennis, GP and clinical lead for Mental Health, Warrington CCG

3. Methodology

The review process used the following methodology:

- Stage 1 – Review of information provided by the CCG
- Stage 2 - Panel Review session
- Stage 3 – Review of information requested by the panel post-review session

3.1 Stage 1 – Review of information provided by the CCG

The following information was made available to the Senate Review Team:

- Newcastle-Gateshead CCG Executive Deciding Together pre-consultation paper
- Newcastle-Gateshead CCG Deciding Together Consultation Document
- Newcastle-Gateshead CCG Deciding Together Consultation Exercise Findings Report
- Deciding Together In-depth Interview Report
- Deciding Together Travel Impact summary
- Deciding Together Northumberland Travel Analysis (Full)
- Deciding Together Case for Change

3.2 Stage 2 - Panel Review session

A panel review session was held on the 31st March 2016 consisting of:

- A formal review session between the Review Team and representatives from the CCG, the provider and the third/voluntary sector to cover the case for change, transformational programme approach, development of the clinical scenarios and early feedback from the listening events from the consultation process
- A formal review session between the Review Team and clinicians and service managers from the service provider and representatives from the third/voluntary sector on the clinical models within the clinical scenarios, particularly interdependencies with other services, clinical evidence base and clinical quality risks and benefits.

3.3 Stage 3 – Review of information requested by the panel post-review session

The following information was requested by the Senate Review Team on the back of discussion in the review session:

- Further information related to the programme governance and consultation process:
    - List of Clinical Engagement events undertaken pre-consultation
    - Programme Board and sub-group structure
    - Membership of the Programme Board and sub-groups
    - Notes of the primary care sub-group where available
- Further information from the CCG on the transformation programme:
    - The Quality and Risk Impact Assessment
    - CCG assessment of Acute Liaison Services in A&E
    - A copy of the Crisis Care Concordat Action Plan
    - Information on the other main programme of transformation work on the community side of mental health service provision (for out of scope services)
- Further information from the provider on the service model:
    - Further detail on the activity and bed modelling used to develop the scenarios
    - Any evaluations of the model implemented in Sunderland and South Tyneside (including impact on staff sickness rates pre- and post-implementation if possible) that would be replicated in Deciding Together
    - Details of the NTW workforce review and skills assessment that was discussed in the afternoon session

4. Views expressed on the day

Key messages heard from CCG session:

- The CCG feel that they have developed a comprehensive and effective transformation programme based on a strong case for change
- Concerns have been heard from GPs regarding access to services and silo working which was leading people to fall through the gaps. The CCG wanted a whole person approach which would enable services to manage complexity more effectively, work to a patient definition of crisis and that had the capacity to support patients as they begin to experience problems.

- The programme board feel that the needs of patients have changed markedly over the last few years with those needing inpatient care having much more complex problems and risks – almost tertiary in nature, whilst at the same time better community care is enabling more patients to receive their care closer to, or in, their own homes.
- They feel that their programme board structure and membership (in particular with representation from the third/voluntary sector) has enabled them to develop clinical scenarios that address the key issues facing the inpatient mental health sector
- They feel that it is justified to separate out the older persons' inpatient services in Gateshead and focus on services provided by Northumberland, Tyne and Wear NHS Foundation Trust based on high user satisfaction rates and confidence in the current model in Gateshead
- The CCG recognise that patients and service users are vocal about the impact of travelling for their service but note the parallels with other physical health conditions where people have to travel further for specialist care (counterbalance by a shorter stay in inpatient care with community based care closer to home)
- The CCG and provider will look to implement 7 day working in whichever option is chosen.
- The CCG want to look innovatively at what else third sector can do, what they may be better placed to provide than statutory organisations etc but recognise the need for increased investment, scaffolding/support to help them do this.

