

**Report to the NHS Somerset Clinical Commissioning Group on 16 January 2020**

<b>Title: Fit for my Future: Proposals for Changing Acute Inpatient Mental Health Services for Adults of Working Age</b>	<b>Enclosure C</b>
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**SUMMARY AND PURPOSE OF PAPER**

The purpose of this paper is to seek approval from the Governing Body to begin consultation on the reconfiguration of acute mental health inpatient services for adults of working age.

The proposal is supported by a suite of documents (including numerous appendices) including the following.

- The Pre-Consultation Business Case, and its appendices, (including the Case For Change, Quality and Equality Impact Assessments, stakeholder deliberative workshop final report and consultation strategy)
- The proposed Public Consultation Documentation

These documents and or their contents have been long in their development and have been subject to numerous levels of scrutiny and refinement including review and feedback/approval from a range of boards including the following:

- The Mental Health and Learning Disabilities Programme Delivery Board
- The Fit For My Future Programme Board
- The Somerset CCG Clinical Executive Committee (CEC)
- The Scrutiny for Policies, Adults and Health Committee
- The Health and Wellbeing Board
- Somerset Partnership NHS Foundation Trust Board
- The South West Clinical Senate
- The NHS England and Improvement (NHSE/I) Assurance Process.

We are consulting on the proposal to move the St Andrews acute mental health ward from its current location at Wells to Yeovil where it will be co-located with another mental health ward.

The change we are proposing will not see a reduction in beds. The primary drivers for the proposed changes relate to improving quality and patient and staff safety, not financial.

## Our changes are set in the context of investment to strengthen our mental health services

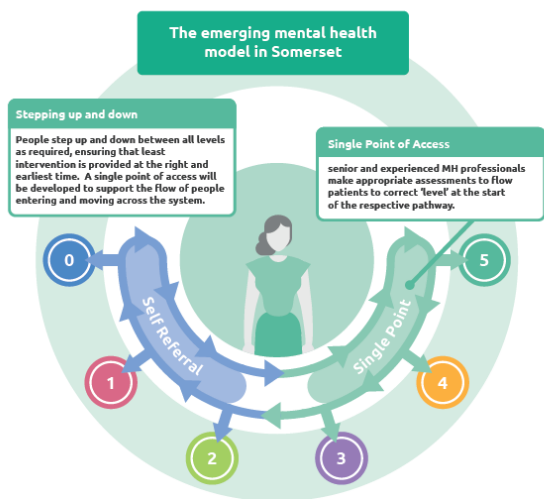
There has been a history of under-investment in Somerset’s mental health services and we are determined to redress the balance and place equal value on the importance of physical and mental health services. We are increasing our investment in mental health, so we can develop a more complete service with a stronger focus on prevention and early help to keep people well wherever possible, and to provide the best care in the right settings for those who become unwell.

People who have used mental health services in the past or are using them now have helped us shape our new model of care; they have told us that we need to make it easier for them to access our service, and to reach a whole system of support through just one referral.

Our overall vision for mental health, and the new mental health model, is innovative. We are enhancing, and investing in, services that are already there, introducing new ones closer to where people live, and making them wholly accessible at every step of the way.

Our new model is shown below.

Long term conditions, including frailty, are health conditions that can't at present be cured but can be controlled by medication and other treatment or therapies.



What does each levels means?

<b>Offer 0</b>	Building and supporting inclusive communities, understanding what makes people ill, tackling social issues leading to health inequalities eg life expectancy.	<b>Thriving</b>
<b>Promoting positive mental and emotional wellbeing</b>		

<b>Offer 1</b>	Community based support including social and leisure activities that promote emotional wellbeing, often provided by people who have experience of mental health issues.	<b>Coping</b>
<b>Emotional Wellbeing Support</b>		

<b>Offer 2</b>	Improving access to psychological (talking) therapies for anxiety and depression including the use of digital technology. Supporting people with long term conditions and symptom management to meet physical and mental health needs.	<b>Getting help</b>
<b>Timely support and early intervention</b>		

<b>Offer 3</b>	Additional support for people with more complex needs eg experience of previous trauma, who would benefit from specialist talking therapies.	<b>Getting help</b>
<b>Specialist Therapies Service</b>		

<b>Offer 4</b>	Specialist recovery-focused multi-disciplinary mental health support for people with higher level mental health needs including psychosis, severe depression and personality disorders.	<b>Getting more help</b>
<b>Community Services</b>		

<b>Offer 5</b>	Crisis and urgent care support to avoid admissions to hospital eg Crisis Cafes and Home Treatment Teams. Inpatient beds for those who require support in a hospital setting.	<b>Risk Support</b>
<b>Acute/Urgent Care including Home Treatment and inpatient beds</b>		

The new model will bring a number of benefits and service improvements:

- ✓ Recognition of the importance of prevention and the promotion of emotional wellbeing
- ✓ Early intervention services to provide support at the first sign of symptoms will be expanded and provided in partnership with voluntary and community organisations to provide more support, much earlier
- ✓ People will be able to self-refer through a Single Point of Access; and the new early intervention services will support self-directed care
- ✓ Getting it right first time; the Single Point of Access will be led by experienced senior mental health clinicians and social care professionals; they will help people get to the correct 'specialist' level at the start of the respective 'pathway'

We are investing more money in mental health services and agreed in early 2019 that we would invest an additional £5m to enhance our mental health services. In addition, in recognition of the work we are doing, we have been awarded additional funding from NHS England to invest in our mental health services over a three year period:

Domain	2019/20	2020/21	2021/22
C&YP Trailblazer	£426,723	£714,150	£758,609
CMHS Trailblazer	£2,815,923	£3,997,705	£3,997,705
Psychiatric Liaison	£659,941	£985,225	£985,225
Home Treatment	£568,394	£568,394	£568,394
<b>Total Additional Funding</b>	<b>£4,470,981</b>	<b>£6,265,474</b>	<b>£6,309,933</b>
<b>Total Additional Funding over the next three years £17,046,388.15</b>			

## REASONS FOR CHANGING OUR CURRENT CONFIGURATION OF SERVICES

The central issue under deliberation has been how to provide the optimal inpatient care for those who require treatment for an acute psychiatric episode. We currently have four wards providing acute inpatient mental health care for adults of working age; Rydon 1 and 2 in Taunton (adjacent to other mental health wards), Rowan ward in Yeovil and St Andrews ward in Wells. Two of our four wards for adults of working age in Somerset are 'standalone' wards, meaning that there is not an adjacent mental health ward where support can be drawn upon at times of need. These wards are St Andrews in Wells and Rowan in Yeovil. In addition, St Andrews ward in Wells is a long way from the nearest emergency department – 45 minutes from St Andrews ward to Royal United Hospital in Bath, compared with several minutes journey time from services located in Yeovil and Taunton, and has limited out of hours support.

The key concerns we have are summarised as follows:

### Lack of local support

Having single wards can cause problems with safe staffing and management of patient risk. When two wards are close to each other, staff from one ward can provide support to the other whenever there is a problem. When there is only one ward, staff have no

immediate back-up and have to resort to calling the police or an ambulance. This is the case in St Andrews ward in Wells and Rowan ward in Yeovil.

### **Distance from an emergency department**

Inpatients in an acute mental health ward will at times require acute medical support following harm to themselves or others in addition to routine medical care, therefore distance from an Emergency Department is important and can impact on the outcome of treatment due to the time taken to reach the appropriate service. Wells is 22 miles away from the nearest District General Hospital and it can take 45 minutes to reach hospital by ambulance. In comparison, Yeovil and Taunton are several minutes away from the nearest Emergency Department.

### **Out of hours medical cover**

Specialist mental health and medical cover is inconsistent across our three sites. On Rowan ward, Yeovil and Rydon wards 1 and 2, Taunton, onsite cover is provided round the clock by junior doctors and consultants. On St Andrews ward, Wells, mental health specialist cover is available Monday to Friday from 9am – 5pm; out of hours cover is provided by a GP and out of hours mental health support is available from the on-call psychiatrist by phone.

## **OUR OPTIONS TO ADDRESS THE CONCERNS**

We worked with stakeholders from across our system to identify options which addressed these concerns. This included Somerset Partnership NHS Foundation Trust (our service provider of inpatient beds) along with colleagues from the Voluntary, Community and Social Enterprise partners, all of whom represented their service users.

A range of options were identified as potential solutions to address the issue and an iterative process was adopted moving from a long list of options, to a short list, to three options. These were:

### **Option 1 – Stay the same**

- Retain wards where they are with the same functions, bed numbers and invest in the buildings where needed to bring them up to modern expectations of inpatient services

### **Option 2 – Relocate Wells service to Yeovil**

- Move St Andrews ward, Wells and create two wards using existing ward space at Rowan/Holly Court. This would require some refurbishment to enable the change

### **Option 3 – Relocate Yeovil service to Wells**

- Move Rowan ward, Yeovil and create two wards, refurbishing or rebuilding the existing Phoenix ward

Working with Participate, who have a great deal of expertise in the field of consultation and engagement on health and care services, a group of stakeholders representing people with lived experience of mental health, carers, voluntary sector, acute mental health inpatient services and primary care spent a day assessing and debating the three options and the evidence on each of the assessment criteria. They were asked to give their own personal view on the performance of each option against the criteria and the degree to which each option did not meet the criteria, was a good fit or exceeded it.

Overall, the stakeholders who attended the workshop expressed a strong preference to Option 2 – to relocate Wells service to Yeovil.

We propose that we consult with the public on a preferred option of all fourteen beds in St Andrews ward, Wells to be relocated to Yeovil alongside the existing Rowan ward.

## **THE REASON WHY OPTION 2 IS OUR PREFERRED OPTION**

Option 2 is our preferred option because:

### **Quality of care – outcomes and safety**

- It's close to the Emergency Department at Yeovil District Hospital, compared to St Andrews Ward in Wells which is 22 miles or 45 minutes away from the nearest Emergency Department at Bath Royal United Hospital
- A risk management protocol is required for Wells which results in around 40 patients a year having to be admitted first to Taunton and then to Wells. Some of the highest risk patients remain at Taunton due to its proximity to an Emergency Department. Even if two wards were to be located at Wells instead of Yeovil, a very small number of patients with high risk of self-harm may still need to be retained at Taunton due to Wells' distance from an Emergency Department

### **Travel time for patients, their carers and visitors**

Calculations of the time for people to get from home to either Wells or Yeovil show an increase in journey times compared to journey times were wards on all three locations to remain open.

Moving the service from Wells to Yeovil is marginally better for most people. Analysing the real experience of patients who used the services at Wells and Yeovil during 2018/19, it's clear that some patients would have a longer journey by private transport if beds were to be moved either to Wells or Yeovil:

- **Moving beds from Wells to Yeovil:** On average, a person previously admitted to Wells would face a longer journey of an extra 6 minutes if they had to go to Yeovil instead; 77 patients in all would have a longer journey time, 28 of them with an increase of more than 20 minutes
- **Moving beds from Yeovil to Wells:** On average, a person previously admitted to Yeovil would face a longer journey of an extra 7 minutes if they had to go to Wells.

145 of them in all would be affected, 111 of them with a journey increase of more than 20 minutes

Calculations of the time for the people who used the service during 2018/19 to get from home to either Wells or Yeovil by public transport on a weekday afternoon show that around 36% of the patients could do the journey to each in less than 60 minutes.

### **Workforce sustainability**

Lack of medical training accreditation at St Andrews ward in Wells creates challenges for recruitment and retention of medical staff, including both the inability to employ junior doctors and retain consultant staff. This means it has not been possible to provide out of hours medical cover, and patients cannot be admitted to Wells after 3pm Monday to Friday. Yeovil already has training accreditation and junior doctors are on site to support admissions and assessments 24 hours a day.

### **Impact on equalities**

Patient engagement and operational staff from Somerset Partnership looked at the potential impact of the options on equalities but did not find any factors which appeared to differentiate between the move of beds to Yeovil or to Wells.

### **Deliverability**

The work required to create two wards at Yeovil would take eighteen months to deliver compared to two years for the work to be completed on the Wells site.

### **Affordability and value for money**

The capital investment cost (bricks and mortar) of moving beds to Yeovil would be significantly less at £5,030,000 than moving beds to Wells, where the capital cost would be £7,166,000. The day to day running costs – the revenue budget requirement – is around £250,000 less for Yeovil than for Wells.

## **THE POTENTIAL IMPACT OF WHAT WE'RE PROPOSING**

### **In Yeovil**

The existing Rowan Ward on the Yeovil site has 18 beds. If the proposal to move beds from Wells were to go ahead there would be 32 acute mental health inpatient beds for adults of working age in Yeovil. Some rebuilding and refurbishment of the old Holly Court ward and the existing Rowan Ward would create two equal sized wards of 16 beds each, both of which would include a bed designated as extra care which would provide a further enhancement to the existing provision. This would mean there would be no changes in the overall number of beds.

### **For people in the north of the county**

Investment in the emerging model of mental health will bring about a significant increase in the capacity of staff across the whole county, and in the skill mix of both our home

treatment teams and our community based mental health teams. This includes the Mendip and Sedgemoor areas where a particular focus will be adopted to enhance the support in the community to avoid hospital admissions.

Specific to these two areas, we will also be developing two Crisis Cafes (current proposals are for these to be located in Well and Bridgwater), enabling people experiencing emotional and / or mental health distress to have access to a safe space where they can speak freely about their experiences at times of greatest need. The Crisis Cafes will provide significant support for people at and just before they reach crisis points which would otherwise result in an admission to hospital. The cafes will be open at times of peak need and will be developed in partnership with the voluntary sector, specialist mental health services and people who have experience of receiving support.

We have developed partnership and joint-working arrangements with a very wide range of voluntary and social enterprise providers in the county. This has already made a significant difference to the level of support we're able to provide across the whole county including the Mendip and Sedgemoor areas.

## **ASSURANCE OF OUR PROPOSALS**

Our proposals have been assured by NHSE/I against the national guidance for service change.

- The South West Clinical Senate has considered the Case for Change and held a Clinical Review Panel (CRP) that convened on 5th September 2019 to review the proposals for change. The panel formed an independent clinical review to inform the NHS England Stage 2 assurance checkpoint. The Clinical Senate Panel supported the proposal to move the location of 14 beds as described, which is supported by clinical evidence and best practice
- The NHSE/I Assurance process for service reconfiguration has consisted of two checkpoints; a stage 1 strategic sense check and a stage 2 assurance checkpoint. Stage 2 took place on 21st October 2019 and comprised a formal, detailed exploration of the service change being proposed. Following presentation of the draft PCBC and consultation documentation, NHSE/I provided feedback particularly around the consultation document and this feedback has been incorporated. We have received confirmation of Regional Director assurance to proceed with our proposals.

## **Recommendations and next steps**

**The Governing Body are requested to:**

- *Approve* the attached documentation, including
  - The Mental Health Pre-Consultation Business Case and appendices
  - The Public Consultation Documentation
- *Approve* the recommendation that the views of the public should be sought through a formal consultation process on the proposal within the Pre Consultation Business Case to move the acute mental health ward currently at Wells to Yeovil. Following

a formal report on the consultation process the Governing Body will make a decision on the proposal taking account of the feedback received.

- *Note* the contents and the full range of activities to date detailed in the supporting documentation
- *Note* the positive feedback from the recent South West Clinical Senate and the NHSE/I Assurance Meeting regarding the proposals and their support for them

**Impact Assessments – key issues identified**

<b>Equality</b>	Included in the documentation. No negative impacts on any of the groups with protected characteristics have been identified			
<b>Quality</b>	Included in the documentation. Overall there will be a positive impact on the quality of support provided to those admitted to the relocated and refurbished wards.			
<b>Privacy</b>	The refurbished wards will be fully compliant with the required regulations in relation to privacy and dignity and will be an enhancement on the current provision.			
<b>Engagement</b>	See documentation: engagement has been undertaken but now full formal public consultation is required and recommended to progress this issue.			
<b>Financial / Resource</b>	See documentation. The proposals are fully costed and have been subject to the appropriate levels of scrutiny.			
<b>Governance or Legal</b>	If the proposed option is to be pursued there is a legal requirement to formally consult the public prior to a definitive decision is made by the Governing Body.			
<b>Risk Description</b>	See attached risk assessment in documentation.			
<b>Risk Rating</b>	Consequence	Likelihood	RAG Rating	GBAF Ref



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## LIST OF APPENDICES

(Appendix files are attached separately to this document)

- Appendix 1 - You Said We Listened phase 1.pdf
- Appendix 2 - Assessment criteria views Apr19.pdf
- Appendix 3 -MH Case for Change v17.doc
- Appendix 4 - Longlist evidence v0.10.docx
- Appendix 5 – Shortlist evidence presented to MH stakeholder panel event
- Appendix 6 - Stakeholder Panel 12th July.pdf
- Appendix 7 - Stakeholder Panel 31st July.pdf
- Appendix 8 - MH PCBC Quality Equality Impact EIA Assessment 1.4.xlsx
- Appendix 9 - Mental Health Consultation Strategy.docx
- Appendix 10 - Mental Health Operational Consultation Plan Final 2
- Appendix 11 – Designed MH Consultation Document A4 v08a.pdf
- Appendix 12 - 18.09.19 DRAFT Somerset LTP Workforce Narrative 2019.pptx
- Appendix 13 - FFMF Mental Health PCBC Feedback and Response Tracker 1.2.docx
- Appendix 14 - Somerset MH Stage 2 Clinical Review Report September 2019 FINAL.pdf
- Appendix 15 - FFMF MH Stakeholder Event Slides final.pptx
- Appendix 16 – Designed MH Consultation A4 Questionnaire v06a.pdf

## EXECUTIVE SUMMARY

### INTRODUCTION

The purpose of this Pre Consultation Business Case (PCBC) is to seek approval from the Somerset CCG Governing Body to begin public consultation on proposals to reconfigure acute mental health inpatient services for adults of working age (AWA).

The proposals have been developed as part of the Fit for My Future (FfMF) programme. This programme is supported by Somerset County Council, Somerset CCG and the main local NHS providers. We are developing and implementing a strategy for how we will support the health and wellbeing of all the people of Somerset by changing the way we commission and deliver health and care services.

The mental health proposals addressed within this PCBC have been developed with substantial engagement of local clinicians, staff working in services, patients, voluntary and community based organisations and the public.

### OUR VISION FOR MENTAL HEALTH SERVICES

Our vision is that future mental health support will wherever possible be:

- Co-produced with and focused on the person concerned, building on their strengths not merely their needs
- Dedicated to maximising each person's ability to 'thrive' in their life
- Provided by a range of agencies including the Voluntary, Community and Social Enterprise organisations (VCSE), peer support, primary care, social care and specialist mental health providers
- Delivered closer to home rooted in community neighbourhood settings, tapping into the person's own network of support (and where necessary helping them develop such a network)
- Accessible with an attitude of no 'wrong' door to gain support – where necessary navigators will ensure people are guided to the right place
- Provided at a level appropriate to the person's level of need: getting it right first time at the lowest level of support required, dissolving the boundaries between health and social care, as well as primary and secondary mental health care
- Holistic, with an equal commitment to meeting the physical and mental and emotional healthcare needs of those receiving support, with a view to closing the health inequalities gap in terms of life expectancy for people with a severe mental health condition

## CURRENT SERVICES AND ACTIVITY

A wide range of health and care community based services are provided across the county by the NHS, Somerset County Council and a number of other organisations.

However, the focus of this PCBC is on inpatient mental health services for adults of working age who require inpatient support. These services are provided at three locations as set out in the table below, which also shows the activity in each ward over an 18 month period, and the home locations of patients using the wards.

**Table 1 : Inpatient wards for Adults of Working Age and their activity (admissions) – November 2017 to March 2019**

Geographical area	Inpatient admissions by site			
	Rowan ward (Yeovil)	Rydon wards (Taunton)	St Andrews (Wells)	All admissions
Mendip	66	38	188	<b>292</b>
Sedgemoor	23	152	23	<b>198</b>
South Somerset	231	42	34	<b>307</b>
Somerset West and Taunton	24	320	16	<b>360</b>
Other ( Out of Area)	12	77	15	<b>104</b>
Unknown	24	64	23	<b>111</b>
<b>Grand Total</b>	<b>380</b>	<b>693</b>	<b>299</b>	<b>1372</b>

## THE CASE FOR CHANGE

### Quality case for change

There is a generally recognised need to enhance the quality of our mental health provision. Services have faced years of relative underinvestment and there are significant gaps in provision. Community based services in particular do not have sufficient capacity to deal effectively with patient demand. We also recognise that we need to do far more to integrate our services. Despite the overall financial position of the health and care system in Somerset the CCG has therefore agreed to provide substantial additional investment to address capacity gaps and improve quality. The main quality concerns in relation to these services are driven by the fact that we have 4 inpatient wards spread over three locations (two at Taunton, one at Wells and one at Yeovil.) The Wells and Yeovil wards are effectively “standalone”, and the Wells ward is also a long way from the nearest Emergency Department (ED).

- Single wards on one site cause problems in providing safe staffing and ensuring that patient risks can be managed effectively. Sites with two wards allow staff to call colleagues for backup whenever there is a problem. Staff on single wards have no immediate backup and may have to rely on calling the police or an ambulance. This issue applies for both Yeovil and Wells
- A mental health inpatient ward that is a significant distance away from an acute hospital with an ED can face problems in getting urgent medical care; this is a risk when patients attempt

suicide or self-harm. This issue applies to Wells which is 22 miles from the nearest District General Hospital

- We cannot provide 24/7 medical cover at three locations at the same time. Medical cover is not available at Wells out of hours (overnight and at weekends)
- The distance from EDs is a risk factor and whilst the probability of needing access to an ED is low, the potential impact is very high. In this document we have shown recent examples where not being close to an ED has created significant additional risk factors in the management of patients on St Andrew’s Ward in .

A risk management approach has been adopted to mitigate these risks. However, it cannot fully address them; several patients are admitted to Taunton each year for their initial assessment and treatment and only being moved to Wells when their risk level is clearly understood. Having to be admitted to two different locations within a short period provides a worse patient experience and will disrupt continuity of care.

The consultant medical staff responsible for all mental health inpatient services for adults of working age have expressed the unanimous view that the current situation is unsatisfactory, particularly in relation to Wells which is both a long way from an ED and is a standalone ward.

### *Capacity case for change*

This PCBC reviews the anticipated demand for inpatient care in the future, taking account of the number of factors. The summary conclusions on each are set out below, however we believe we have the right number of beds for now.

**Table 2 : Summary of demand and capacity case for change**

Factor	Impact on inpatient capacity assessment
Benchmarking against other mental health services	Our numbers of beds per thousand of population is just above the average for England
Somerset has a high rate of admissions; relatively short length of stay; and a relatively high number of readmissions. Occupancy levels are higher than is desirable	<p>We are investing in our community services to reduce levels of admissions, and readmissions. While we will have to audit the effectiveness of the investment to ensure it has the anticipated effect, we believe that:</p> <ul style="list-style-type: none"> <li>• as a minimum it will be more than sufficient to ensure that occupancy levels within the current capacity can be lowered with a resulting quality improvement</li> <li>• this will be sufficient to enable us to operate with a slightly smaller number of beds than now. which we will continue to assess as our community model is implemented</li> </ul>

Factor	Impact on inpatient capacity assessment
Demographic change and demand is likely to be static.	The population of adults of working age will reduce by a small amount (just over 1%) over the next ten years. This reduction is too small to have a significant impact on the beds we require
<b>Overall conclusion</b>	<b>Options should be able to deliver a maximum potential requirement of 62 beds. Long term bed numbers to be reviewed based on audit of the impact of investment in community based provision upon the requirement for admission.</b>

### Financial case for change

The Somerset health system currently has a large financial deficit. It aims to deliver £20m savings in the financial year 2019/20 but even if this is achieved our overall deficit will be around £41m.

As with the rest of the country we also has a history of underinvestment in mental health services in recent years. However, The Somerset system spends significantly less per head of population on mental health services than the average CCG in England (we would need to spend an additional £10.7m per annum to be average).

Despite the major financial challenges identified for health services as a whole the Somerset health and care system has decided to commit significant additional investment into mental health to start the process of tackling this underinvestment. This is detailed within this PCBC and supports the proposals for enhancing the future model of care.

