South West Clinical Senate

# Stage Two Clinical Review Report

# Somerset STP's Fit for My Future Programme: Adults of Working Age Inpatient Mental Health

**11th September 2018**
**Final**

## Document Title: Stage Two Clinical Review Report: Somerset STP's Fit for My Future Programme: Adults of Working Age Inpatient Mental Health Beds

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Signed off by: Dr Sally Pearson, South West Clinical Senate Chair

# 1 Executive Summary

## 1.1 Chair's Summary

This report has been produced by the South West Clinical Senate for Somerset CCG/STP and provides recommendations following a Clinical Review Panel (CRP) that convened on 5th September 2019 to review the Somerset proposals for changes to their adult inpatient mental health beds.

This was an independent clinical review carried out to inform the NHS England stage 2 assurance checkpoint which considers whether proposals for large scale service change meet the Department of Health's 5 tests for service change prior to going ahead to public consultation, which in this case is planned for November 2019. The Clinical Senate principally considers tests 3 and 5; the evidence base for the clinical model and the 'bed test' to understand whether any significant bed closures can meet one of 3 conditions around alternative provision, treatment and bed usage.

I would like to thank the clinicians who have contributed to this review process, providing their commitment, time and advice freely. In addition, I would like to thank Somerset STP for their organisation and open discussion during the review.

The clinical advice within this report is given by external clinicians with a shared interest to the STP in developing the best services for the population, contributing through the value of peer experience and with the intention of supporting the development of clinically sound service models. This report sets out the methodology and findings of the review and is presented to Somerset STP with the offer of continued support.

**Dr Sally Pearson, Clinical Chair, South West Clinical Senate**

## 1.2 Recommendations

The Clinical Review Panel (CRP) concluded that there was consensus in supporting the proposals to move 14 inpatient mental health beds for adults of working age from the ward currently in Wells to Yeovil where two wards will be combined to address concerns around maintaining stand-alone units, and that this proposal is supported by clinical evidence and best practice.

The Clinical Review Panel also noted that there are ongoing patient and staff safety risks at the Wells unit which are being well managed and mitigated but which need to be considered when developing the implementation timeline which should be as efficient as possible.

This report draws attention to a number of observations and recommendations that may strengthen the proposal and clinical model;

1. There was consensus from the CRP to move the location of 14 beds as described in the proposal, which is supported by clinical evidence and best practice.

2. The CRP was satisfied that Taunton as a site for the combined beds had been appropriately discarded for clinical outcome reasons.

3. The CRP noted that there was a strong argument for not co-locating beds at Wells, in particular the lack of a S136 suite.

4. The CRP supported the concept of identifying and developing a supported care area if possible in the future at the Yeovil sites.

5. The CRP suggested that a refurbishment of the existing ward at Yeovil could be undertaken as soon as possible, potentially using bid monies highlighted to the panel. The development of a space to facilitate this could create an emergency decant ward and clinical space of use to the wider system. This would have the added benefit of speeding up co-location of mental health inpatient beds if and when approved so that facilities are not a rate limiting step post consultation.

6. The CRP confirmed that the bed test is not applicable for this review as there are no plans currently being proposed to reduce bed numbers. It was advised that there should be flexibility when configuring inpatient facilities, both futureproofing them for single sex use and in order to review the use of beds over time as their community model, which is not being consulted on, is developed as it may reduce pressures on beds.

7. It was noted that a lot of useful information describing the developing community mental health model had been provided and that this helped to position inpatient mental health services within a wider context of healthcare

provision. The CRP supported the outline community model making the following comments;

- It was noted that a timeline for the delivery of the community model aligned with proposed changes to inpatient services would help give confidence that pathways were joined up to prevent crisis.
- The use of recovery partners and the integration with social care were noted and encouraged.
- The panel commented that there could be greater clarity regarding the plan for an enhanced community mental health provision in the Wells area.
- It was noted that there should be greater clarity to describe the different teams in the community, in particular the crisis team which will need to be staffed to be available when people are mostly likely to present and with a clear 24/7 offer to help reduce admissions.
- An enhanced community model will be drawing from the existing workforce and this should be considered in the workforce planning for the community model implementation.
- The benefit of potential training opportunities resulting from the model should be emphasised and multi-disciplinary roles also fully described, to include the use of OT input to wards.

## 2 Background

In December 2018, Somerset finalised its Fit for My Future Case for Change which proposed changes to its community, mental health and acute setting services.