Key messages heard from provider clinician session:

- The clinicians from Northumberland, Tyne and Wear NHS Foundation Trust clearly feel that a reduction in sites and inpatient beds whilst continuing on the journey to 7 day consultant led services is the correct direction of travel for the inpatient mental health services
- They believe that the model was developed from the "bottom up" by clinicians and patients (siting work undertaken four years ago)
- As part of service model review NTW have redesigned community pathways as well as inpatient pathways. This review looked at the needs of service users and the skill mix of staff to deliver it so as much care as possible can be given in the community with inpatients seen as an augmented service (i.e. only offered when other services can't meet the patients' needs).
- They feel that economies of scale can lead to better multi-disciplinary care with more input from allied health professionals, pharmacy etc and more rapid discharge for patients to more appropriate services provided in the community. This creates a more sustainable inpatient service (via reduced lengths of stay) with quality benefits.

- They feel that the environment and estate are of a much higher quality in scenarios involving the (“state-of-the-art”) St Georges Hospital Morpeth and Hopewood Park sites.
- The clinicians feel that the proposed service models in the clinical scenarios have a high chance of success as they follow a similar model implemented in Sunderland and South Tyneside.
- The clinicians believe that as a result of the introduction of this model in South Tyneside and Sunderland admissions fell, lengths of stay reduced and GP satisfaction in the quality of service improved.
- The voluntary and third sector representatives noted that whilst economies of scale for the provider of inpatient services may be positive, this has an inverse effect on smaller voluntary sector providers who would subsequently have to travel further in scenarios with a reduced number of sites.

5. Findings of the Review Team

5.1 Findings related to the CCG assessment of the clinical evidence base underpinning the in-scope services within the clinical scenarios

In the consultation material, the Deciding Together programme believe that the clinical scenarios allow best practice advice in the provision of a range of adult mental health services on the same site to be achieved. In the clinical scenarios this includes adult acute assessment and treatment wards, psychiatric intensive care and complex care and high dependency rehabilitation wards.

The stated benefits of this would be as follows:

- Staff are able to work together flexibly and reduce ward transfers, reducing risk to safety and disruption to patients
- More staff on site to respond quickly to psychiatric emergencies reducing patient and staff safety risks
- It enables 7 day a week working for consultant psychiatrists which delivers better outcomes for patients
- Provides a more cost-effective way for important clinical support services such as physiotherapy, exercise therapy, occupational therapy, carers’ support and other social and recreational activities. These are significant for physical health as many patients in hospital are detained under the Mental Health Act which restricts their ability to access social and recreational activities outside of hospital.

The independent Review Team agree with this assessment by the CCG, in particular about the benefits that a bigger pull of clinicians/expertise brings into daily operational management (i.e. cover) , initiatives such as 7 days working, specialised assessments/ advice on clinical management as well as a possible easy transition between units.

The Review Team heard how the introduction of the new model in Sunderland had enabled clinicians to hold daily review meetings in inpatient services with an electronic board to review all patients. These reviews allow more effective discussion on the needs of the patient to remain an inpatient, to check whether their Community Psychiatric Nurse (CPN) has visited and consideration of their clinical formulation. This improved communication and information sharing with community services early in care planning improves the quality of care for the patient. It also allows the provider to assess the skill-mix needed to meet the patients' needs and the skill-mix on the ward to understand who is best to deliver which treatments for patients (e.g. the role of pharmacy etc).

The inpatient service provider believes that in order to spread this quality of care, economy of scale is needed to get the best skill mix to be able to deliver all of these treatments and the greater the number of sites, the harder this would be to ensure.

The independent Review Team agree that improved communication should lead to improvements in the quality of patient care. There was no evidence however that this led to shorter lengths of inpatient stay and quicker discharge into community services (based on the evidence provided by the programme following the panel sessions which showed that average lengths of stay had risen in Sunderland and South Tyneside between 2013 and 2015).

This assessment of the improvement in clinical quality in the service is only one aspect of quality and that the CCG will need to balance this with patient views on the impact the scenarios may have on patient and service user experience (in particular related to travel and the effect this has not only on the patient, but on their potential support networks of family, friends and third sector). It is noted however that there is already quite a varied patient flow in the current configuration where not all patients in Newcastle go to Newcastle wards (and the same in Gateshead). Presently some patients already go to St Georges or Hopewood Park sites, sometimes based on clinical need and sometimes by choice.