### FUTURE MODEL OF CARE

Our future model of care is designed to ensure we support people more effectively at the early stages of the pathway with prevention and early intervention, and with far more integrated services. It will deliver:

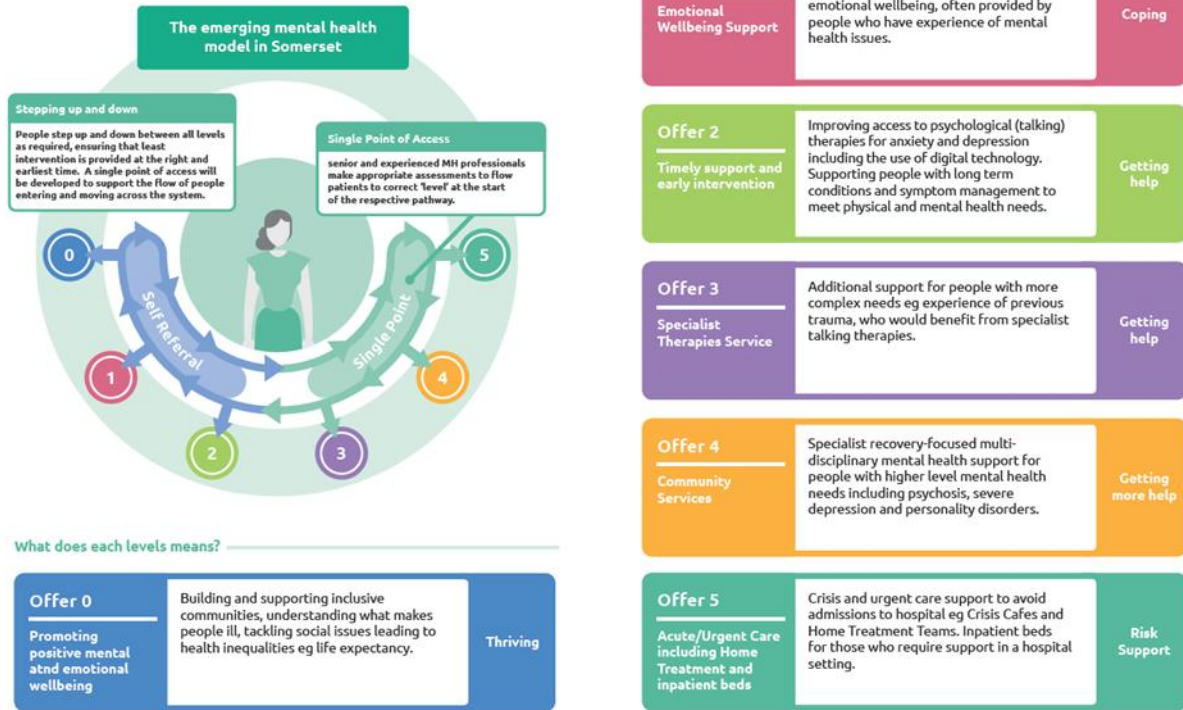
- A single point of access into the system
- A service where people do not “fall between the gaps”
- Increased investment across the spectrum of care

One of the key changes to the mode of delivery is the appointment of eight Recovery Partners, (people with lived experience of mental health problems), to work in each team alongside existing team members in the delivery of care and treatment.

The proposed model is summarised in the diagram below.

**Figure 1 : Our new model of care**

Long term conditions, including frailty, are health conditions that can't at present be cured but can be controlled by medication and other treatment or therapies.



## OPTION APPRAISAL

### Developing a shortlist of options

An initial longlist of potential options that could address the case for change was developed by the programme team. High level evidence was collected to assess the performance of the longlist options against the agreed assessment criteria. After advice from the Mental Health and Learning Disabilities Programme Board the FfMF Programme Board determined an option shortlist.

Three of the six options on the long list were shortlisted. Three were discounted due to poor performance against key criteria including capital cost, deliverability, access and travel time.

The shortlisted options were as follows:

**Option 1** *Do Minimum* – retain current configuration, including ward locations, functions & bed numbers

**Option 2** *Two ward service at Yeovil* – use existing ward space at Rowan and adjacent Holly Court; relocate from the ward at Wells

**Option 3** *Two ward service at Wells* – refurbish two wards at Wells to enable the change

### Assessment of shortlisted options

Information on the relative performance of the shortlisted options against the agreed FfMF criteria was collated and assessed. In each case the assessment focussed on the factors that differentiated between options. The options were also considered at a stakeholder workshop including service users, members of the public, GPs, staff from current services and from voluntary and community sector organisations. Their views were taken into account in the conclusions outlined below.

### *Preferred option*

After detailed consideration, Option 2 (to create two wards in Yeovil and relocate from Wells) has been identified as the clear preferred option. It performs best by a considerable margin on quality of care/safety. It also provides the safest environment for patients, and the best opportunity for good outcomes. On affordability and value for money of ongoing running costs, Option 2 is also the best option by a significant margin.

There are no criteria on which Option 3 (to create two wards in Wells and relocate Yeovil) performs better than Option 2. Option 3 does provide adjacency support to both wards, however the distance from an ED would compromise the quality and safety for each ward.

While Option 1 performs better than Option 2 in terms of travel times, this is more than outweighed by the poor performance of Option 1 against the other main criteria. Option 1 does not sufficiently address the relative isolation of the unit in terms of adjacent support and distance from an ED.

It is concluded that Option 2 (which involves moving inpatient services from Wells to the Yeovil site, adjacent to the current Rowan Ward) should be taken forward to public consultation as a proposal. There are no changes proposed to the overall number of beds; in our proposal, there will be 32 beds across two 16 bedded wards, which will include two designated as extra care beds, plus the existing s136 suite.

## **ENGAGEMENT AND CONSULTATION**

### *Our commitment*

Our principles for communications and engagement, which reflect those of Somerset CCG, have been:

- Openness and Transparency
- Effective and meaningful engagement
- Ensuring equality
- Ensuring accessibility
- Clinical input on engagement and full consideration of patient views



- You said, we did – we will respond to key feedback messages and take full account of them
- Fully informing and engaging staff

### *Clinical engagement*

The proposed way forward from this PCBC has been developed with strong clinical engagement including GP commissioners, the wider GP body, consultant psychiatrists leading inpatient services, other staff supporting inpatient services staff providing support in the community, and wider system partners.

### *How we have engaged so far with patients and the public and other stakeholders*

We have undertaken substantial engagement on the key issues in this business case. The engagement has included the following elements:

- **Early engagement on the case for change and emerging proposals for health and care in Somerset.** An extensive engagement process took place in the autumn of 2018 on our whole system proposals including those for mental health services. The feedback from this work has directly informed the ongoing work of all elements of the Fit for My Future programme
- **Engagement on the criteria for option appraisal.** We carried out three focus groups with staff, service users and the general public to help us consider what criteria we should use in our option appraisal
- **Participation in the option appraisal.** An independently facilitated and documented workshop was held on July 12<sup>th</sup> at which our proposed options were discussed and participants fed in their views on their merits and disadvantages. Attendees included patient and carer representatives, staff from the service area, local mental health organisations, and a GP
- **Participation in designing our approach to public consultation.** On 31<sup>st</sup> July a group of people drawn from the same July 12<sup>th</sup> reference group came together to share their thoughts on the framework for consultation and the stakeholders with whom to consult
- **Regular communication with Somerset County Council's Adult & Health Overview and Scrutiny Committee and Health and Wellbeing Board.** We have regularly attended Somerset County Council's HOSC to keep members apprised of progress on the Fit for my Future programme. On 11<sup>th</sup> September 2019 we reported on the output of the two workshops mentioned above and the next steps. On 2 October we reported further in closed session on the detail of this business case and our consultation proposals

### *Proposed strategy for public consultation*

NHS Somerset CCG has been working with independent engagement and consultation specialists, Participate, to develop a strategy to consult with stakeholders and the public. We also had the involvement of a stakeholder panel who met at the end of July to discuss who we should consult

with and how. Our aim has been to create meaningful engagement with local people and stakeholders to involve them in deliberations about the future configuration of acute inpatient mental health services for adults of working age. Our aims in the consultation are:

- To describe and explain the options, including our preferred option, for acute inpatient mental health beds for adults of working age
- To ensure service users, carers, public and key stakeholders who have an interest in mental health are fully able to be involved in the consultation
- To provide a meaningful and transparent process in which the feedback from those involved in the consultation will help to shape decision making about the future configuration of the service

The strategy sets out how we will maximise the reach of the consultation and includes the following key elements:

- Wide distribution of consultation documentation and survey forms
- Significant use of digital media to communicate information and obtain feedback
- A range of focus group and public events (including attending existing meetings and groups)
- Working with mental health and third sector organisations, GP practices, mental health staff, and Healthwatch to raise awareness of the consultation
- Liaison with the Somerset County Council Adults and Health Overview Scrutiny Committee and with District, Town and Parish Councils

## ASSURANCE

### *The key tests*

The PCBC demonstrates our compliance with the key service change “tests” as set out below.

- ***Strong public and patient engagement;*** demonstrated in section 9
- ***Consistency with current and prospective need for patient choice;*** demonstrated in section 10.1
- ***A clear clinical evidence base;*** demonstrated in sections 6.1.2 and 8.3.1
- ***Support for proposals from clinical commissioners***
- ***Proposals for hospital bed closures should meet specific preconditions*** - The proposal does not reduce the number of inpatient beds and therefore this assurance test does not apply.

South West Clinical Senate and NSHE/I Assurance processes have considered the Case for Change and the proposals for change in this document. The Clinical Senate panel supported the proposal to move the location of 14 beds as described, which is supported by clinical evidence and best practice, and confirmed that the bed test is not applicable for this review as there are no plans currently being proposed to reduce bed numbers.

The NHSE/I Assurance process for service reconfiguration has enabled the regional team to provide broad assurance against the four key tests of service change and the NHS England Beds test and the proposed consultation.

### *Quality impact assessment and equalities impact assessment*

From a quality perspective it is considered that this option would bring about a small positive impact overall, across each of the quality criteria of Patient Safety, Effectiveness, Systems and Patient Experience. No negative impacts of the option were identified.

From an equality perspective it is considered that this option would bring about a small positive impact overall with no negative impact being identified across equality criteria of Age, Disability, Gender Reassignment, Marriage & Civil Partnership, Pregnancy & Maternity, Race, Religion or Belief, Sex, Sexual Orientation, Human Rights and Other Groups [See appendix 8].

### *Programme Governance*

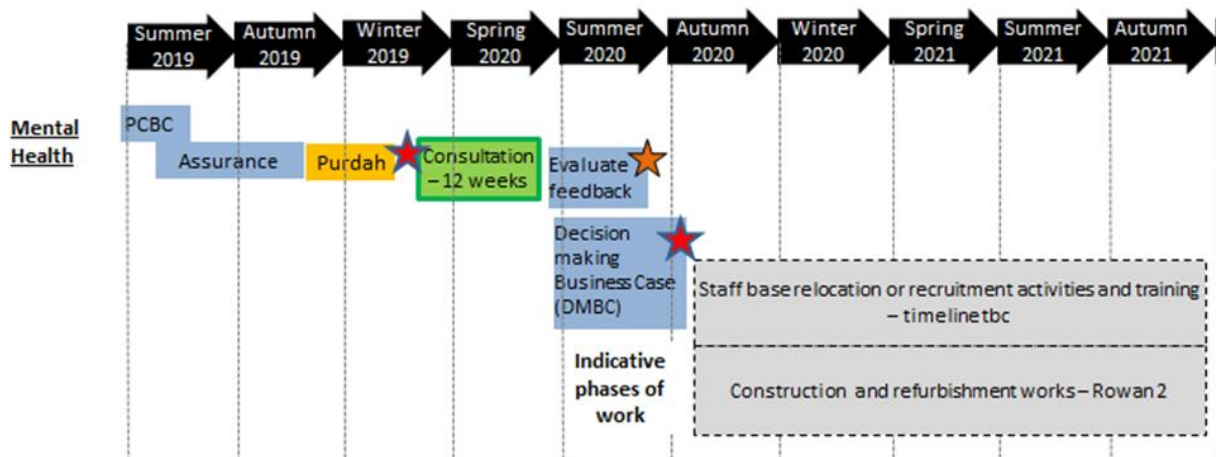
The proposals within this PCBC have been developed through the Somerset Fit for My Future Programme. It should be noted that while the Fit for My Future Programme Board reports to the various organisations supporting the Programme, the decisions required on proposals taken to public consultation are the responsibility of the Somerset CCG Governing Body.

## **NEXT STEPS AND IMPLEMENTATION**

Following assurance of the draft PCBC by the Clinical Senate and NHS England, the Somerset CCG Governing Body will consider the PCBC at its Extraordinary Governing Body meeting on 16<sup>th</sup> January 2020 and will be asked to approve the document for public consultation on the preferred option.

It is anticipated that the timetable will be as shown in the diagram below.

Figure 2 : Timetable for decision making and proposed implementation



## 1 FOREWORD

There has been a history of under-investment in Somerset’s mental health services and we are determined to redress the balance and place equal value on the importance of physical and mental health services.

People who have used mental health services in the past or are using them now have helped us shape our new model of care; they have told us that we need to make access to our services much easier, and that people should be able to access a whole system of support through one referral.

Our overall vision for mental health, and the new mental health model, is innovative. We are enhancing and investing in those services that are already there, and introducing new ones, closer to where people live and making them wholly accessible at every step of the way.

This commitment is made against a backdrop of the serious financial challenges we face as a health and care system in Somerset, and nationwide. We will continue to look for ways of delivering our services in a more cost effective and cost efficient way, whilst maintaining, and improving, their quality. While we are looking to find ways of running our services more efficiently in nearly every other area of healthcare, we are increasing our investment in mental health provision.

Acute mental health inpatient services for adults of working age are just one part of this whole system of care, a very important component for the relatively small number of people facing the most acute mental health issues. We need to ensure that we provide this care in the safest possible way. We are very proud of the dedication and quality of the staff providing these services, but we recognise that it is simply not possible to provide the safest possible care if we continue to operate from three different locations, two of which have standalone wards with limited support available, and one of which is a long way away from an ED.

We believe there is a better solution. This will involve providing our acute inpatient services from two sites and not three, and we know that people will be concerned about extra travel times for both services users and visitors. However, we believe safety must be paramount, and that the proposal set out in this paper will lead to safer services.

Please do respond to this consultation and tell us what you think of our proposal and about anything of importance to you that you want us to consider before we make a final decision on the way forward.



**Dr Ed Ford**

Chair  
Somerset CCG



**James Rimmer**

Chief Executive  
Somerset CCG

## 2 SUPPORT FROM OUR PARTNERS

We have worked closely with our partners throughout the development of this case for change and they support our proposal for the future configuration of acute mental health inpatient services for adults of working age.



**Peter Lewis**

Chief Executive, Somerset Partnership NHS Foundation Trust  
Chief Executive, Taunton and Somerset NHS Foundation Trust



**Jonathan Higman**

Chief Executive, Yeovil District Hospital NHS Foundation Trust



**Pat Flaherty**  
Chief Executive, Somerset County Council

## 3 INTRODUCTION

### 3.1 Purpose of document

The purpose of this document is to seek approval from the Somerset CCG Governing Body to commence a public consultation on proposals to reconfigure mental health inpatient services for adults of working age.

The document sets out:

- Why we believe we need to reconfigure services
- Our assessment of the options for the future
- Our proposals for the future
- How we have engaged with the public, services users and staff so far
- How we will consult with the public to test these proposals
- How we would implement the proposals

This document refers to proposals and indicates changes that will be made to services if those proposals are implemented. However, the CCG has not made any final decisions on (a) whether to make changes to services in accordance with any of the proposals discussed in this document or (b) how to implement any proposal which is subsequently agreed. No decisions will be made until the views of all stakeholders, including members of the public and our patients have been carefully considered following that consultation. Accordingly, nothing in this document should be interpreted as indicating that the CCG has made any decision on any of the proposals described in this document.

These proposals for changing mental health inpatient services form one part of the overall Fit for My Future Programme.

### 3.2 What is the Fit for My Future Programme?

“Fit for my Future” is a strategy for how we will support the health and wellbeing of all the people of Somerset by changing the way we commission and deliver health and care services.

The FfMF programme is jointly led by the Somerset County Council and the Somerset CCG, and it also includes the main NHS provider organisations in the county (Somerset Partnership NHS Foundation Trust, the Taunton and Somerset NHS Foundation Trust and the Yeovil District Hospital Foundation Trust).

### 3.3 The scope of this PCBC and proposed consultation

The scope of the proposed consultation is limited to acute mental health inpatient services provided within Somerset for adults of working age. It does not include any proposals to change either the specialist psychiatric intensive care unit at Taunton, or the inpatient rehabilitation ward at Bridgwater.

### 3.4 Our process in developing proposals

Our proposals have been developed through an open process led by the Fit for My Future Programme Board. It has included the following elements:

- An initial system wide review to consider the future vision for all health and care services which identified a range of areas where change was needed. This process included a specific workstream for mental health. The outcome of this review was written up in the document entitled ***“Case for Change. Why do we need to change health services in Somerset? What are our change proposals so far?”*** (12 September 2018) [see Appendix 3]. This set out a number of proposals for change in mental health services including:
  - ~ Enhancing primary care support for people with common/moderate mental health issues
  - ~ Increasing capacity in community mental health services
  - ~ Increasing capacity in our home treatment service for people experiencing a mental health crisis and identifying alternatives to admission for people in a crisis
  - ~ Developing a county wide intensive dementia support service
  - ~ Reviewing the capacity and configuration of our mental health inpatient services for adults of working age and older people. (This PCBC is primarily focussed on this specific recommendation in relation to adults of working age; developments for older people’s inpatient services are being addressed separately)
- Between September of 2018 and December of 2018 we carried out a broad process of public engagement (described in more detail in section 9) on the ideas and proposal in the Case for Change document and received over 696 questionnaires and written responses in addition to feedback from 18 drop in sessions and over 150 other meetings and events. Feedback received was used to help refine and develop our plans further
- The Mental Health and Learning Disabilities Programme Board led the development of a detailed case for change in relation to mental health inpatient services to help us address the

proposal that we should review the capacity and configuration of our mental health inpatient services. This document is separately available as Appendix 3 and has been drawn on to produce much of the information within this PCBC

- We then undertook an option appraisal process which established a potential longlist of options [Appendix 4], confirmed a shortlist and appraised each of the options against a range of criteria which had been approved by the Programme Board after being tested with focus groups involving members of the public and staff [Appendix 5]. The option appraisal process is described in detail in section 8.1 It included a stakeholder event on 12 July independently facilitated by an independent specialist company “Participate”. The stakeholder panel for the event included clinical staff, patient and user representatives, representatives from independent mental health organisations and GPs. Its report is attached as Appendix 6
- Following the appraisal process the Fit For my Future Programme Board confirmed the preferred option to be taken to public consultation
- We worked with Participate to develop a detailed consultation strategy setting out who we would engage with and how [see appendix 7]

All of the above elements are documented within this business case.

The key principles of our approach developed in April and agreed in May 2019 [set out in appendix 2] were:

- Wide stakeholder and public and patient engagement
- Transparent decision making
- Assessment based on publicly available evidence related to criteria which have been agreed in advance
- Strong internal and external governance throughout the process, including review by the STP, CEC, HOSC and Clinical Senate. Our responses to Clinical Senate feedback are covered in Appendix 13

## 4 THE CONTEXT

### 4.1 Health and Wellbeing in Somerset

Somerset is a largely rural county with a population of 550,000 people, lacking large cities or universities. Its population is relatively older than the national average and over the next 25 years while the overall population will rise by 15% we expect those over the age of 75 to double, resulting in a significant rise in demand for health and care services.

The ageing population brings new challenges:



- The older we get the more likely we are to have more than one long term condition affecting our health. Support for people with multiple conditions is more complex and needs to be much better integrated.
- Dementia is becoming an increasing problem and we could see a doubling of the number of people with dementia by 2035; however, lifestyle choices and a more effective model of care could have a significant impact on the risk of dementia and so this could be partially mitigated

While Somerset is relatively less deprived than other parts of England there are areas with high levels of deprivation. People living in deprived areas in Somerset do not live as long as people from other areas; they are more likely to experience both physical and mental health issues. Deprivation not only impacts on the length of life but its quality. In many cases the differences with people from less deprived areas are linked to lifestyle and environmental factors, including smoking, obesity, housing, income, education and disability. Vulnerability is also often linked to deprivation.

Lifestyle and environmental factors have a huge part to play in maintaining health and wellbeing. These include areas such as smoking, diet, exercise, social isolation, and alcohol. It is estimated that lifestyle factors, environmental and societal factors together account for 60% of health issues (compared to genetic inheritance at 30% and healthcare provision at 10%). The most important reason we need to do more to support health and wellbeing and address inequalities is the impact this will have on the quality of longevity of life for individuals. However, doing so will also help address our financial position. It costs far less to help someone stay healthy than it does to treat and support them when they have become ill.

While we often focus on disease related to physical health, mental health is a major issue in Somerset and is often a life limiting long term condition. Our mental health is an important indicator of our ability to cope with everyday life. It is thought that 70,000 people in Somerset have a mental health problem at any one time.

- People with severe and prolonged mental illness are at risk of dying 10-20 years earlier than other people
- Women with mental illness are at increased risk of antenatal, perinatal and postnatal depression
- People with long term physical conditions suffer more complications if they also develop mental health problems, increasing the cost of care by an average of 45%
- Parenting, bullying, drug and alcohol misuse, income, education, social isolation, having caring responsibilities and housing all contribute to positive or negative mental health

- Somerset's suicide rate is 10.7 per 100,000 population. This is slightly higher than England averages. Rates in men (16.5) are higher than women (5.2)<sup>1</sup>
- Emotional wellbeing and resilience have a major impact on the quality of life for individuals, and knock on implications for local communities and society as a whole. It is therefore of fundamental importance for every area of health and social care provision

Mental health services have to address a very wide spectrum of need

- A relatively small number of people at any one time will have a serious mental illness requiring support from specialist services support – we would expect to have around
  - ~ 75 people under care determined by the Mental Health Act
  - ~ 1,640 people who have a defined care programme, and around
  - ~ 2,400 people in contact with specialist treatment services. Together these amount to less than 1% of the Somerset population

Care for these groups is both specialist and resource intensive

- A much larger number of people face less serious mental health issues. It is estimated that there are over 4,600 people on GP registers with a serious mental illness, while 46,000 are recorded as having depression

## 4.2 The Fit for My Future vision for all services

Our vision for Fit for my Future is to support the health and wellbeing of the people of Somerset by changing the way we deliver health and care services, to become more integrated and located in the community wherever possible closer to where people live.

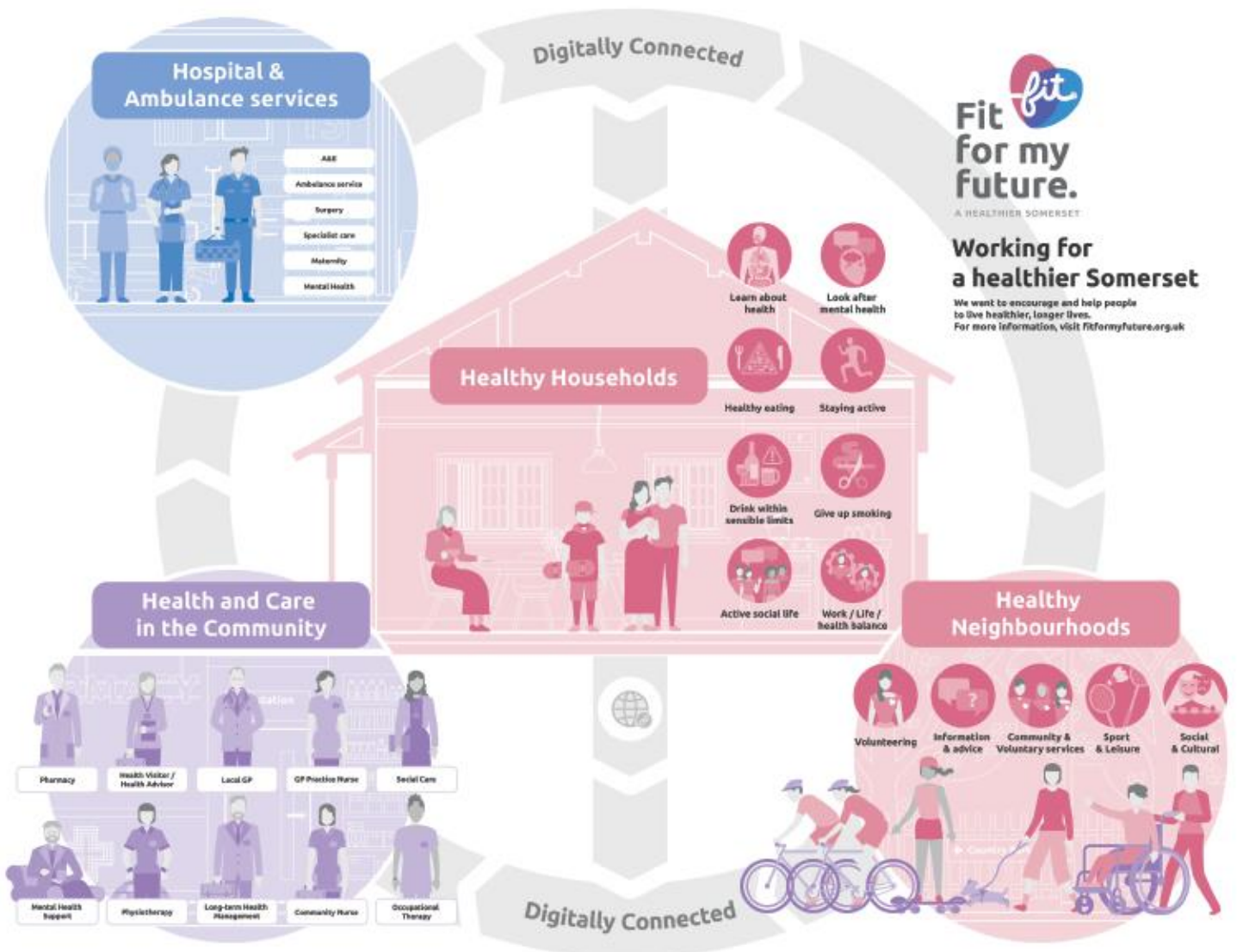
We know the public at large want to see this too. During our engagement with stakeholders, communities, staff and the wider public, people told us that they want a more joined up health and care system with the person at the centre. Whilst people who are acutely ill should be looked after in hospital, once they do not need specialist care it is better for them to be looked after at home. Almost all of the people we spoke to supported the need to give greater priority to helping people stay healthy through making different lifestyle choices and taking personal responsibility for their own health and wellbeing.