In Spring 2019, it was decided that proposals around changes to inpatient beds for adults of working age reached a point where they required assurance as part of NHS England's assurance process ahead of public consultation.

The Somerset Mental Health and Learning Disability Programme Board had reviewed current and future capacity and demand of mental health services and identified that;

- There is a growing trend of increasing non-elective and emergency attendances at hospitals by individuals with acute mental health needs.
- There is a higher rate of suicides in the county for people known to mental health services than elsewhere in the country.
- Significantly less is spent on mental health care services in Somerset than elsewhere and that for adult inpatient provision there are a number of safety concerns within current models and gaps in service provision.

In July 2016 Somerset Partnership (SomPar) Trust Board took a decision not to continue to provide standalone mental health services that were not close to general hospital sites or co-located with other mental health services. St Andrew's in Wells was, at that time, the

only standalone inpatient unit located some distance away from both general hospitals. It also experienced recruitment issues for Psychiatrists to cover the ward. To maintain staff and patient safety SomPar implemented a strict admission and transfer protocol. The consequence of these factors is that, unless a patient is low risk and well known to the clinical team, no new admissions go directly to St Andrew's which in turn places pressure on the other wards in the county.

## 3 Senate Engagement to Date

In advance of the requirement for formal clinical review via panel, the Clinical Senate undertook a desktop review of Somerset STP's case for change and draft options in June 2019. This desktop review was undertaken by a sub-panel of the CRP. The report can be found in appendix 5.

The report provided by the Clinical Senate detailed that the case for change and proposed changes were supported but that some information needed to be clarified.

**Key points noted by the panel were as follows:**

1. There is a case for change for overall improvement to mental health services in Somerset but the specific case for change to move one ward and what issues this will address is less well articulated and evidenced in the case for change document.

2. While there is evidence that stand-alone wards are not best practice and SOMPAR made a decision to not support them in 2016, it is also acknowledged in the report that the safety issues in Wells are not compelling and this does needs to be further explored or clarified. It would be particularly helpful if key statements/recommendations could refer back to the data/tables included that support them.

3. It is not clear what services are currently available, what if anything has already been implemented and what will be available in the future, particularly in relation to the community mental health offer. It would be helpful to set the options for adult inpatient beds against the context of the future of all adult mental health services including IDSS, HTT and 24/7 care which is frequently referred to and how will they differ from now as a case for changing these other services has also clearly been made. (Roadmap and maps of services would be helpful to inform the case for change.)

4. The rationale for and impacting of closing magnolia ward permanently and when this decision was made needs to be described.

4. Clinical engagement to date has not been fully covered and this would be helpful.

5. More information on workforce is required if this is a key driver for changes.

6. The clinical pathways and interdependencies with other services for each option need to be included in the options appraisal. Thought needs to be given to whether other more radical/ambitious options be explored where the critical mass of a more centralised service addresses clinical safety.

**Some of the issues raised were addressed in a presentation at the Stage 1 Assurance meeting by Somerset CCG as follows:**

- The main change being proposed is the move of one ward. There are some wider plans for community services but these don't need to be consulted on, although they provide context.
- Magnolia Dementia ward has already been closed, this has been approved by HOSC and is out of scope for the consultation.
- There has been more clinical engagement than was detailed in the documents shared and this will be referenced in their pre-consultation business case (PCBC)
- There was clarification that their admissions criteria to St Andrew's ward is to accept low risk patients only. This means incidents on St Andrews ward are few in number but there is an impact for incidents on other wards who accept the higher risk patients.
- Options for co-location of all inpatient services in one location are not considered viable but they will include this information and options appraisal in the PCBC.

## 4 The Review Process

The Clinical Senate Review Process is used across England to provide independent clinical review of large-scale service change to ensure there is a clear clinical basis underpinning any proposals for reconfiguration. Reviews are undertaken to inform the NHS England assurance process which signs off proposals for change prior to public consultation.

The Senate's CRP reviewed the final PCBC document provided by the STP to detail their proposals ahead of the panel meeting (appendix 4) and also referred to the desktop review as well as national guidance. The panel also fed in comments to the Senate which were shared with the STP in preparation for the panel meeting itself and which contributed to the key lines of enquiry (KLOEs) used to guide discussion. These supported the generic KLOEs for clinical review processes developed from a national guidance document on conducting senate reviews (appendix 8).

The Head of Senate also held a preliminary meeting with the STP team on 22nd August before hearing its proposals for change presented formally at the clinical review panel meeting on 5th September. The review meeting provided opportunity for the STP's clinical

team to present its proposals and for the panel to discuss the proposals, ask questions and raise concerns. The agenda can be found in appendix 3.