5.2 Findings related to the CCG's assessment of activity, capacity and capability assumptions underpinning the clinical scenarios

During the panel session, the Review Team heard how the lessons learned from the introduction of a similar model in Sunderland and South Tyneside (which serves a similar patient demographic) had given the service provider good evidence on which to base activity and capacity planning. The provider had taken the Royal College of Psychiatrists aspiration of 85% bed occupancy into account when planning future required capacity (but acknowledge this is often difficult to achieve) and is confident that 3 wards will provide sufficient capacity.

The provider would also closely monitor any implemented model to ensure that they try to identify any issues in flow through the system early on a whole system basis.

The Review Team heard how the Sunderland Initial Response Service (IRS)/ single point of access is proving effective and was able to triage and make initial assessment and book relevant appointments/ arrange appropriate response within short timescales (4 hour for crisis, 24 hour for urgent and 4 weeks for routine).

Whilst the community team is not part of this service they do work very closely with them and provide the IRS with a schedule of clinics that patients can be slotted into. This service has coped with a huge number of referrals and provided the learning needed over last 18months to ensure the correct skill mix of staff needed within the inpatient setting. The provider believed that this has had impact on admissions (reduction of around 40%) with an expectation that it is going to continue.

This assessment was based on figures taken over a 6 month period which the Review Team felt should be updated to cover a long period of time (with the service having been operational for 18 months) and further evaluation evidence was requested.

From the follow up information provided, an assessment of the assumptions that supported the bed modelling was made. This found that:

- Emergency re-admission rates are the same for both models of care
- Lengths of stay in Gateshead are already equivalent to those in Sunderland and South Tyneside (suggesting that the opportunity for further reduction only exist in Newcastle)
- It is unclear as to the main causal factor in the reduction of admissions in Sunderland and South Tyneside (e.g. whether this is simply due to the reduced availability of beds or because of the introduction of the Crisis Team at a similar point in time)

- Gateshead has already reduced admissions by 23% in two years as the Initial Response Service was introduced
- The impact of other factors such as changes in consultants personnel, new or improved access to rehabilitation, housing or home treatment services have not been individually assessed

Based on this assessment, the Review Panel feel that it is unclear as to the main causal factor in the reduction of admissions in Sunderland and South Tyneside (e.g. whether this is simply due to the reduced availability of beds or because of the introduction of the new model of care at a similar point in time). This would suggest to the panel that goal of a 10% reduction in admission should be used more as a rough guide than a scientific forecast and as such mitigations will need to be in place in order to be able to flex capacity should it transpire that the reductions in admission are over-estimated.

It was not clear from the evidence provided what the ultimate intended bed base would be in the new clinical scenarios. From the experience of the panel members a reasonable aim may be three wards of eighteen to twenty beds in order to allow for flexibility in the system in the most financially efficient way.

5.3 Findings related to the CCG's identification of clinical interdependencies and plans for ensuring an effective interface between interdependent services

The panel considered the interdependencies of the clinical scenarios with the following services:

- Between inpatient services and community, third/ voluntary sector and other supporting services (e.g. housing)
- With primary care services
- Along the urgent care pathway
- At the point of transition from children's services to adult services
- With the Gateshead MHSOP service
- With specialised mental health services
- With physical health services

5.3.1 Community, third/ voluntary sector and other supporting services

The Review Team wanted to focus on two key areas in regards to the interdependencies between inpatient and community services:

1. The Clinical relationships between inpatient unit staff and community staff in the proposed clinical scenarios, in particular what the effect will be if inpatient units are further away from community teams

2. The readiness, ability and resilience of providers in the community and third/voluntary sector to cope with greater numbers of discharges from shortened inpatient stays

In regards to the first issue, the Review Team heard how community staff will be involved in discharge planning and will come in to see the patient in the inpatient setting regularly prior to discharge. The NTW clinicians outlined work already undertaken to try and enable community staff to do weekly visits with patients whilst they are an inpatient. The Review Team posed the question as to whether or not this is more likely to be achieved if the inpatient units are more closely located to the community teams. It was the opinion of the NTW clinical staff that in fact the fewer inpatients units there were, the easier it may become as more patients are in the same place which saves community staff travelling to multiple units.