The following infographic summarises our vision which has been agreed at all stages of the governance process and reflects the ambitions of the Somerset Health and Wellbeing Board's 'Improving Lives in Somerset' ten year plan.

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<sup>1</sup> PHOF 4.10 - Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population 10.7 based on 2014-2016 data (PHE, Nov 2017).

Figure 3 : The Fit for my future vision



We have identified five key priorities that underpin our vision:

- Shifting our focus towards prevention of ill health and the promotion of positive health and wellbeing, tackling health inequalities to ensure parity of esteem
- Moving to more integrated, holistic services based on the need of the individual and supporting their independence
- Recognising that mental and physical health are equally important

- Ensuring people have the right access to the right skills and expertise when they need emergency and specialist care
- Shifting resources from hospital inpatient services towards community based services, which will support people in their own homes and sustain their independence

The current health and care model is not sustainable, either financially or from a workforce sustainability point of view; these are equally important drivers for change if we are to make our vision a reality.

### 4.3 National context for mental health services

Mental health has over recent years had a much higher profile in society as a whole, and this is reflected in Government policy and initiatives, including the following

- The principle of achieving Parity of Esteem for mental health – so that the NHS is now determined to tackle mental health issues with the same energy and priority as we do physical health issues<sup>2</sup>
- Five Year Forward View for Mental Health<sup>3</sup> published in February 2016. This noted that three quarters of people with mental health needs received no support at all, that there was limited access to appropriate services, wide variations in quality and waiting times, and that many people did not know who was responsible for their care, or what their care plan was. Its priorities for the future were:
  - ~ Establishing 24/7 services for people in crisis
  - ~ Integrated physical and mental health approach
  - ~ The promotion of good mental health and prevention of poor mental health
  - ~ Creating mentally healthy communities
- The Green Paper for Children and Young People’s mental health<sup>4</sup> published in December 2017
- The Long Term Plan published in January 2019<sup>5</sup> and its references to mental health support<sup>6</sup>. As well as setting a context of integrated, proactive and joined up service provision the plan specifically committed to:
  - ~ Expanding the availability of specialist perinatal mental health services
  - ~ A further expansion in the Improving Access to Psychological Therapies

<sup>2</sup> See <https://www.gov.uk/government/speeches/achieving-parity-of-esteem-between-mental-and-physical-health>

<sup>3</sup> See <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf> - published February 2016

<sup>4</sup> See <https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper>

<sup>5</sup> See <https://www.longtermplan.nhs.uk/>

<sup>6</sup> See [https://www.centreformentalhealth.org.uk/sites/default/files/2019-01/CentreforMH\\_LTP\\_summary.pdf](https://www.centreformentalhealth.org.uk/sites/default/files/2019-01/CentreforMH_LTP_summary.pdf)

- ~ Testing a four-week waiting time target for community mental health teams
- ~ Developing a new community-based offer (incorporating psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm)
- ~ Developing crisis care “ensuring the NHS will provide a single point of access and timely, universal mental health crisis care for everyone”
- ~ Designing a “new Mental Health Safety Improvement Programme” to prevent suicide in inpatient units and offer support for people bereaved by suicide

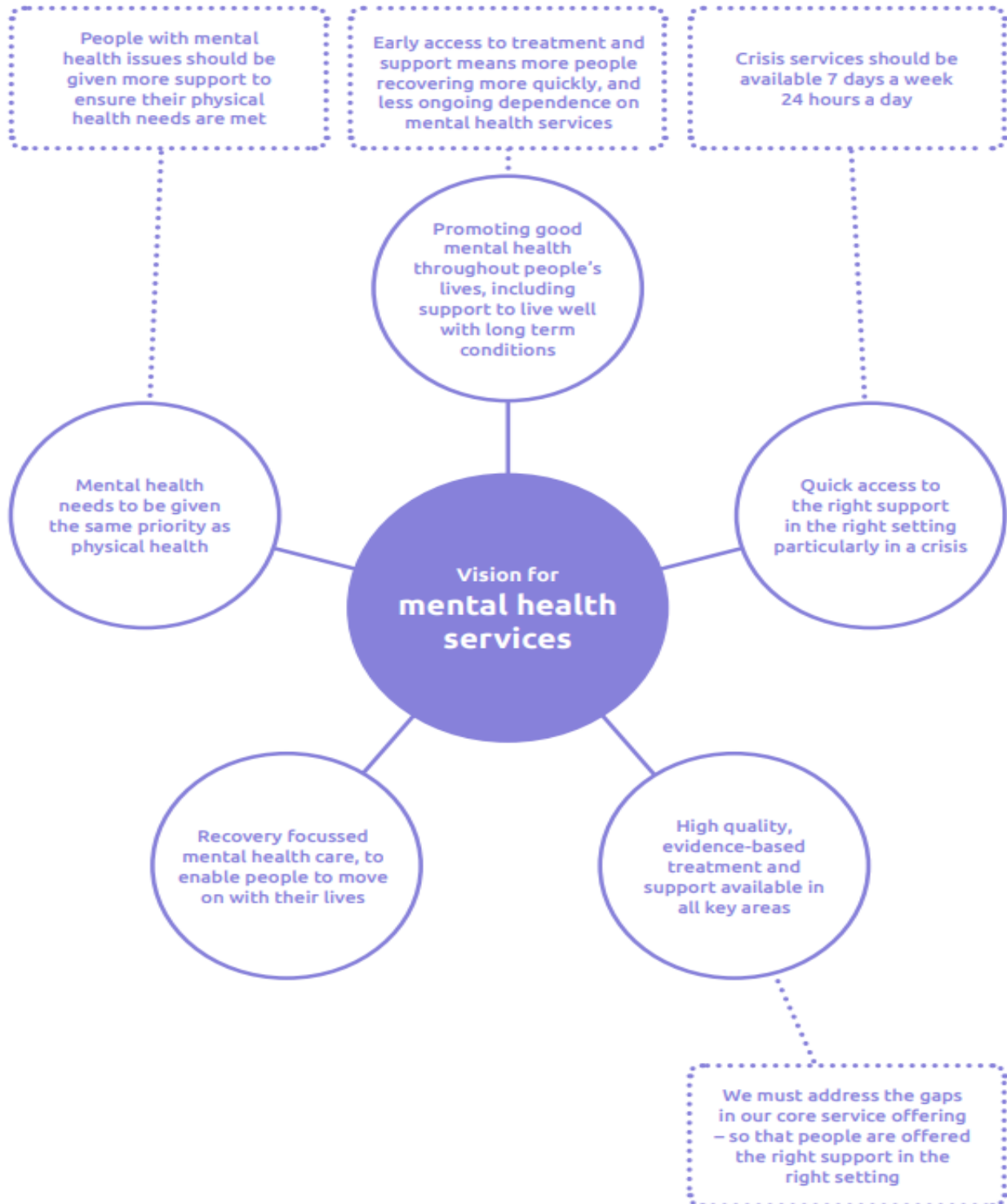
The key themes within all the above documents include: a strong emphasis on prevention; earlier intervention; better integration of services, (health and social care, primary and secondary care, mental health and physical health care); shifting the balance towards community based support; avoiding crises but managing them better when they do occur; and increasing the investment in mental health to improve the provision and outcomes of those who access support.

#### 4.4 Our vision for mental health services

In Somerset, service users, commissioners and providers across primary care, secondary care and voluntary, community and social enterprise organisations have come together to co-produce what they collectively believe is a bold vision of a radical redesign of mental health care that has largely remained unchanged for 20 years.

This vision’s development incorporated the feedback received from the public engagement process on the Fit for My Future programme of work during 2018 and the particular messages received on mental health. The key aims of our vision were summarised in that consultation as in the diagram below.

*Figure 4 : Key components of our future vision*

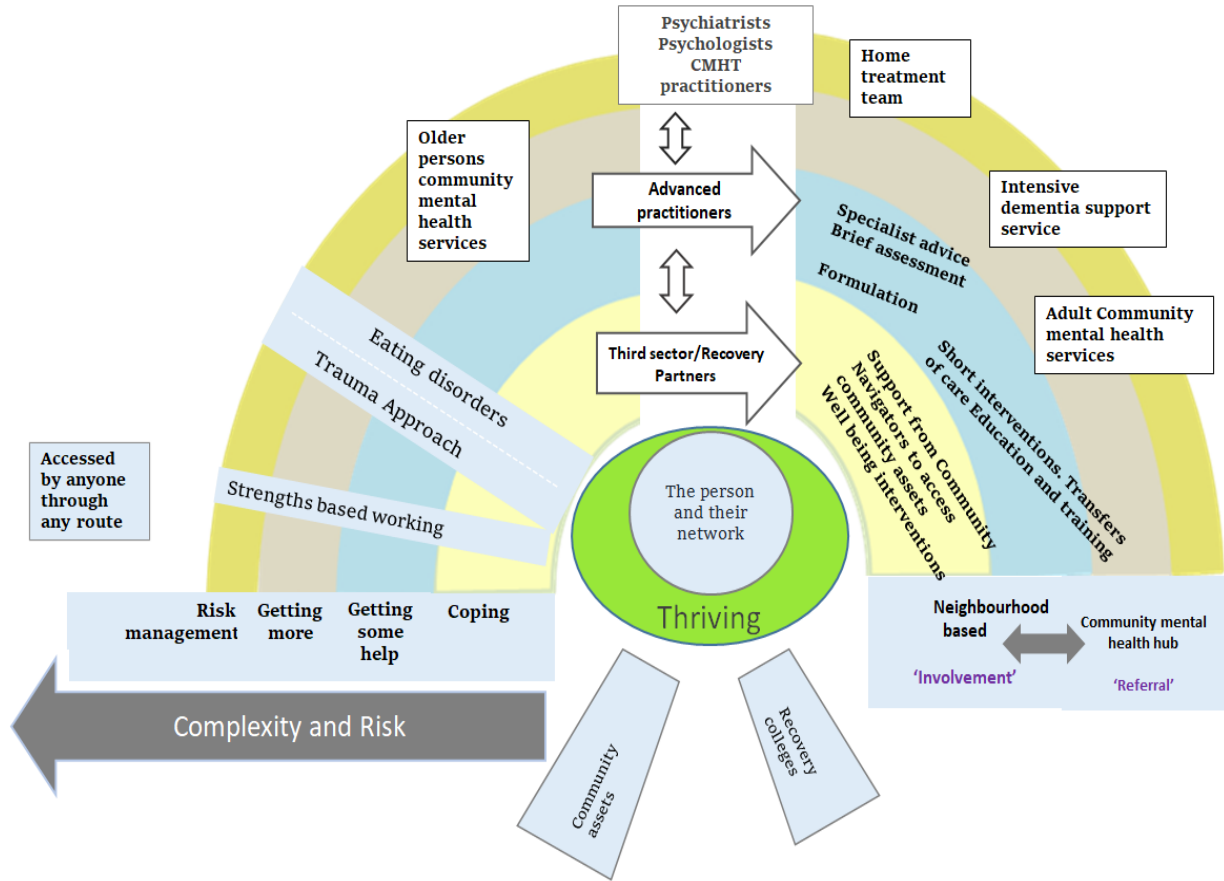


Since that engagement programme the Mental Health and Learning Disability Programme Board has led a whole system process to advance this further, working with people with lived experience, their carers and with health and social care staff along with voluntary and community based organisations. The emerging model includes the following commitments. Future mental health support will wherever possible be:

- Co-produced with and focused on the person concerned, building on their strengths not merely their needs
- Dedicated to maximising each person's ability to 'thrive' in their life
- Provided by a range of agencies including the Voluntary, Community and Social Enterprise organisations (VCSE), peer support, primary care, social care and specialist mental health providers
- Delivered closer to home rooted in community neighbourhood settings, tapping into the person's own network of support
- Accessible with an attitude of no 'wrong' door to gain support – where necessary navigators will ensure people are guided to the right place
- Provided at a level appropriate to the person's level of need: getting it right first time at the lowest level of support required, dissolving the boundaries between health and social care, as well as primary and secondary mental health care
- Holistic, with an equal commitment to meeting the physical and mental and emotional healthcare needs of those receiving support, with a view to closing the health inequalities gap in terms of life expectancy for people with a severe mental health condition

The figure below summarises at high level the vision for services supporting these commitments. The diagram was co-produced with service users, the Somerset Partnership Trust and commissioners as part of the NHSE bid process for adult community mental Health services in July 2019.

Figure 5 : Vision for services





## 5 CURRENT SERVICES AND ACTIVITY

This section describes the key mental health service provision within Somerset. While it summarises information on all services, it provides more detail on inpatient services for adults of a working age, as they are the key focus of the consultation proposals.

### 5.1 Overview of community and primary care based services

A wide range of health and care community based services are provided across the county including the main services described below:

- **Somerset Talking Therapies** (Improving Access to Psychological Therapies - IAPT) time-limited brief interventions for people experiencing mild to moderate depression, general anxiety and worry, panic attacks, social anxiety, traumatic memories, obsessive compulsive disorder and adjustment to living with a long term physical health condition
- **Home Treatment Team** - gatekeeping function to all adult mental health beds, and supports individuals during a time of mental crisis and facilitates earlier discharge from a mental health admission. Currently offered as a 24/7 service, but with telephone access or attendance at a mental health unit from 8pm-8am. Current plans to become fully 24/7 during 2019/20
- **Community Mental Health Services** - four CMHS teams are core providers of support to people with secondary mental health care needs; usually an individual's care co-ordinator is located alongside specialist mental health clinicians who provide targeted interventions as part of the overall package of support
- **Assertive Outreach** – four teams support a small cohort of patients who sit outside the traditional CMHS criteria and are often hard to engage for traditional services
- **Adult Psychology and Psychological therapies** - provide specialist psychological assessment and treatment for patients presenting with severe mental illness in secondary mental health services, and clinical leadership for community mental health and community learning disability services
- **Adult Eating Disorder Service** - specialist multidisciplinary team providing specialist support in the community to service users with an eating disorder
- **Community Forensic Team** - small service supporting mental health patients with a forensic history (i.e., offending or criminal behaviours related to a mental health condition) to return to the community
- **Psychiatric Liaison Team** - works out of both main acute hospitals providing support for emergency and routine deliberate self-harm / mental health assessments of individuals from

age 17 years, and psychiatric liaison assessment for adults. Current plans to become fully 24/7 during 2019/20 in both hospitals

- **Somerset Team for Early Psychosis (STEP)** - service for people (14-35 years) experiencing, or at high risk of developing, their first episode of psychosis. Previously been held up nationally as an exemplar. Staffing levels and funding issues identified as contributing to access issues. Additional service investment in 2019/20 to ensure sufficient capacity to meet the national requirement to provide this service to all age adults with a first episode of psychosis
- **Emerging Personality Disorder Service** - support for young girls/women who have been through CAMHS services and who, as part of the transition process, would have previously ended up on adult inpatient mental health units which was not appropriate for their needs
- **Personality Disorder Service** - small, specialist service embedded within adult community and inpatient mental health teams in Somerset. Its main role is to provide support, training and supervision to frontline staff working with people who have personality disorders
- **Residential Mental Health Services** - including recovery and step down provision; commissioned by Somerset County Council
- **Somerset Mental Wellbeing Service** – Somerset County Council community focussed service, launched October 2017; support for people with mental health issues via wellbeing navigators, peer support workers and structured peer support and self-management
- **Mental Health Social Work**- 4 locality teams support individuals with mental illness and social care needs
- **Mental Health Inpatient Social Care Team**- new team addressing Mental Health social care issues for people currently in a Mental Health inpatient unit
- **Approved Mental Health Practitioner (AMHP) hub** - based on Taunton Wellsprings site, offering 24/7 provision for adults as part of the council's Emergency Duty Team, specifically use of the Mental Health Act
- **Supported living** - placements offered to a small number of individuals
- **Creative Solutions** - new service commissioned by Somerset County Council to support independent living for people with multiple problems due to substance use-related mental health issues
- **Mindline** - telephone helpline provided by MIND for people with mental health needs in Somerset outside of normal operating hours – evenings and weekends

- **Somerset Mental Health Hub** - funded by Public Health to develop capacity and capability within Voluntary, Community and Social Enterprise (VCSE) sector around mental health; acts as information point, develops awareness, and runs initiatives such as Time to Change
- **Social prescribing and community based support for recovery** - provided in a variety of ways across Somerset; funded by Adult Social Care, CCG, Primary Care, Parish Precepts and grants etc

## 5.2 Inpatient services – overview

The core inpatient services in Somerset are as follows.

- **4 assessment and treatment wards for adults of a working age.** Two of the wards are based on the Wellspring site in Taunton; the other two are stand-alone units, one in Wells on the Priory Park site and one in Yeovil at Summerlands. These services are the main subject of this PCBC and are described in more detail in Section 5.3. This PCBC is not making proposals for change in any of the other services listed below. Both the Yeovil and the Taunton wards have a Health Based Place of safety, also referred to as a Section 136 Suite. These are managed by the teams on those sites
- **Psychiatric Intensive Care unit.** Also at the Wellspring Site in Taunton, primarily serving detailed individuals in the most disturbed phase of their illness. This has 10 beds plus an “extra care” suite
- **Rehabilitation ward for people with long term mental health issues who need a period of rehabilitation.** This is a 10 bed unit on the Broadway Health Park site at Bridgwater
- **Low secure ward for men.** This is a 12 bed unit also at the Broadway Health Park site commissioned by NHS England with delegated authority to Devon Partnership to manage the regional network of beds with an aim to support people locally within the South West
- **Two older people’s mental health wards.** These are both based at Taunton. One is a 14 bed unit which primarily supports people with functional illness such as depression and psychosis; the other also has 14 beds and supports people with organic illness such as dementia

## 5.3 Inpatient services for adults of a working age

Inpatient services in Somerset providing assessment and treatment services for adults of a working age are currently provided from 4 wards at 3 locations, as shown in the map and table below.

**Figure 6 : Location of inpatient services**



In total the service has 62 inpatient beds in addition to 10 psychiatric intensive care beds.

**Table 3 : Adults of Working Age (AWA) Inpatient services**

Location	Ward	Description
Taunton – Wellsprings Site	<b>Rydon Ward 1</b> (15 beds):	Single en-suite rooms with dedicated areas for both men and women. The ward focusses on support for people living in Taunton and the surrounding area
	<b>Rydon Ward 2</b> (15 beds)	Single en-suite rooms with dedicated areas for both men and women. The ward focusses on support for people living in the Bridgwater and Somerset Coast areas
Wells – Priory Site	<b>St Andrew’s Ward</b> (14 beds)	Single rooms with dedicated areas for both men and women. The ward focusses on support for people who live in the Mendip area. However, due to strict admissions protocols because of St Andrews’ location, this is not always possible if the person is assessed as unknown or displaying high risk behaviour
Yeovil – Summerlands Site	<b>Rowan Ward</b> (18 beds)	The ward aims to provide services for people who live in the South Somerset area. There are single en-suite rooms with dedicated areas for both men and women available

In all cases the inpatient wards are supported by a team of specialist mental health doctors, nurses and therapists who work closely with the local Home Treatment Team. The overall aim is that each site focusses support on its local population. However, there are some important differences between sites which means that local services cannot always be provided.

- Psychiatric intensive care is only available at the Taunton site. As set out in section 5.2 this is provided in a separate ward (Holford). This is a county wide service, and it does not have the critical mass to be offered in more than one location
- Limitations on the availability of medical cover at the St Andrew’s Ward in Wells mean that it cannot accept admissions for patients after 3pm each day (unless they are medically assessed on another ward), or whose risk has not yet been assessed, or who have high risk behaviours, and/or complex physical healthcare needs. If a patient from the Mendip area (includes Wells) falls into this category they are normally admitted to the service at Taunton. Similarly, unlike the Taunton and Yeovil services, the Wells service cannot offer a designated place of safety (section 136 suite) allowing mental health assessments to be undertaken in periods of crisis

The table below shows the admissions to the AWA inpatients services by different location, and the part of Somerset from which the patients came. It should also be noted that while the units each have their own geographic focus it is often the case that specific capacity constraints may mean that patients cannot be admitted to the unit closest to their own home.

**Table 4 : Activity split by the patients’ home area – November 2017 to March 2019**

Geographical area	Inpatient admissions by site			
	Rowan ward (Yeovil)	Rydon wards (Taunton)	St Andrews (Wells)	All admissions
Mendip	66	38	188	<b>292</b>
Sedgemoor	23	152	23	<b>198</b>
South Somerset	231	42	34	<b>307</b>
Somerset West and Taunton	24	320	16	<b>360</b>
Other ( Out of Area)	12	77	15	<b>104</b>
Unknown	24	64	23	<b>111</b>
<b>Grand Total</b>	<b>380</b>	<b>693</b>	<b>299</b>	<b>1372</b>

The core clinical staffing of the inpatient services – doctors and nursing staff - is shown in the tables overleaf.

**Table 5 : Nursing establishment Inpatient wards AWA**

Wards	Nursing (WTE)
Taunton – Rydon wards	25.69
Wells - St Andrews ward	13.22
Yeovil – Rowan ward	17.47
<b>TOTAL</b>	<b>58.38</b>

**Table 6: Medical staffing (whole time equivalent)**

Location	Ward	Consultant contracted	Locum grade Consultant	Specialty Doctor	Trainee Grade Doctor	Out of hours and weekends
Taunton	Holford *	0.85		0.3	Yes	Psychiatry Trainee Dr
	Rydon 1	1.0		0.3	Yes	Psychiatry Trainee Dr
	Rydon 2	1.0		0.3	Yes	Psychiatry Trainee Dr
Wells	St Andrews	0.6	1.0	1.0	No	On-call GP service
Yeovil	Rowan #	1.4			Yes	Psychiatry Trainee Dr

Note: \*Holford is a Psychiatric Intensive Care Unit, but is included here as the Holford staff provide cross cover for the other wards on the Taunton site. # Rowan ward is slightly larger than the other wards, which is why it has more contracted consultants.

The main differences in staffing relate to the St Andrews ward at Wells. St Andrews is not currently able to support Doctors in training, especially out of hours, due to the lack of critical mass and the lack of availability of Educational Practice Supervisors. On the other wards trainee doctors provide daily medical support to the wards on that site, including medical reviews, admission clerking and emergency support. They also provide the out of hours and weekend cover on a rotational basis as part of their psychiatric placement. At Wells these services have to be provided by Consultant Grade and Specialty Doctors or by on-call GPs. The limitations of this arrangement mean that the St Andrews ward is unable to admit higher risk unknown patients, or to admit patient out of hours (ie outside 9am-5pm and weekends) unless they have first been assessed at Taunton or Yeovil and are then transferred to Wells.

It is notable that Wells requires 2.6 consultant/specialty grade doctors to support the ward. This is the same number as the 2 inpatient wards at Taunton (Rydon 1 and 2), even though Taunton has

twice as many beds. This is necessary because of difficulties with appointing staff into permanent posts, inefficiencies resulting from the inability to use trainee doctors, and to address concerns around the safety of the service. In recent years recruitment difficulties have meant there has been considerable reliance on locum medical staff. For example: between 2014 and 2017 the Trust had to employ 10 different consultant locums at St Andrews who, on average stayed in post for less than 5 months. In the same period it employed 7 Junior Doctors on the ward, 6 of who stayed for 4 months or less.

