NHS
Northern England
Clinical Senate

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Clinical Senate
Yorkshire and the Humber

Clinical Senate Desktop Review Report

Review: Hambleton, Richmondshire and Whitby CCG – Transforming Mental Health Services

Date: April 2017

1. Introduction

The Clinical Senates across Northern England and Yorkshire and the Humber received a referral from Hambleton, Richmondshire and Whitby CCG requesting a desktop review of documentation related to proposed changes to mental health pathways for services provided by Tees, Esk and Wear Valleys NHS Foundation Trust to inform their NHS England Stage 2 Assurance Gateway meeting.

The Clinical Senates received electronic copies of the following documents:

- Hambleton and Richmondshire: Transforming mental health services Strategic Sense check 2 document (dated 17th March 2017)
- Transforming Adult & Older Peoples' Mental Health Services in Hambleton and Richmondshire NHSE Strategic Sense Check 2 presentation (dated 15th March 2017)

Because of the desktop nature of this review, many of the queries and issues raised in this report may well have already been addressed by the programme and it is simply a case of them not appearing in the two documents provided.

Two independent reviewers were identified by the Clinical Senates who have made the following observations based on these documents. The senate panel reviewers were:

Dr Kate Yorke - Consultant Clinical Psychologist
Humber NHS Foundation Trust

Cathy Wright - Allied Health Professions Lead and CAMHS Occupational Therapy and Participation Lead
Bradford District Care Foundation Trust

2. Main findings of the desktop review

The desktop review of the documentation focused on four main areas:

- Is the proposed clinical model clear in the documentation and is it based on the most appropriate evidence base?
- Have the clinical interdependencies with other services been appropriately considered (and if not what areas may require extra work?)
- Do the proposals present any potential clinical risks to patients and where they are known, are appropriate mitigations identified?
- Based on the information provided, are any further details of any aspects of the proposal required in order to be assured that the model is safe and deliverable prior to the beginning of public consultation?

2.1 Clarity of clinical model and use of evidence base

In general, the review panel felt that overall the aspirations described in the documents provided were good, rightly based on the national vision for mental health, key reports and policy drivers. It would have been helpful to have seen more information on how the national drivers link to the local picture and case for change.

Although there is mention of Dementia and the ageing population, it would have been helpful to have a summary of some of the main mental health conditions that are presenting a challenge in the locality and which base the priorities for commissioners to address. This could have included alcohol and substance misuse, depression and anxiety, psychosis and co-morbidity as well as where there are particular 'hot-spots'. This would have made it easier to demonstrate how the proposals link with NICE Guidance to highlight areas of good practice and address any specific gap.

It would have been helpful to show how NICE guidance was being considered for the particular disorders the teams in the proposals would be dealing with to see if the changes would enhance the delivery of recommended treatments (e.g. would it group staff together who could then better deliver particular interventions).

The review panel also felt that more could have been mentioned on the Crisis Care Concordat, how the new model would help to support it as it is really fundamental to what the programme is trying to achieve with the changes.

The review panel felt that Single Point of Access is always a good idea which works well when people are forced to use it and not bypass it. There will be a need to keep the change long enough to be embedded and clear out all of the leaflets, links etc that direct people to previous access points in the system. In practice there will need to be a challenge to queue jumping and professionals bending the rules to expedite people being seen or it will not be as effective.

The review panel had more specific comments on the following areas:

- Assertive Outreach Teams
- Staffing and skill-mix
- Infrastructure to support the proposals

2.1.1 Assertive Outreach

The review panel would suggest that the programme needs to look at the evidence base for Assertive Outreach as a lot of previously established Assertive Outreach Teams have now been disbanded. Whilst patient satisfaction was high for these services, outcomes did not stand up well. Fidelity to the original model became low e.g. small caseloads often grew to unmanageable caseloads which in turn affected outcomes.

The programme will also need to be mindful that there are often misunderstandings about the evidence around Assertive Outreach Team approaches. Service users receiving Assertive Outreach often became mentally well because of the approach but once it was removed it set those people back. As such, the review panel would recommend that the CCG receive assurance that the programme has received expert input on Assertive Outreach to ensure that the pros and cons of the new proposed model Assertive Outreach Team (as a stand-alone approach) have been considered fully.