At the review panel, the Clinical Chair emphasised to the STP that the Clinical Senate regards its role as being a supportive one, with a shared aim of improving healthcare services, raising legitimate clinical concerns aimed at strengthening the clinical case for change, identifying potential gaps and ensuring that the model is as robust and well thought-out as possible through frank and open clinician to clinician discussion.

# 5 Somerset STP's Mental Health Inpatient Beds Proposal

Following a shortlisting process exploring options for the co-location of beds in order that there are no remaining stand-alone units for adult mental health inpatient beds in Somerset, the preferred option being put forward was;

1. The stand-alone unit at Wells to move all 14 of its beds to Yeovil to improve both safety and access to physical care as a preferred option to address the issue of stand-alone units. There is currently no overnight medical cover and patients go via ambulance to Yeovil DGH to access psychiatry and acute medical cover. Yeovil will co-locate two wards together as a result of the move and is within close proximity of Yeovil DGH.

This option is within the context of ongoing development of enhanced community-based mental health services including a further roll out of a dementia prevention programme* and development of the home treatment team. These developments are not subject to consultation.

* Magnolia Dementia Ward situated in Yeovil was closed in July 2017 first temporarily and then permanently in 2019 following HOSC approval. This reduced the capacity of beds for the county by 14. However, existing resources from the ward were reinvested to commission an Intensive Dementia Support Service (IDSS) to cover East Somerset.

**The STP team's intention is to go out to public consultation in November 2019.**

# 6 Panel Discussion and KLOES

## 6.1 KLOES

The CRP identified the following key areas in their pre-meet on the day that they specifically wanted to explore with the Somerset team in addition to those KLOEs included in the agenda (appendix xxx);

- Can the community model be further described?

- Why was Wells not explored further as an option for co-location of two units.
- How is staff safety being managed in the interim until a solution can be implemented?
- Does the workforce plan make appropriate use of the OT workforce?
- How will services flex to meet the needs of different categories of patients to cover age, transition and vulnerable groups?

## 6.2 Presentation

The STP Clinical and Managerial team delivered a comprehensive presentation describing how the proposed model seeks to ensure sustainable safety and quality with the significant change being the relocation of their the stand alone acute unit in Wells, (St Andrew's ward) to be adjacent to another stand-alone adult acute unit in Yeovil. Adjacent to the current Yeovil adult inpatient mental health ward is an available building, Holly Court, which would need to be refurbished for the move.

The beds on St Andrew's comprise 105 admissions per year which represents 16% of their total admissions and 23% of the bed base. Overall there are currently 4 adult inpatient mental health wards with 2 in Taunton, 1 in Wells and 1 in Yeovil. The two stand-alone wards do not exist by design but have been left isolated by other closures. They noted that the core proposal is not considered transformational and neither are the drivers financial but that changes already underway to develop wider community mental health services, and which do not need to be consulted on as they constitute enhancement of existing services, are. The drivers behind the proposals demonstrated that there is historic under investment in mental health services in Somerset, that too many people are going to A&E and there is an increasing rate of suicide, in patients both known and not known to services as well as concerns about safety and gaps in services.

The stand-alone ward in Wells has 14 beds and is an isolated unit with no other inpatient staff close by. There is psychiatric cover on-site Monday-Friday 9am-5pm but no admissions are accepted after 3pm. Out of hours cover is provided by phone by the on-call psychiatric consultant & out of hours GPs who do not have psychiatric training. The nearest Emergency Department is 45 minutes away (Royal United Hospital, Bath).

As a result, staff are dependent on police to provide support to regain control of challenging situations. There is no-one available to prescribe rapid tranquilisation out of hours or manage section 5.2 situations other than OOH GPs which is mitigated by admitting high risk patients to Taunton. Recovery from serious suicide attempts, such as serious and significant self-harm could be seriously compromised with recovery dependent on the severity of attempt & time taken for ambulances to arrive and then reach the nearest ED. There is no junior psychiatric cover and the patient experience is not as good as it could be with current interface risks. Psychiatric patients tend to have higher rates of physical health problems than the general population and as such co-location or proximity to acute services is considered beneficial. It was noted that the Yeovil ward is not on the Yeovil DGH site but across the road from it. Ambulance transfers for patients would still be needed but they would require a journey of a few minutes rather than a 45 minute transfer. The panel heard that that St Andrew's Ward has been a stand-alone for a long period of time with numerous

service reviews and mitigations put in place. This has enabled the effective management of risk on an immediate, day-to-day basis, but does not remove the chronic risk which when linked to both likelihood and impact, arguably leads to inevitability in the longer-term. The STP detailed how they had reduced a long list of 20 options down to six for detailed consideration and then down to 3 for a deliberative workshop. There are currently 62 adult inpatient mental health beds across Somerset as well as a 10 bed PICU and older people ward at the Rydon site (Taunton) and a 10 bed rehab ward at Bridgewater. Admission rates are high across the county but there have been no out of area acute placements in the last year with patients not necessarily going to a bed closest to where they live, but within county.