## 6 WHY WE NEED TO CHANGE

### 6.1 Quality case for change

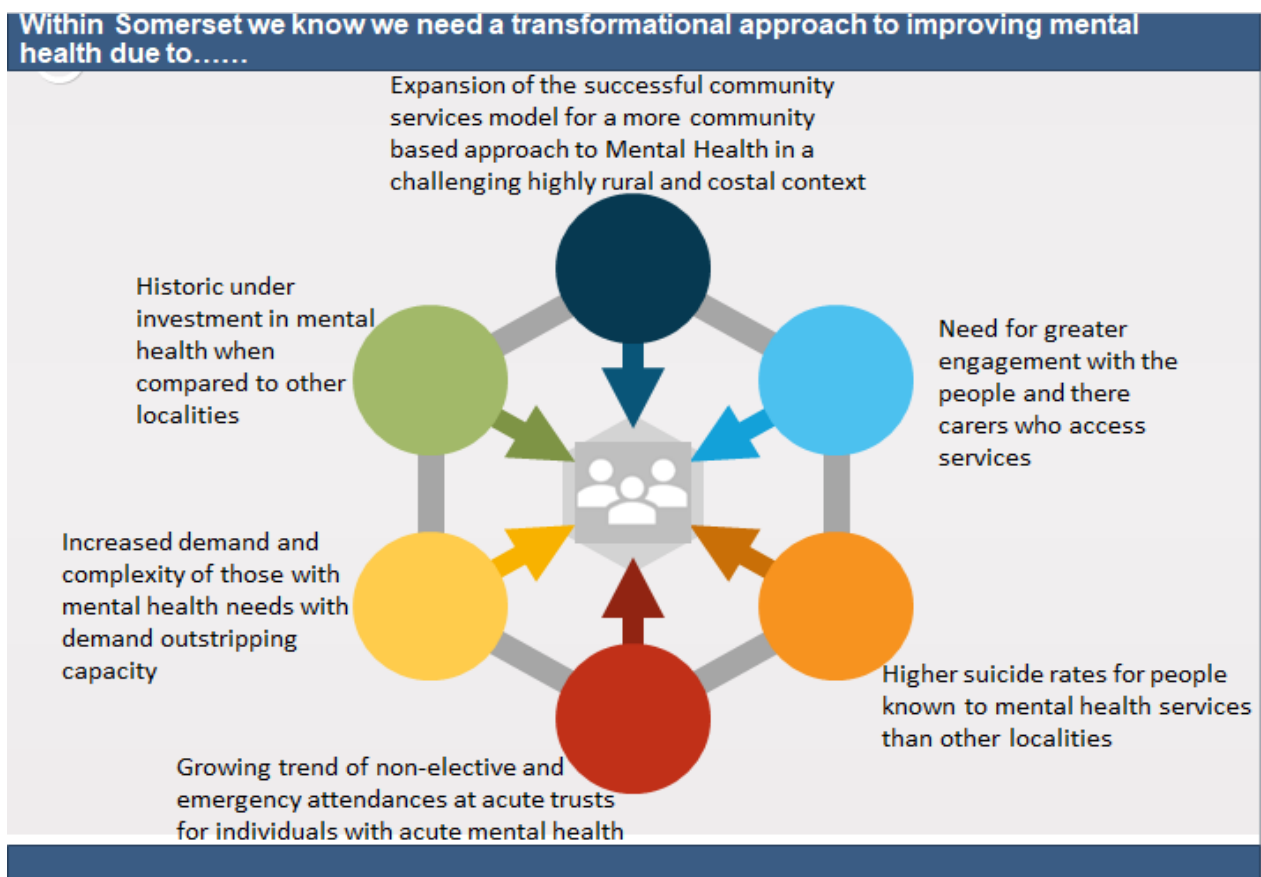
This section

- Summarises the overall case for improving the quality of mental health services
- Describes the specific quality issues faced by inpatients services for adults of working age

#### 6.1.1 Enhancing the quality of mental health services in general

In Section 4.1 we demonstrated the importance of mental health in terms of population health and wellbeing. Our mental service provision faces a number of challenges. The figure below summarises the key reasons we need to enhance the quality of our mental health services.

*Figure 7 : Why we need to transform mental health services*



In addition to the above we recognise that we need to do far more to integrate our services. The Kings Fund has made a compelling case for the integration of mental and physical health care,

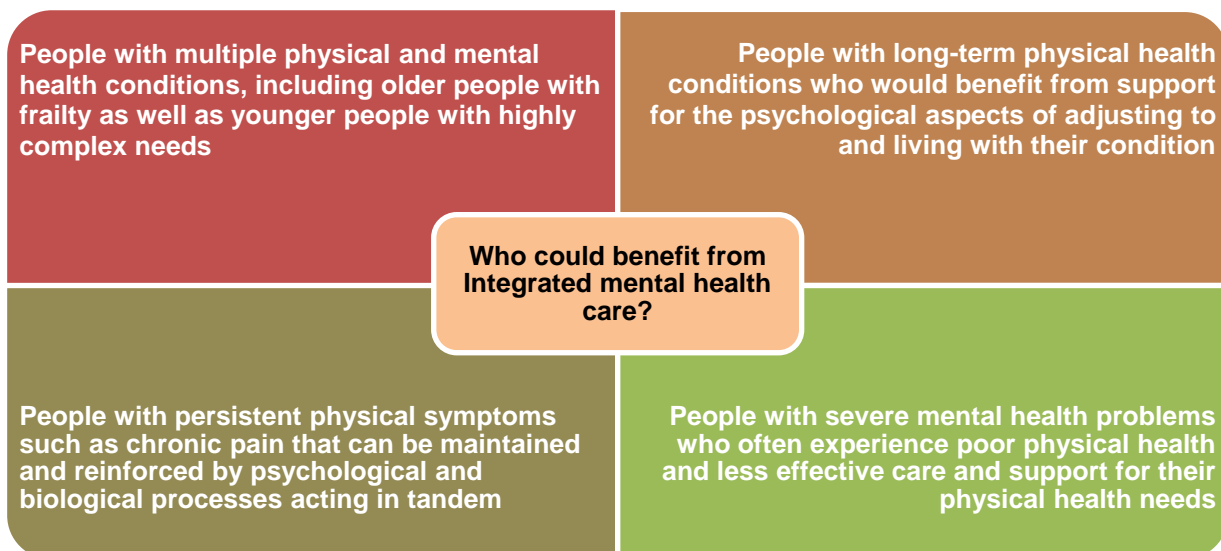


from both clinical outcomes and financial perspectives<sup>7</sup>. They identify that the high numbers of people with both a physical long term condition and a mental health condition. Together with those people with medically unexplained conditions this group costs the NHS in excess of £11 billion per year.

Better integrated care that meets people’s needs at a much earlier stage has a positive impact on both financial and, more importantly, clinical outcomes for the person concerned. Artificial boundaries between services mean that many people do not receive co-ordinated support for their physical health, mental health and wider social needs, and instead receive fragmented care that treats different aspects of their health and wellbeing in isolation.

The figure below illustrates some of the groups of people who frequently suffer as a result.

**Figure 8 : Who benefits from more integrated mental health care?**



<sup>7</sup> See <https://www.kingsfund.org.uk/publications/physical-and-mental-health>

Service quality needs tackling in a number of areas where there are performance issues and service gaps:

- **Somerset Talking Therapies** - not meeting key national targets (such as providing access to 19% of the population) or the 50% recovery target
- **Home Treatment Team** - currently offered as a 24/7 service, but with telephone access or attendance at a mental health unit from 8pm-8am. The service is offered on an “ageless” provision however clinicians report that access to the service for older age adults is not readily available as required. The staffing compliment is not in alignment with national recommendations and standards. Work is underway to improve this situation and move towards full 24/7 coverage
- **Community Mental Health Services** - Caseloads for the 4 locality based CMHS teams are relatively low compared to the average across England, as is the number of contacts relative to the population. However, demand is reported to be increasing and outstripping local capacity to support and respond in a timely manner to patient needs, with a 20% increase in referrals year on year for the past 5 years
- **Psychiatric Liaison Team** – New team from January 2018 but only offering a service Monday to Friday 9am -5pm at Yeovil District Hospital and Musgrove Park Hospital. Outside of these hours, cover is provided by the Home Treatment Team. Services are currently provided for emergency and routine deliberate self-harm / mental health assessments of individuals from age 17 years, and psychiatric liaison assessment for adults over 18 years. These services are not yet 24/7 and this is a core requirement
- **Somerset Team for Early Psychosis (STEP)** – A service for people experiencing, or at high risk of developing, their first episode of psychosis. Having previously been held up nationally as an exemplar team, it is now not achieving its standard targets for access and waiting times. Staffing levels and funding issues have been identified as contributing to the access issues
- **Perinatal support** - Poor provision until January 2019 when fully operational Specialist Perinatal Mental Health (SPMH) service went live. In Somerset it is anticipated that out of c.5,700 births per annum, 285 women will present with severe and complex health needs, all of which will need direct support from the SPMH team. Six months into implementation, almost 200 women have been seen and supported by the team. This indicates the need for the service and the need to expand the provision available

Feedback from across the system, staff, patients and carers confirms that access to appropriate services in a timely manner is a challenge. People report waiting significant time for lower level interventions, leading to potentially further deterioration in their issues and difficulties which then become more entrenched and harder to resolve.

For individuals experiencing significant and acute mental health distress, there is an over reliance on the use of inpatient beds. Management of risk in the community is averse leading to additional pressures on bed occupancy levels, shorter lengths of stay as a means of responding to these

pressures, and subsequently a higher risk of readmission as community-based support following discharge is not sufficient in some cases.

### 6.1.2 Enhancing quality and safety of inpatient services for adults of a working age

The Care Quality Commission assessment of our inpatient services overall from 2017 is summarised in the figure below.

**Figure 9 : CQC 2017 Assessment**

<b>Mental Health and Learning Disabilities</b>	<b>Safe</b>	<b>Effective</b>	<b>Caring</b>	<b>Responsive</b>	<b>Well Led</b>	<b>Overall</b>
Acute wards for adults of working age and PICU units	Requires Improvement	Good	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Long stay or rehab mental health wards for working age adults	Good	Good	Outstanding ★	Good	Good	Good
Forensic inpatient / secure wards	Good	Good	Good	Good	Good	Good

Despite the overall positive CQC ratings we do face key challenges in Somerset in delivering high quality, safe inpatient services that result from having four wards in three geographically distinct locations. There is a two ward service at Taunton, and single wards at Yeovil and Wells. These latter two are effectively “standalone” without the support of adjacent inpatient wards.

In addition, the provision and configuration of medical staff (psychiatric cover) within the 3 locations is not consistent as outlined below, and the Wells ward is a significant distance from the nearest ED (22 miles).

The key risks associated with these factors are:

- Distance from an ED when a patient needs emergency physical healthcare support, be that for their own physical health, self-injurious behaviour, or from the behaviour of another patient
- Stand-alone wards: Lack of adjacent inpatient wards and the availability of additional nursing staff when required
- Medical staffing limitations

Each of these is described in more detail below.

### Distance from an ED when patients need emergency physical health care.

This issue applies specifically to patients attending St Andrews ward at Wells.

Adults within the inpatient units can often pose a risk to themselves or others, and despite all attempts to prevent harm, at times patients will either attempt self-harm or suicide, or can harm members of staff or other patients. At these times rapid access to an ED can be key to the ultimate outcome for the person concerned. Wells is 22 miles from the nearest District General Hospital (Royal United Hospital, Bath), normally a 45 minute journey after the ambulance has arrived. The wards at Taunton and Yeovil are both within minutes of the local ED (Musgrove Park Hospital and Yeovil District Hospital respectively). In addition, people with significant mental illness also have a greater risk of physical ill health, including heart disease, respiratory disease and others. As a result they are more likely than the general population to require urgent medical attention, particularly at times of acute distress, potentially requiring rapid access to an acute medical facility.

While the need for a patient to have rapid access to an ED is only occasional, when it occurs there is a potential threat to life if such access is not available, i.e. relatively low incidence but with potentially high / catastrophic consequences. The box below describes real incidents that have occurred in the last three years where this threat could have materialised, because of the distance to an ED.

#### **Tom's story – admission to St Andrews with a diagnosis of paranoid schizophrenia**

Tom's use of drugs in his early life had led to significant bowel problems. One day he was nauseous and constipated; his temperature was high and his skin clammy and he had an irregular heartbeat. These symptoms are sometimes caused by a reaction to some antipsychotic drugs which can lead to a serious condition that needs rapid treatment. Staff called an ambulance but it was an hour and 45 minutes before support arrived to assess Tom and take him on the 45 minute journey to Bath Royal United Hospital, the nearest hospital with an Emergency Department. Once he was finally admitted, Tom spent several days receiving support in the surgical admissions unit.

#### **Laura's story – admitted in crisis to St Andrews with a diagnosis of Emotionally Unstable Personality and a history of overdoses**

During the process to admit her to the ward, Laura went to the bathroom. When staff went to check on her safety they found her with leggings tied round her neck in a ligature and an empty paracetamol container. Laura was red, swollen and didn't respond to attempts by staff to speak to her, nor to pain stimuli. It took 45 minutes for the ambulance to arrive and another 45 minutes to get her to the Emergency Department at Bath Royal United Hospital (RUH) for attention. Although it took 1 hour 35 minutes for her to receive the medical support she needed, she recovered.

#### **Claire's story – admitted to St Andrews after a serious attempt to end her life and with a diagnosis of Emotionally Unstable Personality Disorder**

After returning to the ward from leave Claire was very sleepy and felt physically unwell. Her heartbeat was irregular, her pulse very fast, and she had a rising temperature; staff were concerned that a wound in her leg had the potential for sepsis. It was 45 minutes before the ambulance arrived and, as in the other cases here, it took another 45 minutes to reach the Emergency Department at Bath RUH. After medical treatment at Bath RUH she recovered but as Laura and Claire's cases each demonstrate the risks are too high to be acceptable.

The Kings Fund drew attention to the issue of access to EDs in its 2016 report *“Bringing Together Physical and Mental Health”* in which it said “Reports from some mental health inpatient facilities indicate high rates of emergency transfers to general acute hospitals.”

Stand alone wards – with no staff backup from adjacent wards.

Adult acute mental health inpatient units by default have adults who are a potential risk to either themselves or others. When an incident occurs, nursing staff would usually press a ‘panic button’ that would call additional nursing staff from the ward and from adjacent wards (if there is one) to help support both the management of the patient concerned, but also help to manage the ward as a whole.

At the St Andrews ward in Wells there may be 3-4 people available at weekends and out of hours to respond to alarms (4 or 5 during normal working hours). If some of those staff are already engaged in supporting patients on a one to one basis they are not able to assist.

At the Rowan ward in Yeovil there is a greater chance of support being available because the ward is bigger and so has more staff on duty at any one time. There is also the potential to call on staff from the nearby home treatment team, who are based on the ward at night.

The best support is available at Taunton where staff from 3 adult wards are available to provide support.

If the incident is due to violence and aggression the same protocol will apply, however if the available staff are unable to contain the situation, and staff and patients are at risk the Police will be called to attend the ward and “regain control”.

Staff report that with some patients the alarm has to be sounded several times a day. When there is a more settled patient group this might be several times a week.

The confidence of the staff on the Rydon site at being able to manage the incident itself and as importantly, if the incident is sustained, managing and supporting the other patients is naturally much higher having the knowledge that other staff and resources are readily available on site.

Whilst additional staff are often deployed to St Andrews the staff there have expressed some concerns, especially when they have patients with a history of significant self-harm and are working out of hours with minimal additional support.

The problems caused by lack of support available from neighbouring wards and the resulting risks when there is reliance on police support are illustrated by the example in the box below.

### **George's story – admitted to St Andrews with a history of Emotionally Unstable Personality Disorder**

George was increasingly anxious and agitated as the time for his discharge drew closer and his behaviour towards staff became aggressive and violent; eventually he smashed an office window. Staff felt the situation was beyond their control and, since there were no other staff close by to provide support, they called the police who were unable to attend at that time. Later in the day George's behaviour escalated and he threatened staff with an object and smashed a second window; this time after the call to the police was escalated through the on-call manager they agreed to attend as a priority when an officer was available. Four hours later the police had still not arrived; in the meantime staff had managed to calm George. Whilst they were able to do so on this occasion, staff expressed their concerns about the difficulties in managing incidents such as this safely, for staff and other patients.

### Limitations of medical staffing

There is a 24/7 provision of medical staff at Yeovil, and Taunton, but only 'in hours' support (9am-5pm) in Wells. This means that in times of crisis (24/7), at Yeovil and Taunton the doctor can be called and is able to assess and prescribe 'rapid tranquillisation' when needed to help in the immediate management of the crisis. This is not available at Wells out of hours (weekends and 5pm-9am on weekdays) risking potential further escalation of the situation as one of the management options for care of people in crisis is unavailable. The lack of out of hours medical provision also means patients can only be admitted to Wells between 9am-3pm to allow time for the patient to be fully assessed and a management plan instituted, with all admissions after 3pm needing to be directed to either Taunton or Yeovil.

Junior doctors currently on Rydon and Rowan tell us that they are called on average between 4 and 10 times per shift (at night and weekends), generally for medication review and guidance/advice and attending medical emergencies. This is also dependent on the clinical acuity and patient presentation on the ward at that point, which varies significantly, ie a patient presenting with a personality disorder and risk of self-harm may tie ligatures on a regular basis all of which may require medical review. This gives an indication of the level of support that is not available for patients at Wells. While it would be expected that the requirement for medical support was lower at Wells (because of the current risk management protocol) it is clear that patients there are missing out on the regular availability of medical assistance.

There is a further challenge with the Wells unit as it is not currently able to accept psychiatry trainee Doctors due to the lack of critical mass and the availability of the required Clinical Practice Supervisors registered for training by the local Deanery (the authorised training agency for medical staff). This affects the potential supply of psychiatrists to the unit and exacerbates the historic difficulties in attracting and retaining medical staff, resulting in over-reliance on locum cover. Although this has stabilised recently with the employment of two psychiatrists it remains a vulnerability of the ward in the medium to longer term.










The medical staffing details for all the inpatient wards are set out in section 5.3. It is clear from the data that difficulties in recruiting and retaining medical staff at Wells have resulted in a high use of locum consultants and other doctors.

The position has stabilised in the last 2 years, but in the three years before this a total of 10 locum consultants had to be employed, with an average period on the ward of only 5 months or less.

Summary of impact on ability to provide safe, high quality services

The table below summarises the critical factors which enable a safe, high quality mental health inpatient services in relation to our three geographic locations.

**Table 6 : Delivering safe and sustainable inpatient services – limitations resulting from current geographic configuration**

Drivers of high quality and safe services	Can this be delivered ?		
	Taunton (Rydon 1 and 2)	Wells (St Andrews)	Yeovil (Rowan)
<p><b>Co-located wards.</b></p> <p>If there are two mental health inpatient wards on the same site, staff from each can offer the other support whenever there is a high risk incident. If the ward is isolated the only support available may be from the police or the ambulance service.</p>	Two wards are next to each other – if a staff member needs assistance they can press a bleep alarm and staff from both wards are available to support 	Single ward with no ability to call on additional help from another ward if there is an incident. 	Single ward with no ability to call on additional help if there is an incident. 
<p><b>Medical cover 24 hours a day, 7 day a week.</b></p> <p>This means patients can be assessed for admission at any time, risks can be identified and treatment start. If a patient’s risk changes rapidly while they are in the ward they can receive the appropriate medical intervention immediately</p>	Yes – service is efficient to staff and there is a full 24/7 service 	No, and Wells is not supported by Trainee Doctors. Medical cover OOH and weekends is provided by the “on call GP service.” 	Yes – 24/7 cover is in place at Yeovil which is accredited for Junior Doctor training 
<p><b>Close to an ED.</b></p> <p>Many mental health inpatients are at risk of self-harm, and possibly of harming others, such as staff. If harm does occur the patient or staff member must have very rapid emergency support to provide the best chance of a positive outcome in what might be a life threatening situation</p>	Yes – service is two miles from Musgrove Park Hospital 	No. 45 minute journey and 22 miles to the nearest ED 	Yes – service is a one mile from Yeovil District Hospital 

The consultant medical staff who are responsible for the service at Somerset Partnership recognise these challenges and have expressed the strong view that the current situation is unsatisfactory. This is evidenced in a recent letter from Dr Sarah Oke, Medical Director for Adult Mental Health, in which she says

“It is the unanimous view of the medical staff of Somerset Partnership that the current situation of a stand-alone inpatient acute adult ward in Wells is a very unsatisfactory. This has been discussed repeatedly at the Trust medical staff meeting (SMSAG). The reasons for this are well known and have been repeatedly voiced. They include the risks of no on call mental health medical staff, the lack of back up from local wards for nursing staff in a psychiatric or medical emergency, the distance from DGH and the risks this poses as well as the ignoring of Parity of esteem principles and recruitment and training problems.”<sup>8</sup>

The doctors and nurses supporting these wards have worked hard to minimise the risks that result from the configuration issues identified above. As shown in the table the issues particularly affect the Wells ward, and as a result there is a clinical protocol in place designed to minimise risks to patients and staff. This is illustrated in the box (below), and its prime impact is that higher risk patients or patients for whom the risk is not known are not admitted directly to Wells but are admitted to Taunton first. If their risk is at the appropriate level, they are then moved to the Wells service if it is most local to them.

#### **Risk management protocol for St Andrews ward**

1. Unless a patient is well known to the team, no new admissions go directly to St Andrews but are admitted to Rowan or a Rydon ward and transferred to St Andrews once they have been risk assessed and stabilised, potentially disrupting continuity of care and causing logistical travel problems.
2. Due to the need for a Dr to ‘clerk’ in new admissions no one is admitted to St Andrew’s Ward after 3pm Monday-Friday, and at weekends unless they are “medically “clerked in” by Rowan or Rydon and then safely transferred to St Andrews. (this could be approx. 45 mile round trip).
3. Patients with complex physical healthcare needs are not admitted to St Andrew’s due to the proximity to a general hospital
4. People with known severe aggression, self-harming, or suicidal type behaviours are not admitted to St Andrew’s due to its relative isolation.

<sup>8</sup> Letter from Dr Oke to the Chair of the Mental Health Programme Board emailed on 20<sup>th</sup> June, 2019



While this clearly reduces the risk, the approach has negative consequences, as follows:

- It is estimated that around 40 patients a year have to be admitted to both Taunton and Wells in the same care episode – this has negative impacts on continuity of care, is disruptive and can be upsetting to the patients
- At times the Taunton wards may have a high proportion of high risk patients as they are not equally spread around the system – this can have negative impacts on the quality of care in the wards. While the Taunton wards have 32% of the bed base they have 38% of serious incidents. There may be a number of factors causing this however it is desirable to minimise the imbalance and so any factors which tend to increase it should be addressed

As set out above the risk management protocol means that a significant number of patients have to be admitted for assessment first to one of the Taunton wards, and then move to Wells when they have been fully assessed for risk and their needs are understood. While it is the case that effective management of bed capacity does in some cases mean that patients need to be moved from one ward location to another, the risk management approach significantly increases the percentage of patients for whom this occurs, as shown in the table below. It can be seen that only 60% of patient admissions to Wells are direct, compared to 87% for Rowan ward at Yeovil and 74% for Taunton.

**Table 7 : Direct admissions and patient transfers by ward**

Wards	Direct Admission	Transfer from other Ward	All admissions	% Direct Admission	% Transfer from other Ward
Rowan (Yeovil)	329	51	<b>380</b>	87%	13%
Rydon wards (Taunton)	516	177	<b>693</b>	74%	26%
St Andrews (Wells)	179	120	<b>299</b>	60%	40%
<b>Grand Total</b>	<b>1024</b>	<b>348</b>	<b>1372</b>	<b>75%</b>	<b>25%</b>

We estimate that if the risk management regime for St Andrews ward at Wells did not have to be in place, up to 40 patients a year would not have to be admitted to one ward and then moved on to another one. (Calculation assumes that Wells direct admissions were the same average percentage as that for the other two locations together).

## 6.2 Need and future activity/capacity

In this section we assess whether there is a case for changing the future capacity of the AWA inpatient service in Somerset.