2.1.2 Staffing and skill mix

The review panel felt that more information on the workforce considerations of the proposals would have been helpful than was in the documents provided (recognising that this may come later in the process). The review panel would expect to see the following areas considered in future documentation (if it has not already been considered in other documentation):

- Much greater detail on staffing numbers, WTEs, staffing ratios and skill mix. It is unclear in the documentation if there are actually enough staff available to spread across to a 7 day service.

- The role of Occupational Therapists and other Allied Health Professionals (AHPs). There is reference to the Multi-Disciplinary Team (MDT) within the documents but OT's and other AHPs are omitted from within the list of professionals forming part of the MDT. Occupational therapy is essential to help support recovery focused services that can enable people to re-connect with their everyday lives, roles and routines.

- The review panel felt that the proposal does not go into enough detail about the types of therapy that a psychologist might offer. Whilst there might be quite a number of psychologists, they may not be trained in the correct NICE approved therapies which are suggested for the particular client groups (e.g. there is often a significant gap for staff in nursing and psychology to be trained in Cognitive Behavioural Therapy which is a treatment of choice for depression and psychosis). Even where there are skilled staff, there can be a problem accessing enough supervisors for the interventions. Similar issues might be apparent in other professions.

- Staff training needs. The improvement talks a lot about building and systems but there are no tests of whether clinical skills have fallen out-of-date in the same way as the infrastructure. To provide an improved quality of service, additional training needs may have to be factored in so an assessment of this would be helpful.

- Staff support. There is a risk that the changes for staff e.g. 7 day working actually cause more people to leave which would exacerbate any recruitment issues if not mitigated. There will also be a number of people for whom 7 day working simply might not be an option (e.g. single parents without support and those who come to work on public transport). The arrangements for staff support and supervision/ wellbeing at work which will underpin the delivery of the service will be critical. The programme should be minded that the new model enhances this support e.g. making staff less isolated, making a better grade mix in the teams to support a good supervision structure, creating a situation where a multi-disciplinary team can, for example, access each other more effectively.

- The cost of transition to the new model. Consideration will need to be given to skill enhancement or the possible absence costs of staff who may be unable to cope with the proposed changes (e.g. staff who have worked for 20 years in an inpatient setting may not have transferrable skills to a community base). The provider will also need to ensure that the cost implications in changes of base (e.g. having to pay staff to travel further through HR rules around change of base)

- Current use of inpatient beds. It was unclear in the documentation as to what the inpatient beds are currently used for. Short stay crisis management would

be most appropriate for some people (e.g. persons with Emotionally Unstable Personality Disorder) so a short elective planned admission can be helpful. A modern PD pathway and Knowledge and Understanding Framework training re PD would be helpful for staff. Further details are needed on how staff are trained in suicide and self-harm to look at the pros and cons of admission in the case of suicidal behaviour.

- Team culture. The integration of teams which currently work in a different way will need to be handled carefully and approaches to how this may be undertaken outlined clearly in future documentation. The Community Mental Health Team and an Assertive Outreach Team model of working with patients are very different and if the difference is not discussed and appreciated/ understood, conflict can arise in staff teams. Ordinarily an AOT worker would spend much longer with a patient with a very different model such as supporting social activities. This can be easily misunderstood or teams can revert to “one size fits all” sessions losing the benefits of the AOT approach. Arguably there is no less argument for separating off AOT than EIP which is being protected as a more stand-alone service in the proposal. As mentioned above the AOT evidence base needs examining as patients did prefer the approach but it did not save resource.

2.1.3 Infrastructure

The review panel would have found it helpful to have further information in relation to the following infrastructure issues within the documentation:

- A description of the IT support to staff within the proposed service changes. It would have been particularly helpful to understand:
  - if are there any issues with connectivity
  - what IT clinical systems will be used and how will these be linked into the wider IT health systems (e.g. SystmOne or similar).
  - will staff have the resources and IT devices to work in an agile way to deliver care effectively across the patch and what consideration has been given to enable staff to log-on in rural areas where connection is more difficult.

- A description of the transport links across the patch that will enable service users to easily access mental health services (and an understanding of any potential future changes based on local authority transport plans).

- There is a case made for change in terms of outdated estate but it would have been helpful to have further details on the proposals for new estate to know how the proposed changes will address this.

2.2 Consideration of clinical interdependencies

The review panel felt strongly that while there is some reference to clinical interdependencies (such as the voluntary sector and care home liaison) within the documentation provided, there is not enough detail on how these services will link in, and what the pathways are to access these services.