The clinicians' experience of the model already implemented in Sunderland suggests that teams are much better at liaison between inpatient and community team as they have to give this greater consideration and do so in more of a planned way where beforehand it was ad-hoc. Parallels were also drawn to the NTW learning disabilities service only have one inpatient unit for whole trust and feedback from community teams has shown this works well as it makes it easier to plan meetings with inpatient teams .

This is helped by having daily review meetings every day at the same time so community teams can drop in to join that if they want. NTW clinicians also described how they are exploring IT solutions to help Northumberland teams, who cover the greatest geography, to join.

In regard to the second issue, the Review Team heard that the:

- The CCG are committed to rolling out the NTW community pathways that have been implemented in Sunderland and South Tyneside in Newcastle and Gateshead. Whilst this will happen regardless of which inpatient model is chosen, the pace at which they could be implement would be affected by which inpatient scenario was chosen as the preferred model.
- The CCG absolutely recognise the need to ensure very close working between third sector and NHS community teams and GPs to ensure very comprehensive and rapid risk assessments are carried out as more complex patients will be managed in the community.
- The Solidarity In Crisis service is non-professionally aligned and will follow people when they move from secondary care into primary care.

- The capacity of third/voluntary sector is a changing picture as there are some providers who are losing funding and are therefore at risk. The sector recognises the intention that this model will potentially see greater levels of NHS investment but this is set against the backdrop of ongoing economic austerity. Individual organisations within the sector have varying levels of ability to respond to the “ask” of this service change and there is a risk that some organisations may not be able to respond to increased demand.
- Other services that impact onto the care of mental health patients should also be taken into consideration e.g. housing (where there is unmet need for housing with support) which is mainly managed by third sector and the LA commissioned crisis house service which will require investment from the health sector to maintain it in the long-term.

The Review Panel feel that the CCG have recognised the vital role that the third/voluntary sector will play in the transformation of mental health services being taken forward by the Deciding Together programme. In particular the Review Panel commend the role of the Deciding Together Advisory Group (chaired by Steve Nash from VOLSAG) which has brought together third sector and service user groups to oversee consultation process and the willingness of third/voluntary sector reps to take a leading role in the development of the programmes proposals.

Whilst the third sector already employ clinicians and deliver services for those with complex needs, the CCG will need to include the workforce development needs of the third sector at the same time as those for health and social care sector workforce (with core skills training being applicable to all via Skills for health, Health Education England and Skills for Care). The Review Panel also recommends that the CCG look at the Voluntary and Community Social Enterprise offer when commissioning new areas of services.

5.3.2 Primary care services

The Review Team were keen to understand what consideration the CCG had given to the ability of primary care to meet their responsibilities in the proposed clinical scenarios. This is especially important given that a care model that creates an “easier way in” by nature relies on an easy way out with appropriate discharge arrangements in place.

The Review Team heard an honest assessment regarding the varying levels of relationships (ranging from “good” to “developing”) between the inpatient service provider and general practice and the acknowledgment of wider system pressure in primary care (which is reflected in primary care across the country).

Examples were shared of how some shared care agreements with primary care are in place (e.g. anti-psychotics) and the belief from the NTW clinicians that this model will help as they will have clinicians who can focus on discharge and will therefore have more time to liaise with GPs and other community providers.

The CCG were aware of the need to continue to develop the primary care interface with inpatient mental health services and had formally recognised this through the primary care workstream (led by a GP in Newcastle) under the mental health programme board. This workstream is looking at the needs of GPs to enable them to support people to be discharged early and discussions have taken place with NTW clinicians about education for GPs as well as process and infrastructure to support GPs to get help and advice if needed.

The Review Team support this approach and encourage the continued development of support to GPs and their primary care teams to enable the new clinical scenarios to be implemented effectively.

5.3.3 The Urgent Care Pathway

The Review Team were keen to hear how the Urgent Care Pathway would work in the new clinical scenarios. NTW clinicians outlined how they are involved right from the request for help and will help everyone who presents (self-referral, family/ friend referral, professional referral). The CCG are keen to support this move towards patient defined crisis (away from a clinically defined crisis) service.

The Review Team questioned the CCG on the financial implications in this scenario as these services will currently be paid for under a block contract so potential increased activity may create cost pressures for the provider.