Although proposals for community services were not formally subject to panel review, the STP helpfully described changes to inpatient bed sites within the context of significantly expanded community mental health services under the vision of 'no wrong door' with earlier intervention to reduce reliance on crisis management to include:

- Emotional Wellbeing Service, expanded IAPT and a newly developed 'Stepping Up' service to support people at an earlier stage, reducing risk of crisis and enabling support both before significant mental ill health and in recovery and reengagement back in the community, linked with Primary Care, Social Care and VCSE services.
- Greater peer support, recovery college(s), and expanded VCSE provision
- Crisis cafes – Mendip and Bridgwater
- Core 24 psychiatric liaison
- Expanded 24/7 crisis home treatment

Overall, the data presented suggests that the current number and configuration of working age beds are appropriate to meet current demand. However, it was noted that with development underway across community mental health services in Somerset it is possible that reduced capacity will be required for inpatient beds in the future as support for patients currently requiring admission is improved in the community. It was also referenced that there may be potential funds through NHSE transformational bids to support this work which may in turn, if inpatient demand reduces, enable opportunities to develop an additional section 136 suite and 'extra care' area at Yeovil.

**Overall Observations**

The Chair praised the Somerset team for the huge improvement to the PCBC since an earlier draft had been shared with the panel, taking into account suggestions from the Clinical Senate. The Devon team and the review panel team explored the KLOEs as follows;

- It was noted that Taunton was not considered viable to host all inpatient beds due to a lack of space, the prohibitive cost and some concerns around staffing of this as well as the distance in travelling to and from the site for patients furthest away from

Taunton. It was acknowledged that both staffing and travel can also impact upon clinical outcomes for patients.

- That the current risk mitigation plans in place for managing challenging situations on St Andrew's ward has worked well but that pending support via public consultation, implementation of the proposed clinical model should not be delayed.

- It was noted that in the future, an extra care area and additional S136 suite at the Yeovil site would be desirable, although not immediately essential, given that there is no PICU on the Yeovil site. However, this would be reliant on the community model reducing inpatient demand by 4 beds which would need to be monitored and demonstrated at a future point in time before any additional changes could be implemented. The panel commented that this would need to take into account that inpatient capacity had been reported as average for the population in Somerset, alongside high utilisation and historic under investment in mental health services.

- There was some discussion around the sustainability of the proposed model set against any future changes to wider services across Somerset and that the future vision is for two vibrant acute hospitals in Taunton and Yeovil with 24/7 A&Es and full medical takes to continue.

- It was understood that the option to co-locate beds in Wells was not favoured due to the lack of access and proximity to an A&E and that this access to A&E underpinned the clinical case. The option of linking with other units across county boundaries was explored but none are close enough or have the ability to expand. It was noted that it should be made clear that the Yeovil ward is not on the Yeovil DGH site and therefore ambulance travel will still be required. However, there was consensus that the reduced transfer time and from experience, reduced wait for ambulances, would have a significant impact on safety and the patient experience and outcomes.

- Workforce was discussed by the panel and it was noted that recruitment and retention is good in Yeovil, that no redundancies were anticipated as a result of the move and that staff from Wells who do not want to work in Yeovil would have opportunities in the expanding community team. There are also no psychiatric trainees based at Wells while in Yeovil there would be better training opportunities through co-location, the proximity of the acute trust and through links to the psychiatric liaison service. It was noted that there are plans for the community mental health team in Mendip to expand their service including the HTT. The panel were also reassured that the model proposed is not dependent on retraining staff which can delay implementation. In addition to this there is anticipated benefit through having a larger team on a co-located ward for shared learning and continuing professional development.