Whilst the link between physical and mental health was articulated in the documents, with an ageing population it will be essential to consider the physical health and rehabilitation needs for service users and to ensure that pathways with partner providers for physical health are clearly defined.

There is often a risk that people with mental health difficulties can fall through the gaps for physical health care provision. For example, someone with mental health needs who suffers a stroke, who then needs physical rehabilitation through physiotherapy, occupational therapy, dietetics etc, often find access to these services stopping once they are admitted to mental health services.

Similarly for service users with co-morbid mental health and physical health long term conditions such as diabetes, respiratory and cardio-vascular conditions there is a need to ensure that pathways for continued care are accessible.
Whilst the documentation mentions links with voluntary sector and recovery focused services further detail is needed on what the pathways to these services and the recovery college are.

The voluntary sector is becoming a real alternative in places where the sector is well established and there is resource available. Further information on how the programme has considered their potential role in the future service model would have been helpful (e.g. transport volunteering).

Overall the documentation provided would have benefitted significantly from more detail on the consideration of the voluntary services available, community resources and social prescribing as well as peer-led models and co-production opportunities which could enhance the community mental health provision. This would have included a demonstration of where the voluntary sector fits within the model outlined on page 53 of the “Hambleton and Richmondshire: Transforming mental health services Strategic Sense check 2” document.

Whilst there is reference initially in the documents to previous consultations about links with young people services, a description of the consideration of interdependencies with CAMHS would be helpful to show how the proposals would support young people in transition.

The review panel felt that the section on police partners needs expansion to more fully cover more of the Criminal Justice System. This would include partners in the courts, police and prisons who have committed to working more closely in a system wide approach (e.g. with shared training).

There have been a lot of changes in this area recently (such as with public protection guidance) which will have relevance with some mental health patients whilst probation services underwent huge changes last year. There will also be some sweeping changes for the court system in the future.

The local Criminal Justice Board would be a good link for further information in this area and will have an interest in the proposed change to the current services. Further detail on this would be available on request from the Senate Panel should it feel like a significant issue for the CCGs population).

2.3 Identification and mitigation of clinical risk

Overall the panel felt that there was not enough detail in the documentation provided regarding the working s of the clinical model (see earlier points about staffing) to make a full assessment of clinical risk (again this may exist in other documentation or be a feature of where the programme is within their transformation timeline).

The panel did highlight two areas of clinical risk that could benefit from further detail:

- The review panel support the single point of access concept within the model but would highlight that even with a single point of access there will still be the same numbers of people waiting (i.e. the total does not reduce). This means that the programme will need to ensure that people are helped whilst they wait.

- In a 7-day service model there are likely to be times when some staff will be working with limited support (for example with less OT on duty over a weekend) and will find that they need to be able to contact a clinical colleague with a practice question. If (if this example an OT) is not available to give advice, there will need to be clarity of the contingency arrangements that will be in place (e.g. consulting a senior nurse). The programme / provider will need to understand under what circumstances this is most likely to occur (e.g. how easy would that be on a weekend community shift?) and to have a clear plan for how these challenges will be addressed (which was not clear in the documentation at this point in the process).

2.4 Further clarifications required

The panel reviewers also had the following questions on points of clarity of the following areas that were not covered in the documentation:

- Is there further information on why single sex accommodation has not yet been delivered when it has been a requirement for so long? Has a simple solution been missed e.g. one male unit and one female unit?

- Has the administrative support for the new model been considered? For a really good triage system to be effective, the administration needs to be considered as a priority. There will be a lot of referrals coming through one point and poor information exchange can lead to serious incidents.

- Further clarification on which staff will operate the triage e.g. will it be an MDT discussion or a screening by an individual professional? Many teams use an individual and often the least trained, whereas arguably the most trained people need to see the case first to quickly analyse the problem and signpost. It would be helpful to have clarification on this.

3. Summary

In summary, based solely on the documentation at this stage in the process, the review panel felt that further detail on the current provision and proposed clinical model would be required to give full clinical assurance on the proposals.

In particular this would relate to further detail on staffing numbers, WTE's and skill mix before the panel could be assured by the options presented. The panel felt that a seven-day service is well justified but more detail on how will this be staffed and what the considerations are that will need to happen to support the workforce for this model of working (especially in view of the geography of the patch and difficulty recruiting).

Having said that, the panel did not consider any of the issues raised in this review to be significant enough at this stage in the CCG's process to delay the move towards public consultation (although further independent clinical assurance of the proposals post-consultation but ahead of final decision-making would be advised).