We have looked at the following factors:

- Are the current bed numbers appropriate for the current level of demand? – taking account of:

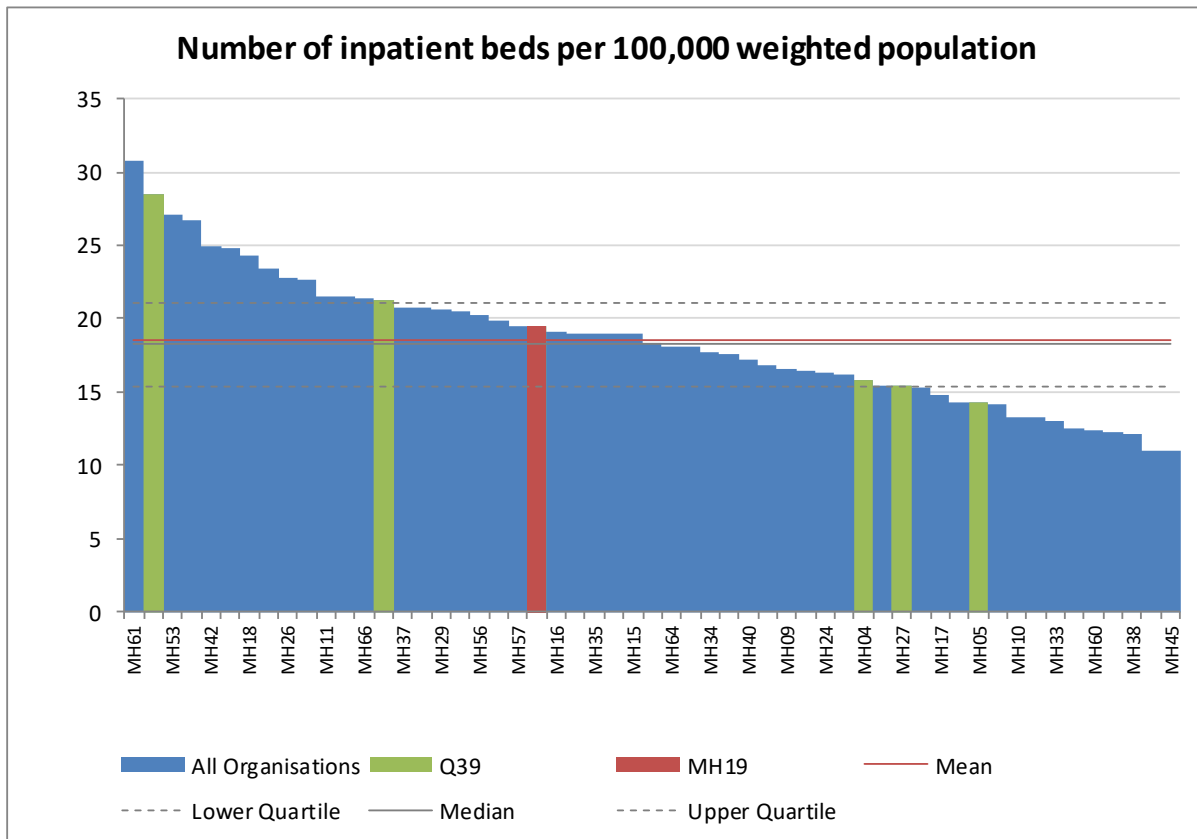
- ~ Benchmarking of the number of beds we have for our population compared to those available in other similar geographies.
  - ~ Benchmarking of admission and readmission rates
  - ~ Our performance on length of stay.
  - ~ The occupancy levels of our current beds
- How will population change affect demand in the future?
  - Whether enhancing our community based provision will reduce the number of people who need to be supported within specialist inpatient beds.

### 6.2.1 Do we have the right number of beds currently?

#### Benchmarking bed numbers in relation to population

NHS Benchmarking data (2017/18) indicates the number of beds per weighted 100,000 population is comparable to the national average as set out in the chart below.

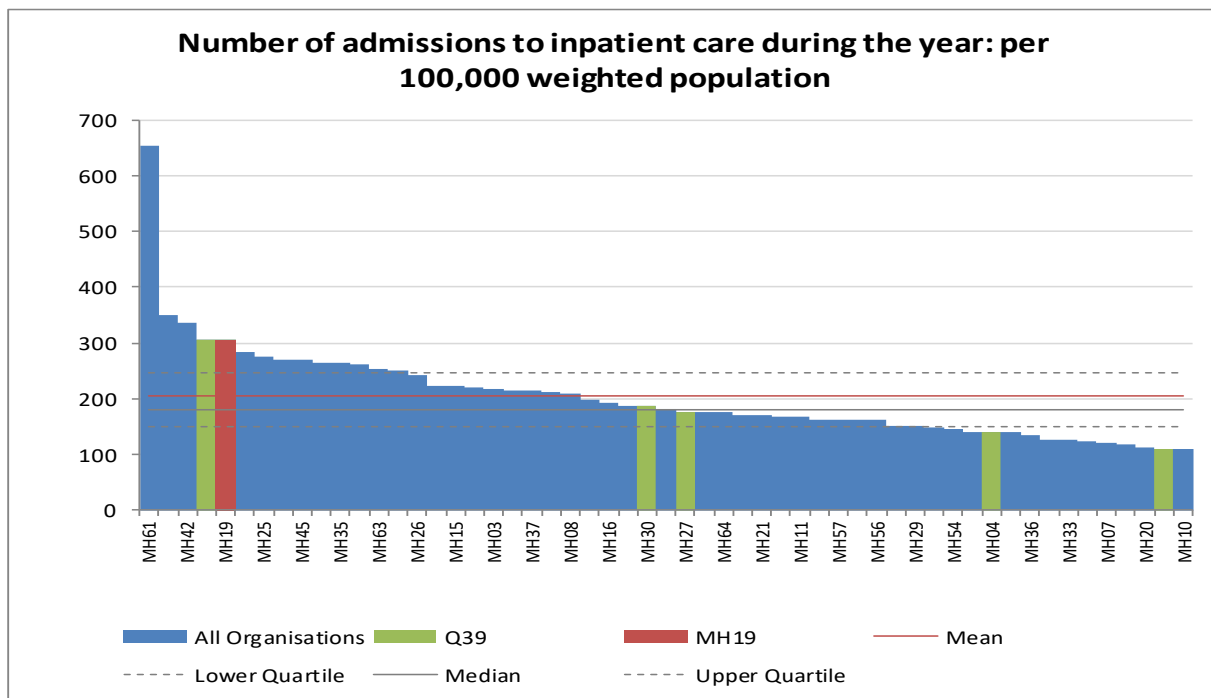
**Figure 10 : Number of Inpatient beds 2017/18 (Somerset service in red, green bars are providers in the same region)**



**Benchmarking of admission and readmission rates**

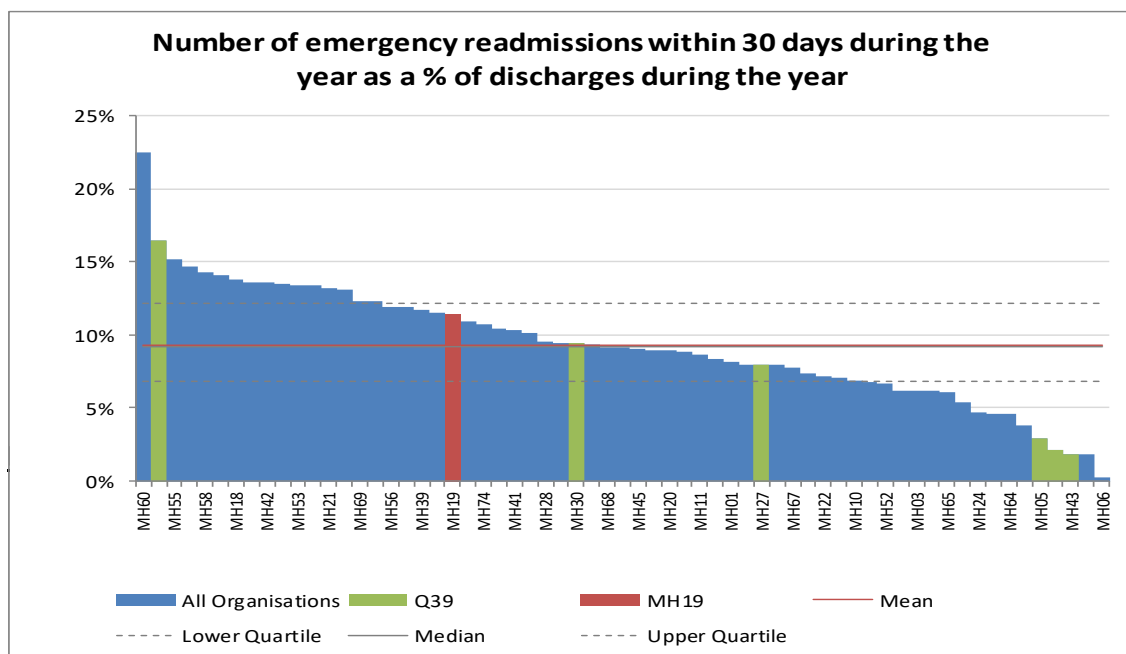
Although as set out above we are average in terms of numbers of beds, we are an outlier in terms of numbers of admissions per head of population. In Somerset around 300 people are admitted each year for every 100,000 people – this compares to just over 200 as the national average. This suggests we are admitting more individuals to an inpatient bed than we should.

**Figure 11 : Inpatient admissions 2017/18. (Somerset service in red, green bars are providers in the same region)**



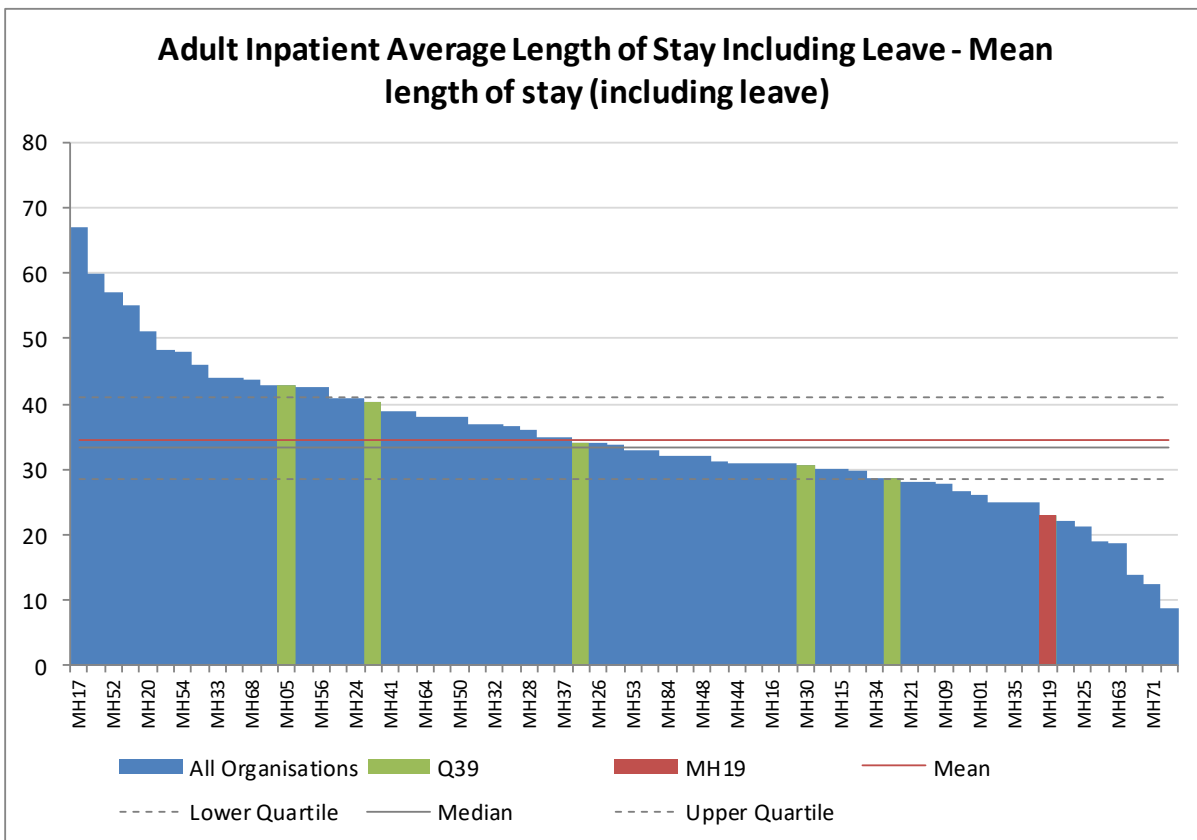
At the same time, our readmission rates are relatively high. Having to admit people again soon after discharge is clearly not ideal.

**Figure 12 : Emergency readmissions (Somerset service in red, green bars are providers in the same region)**



People admitted to our inpatient wards normally stay for a shorter period than the national average (see figure below). The national average is circa 33 days but in Somerset the average stay is close to 23. This indicates that there are a higher number of very short admissions that skew the average downwards. This would suggest that there are too few community based admission avoidance support services in the community to manage people in shorter term crises. If such services were available, it is likely that the average length of stay would better align to the national average.

**Figure 13 : NHS Benchmarking Adult Inpatient Length of Stay 2017/18 (Somerset service in red, green bars are providers in the same region)**



**Table 8 : Length of stay split by time periods excluding direct transfers and excluding leave**

Wards/ LOS	0 days	01-03 days	04-07 days	08-13 days	14-20 days	21-30 days	31-40 days	41-50 days	51-60 days	61+ days	Total
<b>Working Age Adult</b>	<b>18</b>	<b>109</b>	<b>112</b>	<b>127</b>	<b>75</b>	<b>104</b>	<b>47</b>	<b>31</b>	<b>22</b>	<b>94</b>	<b>739</b>
Yeovil - Rowan	7	46	38	37	19	18	12	7	6	30	220
Taunton-Rydon One	3	17	24	27	21	40	16	5	4	21	178
Taunton-Rydon Two	5	27	18	33	15	23	7	8	6	22	164
Wells - St Andrews	3	19	32	30	20	23	12	11	6	21	177

Note: Often prior to discharge a test period of ‘leave’ is undertaken to see how the individual copes at home or wherever they will be residing. Given they could be on leave for days or weeks at a time it is usual to exclude leave from the figures to reflect the actual days on the ward not the length of the episode. If they are on a section of the MHA this is often referred to s17 leave

**Table 9 : Length of stay by ward and average length of hospital stay by discharging ward Nov 17 to Oct 18**

Wards	Average of Ward LOS Including Leave	Average of Ward LOS Excluding leave	Average of Spell LOS Including Leave	Average of Spell LOS Excluding leave
<b>Mental Health Inpatient Adult</b>	<b>26.4</b>	<b>19.4</b>	<b>36.5</b>	<b>32.1</b>
Rowan (Yeovil)	29.4	22.2	39.6	35.6
Rydon One (Taunton)	25.0	18.5	34.0	30.3
Rydon Two (Taunton)	24.5	16.9	36.5	29.6
St Andrews (Wells)	26.2	19.6	35.3	32.1

Best practice suggests that longer stays (for fewer people) would support recovery and prevent readmissions, in line with the ‘getting it right first time’ ambition. It may therefore be concluded that reducing the number of admissions would allow a more optimal length of stay for people who require inpatient treatment and improve outcomes and reduce readmission rates.

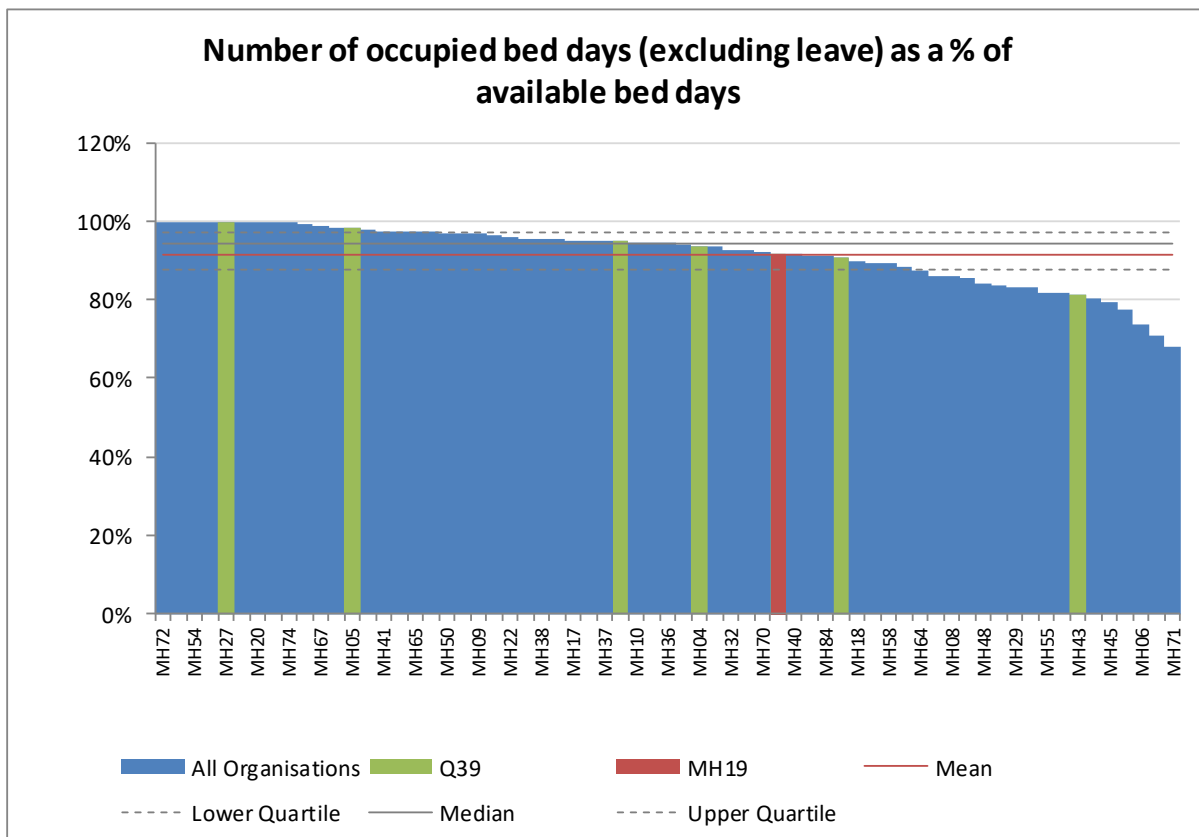
**Bed occupancy levels**

The NHS routinely advise an aim of 85% bed occupancy levels which is generally applied to General Acute Hospitals and, in the absence of a specific NHS occupancy rate for mental health inpatient services, 85% occupancy is widely accepted by Commissioners and Providers. However, it is acknowledged that this is seldom achieved with many services working above this level.

As can be seen by the NHS Benchmarking (see figure below) and Somerset Partnership Trust data (see table below) occupancy is consistently above 85%. There are potentially two key drivers for higher occupancy on Rowan and Rydon Wards;

- The restricted direct admissions to St Andrews
- The considerable work being carried out nationally to drive a reduction in non-specialist acute out of area mental health admissions. Somerset reports no out of area non-specialist acute bed days for the period July 2018 to March 2019

**Figure 14 : NHS Benchmarking Occupied Bed Days 2017/18 (Somerset service in red, green bars are providers in the same region)**



**Table 10 :** Average bed occupancy by ward January to December 2017

Ward	Occupancy Level
Rowan Ward (Yeovil)	92%
Rydon Wards (Taunton)	95%
St Andrews Ward (Wells)	80%

*Somerset CCG report Average Stay and Bed Occupancy Rates 2017*

### Conclusion

Drawing all of the above information together the number of beds we have for Somerset is very similar to the national average but we also have:

- A higher rate of admissions
- A higher rate of re-admissions in an emergency
- A shorter average length of stay
- Busy wards with high occupancy levels

The conclusion we can draw is that these issues are likely to be linked. Because we admit more people than in other systems, we have a pressure on beds which results in high occupancy levels, and potentially a need to discharge people quickly to make space for new admissions. Some of those people then need to be re-admitted as an emergency.

Section 7 set outs our plans for investment in additional community based provision which should have two key benefits:

- Reducing the number of people who need to be admitted in the first place
- Providing more effective support for patients who have been discharged so that they do not need to be readmitted

### **6.2.2 How will population change affect demand in the future?**

The current estimated number of people with severe mental illness in Somerset is 4,816 people (Public Health England fingertips MH profiles 2017 data). Applying the % change in the population projections for people aged 20 to 64 to that number, there is an estimated decrease in the number of people with severe mental illness over the next 10 years. This is due to the decrease in the population estimates in that age range as described in the table below.

**Table 11 :** *Projected population change for working age adults*

Year	2018	2023	2028
Projected population aged 20- 65	296,900	296,600	293,300
Population projections % change		-1.11%	-1.21%

This very low level of change should not impact significantly on the bed numbers needed in Somerset.

### 6.2.3 Capacity impact of future service model

Section 7 describes our plans for enhancing community based services.

These include two specific investments which should have an impact on our need for inpatient services. These are increasing the capacity within our Community Mental Health Services teams and within our Home Treatment teams. The prime aim of these investments is to enhance the quality of provision but it is also hoped that they will reduce the number of inpatient admissions and readmissions by providing a higher level of support within the community. We have considered whether we should assume this impact will be sufficient to allow us to reduce the number of inpatient beds. We anticipate that there should be some reduction, but until we have implemented the new services it is too early to make an assumption that there definitely will be. We would however expect that as a minimum a key impact of the provision would be to reduce the current levels of bed occupancy. This should have a positive impact on our ability to provide a better quality experience within inpatient services.



### 6.2.4 Summary of demand capacity case for change

The table below summarises the key factors we have taken into account in considering whether we need to increase or decrease bed numbers in the future from the current 62 beds across our 4 wards.

Factor	Impact on inpatient capacity - assessment
Benchmarking against other mental health services	Our numbers of beds per thousand of population is just above the average for England
We have a high rate of admissions, a relatively short length of stay, and a relatively high number of readmissions. Occupancy levels are higher than is desirable	We are investing in our community services to reduce levels of admissions, and readmissions. This will directly impact on numbers of admissions and occupancy levels within inpatient services preventing any need to invest in additional beds to address the problems identified.
Demographic change and demand is likely to be static.	The population of adults of working age will reduce by a small amount (just over 1%) over the next ten years. This reduction is too small to have a significant impact on the beds we require.
Invest in community based services	<p>Our proposed service model includes targeted investment in community services that will support the reduction in admissions described above. While we will have to audit the effectiveness of the investment to ensure it has the anticipated effect, we believe that</p> <ul style="list-style-type: none"> <li>• as a minimum it will be more than sufficient to ensure that occupancy levels within the current capacity can be lowered with a resulting quality improvement</li> <li>• this will be sufficient to enable us to operate with a slightly smaller number of beds than now. which we will continue to assess as our community model is implemented</li> </ul>
<b>Overall conclusion</b>	<b>Options should be able to deliver a maximum potential requirement of 62 beds. Long term bed numbers to be reviewed based on an audit of the impact of investment in community based provision upon the requirement for admission.</b>

## 6.3 Financial case for change

### 6.3.1 Health system financial position

The Somerset health system faces major financial challenges. In the financial year 2018/19 its collective deficit was approximately £46m. Its true underlying deficit was worse than this at approximately £62m.

The 2019/20 year financial plan aims to deliver around £20m of savings, reducing the underlying deficit to £41m and the requirement is to break even the following year.

**Table 12 :** *Health system financial position*

	18/19 Outturn £m	18/19 Underlying position £m	19/20 Plan £m
Somerset CCG	(9.0)	(13.6)	(4.5)
Somerset Partnership NHSFT	1.8	(0.5)	0.5
Taunton and Somerset NHSFT	(17.1)	(20.7)	(17.9)
Yeovil District Hospital NHSFT	(22.2)	(27.1)	(19.3)
<b>Total</b>	<b>(46.5)</b>	<b>(61.8)</b>	<b>(41.2)</b>

The table below shows a breakdown of the Somerset CCG's expenditure on different elements of healthcare.

**Table 13 :** *Somerset CCG expenditure breakdown 2019/20*

Area	£'000	Percent
Secondary Care Commissioning (Acute services)	431,739	50%
Primary Care (including GP prescribing)	100,316	12%
Delegated Primary Care	75,683	9%
Community Health Services (including community hospitals)	92,799	11%
Mental Health Services	63,679	7%
Continuing Care and Funded Nursing Care	48,397	6%
Learning Disabilities	24,106	3%
Other Programme Services	21,210	2%
Running Costs	11,855	1%
<b>Total</b>	<b>869,784</b>	<b>100%</b>

### 6.3.2 Mental health expenditure

The section above has highlighted the scale of the challenge for the NHS in Somerset in delivering financial balance.

Against this background it is important to note there is clear evidence of historic underinvestment in mental health services, both nationally and in Somerset.

The NHS Long Term Plan published in January 2019 includes a plan to spend an additional £2.3 billion a year on mental health services to address the national underinvestment.

We recognise that the need for local action on mental health underinvestment is also pressing.