There was further discussion on the implication of any move to Payment By Results (PBR) for this service model (which would transfer the risk of cost pressure back to the commissioner).The CCG will need to impact assess this as part of their work and may consider the utilisation of a risk-sharing financial arrangement with the provider.

The Review Team also had questions around crisis presentation in A&E and in particular around the state of liaison psychiatry. The Review Team heard that there are services located in Newcastle and Gateshead but they will need to be enhanced. There is a commitment from providers and the CCG to develop a robust liaison model with the intention of it being a 24 hour service.

The Review Team feel that the CCG need to be mindful of the likelihood of a person presenting to A&E with a mental health problem and being admitted to the acute trust (rather than the mental health trust) being directly affected by how far they would have to travel to be admitted to mental health inpatient service.

This risk would need to be most carefully considered for clinical scenario T to ensure that all providers and clinicians are clear on how a patients presenting to the A&E in the Royal Victoria Infirmary in Newcastle or the Queen Elizabeth hospital in Gateshead would get to St Georges Park or Hopewood Park.

An unintended consequence that may arise from the change from clinically- to patient-defined crisis is the impact this will have on the ability of the liaison psychiatry service to fulfil its obligations to the acute trust. Improving efficiency in the acute setting is a key facet of this service, which may be compromised by the anticipated increase in 'self-defined crisis' presentations.

As has been seen in Accident & Emergency (A&E) which relies upon self-defined physical presentations, an over-zealous use of these services is considered one of the reasons why A&E services find themselves under much pressure. At a time when A&E services are over-whelmed, and taking steps to try to reduce presentations, the proposed arrangement may serve contrary to these goals. This would particularly be the case if service users present to A&E at a time of self-defined crisis, rather than to mental health services.

Should this be the case, then the extra demands would presumably fall upon the liaison psychiatry service. The role of liaison psychiatry is to assist acute trusts in managing acute trust patients (those with physical illness) however in seeing individuals with a self-defined mental health crisis; the liaison psychiatry service would most likely be approached by A&E staff to see patients who should belong to the mental health trust. Should this occur, it would negatively impact upon the efficiency of the liaison psychiatry service & thereby negatively upon the acute trust (undermine the effective working of the clinical model).

Another key consideration that the CCG need to make is the seniority of staff in liaison services 24/7 as, as discussed in national guidance, Liaison Psychiatry is a high risk specialty and in order to achieve its potential & deliver its benefits, it requires sufficiently senior staff that are trained to consider risk and make decisions around discharge. In the absence of this, risk is more likely to be 'passed on the good chain' and result in admissions that might otherwise be avoided.

These aspects would benefit from being addressed as part of the implementation of the urgent care pathway so as to ensure that the 'self-defined crisis' initiative has it's desired positive impact, whilst ensuring it is consistent with the requirements of the wider healthcare system.

Finally, the CCG and provider recognise that further work needs to be done to link services such as IAPT and Early Intervention in Psychosis (EIP) into the urgent care pathway. The CCG will need to ensure that the admirable move to patient defined crisis does not inadvertently draw services away from those with severe mental health problems, who are unwilling or unable to present to crisis services.

5.3.4 Transition from Children's Services

Whilst Children's' Services were out-of-scope in terms of this review, the Review Team wanted to understand what arrangements were in place for transition into adult services. The Review Team heard that the CCG have a separate stream looking at children and young people which is considering at 0-25 model with transition planning starting at age 12 to identify what their needs are likely to be as they get older.

This transition to adult services will be based on need rather than age so people will transition at different ages and the CCG are working with young commissioners on developing and implementing CAMHS transformation plans. The Review Panel also heard that NTW do not (and will not in the future clinical scenarios) admit young people, even mature young people, into adult inpatient wards.

The Review Panel note the laudable nature of this person-centred approach, care will need to be given that there is clarity at the point of referral into the single point of access (i.e. which team would assess and manage the patient) from an operational point of view.

5.3.5 Gateshead Mental Health Older Peoples service

Whilst the Mental Health Older Peoples service in Gateshead themselves were out-of-scope in terms of this review, the Review Team were keen to understand how the proposed new models of the in-scope services will interact with them.