- The panel discussed with the presenting team from Somerset how variation in need and casemix such as patients transitioning for CAMHS would be managed and how this is supported by the development of an enhanced community model. Patients are not always placed in the ward closest to their home but there is flexibility across

teams with newly appointed peer support workers linking in before, during and after discharge. Strong links demonstrated with social care were praised, noting that through co-location of services social care would be able to be more involved and intervene earlier. The panel encouraged the principle that equality is delivered by the ability to adjust services to need. It was noted that a timeline for the delivery of the community model aligned with proposed changes to inpatient services would help give confidence that pathways were joined up to prevent crisis.

- There was some concern that there is not currently a 24/7 HTT although it is anticipated that this will be delivered through funding and supported by the development of two crisis cafes. However there is no crisis house or overnight provision for crisis and the difference between the crisis offer and the HTT should be distinguished rather than the HTT becoming a crisis team by default. An out of hours mobile workforce is needed to address crisis management which in turn could prevent short term admissions resulting from inadequate crisis coverage.

## 7 Conclusion

The Clinical Review Panel support the proposal to move 14 adult inpatient mental health beds from Wells to Yeovil for the co-location of two wards. Pending consultation approval, a swift timeline for this is encouraged. Whilst not part of the proposal for consultation and therefore not explored in depth, the proposals for ongoing development of community mental health services were praised and encouraged, noting that these may impact on inpatient demand in the future.

## 8 Next Steps

The summary recommendations were shared verbally with the STP at the end of the panel meeting. This report will be shared in draft version with the STP for fact checking and with the CRP prior to sign off by the Senate Council.

## 9 Reporting Arrangements

The CRP team will report to the Clinical Senate Council which will agree this final report and be accountable for the advice contained therein. The report will be shared with the STP and NHS England Assurance Team. Somerset STP will own the report and be expected to make it publicly available via its governing body or otherwise after which point it will also become available on the Clinical Senate website.

## 10 Appendices

### 10.1 The Somerset STP Presenting Team

| | |
|---|---|
| | **Title, organisation** |

| Name | |
|---|---|
| Alex Murray | Clinical lead, Somerset STP |
| Maria Heard | Programme Director, Fit for My Future Programme, Somerset CCG |
| Peter Bagshaw | Clinical Lead Mental Health, Somerset CCG |
| Tim Baverstock | Strategic Manager Commissioning (Adult Social Care), Somerset County Council |
| Neil Jackson | Deputy Service Director, Mental Health and LD, Somerset Partnership NHS Foundation Trust |
| Sarah Oke | Medical Director, Adult Mental Health, Somerset Partnership NHS Foundation Trust |
| Jess Popham | Operational Service Manager, Home Treatment, Somerset Partnership NHS Foundation Trust |
| Jenny Walton | Ward Manager, St Andrews, Somerset Partnership NHS Foundation Trust |
| Jane Yeandle | Service Director, Mental Health & LD, Somerset Partnership NHS Foundation Trust |

## 10.2 The Review Panel

The review panel comprised members of the Clinical Senate Council, Assembly and clinicians brought in specifically for this panel.

| Panel Role | Name | Title |
|---|---|---|
| Chair | Sally Pearson | Clinical Chair, South West Clinical Senate |
| Vice Chair | David Halpin | Clinical Vice Chair, South West Clinical Senate |
| Secondary Care Mental Health | Paul Winterbottom | Consultant Learning Difficulties Psychiatrist |
| Mental Health Network | David Soodeen | Mental Health lead SW Clinical Network |
| GP | Anita Pearson | Clinical lead, NEW Devon CCG Clinical lead |
| Allied Health Professional | Jane Mitchell | AHP (Allied Health Professional), Cornwall Partnership Foundation Trust |
| Community Health Nursing | Debbie Gall | Adult Home Team Manager, Dudley and Walsall Mental Health Partnership NHS Trust |

| | | |
|---|---|---|
| Social Care | Sharon O'Reilly | General Manager for Older Persons Mental Health (OPMH), Devon Partnership Trust |
| Secondary Care | Tara Fleming | Consultant, Care of the Elderly, Musgrove Park Hospital, Taunton* |
| Patient/citizen representation | Nick Pennell | Chair, Healthwatch Plymouth |
| Patient/citizen representation | Jon McLeavy | Healthwatch, Cornwall |
| Managerial Lead | Ellie Devine | Head of South West Clinical Senate |

Review panel biographies are available upon request.

*COI declared (in area clinician)

**The following appendices are available by email upon request.**

## 10.3 Clinical Review Panel Agenda (includes KLOEs)

## 10.4 Pre-Consultation Business Case

## 10.5 Desktop Review Report

## 10.6 STP Slides

## 10.7 Terms of Reference for Clinical Review Panel