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Lisa Pope
Deputy Chief Operating Officer
Hambleton, Richmondshire and Whitby CCG
Civic Centre
Stonecross
Northallerton
North Yorkshire
DL6 2UU

By e-mail: lisa.pope3@nhs.net

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Dear Lisa

RE: Clinical Senate review of additional documentation related to the Transforming Mental Health proposals submitted by Hambleton, Richmondshire and Whitby CCG

I am writing to you to inform you of the outcome of the review of the additional material provided by Hambleton, Richmondshire and Whitby CCG following the recent completion of the public consultation on the Transforming Mental Health proposals.

The documentation provided by the CCG has been reviewed by two representatives of the Yorkshire and Humber and Northern England Clinical Senates to see if the issues raised in the initial joint clinical senate review have been addressed prior to your decision-making process.

The clinical senate reviewers of the additional documentation were:

Catherine Wright
Allied Health Professions Lead and CAMHS Occupational Therapy and Participation Lead -Bradford District Care Foundation Trust, and
Yorkshire and Humber Clinical Senate Council Member

Dr Ester Cohen-Tovee
Director of Allied Health Professions and Psychological Services - Northumberland, Tyne and Wear NHS Foundation Trust, and
Chair, Division of Clinical Psychology, British Psychological Society
On behalf of the Northern England Clinical Senate

The additional documents considered by the senate reviewers were as follows:

- The full Public Consultation Document,
- The Post-Consultation Report, and
- The Post-Consultation Supporting Evidence Report

Having completed the review of these additional documents, the senate representatives found that many of the issues that had been raised in the initial clinical senate report have been addressed. Whilst there were some issues that were not addressed in these documents, the senate reviewers felt that overall, enough additional information had been provided for the CCG to move to the decision-making stage of the process. This view is based on the understanding however, that a clear commitment is made by the CCG and the provider to undertake further work on the issues identified in this letter during the implementation (post-decision-making) phase of the programme.

The areas where more information could be found are as follows:

- There was a much clearer alignment of national policy drivers and local health need priorities within the additional documentation.
- Greater detail on engagement of local voluntary sector providers was evident
- The reviewers were very pleased to see the additional detail on the skill-mix of the multi-disciplinary teams for older people including social work, OT and physio, dietetics and SALT.
- There was clear consideration of the proposals alongside the local Crisis Care Concordat (this was particularly well outlined in the section *"Alternative and health-based places of safety"* within the post-consultation report document).
- More detail on engagement with the Criminal Justice System could be found in the documentation (e.g. section *8.5.3 "Police partners"* in the full Public Consultation Document). The reviewers feel that this could be further expanded to include the courts and prisons however due to the increasing demand on services for people with both mental health problems and with forensic issues (current and past). The reviewers would re-state the advice in the initial senate report to engage with the local Criminal Justice Board.
- The intention to *"explore opportunities to remodel provision for people who suffer from significant physical health issues and 'organic' mental health issues"* was much welcomed by the reviewers who believe that the next step should be to clarify timescales for moving this important piece of work forward.
- There was a much clearer description of how IT will support staff within the proposed changes as outlined in the section *"Information technology; realising the benefits"* within the post-consultation report document. It would be hoped that this is developed further during implementation to show how IT can reduce the recording burdens on clinicians.

- The additional detail on Triage was very helpful (e.g. section *"Section 10.1 Triage and access to community services"* in the Public Consultation Document) although clarity is required on who will actually be doing the Triage (as opposed to it being "supported by the MDT")
- Additional detail on the current use of inpatient beds was provided in *"Section 8.3 - Current secondary mental health care provision - Inpatients"* in the Public Consultation Document.
- The additional detail on the transport arrangements in the Public Consultation Document was helpful and an assumption is made that there will be ongoing dialogue with local authorities on this issue throughout implementation and delivery.

The areas of greatest commitment to undertake further work immediately after decision-making (if it does not already exist outside of the documents provided) are as follows:

- Whilst some additional detail could be found in the documentation on how the proposals will see the delivery of NICE based interventions for IAPT and EIP services, for other adult and older adult services this is much less clear. There will be people needing help from these services with a wide range of problems for which NICE specifies evidence based psychological interventions including depression and anxiety disorders, PTSD, OCD, Eating Disorders, EUPD, Bipolar Disorder and Psychosis (out-with of EIP). The teams in the new service will need qualified psychologists and psychological therapists to deliver these interventions and to train and supervise colleagues in specific psychological skills so an undertaking that this will be given serious consideration during implementation is required.
- The initial senate report on the Transforming Mental Health proposals highlighted the need for the programme to review the evidence base for Assertive Outreach and to have ensured that expert opinion had been considered on the use of the model as a stand-alone approach. No reference to further work could be found within the additional documentation so this recommendation still stands.
- Whilst there was greater detail on the skill mix within the new teams within the document, appropriate staffing levels would need to be considered by the provider at the implementation stage of the work. The establishment of adequate WTE numbers for all staff groups will need to be ensured (e.g. within the documentation provided, the WTE numbers for dietetics and SALT appear very small).
- Greater consideration of how occupational therapists will feature in the adult community teams will be a very important consideration when implementing the new model as recovery is not just about psychological recovery (OTs can help people recover their lives). Consideration needs to be given to their input so as not to under-estimate the OT (and other AHP) resource requirements.

- How staff potentially working with limited support in a 7-day service model was raised as an important issue in the initial senate report and has not been referenced in the additional documentation. The mitigations to this will need to be considered by the provider during the implementation stage as a matter of urgency (if they have not already done so).

Other issues highlighted in the initial senate report where no further information could be found in the additional documentation that the provider will need to consider during the implementation phase are as follows:

- The intended approach for staff training and support in the new model;
- How short stay crisis management to enable a short elective planned admission could be used for some people (e.g. persons with Emotionally Unstable Personality Disorder);
- How a modern PD Pathway and Knowledge and Understanding Framework training could be used to help staff in the new model;
- How staff will be trained in suicide and self-harm to look at the pros and cons of admission in the case of suicidal behaviour;
- How the provider will support the development of a new team culture as the integration of teams which currently work in a different way takes place and
- The estate requirements of the new service (and how this fits within the whole system estate).
- As noted in the initial senate report, the reviewers were supportive of the aspiration of a Single Point of Access but recognised that this model can be undermined so anticipating issues (such as supporting people waiting for service) and addressing them early in the implementation phase is still recommended.
- In regards to the links between physical and mental health the provider will need to consider whether physical health and rehabilitation needs will be provided through an ‘out-patient’ type approach or not (as this may not work for people who need more support to engage). Consideration will also need to be given to determine what access people will have to continuing physical healthcare if their mental health deteriorates needing admission (especially if physical health providers do not provide in-reach into mental health provision).

As this review only covered the specific additional documentation submitted, it may well be that information or plans that address these issues already exists elsewhere (and was not included in the new documents available to the senate reviewers).

If the clinical senate can provide any more support to the programme during the implementation phase, or if you have any questions regarding the issues highlighted in the letter, please do not hesitate to contact me.

Regards

Ben Clark

Senate Manager
North England Clinical Senate

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Jo Poole
Senate Manager
Yorkshire and Humber Clinical Senate