The panel heard that the NTW Adult Team have good working relationships with MHSOP from Gateshead Health NHS Foundation Trust with effective discussions about patients when they need to happen (e.g. for patients with complex needs etc). This close working extends to joint education meetings, junior doctors on same rota, and in some cases shared premises and these relationships mean that changes being put in place by NTW are being communicated with the Gateshead MHSOP. The Review Team were pleased to hear that the Gateshead MHSOP are members of the Mental health programme board.

5.3.6 Specialised mental health services

Whilst specialised mental health services were out-of-scope in terms of this review, the Review Team sought to understand the discussion held with Specialised Commissioners services to assess the potential impact of the clinical scenarios. Whilst the CCG have had some feedback and response from forensic services in NTW, the Review Team heard how further discussions with specialised services and specialised commissioners are planned prior to decision-making. The Review Team would encourage this further dialogue.

5.3.7 Integration with physical health

The Review Team heard how NTW provides holistic physical health assessment at initial assessment and offer interventions where possible or support to access them – linking with primary care and wider services to enable that to happen. This included the piloting of improved access to GP summary care records for patients and sharing of blood test results etc and the development of a physical health monitoring form which prompts staff to complete a physical health assessment, highlights which patients meet Lester tool criteria and which patients haven't been offered smoking cessation support etc.

The Review Team support this recognition of the link between mental and physical health services and encourage the continued development of these links in the future clinical scenarios with the same practice being needed in the new inpatient service model. There is opportunity for service providers to holistically manage patients as well as assess them, for example supporting patients to access and attend national cancer screening programmes.

In terms of emergency access to physical healthcare (e.g. a mental health patient suffering a stroke) clear arrangements need to be put in place for the clinical scenarios where there was no co-location with acute physical health services (e.g. St Georges is circa 10 miles to the Northumbria Specialist Emergency Care Hospital).

Clear protocols will need to be in place to reduce the risk that patients in mental health hospitals who have medical emergencies have their response category unintentionally downgraded by ambulance providers (on the grounds that the patient is already in a hospital setting).

5.4 Findings related to other clinical and configuration risks associated with the clinical scenarios

Outside of the risks identified in the sections on activity and demand modelling and the clinical and supporting interdependencies between services, a small number of other risks were discussed during the review process and in the majority of cases were linked to the development and support of the workforce.

The NTW provider feels that the needs of the workforce were well recognised at early stage of the design process. They described the development of an in-house training programme to bring community staff and inpatient staff up to desired skill level (both core levels and then stepped levels) to ensure appropriate skills are available for patients with different level of need.

The provider also feel that the experience gained from the implementation of the model in South Tyneside and Sunderland has given them a better understanding of the skills the workforce require, where teams may need some skills development and where new teams may need to be formed. Examples were given where psychosis and non-psychosis staff work very closely together and can flex between teams if skills are needed in the other team. The provider constantly reviews demand data to see whether the skill mix of staff is correct.

NTW recognise that they too are affected by national workforce pressures (having staff with a range of skills in medical and nursing etc) and have begun looking at the skills that are needed to best deliver different services rather than the profession – thinking differently about roles and responsibilities to manage workforce pressures.

The CCG might consider reviewing the workforce and training planning from the provider to be reassured that staff have the right skills /competences for their post and to ensure adequate individual and team clinical supervision arrangements are in place.

The CCG Director of Nursing is working with the NTW Director of Nursing to understand the workforce needs for the implementation of the community pathways. The Review Team also heard that the CCG are keen to build on a peer support model and recognise that this is of increasing value and should become an important part of workforce development.

The Review Panel recommends that the CCG work with other partners to impact assess the potential service changes onto other parts of the system in terms of movements of demand, This “demand check” will help the CCG understand shifts in mental health demand and levels of currently unmet need, for example between cases identified via 111 and 999 to those being dealt with by the police through section 136 orders.

The Review Panel feel that specific consideration needs to be given to the impact of the proposed changes on other services (such as the police and ambulance services) through the Crisis Care Concordat work and similarly services such as street triage and crisis simulation training which are being developed in response to the Crisis Care Concordat need to be considered as part of the final model.