The financial investment of NHS Somerset when benchmarked both nationally and with its 10 most comparable demographic 'neighbours' (our "Cluster Group") shows a significant deficit as illustrated in the figures below. We would need to spend

- An additional £10.7m per year on mental health services to match the national average
- An additional £26.5m per year on mental health services to match the average of a group of CCGs with similar demographic and other characteristics (a cluster group).

**Figure 15 : Relative expenditure 2017-18 on mental health and learning disability services – national comparison**

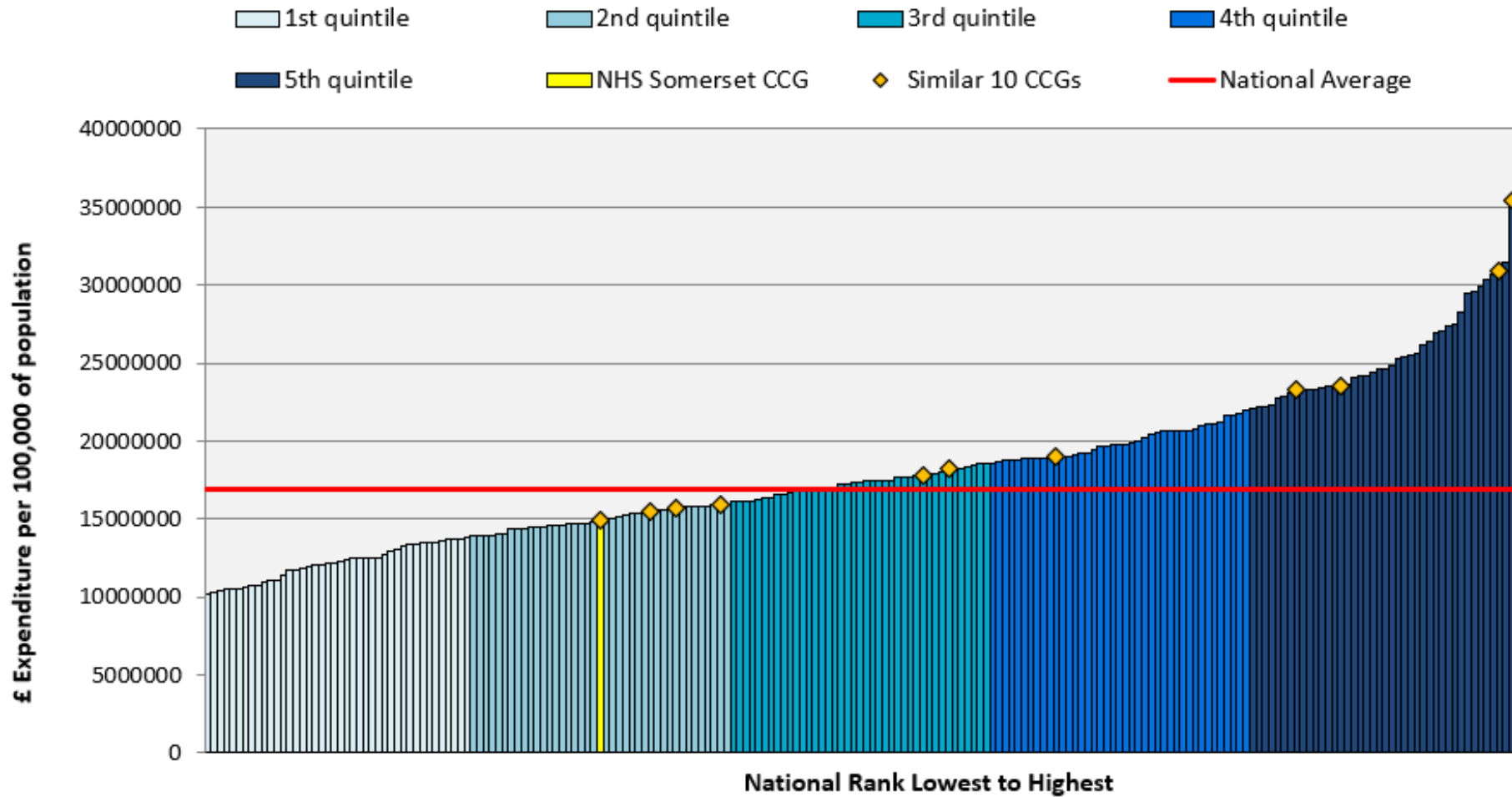
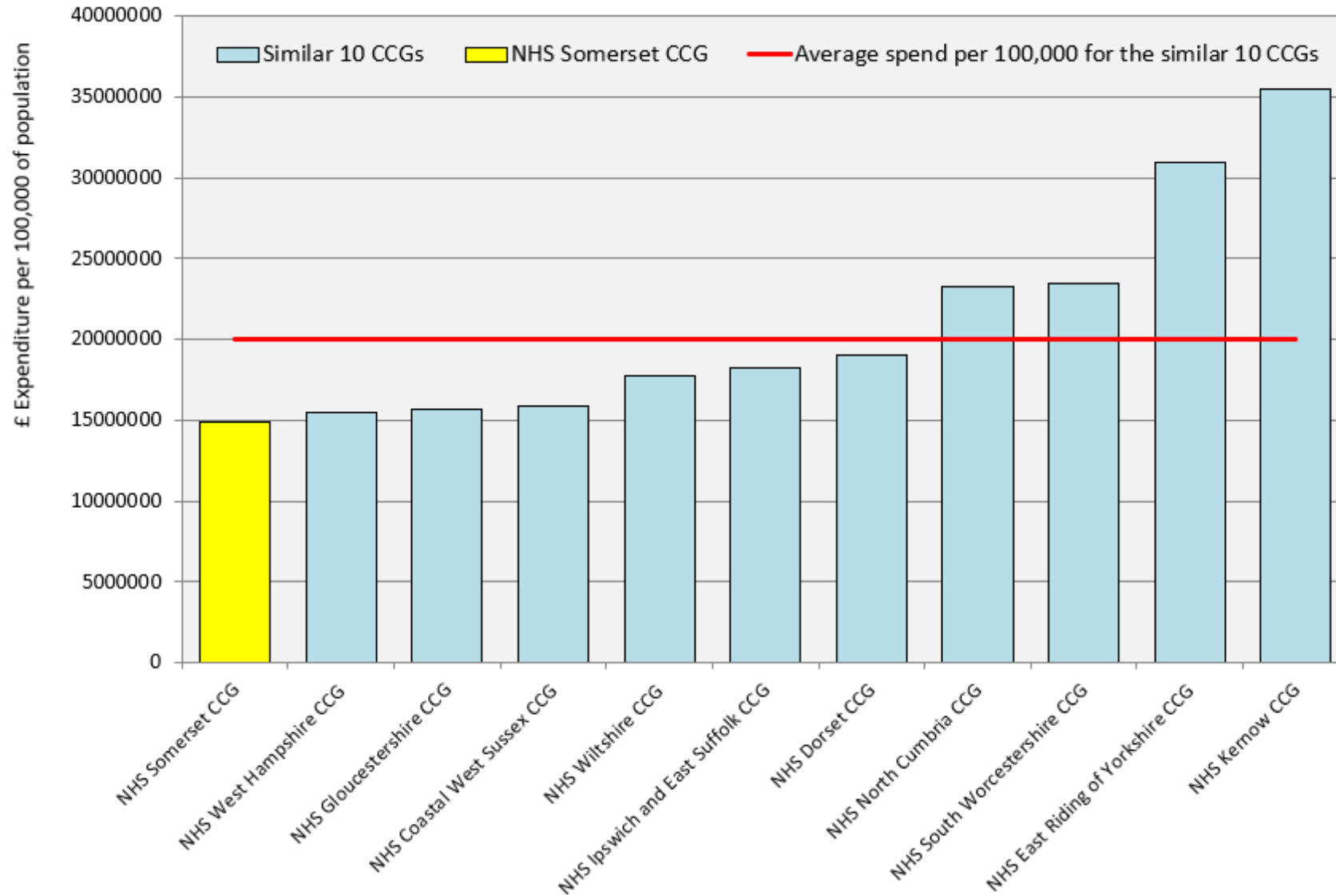


Figure 16 : Relative expenditure 2017-18 on mental health and learning disabilities services – cluster group comparison



Despite the major financial challenges to health services as a whole identified in this section the Somerset health and care system has decided to commit significant additional investment into mental health to start the process of tackling this underinvestment.

- During 2018/19 more than £2m was invested in mental health enabling the introduction psychiatric liaison support in both acute hospitals, and medical leadership into the adult home treatment team)
- The 2019/20 plan includes a further investment of an additional £2.3m in mental health services, supporting the development of our model of care as outlined in section 7 below. These are the nationally mandated Mental Health Investment Standard funding increases. In addition to this there is the expectation of an additional circa £500k for both expansion of the Home Treatment Team and the Psychiatric Liaison services in the County, to support the delivery of the NHS Long Term Plan's objectives. However, despite these very welcome additional resources to the County's mental health services, it should be noted that all commissioners are expected to invest in mental health services in order to achieve the national Mental Health Investment Standard, and so the relative under investment when compared to other localities remains unchanged by these additional resources

## 7 FUTURE SERVICE MODEL FOR ADULT MENTAL HEALTH SERVICES

### 7.1 Transforming the model of care

As previously indicated, Somerset as a system has historically under-invested in the support and services provided to people with mental health needs. This was recognised by Somerset’s STP (the local mandated strategic Sustainability and Transformation Partnership) and a commitment has been made by the STP to address this deficit. In 2017 a system wide mental health gap analysis was undertaken to identify the priority areas for investment.

In 2018 some rebalancing of budgets and further investments were made into mental services which led to, amongst other things, the creation of the Psychiatric Liaison Service in both TST and YDH hospitals, the establishment of a local perinatal support service, the development of the county’s eating disorder service for young people as well and expansion of both children’s and adult’s community mental health services.

However, these changes are not enough to tackle the key issues identified in our case for change in Section 6.

Consequently, early in 2019 the ‘Rapid Improvement Proposals’ were agreed directing £5m additional investment into Somerset’s community mental health support services across all age and client groups (via the Mental Health Investment Standard – MHIS). Of the £5m, £2.7m was pre-allocated, leaving £2.3m available to support the delivery of the emerging model in Somerset, as set out below.

**Table 14 :** *Investing in our new model of care – Rapid Improvement Proposals*

Domain	Service change and cost	Benefits
Adult Community Mental Health	Improve the quality and expand the capacity of Community Mental Health Services. <b>£460,000</b>	<ul style="list-style-type: none"> <li>• A more responsive service from a team with more capacity</li> <li>• More people supported at home,</li> <li>• Fewer presentations to A&amp;E and fewer admissions to hospital,</li> <li>• Increased capacity of the team</li> <li>• Improved patient safety</li> </ul>
Adult Intensive Home Treatment Support	Improve the quality and expand the capacity of the Home Treatment Team. <b>£265,240</b>	<ul style="list-style-type: none"> <li>• A more responsive service from a team with more capacity</li> <li>• More people supported at home</li> <li>• Fewer presentations to A&amp;E, s136s and admissions to hospital,</li> <li>• Reduction in instances of suicide - improved patient safety</li> </ul>

The dementia pathway	Improving the diagnostic pathway in the county by reducing variation and expanding post diagnostic support – living well with dementia <b>£300,000</b>	<ul style="list-style-type: none"> <li>• More people getting a dementia diagnosis earlier, enabling them to manage their condition more effectively</li> <li>• Improved diagnostic rates for people with dementia in the county</li> <li>• Better quality of support, intervening earlier thereby avoiding crises and hospital admissions</li> <li>• Reduction in the number of people being admitted to formal care settings and high quality support for those who are.</li> </ul>
Children and Young People’s Emotional wellbeing	Developing the voluntary and community provision – building a ‘Big Tent’ – to provide more early targeted support in community and school settings. <b>£95,000</b> <i>(this is funded outside of the MHIS and so is in addition to the £2.3m referred to above)</i>	<ul style="list-style-type: none"> <li>• Better integrated working with Third Sector</li> <li>• More responsive at early stages to CYP in need</li> <li>• Provision in non-stigmatised settings</li> <li>• Clearer pathway</li> </ul>
	Extending and improving the support to children and young people in crisis - Increasing the hours of operation of the Enhanced Outreach Team (EOT). <b>£168,500</b>	<ul style="list-style-type: none"> <li>• Better management of self-harm</li> <li>• Admission avoidance</li> <li>• Improved coping mechanisms</li> <li>• Improved patient safety</li> </ul>
To develop an Enhanced Primary Mental Health Care Service	Emotional Wellbeing for people with lower level mental health needs – VCSE provision with specialist knowledge and expertise. <b>£487,400</b>	<ul style="list-style-type: none"> <li>• More capacity in primary care to support people with mental health needs who do not meet the criteria for secondary care</li> <li>• Reduction in ‘bounced back’ referrals</li> <li>• Prevention of a deterioration in service users conditions</li> <li>• Better management of LTCs, MUS and moderate mental health conditions, that will reduce acute spend.</li> <li>• Reduction in presentations at A&amp;E, admissions to hospital and improved recovery rates</li> <li>• Improved patient safety</li> </ul>
	IAPT – expanding current core provision. <b>£330,800</b>	
	Stepping Up service closing the gap between IAPT and secondary services for those with more complex needs in Primary care. <b>£309,700</b>	

The emerging model underpinning the Rapid Improvement Proposals establishes a platform for the integrated delivery of support to people in need from prevention through early intervention to specialist service levels as represented in the schematic on the next page. This model will help us to deliver the vision outlined in section 4.4 and tackle the major issues set out in our case for change as described in section 6.



The emerging model of delivery will be supported by an expansion of early intervention services, provided in partnership between statutory and VCSE agencies, open to self-referral in primary care and community settings, supporting self-directed care and a **single point of access** (SPA).

The SPA will be led by senior experienced mental health clinicians and social care professionals making appropriate assessments to assist the flow of people accessing the service to the correct specialist 'level' at the start of the respective pathway. The principle supporting this model is one of 'getting it right first time, every time'. People will then step up or down according to their needs.

This model differs from others in that it recognises and seeks to address the gaps that have emerged in relation to people who do not 'fit' the criteria to access the nationally mandated IAPT programme. These include those (at level 1) who need lower level, often practical, support to enhance their coping skills and resilience, and / or people who have higher level needs but lack the motivation or have such anxiety that accessing and maintaining support (such as IAPT) is problematic.

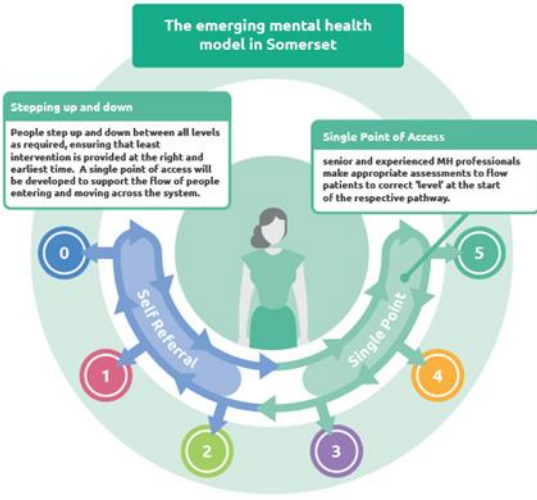
Alternatively (at level 3) there are people who exceed the IAPT criteria but do not meet the thresholds to access specialist secondary care services. Typically these are people with longer term non-psychotic mental health needs, including people with personality issues, and or previous trauma, that impact upon their lives and emotional wellbeing. These two levels are in addition to an expansion locally to the core IAPT offering (level 2).

By focussing support earlier in the pathway, the expectation is that more people's needs will be met earlier, thereby avoiding some of the demand placed on specialist secondary care: releasing those services to have more capacity to meet the needs of those who do require highly specialist support. However, the model also recognises that these specialist secondary care services, (levels 4 and 5), also required both additional investment and a different model of delivery.

Therefore both the community mental health service and the home treatment (crisis) team were reviewed and received further investment to expand their provision. One of the key changes to the mode of delivery is the appointment of eight Recovery Partners, (people with lived experience of mental health problems), to work in each team alongside existing team members in the delivery of care and treatment, (one Recovery Partner in each of the CMHS and Home Treatment Teams). This has a profound positive impact upon the culture of how, as well as what support is provided by these teams.

**Figure 17 : Our new model of care**

Long term conditions, including frailty, are health conditions that can't at present be cured but can be controlled by medication and other treatment or therapies.



What does each levels means?

<b>Offer 0</b>	Building and supporting inclusive communities, understanding what makes people ill, tackling social issues leading to health inequalities eg life expectancy.	<b>Thriving</b>
<b>Promoting positive mental and emotional wellbeing</b>		

<b>Offer 1</b>	Community based support including social and leisure activities that promote emotional wellbeing, often provided by people who have experience of mental health issues.	<b>Coping</b>
<b>Emotional Wellbeing Support</b>		

<b>Offer 2</b>	Improving access to psychological (talking) therapies for anxiety and depression including the use of digital technology. Supporting people with long term conditions and symptom management to meet physical and mental health needs.	<b>Getting help</b>
<b>Timely support and early intervention</b>		

<b>Offer 3</b>	Additional support for people with more complex needs eg experience of previous trauma, who would benefit from specialist talking therapies.	<b>Getting help</b>
<b>Specialist Therapies Service</b>		

<b>Offer 4</b>	Specialist recovery-focused multi-disciplinary mental health support for people with higher level mental health needs including psychosis, severe depression and personality disorders.	<b>Getting more help</b>
<b>Community Services</b>		

<b>Offer 5</b>	Crisis and urgent care support to avoid admissions to hospital eg Crisis Cafes and Home Treatment Teams. Inpatient beds for those who require support in a hospital setting.	<b>Risk Support</b>
<b>Acute/Urgent Care including Home Treatment and inpatient beds</b>		

The emerging model above is already in the active stage of roll out, however it remains an ‘emerging’ model in that we recognise that it is still not the end point of transformed mental health service, rather it is a robust stepping stone.

Over time due to the rise in demand and stretched capacity, the secondary care MH service has raised thresholds, meaning service users often ‘need to deteriorate’ in order to meet the criteria for getting help.

Conversations with people who have used mental health services (often referred to as recovery partners) have described a “cliff edge” which comes after discharge and a feeling that they are left with no one who understands how they feel. They may then see the GP which ultimately may lead to referral back to specialist services.

Recovery partners also noted that whilst they had mental health needs, their physical health needs were often missed. This could lead to a situation where physical illness problems result in recurrence of mental health needs, leading to admission to secondary care. This kind of admission could be avoided if the initial support was available to manage their physical wellbeing.

Strengthening and improving the management of the physical health of people with mental health needs is a key part of our future model and one of the areas we expect to work more closely with primary care to better support physical health and well-being. This, aligned with better social care and self-directed support within communities including the enhanced Recovery College<sup>9</sup> and access to Neighbourhood Peer Support (i.e., locally provided support from people with a lived experience of comparable mental health conditions), will improve self-management, reducing the incidence of relapse, avoid multiple crises and admissions. It will also have an effect of reducing the numbers of people who need secondary care support, thereby reducing wait times which are currently experienced.

Our proposed future model aims to build on mental health, physical health and well-being across the system – with what recovery partners describe as ‘one door’ and ‘no wrong doors’ approach. This means that there are clear accessible routes to support – one door – but even if an individual presents at the ‘wrong’ place they can be helped, or navigated, to the right place for support with a minimal number of obstacles or ‘doors’. This transformative approach will include a range of key features:

- Neighbourhood based peer support workers using a recovery-based model to actively support engagement with community assets

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<sup>9</sup> Recovery Colleges offer educational courses about mental health and recovery which are designed to increase students' knowledge and skills and to help them feel more confident in self-management of their own mental health and well-being. They are deliberately non-stigmatising and are usually co-produced by people with lived experience and professionals working in the field.

- Stronger support within Primary Care to support improved physical health with a more proactive approach to well-being
- In-reach neighbourhood oriented multi-disciplinary (health and social care) team workers providing a community based assessment and brief intervention service alongside advice and liaison to primary care. These workers will be needs led and work to develop a personalised approach to care. It is anticipated that there will be shared care arrangements with primary care and a holistic care and support plan, with both drop-in and bookable appointments.
- Embedding expertise and building skills in relation to a range of difficulties will be a key role in the integrated pathway; with a sustained learning and development plan supporting strengthening of approaches to physical health inequalities, dual diagnosis, and trauma, at risk mental state, support planning and positive risk. In addition, we would anticipate that recovery partners and peer support workers would contribute to training across the whole system.
- Improved use of technology to support hard to reach communities; including a peer led social media platform, and development of digital applications, with patient portal and IT interoperability.

To further support the delivery of the Somerset model and achieve the mental health objectives of the NHS Long Term Plan, the local mental health system (CCG, adult social care, public health, and VCSE providers) bid and were successful in securing additional Transformational Funding from NHSE covering the following areas.

- Children and Young People's emotional support in schools, Tier 2
- Community adult mental health services, dissolving the boundaries between primary and secondary MH care
- Expansion of the Crisis Home Treatment Team to ensure it is fully multi-disciplinary and is 24/7 county wide
- Expansion of Psychiatric Liaison services to ensure Core 24 compatibility

The breakdown of this additional investment over the next three years is as follows.

**Table 15 : Additional investment**

Domain	2019/20	2020/21	2021/22
C&YP Trailblazer	£426,723	£714,150	£758,609
CMHS Trailblazer	£2,815,923	£3,997,705	£3,997,705
Psychiatric Liaison	£659,941	£985,225	£985,225
Home Treatment	£568,394	£568,394	£568,394
<b>Total Additional Funding</b>	<b>£4,470,981</b>	<b>£6,265,474</b>	<b>£6,309,933</b>
<b>Total Additional Funding over the next three years</b>			<b>£17,046,388.15</b>

This £568k investment in Crisis Home Treatment is in addition to the £265k detailed in the rapid improvement proposals table above. The additional capacity from this investment coupled with the change in the service model – increasing peer support – will enable more people to be supported in their own home and thereby reduce the number of avoidable admissions to an adult acute ward. The further expansion of the existing psychiatric liaison will also ensure that the service will be able to fully comply with the nationally recommended Core 24 model.

The table below illustrates the funded *increase* in staff numbers to support the Community Workforce Model. This represents an expansion in both the capacity and expertise of the community workforce, expected to reduce the demand for AWA inpatient beds over the longer term. At the time of writing (September 2019) recruitment is already underway for the NHSE trailblazer bids and the recruitment for Rapid Improvement Proposals has already been completed.

The new Community Workforce Model is already being delivered; the expanded elements will be fully operational from April 2020 and will grow in maturity and effectiveness thereafter. This will result in, before any of the proposed ward moves are made, a fully comprehensive community based mental health provision countywide.

Specific to the northern part of the county, by summer 2020 there will be an additional provision of two Crisis Cafes (one in Mendip, one in North Sedgemoor) that will be able to support people in emotional distress and mental health crises at times of greatest need. This will have a positive impact on reducing some admissions to hospital and will be closely integrated to the community mental health services and the Home Treatment Team.