Further consideration also needs to be given to how older people will travel between sites in each of the clinical scenarios.

Finally the Review Team heard of the development of standard work E-pathways where each patient works with their clinical team to build what their care will look like depending on their illness. The E-pathways then include a list of set tasks that have to be done in order to give that patient evidence based treatment no matter where in the Trust they are and these can be accessed in any facility.

6. Conclusions

Conclusion 1 - The Review Team were impressed by the Deciding Together programme approach

The evidence heard and seen on the membership, inclusion and engagement of clinicians, stakeholders and in particular patients and the third/voluntary sector in the Deciding Together Programme Board and its sub-groups and supporting workstreams is highly commended by the Review Team.

Conclusion 2 – The appropriate clinical interdependencies and risks have been identified, considered and mitigated

Other than those high-lighted in section 5, the Review Team found that the Deciding Together programme has considered the key clinical interdependencies appropriately and has clear mitigations in place for the clinical risks that have been identified.

The Review Team also note that as IAPT services are not yet integrated, it will be important to consider how this will affect the number of referrals to secondary services (i.e. with a single point of access offering a much easier route into secondary care.) This will be complicated by the waiting time for IAPT services (potentially up to three months), so strong links between the single point of access and the IAPT service will be absolutely essential.

Conclusion 3 – The programme is right to look to reduce the number of inpatient settings and rebalance the service with greater community provision closer to patients homes

The Review Team agree with the Deciding Together programme that the current number of sites is unsustainable and a barrier to providing best quality care and the rationale for the reduced number of sites in the clinical scenarios is sound.

Whilst reducing the number of units could be considered a straight forward decision, reducing the number of beds in those units is another. The CCG will need to be mindful of the risk of increased out-of-area placements and the financial and practical complexities associated with this. Although the CCG and provider are reasonably confident this won't be an issue (based on the experience of the implementation of the model in Sunderland and South Tyneside) there is a need to keep this under review whilst the community pathways are developed. If numbers are showing that they will still need more beds than planned once pathways are in place they will need to manage that.

Overall, there is reasonable evidence to suggest that reducing beds and collocating services will ultimately lead to the improvement in the quality of patient care.

Conclusion 4 – The ultimate success of this programme will rely on the development and continued investment in services and sectors that are "out-of-scope" of this review

The Review Team feel that the programme has worked with reasonable assumptions on the assessment of activity. The follow up information provided by the programme gave the Review Team confidence that the CCGs assessment of activity and capacity is a good as the data available to base this assessment on.

Having said this, if the capacity and skill mix in primary care and access to community psychiatry, IAPT and crisis services is inadequate, the consequences will be felt within the "in scope" services. The immediate consequence would be to create pressure on the new bed capacity which in turn could create new pressures on other parts of the health system (especially Accident and Emergency services). This would ultimately undermine the programmes over-arching case for change if adequate phasing of implementation, monitoring of impact and risk management arrangements are not put in place from the very start.

The Review Team recognise the CCGs acknowledgement that there may be some double-running costs incurred during the implementation of any of the clinical scenarios and believe they would be right to adopt the approach in maintaining bed numbers until they are satisfied that community services are in place to support those patients being discharged.

Whilst the Review Team would recommend that the CCG Governing Body moves to identify and implement a preferred scenario following the full assessment of the public consultation (recognising that trade-offs between affordability, clinical quality and access will have to be made), the ultimate success of this programme will depend on the transformation of community services and resilience of the third/voluntary sector.

The community services, primary care and third/voluntary sectors will need to be in place in order to accept the patients discharged following shorter lengths of stay under whichever configuration scenario the CCG may choose to implement.

The CCG may also find it useful to invest time in ensuring GPs are clear on what this community model actually will mean to them i.e. in terms of higher number of patients with severe mental illness (SMI) discharges back to Primary Care before the changes are implemented.

The Review Team heard during the review process that these plans were in place but as these services were out-of-scope of this review, no opinion will be given on their efficacy or robustness. The panel would urge the CCG Governing Body to ensure that their community transformation programme is aligned to Deciding Together to ensure there are no unintended consequences following decision—making and implementation.