**Table 16 :** *Increase in staff numbers to support the Community Workforce Model*

Description / role	WTE
<b>Psychiatric Liaison Expansion</b>	
Qualified Staff	12
Support staff	4
<b>Home Treatment NHSE Bid</b>	
Qualified Staff	3.0
Support Staff	6.0
<b>Community Mental Health Rapid Improvement</b>	
Qualified Staff	13.7
Support Staff	6.0
<b>Primary Care Liaison Rapid Improvement</b>	
Qualified Staff	4.0
Trainee PWP	4.0
PWPs	5.0
Trainee HI	3.0
HI CBT	5.0
<b>Stepping Up Rapid Improvement</b>	
Emotional Wellbeing Practitioners	5.0
Psychological Therapists	8.0
<b>Community Mental Health Bid</b>	
Admin	4.40
Third Sector	24.00
Support Worker	12.00
Assistant Psychologist	9.00
FREED Therapist	5.60
Mental Health Liaison Advance Practitioners AMH/OPMH	16.00
OPMH Leads	2.00
<b>TOTAL</b>	<b>151.70</b>

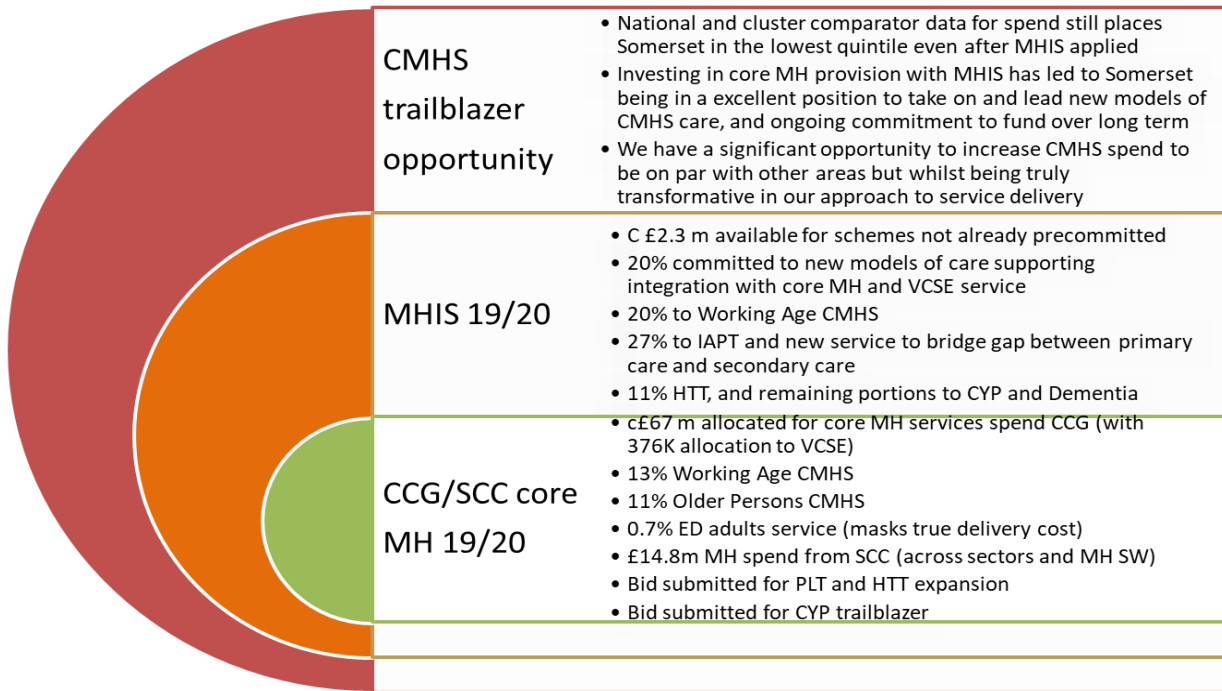
There is a national recruitment challenge: Somerset is not exempt from this, however when approaching the issue of recruitment to the expanded services there are a number of mitigating factors that will benefit the workforce requirements including the following points.

- Consolidating resources on 2 inpatient sites will create more attractive options for recruitment and sustained retention
- A Safer Staffing review has been commissioned by the Chief Nurse on all inpatient wards nationally to include the more effective utilisation of the wider multidisciplinary workforce

- There is no expectation for compulsory redundancies and staff who do not wish to transfer will be offered alternative roles within the expanded community mental health services
- Active recruitment programmes are underway for all mental health services, including proactively approaching universities and other recruitment supply routes, including utilising the Nurse Associate training programme which is active on all the inpatient wards Trust-wide
- A workforce plan has been developed with Health Education England and Local Workforce Action Board, linking in with national initiatives and local universities
- There is a more diverse skill mix proposed in the proposed model – increased peer support workers, with appropriate supervision by qualified staff
- Rowan Ward in Yeovil has historically not had difficulty recruiting staff members and has the highest number of trained staff, therefore whilst we acknowledge workforce is a risk, it is mitigated by the higher numbers of staff on the ward, the good record of both wards in terms of recruitment and the reduced number of staff to support two integrated wards
- Given both St Andrew's and Rowan Wards are stand-alone units their respective staffing numbers are higher than they would otherwise be under 'Safer Staffing'. Therefore if co-located the total number of staff could be safely reduced alleviating some of the recruitment pressures that might otherwise be present
- Recruitment to date for the 'Rapid Improvement Proposals' has been very successful, we have no reason to believe this will be any different going forward in relation to the proposed service changes

In summary, the additional investment and expansion of mental health services is represented in the diagram below, differentiating between the core service, the expansion via the Mental Health Investment Standard, (Rapid Improvement Proposals), and the additional Trailblazer NHSE Transformational funds. This expansion and future model of care is the strategically agreed way forward by all partners.

Figure 18 : Incremental impact of investment





## 8 OPTIONS APPRAISAL

### 8.1 Process followed and assessment criteria

#### 8.1.1 Process

The process followed for the option appraisal described in this section included the following steps:

- A case for change for mental health inpatient services was developed – this addressed both adults of a working age inpatient services and older age adult inpatient services. Following consideration of the paper the Fit for My Future Programme Board determined that for:
  - ~ **Inpatient services for adults of working age** there was a need to consider options that would address key risk issues resulting from maintaining “standalone” inpatient wards and take proposals for change to public consultation. It is this element which is the subject of the option appraisal in this PCBC
  - ~ **Older age adult inpatient services** the Intensive Dementia Support service should be expanded across the whole county and the permanent closure of Magnolia ward should be discussed with the Somerset County Council’s Adult & Health Overview Scrutiny Committee. This change has now been approved by the Somerset CCG Governing Body
- The Fit for My Future programme team identified an initial longlist of options for AWA inpatient services that could potentially address the case for change
- High level evidence was collected to assess the performance of the longlist options against the agreed assessment criteria. After advice from Mental Health and Learning Disabilities Programme Board the FfMF Programme Board determined an option shortlist. Options were not selected to be shortlisted in the event that:
  - ~ Their performance against any of the specific criteria was demonstrably unacceptable based on the evidence available
  - ~ It was clear that their performance against the full range of criteria was such that it is unrealistic they would ever be selected as the preferred option
- Detailed evidence was then identified to assess the performance of each of the options against the criteria and pulled together in an evidence pack
- A stakeholder workshop was held on 12 July. This was attended by patient representatives and a wide range of people from different stake holding organisations and groups (see section 8.4 for more details). The workshop considered the overall case for change, the choice of shortlisted options, and carried out an assessment of the performance of the shortlisted options against the agreed criteria. The workshop was independently facilitated by Participate
- The feedback from the workshop was documented (see Appendix 6] and it was considered by the Mental Health Programme Board, and the Fit for My Future (FfMF) Programme Board. At

its meeting on 6th August 2019 the FfMF Programme Board confirmed its support for a preferred option

### 8.1.2 Criteria

The criteria used in the review were agreed by the FfMF Programme Board on 8<sup>th</sup> May after a process of engagement on what the criteria should be. This included:

- Two focus groups with members of the public, and one with members of staff
- Inviting over 800 stakeholders (individuals and organisations) to feedback on our initial draft criteria.

More detail on this is included in Section 9.3.2 and the feedback report from this report is available in Appendix 6.

The FfMF Programme Board considered the feedback from these events, and then adopted the following criteria:

- Quality of care – impact on patient/service user outcomes, including safety
- Quality of care – impact on patient/service user experience
- Travel times for patients, their carers and visitors
- Workforce sustainability
- Impact on equalities
- Deliverability
- Affordability and value for money

## 8.2 Developing a shortlist of options

The case for change (see section 6) identified a number of substantial risks related to continuing with isolated mental health wards. There are two components to this risk:

- When a single mental health ward is operating on one site this causes problems with providing safe staffing and ensuring that patient risks can be managed effectively
- When a mental health ward is a significant distance away from an acute hospital with an ED the risk when patients display behaviours which are high risk to themselves or others is increased

The two services currently subject to these risks are at Wells (where both risks apply as there is a standalone single ward and it is a long distance from an ED) and at Yeovil (where the first risk applies).

There are a limited number of theoretical options which could potentially resolve either or both of these risks as set out below.

1. **Do minimum** – retain current configuration, including ward locations, functions and bed numbers. Investment would be required over time to ensure the wards were fit for purpose.
2. **Two ward service at Yeovil** using existing ward space at Rowan/Holly Court which could be refurbished to enable the change. This would involve moving the current service at Wells to Yeovil, and no change for the Taunton service.
3. **Two ward service at Wells**, refurbishing an existing ward to enable the change. This would involve moving the current service at Yeovil to Wells, and no change for the Taunton service.
4. **Move all services to Taunton**. This would involve moving both the Yeovil and Wells services to Taunton and would probably require additional building.
5. **Move both the Wells and Yeovil services to another location** in a new build. Clearly this option could have several different location variants. It would not result in changes to services at Taunton.
6. **Move all the services in the county to another location** in a new build. Clearly this option could have several different location variants.

Each of these options was assessed at high level to enable a decision on whether they merited being shortlisted for detailed appraisal.

The supporting evidence for this appraisal is included in Appendix 4 and 5.

The table summarises the performance of the options and the recommendation on shortlisting resulting from that.

Table 17 : Shortlisting assessment

Option	Summary of assessment and shortlisting recommendation
<p>1. <b>Do minimum</b> – retain current configuration, including ward locations, functions and bed numbers. Investment would be required over time to ensure the wards were fit for purpose.</p>	<p>This option does not address either of the two main quality drivers for change (isolated single wards, and isolation from EDs).</p> <p>It is the best option for maximising patient access across the county as it retains services in three locations – nearly 89% of the Somerset population are within a 30 minute drive time in non-peak hours of at least of the one of the current units.</p> <p>The ward at Wells would require significant additional investment of £3.4m in order to ensure acceptable long term quality of accommodation with en suite rooms and disabled access.</p> <p>As this is the current operational configuration it is the benchmark against which all change options need to be measured</p> <p><b>The option was shortlisted for full appraisal</b></p>
<p>2. <b>Two ward service at Yeovil</b> using existing ward space at Rowan/Holly Court which could be refurbished to enable the change. This would involve moving the current service at Wells to Yeovil, and no change for the Taunton service</p>	<p>This option fully addresses both main quality drivers for change.</p> <p>It results in some loss of local access to service as there would be two inpatient locations and not three in the county. 74% of the Somerset population would be within a 30 minute drive of an inpatient facility compared to the current 89%.</p> <p>There are no significant deliverability issues. The capital cost is estimated to be £5.03m</p> <p><b>The option was shortlisted for full appraisal</b></p>
<p>3. <b>Two ward service at Wells</b>, refurbishing an unused ward to enable the change and also investment in the existing ward to provide en-suite facilities and improved disabled access. This would involve moving the current service at Yeovil to Wells, and no change for the Taunton service</p>	<p>This option addresses the problem of standalone wards, but not the issue of distance from an ED.</p> <p>It results in some loss of local access to service as there would be two inpatient locations and not three in the county. @ 71% of the Somerset population would be within a 30 minute drive of an inpatient facility compared to the current 89%.</p> <p>There are no significant deliverability issues. The capital cost is estimated to be £7.2m</p> <p><b>This option was shortlisted for full appraisal</b></p>

Option	Summary of assessment and shortlisting recommendation
<p>4. <b>Move all services to Taunton.</b> This would involve moving both the Yeovil and Wells services to Taunton (the Wellsprings site) and would probably require additional building</p>	<p>This option fully addresses both main quality drivers for change.</p> <p>It results in significant loss of local access to service as there would only be one location not three in the county. Only 45% of the Somerset population would be within a 30 minute drive of an inpatient facility compared to the current 89%.</p> <p>There would be significant deliverability issues in terms of the ability to find space for the necessary new build wards at the Wellspring site, with problems in terms of loss of parking and the need to change access routes. Capital costs are likely to be at least £8.3m. This option would also be in danger creating a ‘campus’ site which would be counter to National policy.</p> <p><b>Not shortlisted as performance is unacceptable in terms of access, deliverability and cost.</b></p>
<p>5. <b>Move both the Wells and Yeovil services to another location</b> in a new build. Clearly this option could have several different location variants. It would not result in changes to services at Taunton.</p>	<p>This option addresses the problem of standalone wards, but not the issue of distance from an ED (unless the new build location was in in Taunton in which case it would effectively be Option 4, or Yeovil in which case it would be Option 3.</p> <p>Without the identification of a specific site the distance impact cannot be quantified at this stage. Performance against travel times will inevitably be worse than option 1, but depending on location may be close to that of options 2 and 3 which both also have two sites retained.</p> <p>Deliverability is very high risk. No specific suitable site has been identified, so there can be no confidence in whether the land would be available, or whether planning permission could be achieved. It would take much longer to deliver than options involving refurbishments to known facilities on existing NHS owned sites. It is considered that performance against this criterion alone is unacceptable.</p> <p>Cost is likely to be £8.9m for the new build alone, with additional costs for site acquisition. This option would also be in danger creating a ‘campus’ site which would be counter to National policy.</p> <p><b>Not shortlisted as performance against deliverability criterion is unacceptable</b></p>

Option	Summary of assessment and shortlisting recommendation
<p>6. <b>Move all the services in the county to another location</b> in a new build. Clearly this option could have several different location variants</p>	<p>This option addresses one of the two drivers for change in terms of single site working, but it would be detrimental in terms of the second driver (access to a nearby ED) unless the new location was either at Taunton or Yeovil.</p> <p>Without the identification of a specific site the distance impact cannot be quantified at this stage.</p> <p>Performance against the access criterion will inevitably be very poor compared to options 1-3 as we would be moving from 3 locations to 1.</p> <p>Deliverability and capital costs would be worse than for any other option, including option 5. The option would require the most substantial new build, probably also needing to include the PICU ward from Taunton as well as the AWA wards. This option would also be in danger creating a ‘campus’ site which would be counter to National policy.</p> <p><b>Not shortlisted as performance against, travel time, deliverability and capital cost are unacceptable</b></p>

### 8.3 Appraisal of shortlisted options - evidence

The shortlisted options are set out below.

**Table 18 :** Shortlisted options

Ref	Description
1	<b>Do minimum</b> – retain current configuration, including ward locations, functions and bed numbers. Investment would be required over time to ensure the wards were fit for purpose.
2	<b>Two ward service at Yeovil</b> using existing ward space at Rowan/Holly Court which could be refurbished to enable the change. This would involve moving the current service at Wells to Yeovil, and no change for the Taunton service.
3	<b>Two ward service at Wells</b> , refurbishing an existing ward to enable the change and also investment in the existing ward to provide en-suite facilities and improved disabled access. This would involve moving the current service at Yeovil to Wells, and no change for the Taunton service.

All options have been designed to meet the projections in section 6.2 regarding future capacity, That section suggests that we should continue to commission 62 beds, but have the ability to

reduce bed numbers by a small amount in the event that the successful implementation of better community based services will allow for this.

The following sections set out in summary the evidence on the performance of the options against each of the agreed criteria.

In each case the assessment focusses solely on the areas where the options perform differentially (i.e. excluding all elements where the option choice would not have an impact on performance). For each factor the tables below identify why the factor is important and then analyse the relative difference between the options.

The tables also rank each option against the specific factor being considered.

### 8.3.1 Quality of care – outcomes/safety

Five factors have been identified where the different options may have a different impact on the patient outcomes and safety of care. These are each addressed below.

Differentiating factor: <i>Distance of the inpatient services from the nearest physical health ED.</i>										
<p><b>Why important?</b> Significant impact on safety of care and potentially on loss of life. Services support patients at risk of harming themselves and others. In the very rare event of this occurring it is essential that the person concerned can be quickly and safely transferred to an ED so that they can be treated effectively. (See section 6.1 for more detail)</p>	<p><b>Key evidence and analysis of options</b> St Andrews Ward in Wells is 22 miles from Yeovil District Hospital and 28 miles from Musgrove Park Hospital. The journey time is approximately 45 minutes. The Rowan Ward at Yeovil is 1 mile away from Yeovil District Hospital, a journey of a few minutes at most (response time is 8 to 10 minutes, conveying the patient to the ED is 5 minutes.</p> <p>This is a significant differentiator between the options as under Option 2 all patients would be supported in wards close to an ED, while under Option 1 and 3 patients occupying 14 beds and 32 beds respectively would be a significant distance and travel time from an ED.</p>	<table border="1"> <thead> <tr> <th style="background-color: #0070C0; color: white;">Option</th> <th style="background-color: #0070C0; color: white;">Rank</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">2nd</td> </tr> <tr> <td style="text-align: center;">2</td> <td style="text-align: center;">1st</td> </tr> <tr> <td style="text-align: center;">3</td> <td style="text-align: center;">3rd</td> </tr> </tbody> </table>	Option	Rank	1	2nd	2	1st	3	3rd
Option	Rank									
1	2nd									
2	1st									
3	3rd									
Differentiating factor: <i>Ability for staff to access support from a neighbouring ward when dealing with high risk incidents/behaviour</i>										
<p><b>Why important?</b> If staff do not have access to backup support when needed their ability to deal with high risk incidents and behaviour may be compromised, or they may be unable to support the remaining patients as required. This could impact on the specific outcomes for patients, and is also a source of stress and potential risk for staff</p>	<p><b>Key evidence and analysis of options.</b> Option 1 retains standalone wards at both Yeovil and Wells and is significantly worse than the other options. Options 2 and 3 both have two wards on a single site, enabling effective backup support to be provided.</p>	<table border="1"> <thead> <tr> <th style="background-color: #0070C0; color: white;">Option</th> <th style="background-color: #0070C0; color: white;">Rank</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">3rd</td> </tr> <tr> <td style="text-align: center;">2</td> <td style="text-align: center;">1st=</td> </tr> <tr> <td style="text-align: center;">3</td> <td style="text-align: center;">1st=</td> </tr> </tbody> </table>	Option	Rank	1	3rd	2	1st=	3	1st=
Option	Rank									
1	3rd									
2	1st=									
3	1st=									



**Differentiating factor: Risk management protocols – impact on continuity of care and on ward casemix**

<p><b>Why important?</b> Having to be admitted to two different wards in different locations within a short period can disrupt continuity of care with negative impact on outcomes and is therefore a significant issue. If one ward is not taking high risk patients it also changes the case mix at the Taunton wards (which may be making it harder for staff on those wards to provide the best possible care to all patients). The evidence from incidents does not suggest the latter point is currently a major issue</p>	<p><b>Key evidence and analysis of options.</b> The limitations of the medical cover at Wells means that under Option 1 a risk management protocol is required which results in up to 40 patients a year having to be admitted first to Taunton and then to Wells. It therefore provides the worst continuity of care and it is significantly worse than the other options for this factor. Option 2 is the best option as there is no impact on continuity of care, and no risk of distorting the case mix at other wards. Option 3 is close to option 2, but is slightly worse as a very small number of patients with high risk of self harm may need to be admitted to Taunton because of the lack of access to a nearby ED.</p>	<b>Option</b>	<b>Rank</b>
		1	3rd
		2	1st
		3	2nd

**Differentiating factor: Availability of 24/7 medical care**

<p><b>Why important?</b> The lack of 24/7 medical care at the Wells site means that out of hours patients at Wells cannot receive rapid medical support when they have escalating needs which may require immediate treatment</p>	<p><b>Key evidence and analysis of options.</b> Medical cover is not available at Wells under Option 1 between the hours of 5pm and 9 am or at weekends and under this option patients occupying 14 beds will not have cover for some of the day. Options 2 and 3 should both address this issue subject to training accreditation for both options.</p>	<b>Option</b>	<b>Rank</b>
		1	3rd
		2	1st =
		3	1st =

**Differentiating factor: *Rapid support for patients with both mental and physical healthcare needs***

**Why important?** Many mental health patients also have physical healthcare needs which should be identified at admission and treatment plans agreed. Junior Doctors support for admissions is a benefit in the rapid identification and treatment of physical health needs. They have recent training on the full spectrum of mental and physical health issues

**Key evidence and analysis of options.** The service at Wells is not accredited to provide training for Junior Doctors and under Option 1 the service would continue to be managed without them. It is anticipated that both option 2 and 3 would receive accreditation for training and would have the benefit of Junior Doctor support. We know that Trainee Doctors are providing significant support to patients at Taunton and Yeovil (see section 6.1.2 for details) and this support is not available at Wells and would not be under Option 1.

Option	Rank
1	3rd
2	1st=
3	1st=

### 8.3.2 Quality of care – patient experience

All the options include the necessary financial investment to ensure patients receive their care in a similarly high quality environment with good disabled access and en-suite facilities. Options therefore perform very similarly under this criteria, with the only major differentiating factor not already identified under the criterion above being the one identified below.

**Differentiating factor: *Continuity of care***

**Why important?** The risk management protocol in place means that up to 40 patients a year currently face disruption to continuity of care as they have to be admitted first to Taunton and then to Wells. Hospital transfers of this nature are disruptive for patients, can result in stress, and may increase lengths of stay

**Key evidence and analysis of options.** Option 1 clearly performs significantly worse under this factor because of the negative impact on the patients experience of the patients who would need to be transferred. Options 2 and 3 perform equally well.

Option	Rank
1	3rd
2	1st=
3	1st=

### 8.3.3 Travel times for Patients, their carers and visitors

The options have a significant differential impact between in terms of travel times for patients, carers and visitors. To assess this we have analysed the following (full details are in Appendix 5):

- What each option would mean in terms of the proportion of the Somerset population within distinct travel time bands by both private and public transport.
- The impact of the options on average travel times for patients
- The impact of the options in terms of travel time increases and decreases for specific groups of patients.

Differentiating factor: Performance of the option in terms of public and private transport travel times – population coverage																																				
<p><b>Why important?</b> Population coverage indicates the relative attractiveness of sites to the total Somerset population in terms of access</p>	<p><b>Key evidence and analysis of options.</b> The table below shows the relative performance of the options on travel time measures. These are based on a comparison of travel times at off peak periods for private transport and on a Tuesday afternoon for public transport. Public transport can change on a daily basis and times are highly dependent on exactly where a person lives, and on their start time, so the figures should be viewed as indicative. However the clear conclusion is that option 1 is significantly ahead of the other two in terms of population coverage. Option 2 and 3 are relatively close, but Option 2 is marginally better on both public transport and proportion of population within 30 minutes. Option 3 is better than option 2 in terms of the percentage of the population travelling 40 minutes or more – so on this factor Options 2 and 3 are considered to be ranked equal.</p>																																			
	<table border="1"> <thead> <tr> <th>Travel time</th> <th>Option 1</th> <th>Option 2</th> <th>Option 3</th> </tr> </thead> <tbody> <tr> <td colspan="4">Private transport (cumulative figures - off peak travel times)</td> </tr> <tr> <td>Journey of less than 30 minutes</td> <td>88.5%</td> <td>73.9%</td> <td>70.4%</td> </tr> <tr> <td>Journey of less than 40 minutes</td> <td>98.3%</td> <td>91.6%</td> <td>98.2%</td> </tr> <tr> <td colspan="4">Public transport</td> </tr> <tr> <td>60 minute journey or less (weekday)</td> <td>50.7%</td> <td>37.2%</td> <td>36.1%</td> </tr> </tbody> </table>	Travel time	Option 1	Option 2	Option 3	Private transport (cumulative figures - off peak travel times)				Journey of less than 30 minutes	88.5%	73.9%	70.4%	Journey of less than 40 minutes	98.3%	91.6%	98.2%	Public transport				60 minute journey or less (weekday)	50.7%	37.2%	36.1%			<table border="1"> <thead> <tr> <th>Option</th> <th>Rank</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>1st</td> </tr> <tr> <td>2</td> <td>2nd=</td> </tr> <tr> <td>3</td> <td>2nd=</td> </tr> </tbody> </table>	Option	Rank	1	1st	2	2nd=	3	2nd=
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1	1st																																			
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3	2nd=																																			

**Differentiating factor: Performance of the option in terms of private transport travel times – using recent patient data**

**Why important?**  
This analysis focusses on how travel times for patients who have recently attended services would change under the options. This is different from population coverage as it shows the realistic change based on a very recent cohort of patients

**Key evidence and analysis of options.** The table below shows the impact of the options on average travel time in minutes using 2018/19 patient data. Option 1 clearly performs the best, but it should be noted that average travel times are only 2-3 minutes worse under the other options if considering all patients. The average patient who was admitted at Wells would have faced a 6 minute longer journey if they had had to go to Yeovil instead (Option 2). The average patient who was admitted to Yeovil would have faced a 7 minute longer journey if they had to go to Wells (Option 3)

<u>Option</u>	<u>Rank</u>
1	1st
2	2nd
3	3rd

	Option 1 (No Change)		Option 2 (two wards at Yeovil)		Option 3 (two wards at Wells)	
	No of admission	Average travel time	No of admission	Average travel time	No of admission	Average travel time
Patients currently attending Taunton	318	49.8	318	49.8	318	49.8
Patients currently attending Wells	105	35.5	<b>105</b>	<b>41.42</b>	105	35.5
Patients currently attending Yeovil	216	40.59	216	40.59	<b>216</b>	<b>47.54</b>
All patients (total)	639	43.9	639	45.06	639	46.23

Note: Impacted patients are highlighted in **bold blue**, Travel times based on journeys at peak time.

We have also calculated how many patients would have had worse travel times under options 2 and 3 than they would have now. Under Option 2 last year 77 patients would have faced a longer journey time, of whom 28 would have a journey time increase by more than 20 minutes. Under Option 3 last year 145 patients would have had a longer journey time, of whom 111 would have had a journey time increase of more than 20 minutes.

Using these average travel times based on last year's patient group it is clear that Option 1 is better than the other options although the gap is not substantial, and that Option 2 is marginally better than option 3.

### 8.3.4 Workforce Sustainability

#### Differentiating factor: Sustainable medical support for options

##### Why important?

Patients requiring inpatient support by definition need specialist input in order to ensure the best possible outcomes and safety

##### Key evidence and analysis of options.

Section 6.1.2 summarises the current issues at the St Andrew's ward in Wells in terms of medical staffing. The lack of training accreditation means it has not been possible to provide 24/7 medical cover and recruitment and retention difficulties in the past (and which could recur as the service depends on two specific staff members) have resulted in over use of locums. Option 1 will not improve the position in any way. It is anticipated that both options 2 and 3 will provide significantly more sustainable staffing. Both would have two wards alongside each other, and it is anticipated that both options would have training accreditation.

Option	Rank
1	3rd
2	1 <sup>st</sup> =
3	1 <sup>st</sup> =

#### Differentiating factor: Sustainable nursing support for options

##### Why important?

Having fully staffed nursing support is essential to the quality of service

##### Key evidence and analysis of options.

The recent experience of the Somerset Partnership Trust is that it has been able to recruit and retain nursing staff at both wards affected by the options (St Andrews at Wells, and Rowan at Yeovil.) There is no particular reason to assume that either location would be more attractive a location for nursing staff in the future. It is likely that Option 1 is the most likely to be able to recruit and retain nursing staff because a large population including potential staff is within a reasonable driving distance or one or both of the sites. It is anticipated that some staff would not be willing to move from Wells to Yeovil, or vice versa, because of their current home location, and therefore that there could be some challenges in the period immediately after implementation. However, there is no reason to assume that either Option 2 or Option 3 will cause significant difficulties in terms of the ability to recruit and retain staff.

Option	Rank
1	1st
2	2 <sup>nd</sup> =
3	2 <sup>nd</sup> =

### 8.3.5 Impact on Equalities

The potential impact of the options on equalities has been considered. However, no factors have been identified which appear to differentiate between the performance of the options. While the current inpatient ward at Wells does not provide good disabled access or en-suite facilities, we have included costs within the appraisal for remedying these issues. We therefore anticipate that under all options patients will have access to high quality facilities supporting privacy and dignity. Assessments against other criteria have identified quality and access impacts but we do not have any analysis which suggests these would bear disproportionately on any protected group. It is therefore suggested that there is no reason to assume that any of the options performs significantly better or worse than the others in terms of equalities. Section 10.2 summarises the Equalities Impact Assessment on the preferred option.

### 8.3.6 Deliverability

Differentiating factor: Difficulty of implementation and transition timescale									
<p><b>Why important?</b> Earlier delivery will mean the issues in the case for change will be tackled more quickly, and the quality of experience may be affected by building works</p>	<p>It is estimated that options 1 and 3 would take 24 months to deliver, while option 2 should take 18 months. None of the options would involve a need for “decanting” of wards during upgrade. It is considered that the 6 month difference represents a relatively marginal difference in favour of option 2.</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="background-color: #0056b3; color: white;">Option</th> <th style="background-color: #0056b3; color: white;">Rank</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">2<sup>nd</sup> =</td> </tr> <tr> <td style="text-align: center;">2</td> <td style="text-align: center;">1<sup>st</sup></td> </tr> <tr> <td style="text-align: center;">3</td> <td style="text-align: center;">2<sup>nd</sup> =</td> </tr> </tbody> </table>	Option	Rank	1	2 <sup>nd</sup> =	2	1 <sup>st</sup>	3	2 <sup>nd</sup> =
Option	Rank								
1	2 <sup>nd</sup> =								
2	1 <sup>st</sup>								
3	2 <sup>nd</sup> =								

### 8.3.7 Affordability and Value for Money

#### Differentiating factor: *Capital Cost of options*

##### Why important?

The system has very limited capital available and a whole range of competing priorities for its use. Options which use less capital are therefore highly advantageous

##### Key evidence and analysis of options.

The table below sets out the capital costs of the different options. The key elements driving costs are

- Option 1. – This option retains wards at both Yeovil and Wells; it would require significant expenditure at Wells to address the lack of en suite facilities and poor disabled access. This expenditure would enable the development of a modern facility at Wells as the current ward there is not acceptable for the long term.
- Option 2 – The existing Rowan ward at Yeovil is of good quality and does not require significant refurbishment – options costs allow for a major refurbishment of a second ward.
- Option 3 – Both the current ward (St Andrews) and an additional ward would require substantial upgrade and refurbishment which is why costs are highest for this option.

Initial Capital Costs	Option 1	Option 2	Option 3
Building Works	1,964,000	2,862,000	4,120,000
Overheads	197,000	288,000	412,000
Design Risk	197,000	317,000	412,000
Build Contingency	118,000	175,000	248,000
Fees	372,000	548,000	779,000
<u>Net cost excl VAT</u>	<u>2,848,000</u>	<u>4,190,000</u>	<u>5,971,000</u>
VAT	570,000	840,000	1,195,000
<b>Total Costs</b>	<b>3,418,000</b>	<b>5,030,000</b>	<b>7,166,000</b>

Option	Rank
1	1st
2	2nd
3	3rd

**Differentiating factor: Revenue Cost of options**

**Why important?**

We have described the very challenging financial position in Section 6.3 . It is therefore essential that we minimise additional costs related to options

**Key evidence and analysis of options.**

The table below shows the revenue costs of the different options. All options will cost more in 2023/4 than now because of inflation. The additional costs of capital of options 2 and 3 are mitigated by savings in staffing, as it is more efficient to staff 2 wards together on a single site, than to manage them as separate wards. There is a significant gap between the options, with Option 1 being the worst by a significant margin. Option 3 is more expensive than option 2 primarily because of the significant extra build costs which result in annual capital charges being greater.

Cost element	2019/20	Costs in 2023/4		
	Current cost	Option 1	Option 2	Option 3
	£	£	£	£
<b>Ward costs</b>				
Ward Pay	3,070,473	3,455,844	3,080,285	3,080,285
Ward Non Pay	356,392	457,398	374,670	374,670
Drugs	54,830	61,712	55,076	55,076
Medical	340,694	383,454	274,795	274,795
<b>Capital/site revenue costs</b>				
Depreciation	107,269	272,338	300,974	429,037
3.5% Public dividend capital	90,322	197,056	181,081	309,488
<b>Total</b>	<b>4,019,980</b>	<b>4,827,803</b>	<b>4,266,880</b>	<b>4,523,350</b>

Option	Rank
1	3rd
2	1st
3	2nd



## 8.4 Stakeholder assessment of options

A key part of the option appraisal process was a stakeholder event on 12<sup>th</sup> July 2019. This event was independently facilitated by Participate and was attended by a range of staff, patient representatives and organisations working in the mental health arena as set out in the table below.

**Table 19 : Event attendees**

Attendees from....	Number
Somerset Partnership Trust staff from the service area	7
GP (with an interest in Mental Health)	1
Healthwatch representative	1
Patient Participation Group representatives	2
Patients and carer representatives	5
Mental health organisations representatives	4
<b>Total</b>	<b>20</b>

The representatives were taken through a structured process to consider the case for change, the proposed model of care, the criteria to be used to assess the options, and the relative performance of the options. This was supported by a number of presentations from Dr Alex Murray the clinical lead for the Fit for My Future Programme. Participants were asked to discuss the options, considering the following questions:

- What was good about them?
- What were there concerns?
- What else needed to be taken into account?
- What further information was needed?

The key findings from the discussion as recorded by the independent facilitator are set in the box below.

### Key Findings

Overall, participants gave the impression that they felt something needed to change but stated retention of staff, travel and gaps in service as their main concerns. Travel was considered by some to be manageable if it meant the quality of service would be improved, others however, were concerned that travel would have a large impact on staff retention and patient accessibility. Generally, participants gave the impression at this stage that they were leaning towards Option 2 as the preferred option with some feeling it was a done deal already. A few people thought there should be other Options and that *'it is not as simplistic as it has been presented'*.

Following the discussion participants were asked to give their own personal view on the performance of the options against the individual criteria, in each case confirming whether they thought it did not meet the criteria (red), was a good fit (yellow) or it exceeded the criteria (green). The table below sets out their evaluation.

**Table 20 :** *Stakeholder assessment of option performance*

Evaluation Criteria	Option 1 Do Minimum; retain current configuration			Option 2 Relocate Wells service to Yeovil			Option 3 Relocate Yeovil service to Wells		
	Doesn't meet the criteria	Good fit	Exceeds the criteria	Doesn't meet the criteria	Good fit	Exceeds the criteria	Doesn't meet the criteria	Good fit	Exceeds the criteria
Quality of care	10.5	4.5	0	0	5	11	10	5	0
Impact on patient and carer experience	12	1	0	1	2	12	8	7	0
Travel times for patients, carers & visitors	0	8	7	3.5	11.5	0	3	11	1
Impact on equalities	6	8	0	1	5	10	1	7	8
Affordability and value for money	1	12	0	0	10	2	12	3	0
Deliverability	6	7	0	0	11	4	14	0	0
Workforce sustainability	5	5	5	2	7	5	9.5	5.5	0
<b>TOTAL</b>	<b>40.5</b>	<b>45.5</b>	<b>12</b>	<b>7.5</b>	<b>51.5</b>	<b>44</b>	<b>57.5</b>	<b>38.5</b>	<b>9</b>

These scores are clearly based on individual judgements and their sole purpose is to indicate the views of the attendees – each of whom may have placed different importance on different factors

and taken account of different evidence. There is also no consideration of the relevant importance of each criterion. However, they provide a useful indicator of how an informed group taken through the evidence viewed the options.

The table below summarise the assessment by assuming that if a person thought an option did not meet a criterion it would receive 0 points, if it met the criterion it would receive 1 point, and if it exceeded the criterion it would receive 2 points.

**Table 21 :** Stakeholder views on options turned into overall scores

	Option 1 Do Minimum; retain current configuration			Option 2 Relocate Wells service to Yeovil			Option 3 Relocate Yeovil service to Wells		
	Doesn't meet the criteria	Good fit	Exceeds the criteria	Doesn't meet the criteria	Good fit	Exceeds the criteria	Doesn't meet the criteria	Good fit	Exceeds the criteria
No of assessments	40.5	45.5	12	7.5	51.5	44	57.5	38.5	9
Points	0	1	2	0	1	2	0	1	2
Weighted score	0	45.5	24	0	51.5	88	0	38.5	18
<b>Total option weighted score</b>	<b>69.5</b>			<b>139.5</b>			<b>56.5</b>		

The table indicates that overall attendees were expressing a strong preference for option 2 and that options 1 and 3 were both considerably less attractive.

## 8.5 Option appraisal conclusion

The table below draws together the conclusions on the performance of the options against the criteria and sets it alongside the outcome of the stakeholder workshop.

**Table 22 :** *Summary of option appraisal*

Criteria	Performance
Quality of care (including both outcomes and safety)	On the 5 differentiating factors identified Option 2 is ranked either first or first equal under every factor. Option 3 performed equally well on 3 factors but on one was significantly worse than Option 2. This is the critical issue of distance from an ED with potential for high risk for patients. On another it was marginally worse. Option 1 performed poorly on all factors. It has the same problem as Option 3 in terms of distance from ED and it also does not have any adjacent wards allowing staff to provide backup support when there is an incident which ward staff are having difficult dealing with <b>Option 2 is clearly the best on this criterion. It provides the safest environment for patient and is most likely to lead to good patient outcomes</b>
Impact on patient and carer experience	Both Options 2 and 3 perform significantly better than Option 1 on the only identified differentiating factor. <b>Options 2 and 3 are equally good on this criterion.</b>
Travel times for patients, carers & visitors	On all measures identified including private and public transport assessments, and journey times Option 1 is clearly the best option by some distance. It is arguable which of Options 2 and 3 is better, <b>Option 1 performs the best. The other two options perform similarly</b>
Impact on equalities	No difference between options
Deliverability	Option 2 will be the quickest option to deliver by 6 months. The other two options have very similar timescales. <b>Option 2 is the best on this criterion</b>
Workforce sustainability	Different considerations apply to the medical and nursing workforces. Option 1 has the highest risks in terms of medical staffing sustainability, and inevitably results in a continuation of the position where one ward is not supported by trainee doctors. This is considered a substantive issue. It is likely however that option 1 would be the best in terms of recruiting and retaining nursing staff because it has a larger catchment population and there is no risk of losing staff as a result of ward relocation. However, after the immediate transition there is no reason to assume this would result in a significant problem. <b>Options 2 and 3 are the best under this criterion as the impact of the medical staffing issues outweigh the potential advantage of option 1 in terms of nursing staff.</b>

Criteria	Performance
Affordability and value for money	Option 2 is the best option over the long term as annual running costs are circa £250k per annum less than Option 3 and circa £550k less than Option 1. It also requires significantly less capital than Option 3. <b>Option 2 is the best option by a significant margin</b>
Stakeholder views at July 12 workshop	See section above for summary of analysis. <b>Option 2 was the strong preference as preferred option as shown in Table 21.</b>

### Preferred option

After detailed consideration, Option 2 (to create two wards in Yeovil and relocate from Wells) has been identified as the clear preferred option. It performs best by a considerable margin on quality of care/safety. It also provides the safest environment for patients, and the best opportunity for good outcomes. On affordability and value for money of ongoing running costs, Option 2 is also the best option by a significant margin.

There are no criteria on which Option 3 (to create two wards in Wells and relocate Yeovil) performs better than Option 2. Option 3 does provide adjacency support to both wards, however the distance from an ED would compromise the quality and safety for each ward.

While Option 1 performs better than Option 2 in terms of travel times, this is more than outweighed by the poor performance of Option 1 against the other main criteria. Option 1 does not sufficiently address the relative isolation of the unit in terms of adjacent support and distance from an ED.

It is concluded that Option 2 (which involves moving inpatient services from Wells to the Yeovil site, adjacent to the current Rowan Ward) should be taken forward to public consultation as a proposal. There are no changes proposed to the overall number of beds; in our proposal, there will be 32 beds across two 16 bedded wards, which will include two designated as extra care beds, plus the existing s136 suite.

## 9 ENGAGEMENT AND CONSULTATION

### 9.1 Our Communications and Engagement Commitment

We established our principles of communications and engagement at an early stage in order to shape our continuing approach to Fit for my Future and ensure consistency and quality of approach across the programme<sup>10</sup>:

- **Openness and Transparency:** We will be open and transparent in our approach, communicating and engaging as widely as possible to encourage open and honest debate and feedback. Health and care leaders and experts will explain our changes as comprehensively, openly and frankly as they can
- **Effective and meaningful engagement:** We will be as creative as possible in our engagement, working with existing user and patient involvement channels and seeking out new ways of reaching the seldom heard to ensure all are heard and listened to. We will listen to all views, and take account of what they say [see Appendix 6, 7, 9 and 10]
- **Equality:** We have carried out a full assessment of the likely impact of any changes which could affect health inequality; and have researched the most appropriate channels to carry out targeted engagement activities. Engagement events will be held in a mix of areas chosen for their contrasting demographic diversity and geography to reach the most representative cross-section of the communities of Somerset
- **Accessibility:** Our documents will be published on a dedicated website and made available in print and different formats to meet specific needs. We will present them in clear, plain language with simple explanations of the clinical evidence base, the proposed changes and how people might influence them
- **Clinical input and patient views:** Clinical staff - the experts in delivery of care - will be closely involved in engaging with patients, service users and communities. We will ask clear questions and give opportunities for those people to be involved in the design of new services so patient views and experiences can be considered alongside clinical input
- **You said, we did:** We will listen and consider ideas, proposals and suggestions, before key decisions are made, and we will feedback how we are using the ideas and views we receive
- **Informing and engaging staff:** We recognise the uncertainty for staff during times of change; we will keep them regularly updated, even when there may be little to report. They are crucial change ambassadors and advocates for new ways of working and new service models

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<sup>10</sup> See Appendix 9 ] “Fit for My Future Communications and Engagement Strategy”

We recognise that we cannot achieve our goals in isolation; we have harnessed the knowledge and experience of our clinical membership, CCG and council commissioners, and that of our provider partners throughout the development of our overall strategy and our mental health model.

## 9.2 Clinical focussed engagement

Clinicians and staff who are responsible for providing mental health services have been heavily involved in leading the development of the proposed model for delivery of mental health services, in identifying the need to change the configuration of inpatient services, developing the evidence to support the appraisal of options in this business case and in identifying the options strengths and weaknesses. The involvement includes:

- **Senior GP commissioners.** The current clinical lead for the whole Fit for My Future Programme, Dr Alex Murray, was involved in the first stages of the programme as lead clinician responsible for the mental health workstream and she has personally led stakeholder engagement on mental health issues, contributing significantly to the stakeholder workshop on 12<sup>th</sup> July. The workstream now benefits from the leadership of Dr Peter Bagshaw who chairs the Mental Health and Learning Disabilities Programme Board. Other primary care medical staff on the Board includes Dr Amelia Randle who leads on learning disabilities and safeguarding
- **Engagement with wider GP body,** the emerging model has also been presented to and refined by the CCG's Clinical Executive Committee (CEC) on a number of occasions through its development. We have sought input from our wider GP membership through our quarterly GP Roadshows
- **Engagement with senior health and care professionals.** The emerging model and proposals for acute mental health inpatient beds have been presented to senior health and care representatives from across Somerset
- **Consultant psychiatrists who lead inpatient services in Somerset.** A number of clinical leads from within the Trust have also led on the clinical models development, most notably Dr Sarah Oke, Medical Director leading on adult mental health, and Dr Lucy Knight, Medical Director leading on CAMHS and Older People's Mental Health – and their respective clinical teams
- **Other staff supporting inpatient services.** Significant input from the Somerset Partnership Trust manager responsible for all the inpatient wards has facilitated the provision of much of the evidence to assist in option assessment, and he has worked with the estates team to ensure the options developed will be fit for purpose. Prior to this stage of the process the Trust had held many workshops and meetings with clinical and operational teams over the last few years to explore the issues and identify options to deliver solutions to the challenges presented by the current inpatient configuration. The Trust Board itself (and the executive team) have also very regularly discussed and reviewed the situation for the past few years
- **Staff providing community based care for people with mental health issues** and the wider health professionals within the Trust have been regularly updated and their views sought via

staff briefings, away days for managers and the normal Trust cascading of information processes (e.g., their intranet, newsletters, briefing emails, etc.)

- **Wider system partners including social care** practitioners have been informed and involved in the clinical model's development most notably via the Mental Health & Learning Disabilities Programme Board and its supporting Collaborative Groups (multi-agency forums covering adult mental health, older people's mental health, children and young people's emotional wellbeing, and learning disabilities and autism) as well as other forums that report to the MH&LD Programme Board such as the crisis concordat and the suicide prevention group

### 9.3 Engagement with staff, the public and other stakeholders.

This section outlines our engagement with staff, the public and other stakeholders that are informing our proposals for consultation later in the year (see Appendix 6 and 7).

The purpose of our pre-consultation engagement was to:

- Provide meaningful information to help people understand and feel confident enough to get involved and share their views
- Listen to their views and ideas
- Use the information from the pre-consultation engagement to shape and refine our proposals and the criteria we use to assess them ready for public consultation
- Work with a wide-ranging group of people to co-design our approach to consultation for acute mental health inpatient beds

In order to meet our principles of transparency and openness we adopted the following approach which included five specific elements:

- Early engagement on the case for change and emerging proposals for health and care in Somerset
- Engagement on the criteria for option appraisal
- Participation in the option appraisal
- Participation in designing our approach to public consultation
- Regular communication with the Somerset County Council Adult and Health Overview Scrutiny Committee and the Health and Wellbeing Board

Each of these is described in more detail below



### 9.3.1 Autumn engagement – Fit for my Future case for change and emerging options, including mental health

During autumn 2018 we carried out an extensive engagement exercise on the broad case for change, across all Fit for My Future workstreams including mental health. Somerset Partnership had already carried out some engagement on the future of St Andrew's Ward in Wells however the Fit for My Future Autumn engagement considered the wider mental health model including the future configuration of acute inpatient mental health beds for adults of working age. Our engagement approach is set out below:

- **Bespoke Fit for my Future website** setting out our case for change, briefing materials, details of drop-in sessions held in the autumn, and published reports setting out the feedback we received from each of our engagement events. From the public launch on 2 October to 19 December, 740 unique visitors visited our website and together they viewed 7,024 pages
- **Social media** Facebook and Twitter have been used extensively throughout our engagement so far, including four Facebook Live events, one of which focused specifically on mental health. Short videos and online polls have been incorporated into social media to engage and educate people in the concepts of Fit for My Future and supporting the healthy lifestyle and health and wellbeing ambitions of our vision. During the autumn engagement we achieved the following reach:
  - ~ Twitter – 223 followers (from a zero base) and 286 tweets
  - ~ Facebook – 222 followers (from a zero base) and 58 posts
  - ~ Facebook Live – 4 events; 1,934 views, 1418 minutes watched and 71 comments

Social media was monitored throughout the autumn engagement (and continues to be) to discern and respond to views and concerns of those engaging on line, including lobby groups; so far only one small online lobby group concerned with transport and access has emerged.

- **Face to face engagement sessions** From summer to December 2018 we ran twenty drop-in sessions, attended by 315 people, across the county at different times of the day to reach as many people in as many different locations as possible
- **Online and paper survey** Responses from our survey totalled 659 and the results were published on 23 January 2019 in a document 'You said, we listened'. 84% of respondents were residents, the remaining 16% included a range of organisations such as Diabetes UK; getset; Taunton Deane Borough Council; Street Man's Shed; Medical Centres, Action on Hearing Loss; Compass Disability; British Red Cross; Young Somerset; and Community Mental Health Services
- **Stakeholder outreach** At the outset we sought the views of 725 stakeholder organisations, charities, community groups, patient groups, GP practice managers, PPG chairs and parish,

district and county councillors. The Programme Director and other members of the programme team attended a series of meetings including PPG Chairs, Healthwatch Board, Community Hospital Leagues of Friends and Somerset Engagement Advisory Group. The Chair of Healthwatch is a standing member of the Fit for my Future Programme Board

- **Political briefings.** We know that there will be great political interest in the wider strategy as we engage on the detail of individual programmes. We have engaged with MPs through briefings and face to face meetings, the Health and Wellbeing Board, and Somerset’s Adults and Health Scrutiny Committee throughout the development of the Fit for my Future programme and continue to do so. During our autumn engagement we invited district and county councillors and the chairs of neighbouring HOSCs to a series of special briefings, which 32 councillors attended. We are working with Somerset County Council to arrange special workshops for the Health and Wellbeing Board and the Scrutiny Committee to ensure they understand the scope and detail of the overall programme and, at this stage specifically the mental health model, in order to come to properly informed positions
  - ~ We recognise the sensitivity of the options set out in this business case and part of our pre-consultation planning for the summer will pay particular attention to local MPs and councillors from parish and district councils across the county
  - ~ We have been in contact with the HOSCs of our five neighbouring county and unitary council areas and, subject to their agreement, hope to attend meetings of each in the autumn
- **Stakeholder and service user involvement in mental health** - External stakeholders, including representatives from MIND, Rethink and Young Somerset, all of whom are on the Mental Health and Learning Disabilities Programme Board, have been involved in developing the model from the outset

The findings of this engagement were published in a document ‘You said, we listened’ on 23 January 2019 and available at <https://www.fitformyfuture.org.uk/> and included as Appendix 1.

## What we learnt and how we have responded

Overall the concepts outlined in the overall case for change during the autumn engagement met with a positive reception. On mental health, 93% of people agreed that services for people with mental health conditions should be afforded the same priority and focus as services for people with physical health conditions. There was support for greater investment in mental health services if real change was to happen. One of the emerging proposals set out in the case for change specifically focused on a review of the capacity and configuration of mental health inpatient services for adults of working age, the subject of this business case, but there were no comments specifically relating to this during the autumn engagement. However, some of the suggestions and ideas captured support the wider expansion and investment in community-based mental health services. Suggestions included greater reliance on local community based services and more support to GP surgeries to promote prevention of mental health conditions with more psychological wellbeing practitioners and psychological therapists working out of community hospitals and GP surgeries ('You said, We listened' Appendix 1, p16).

The detailed suggestions for what we had missed and additional ideas provided a rich source of feedback; this was passed to each of the workstreams, including mental health, and continues to be used in shaping and refining emerging proposals in each of the settings of care programmes.

The suggestions specifically relating to mental health reflect the work underway to invest in and expand the community based mental health services.

### **9.3.2 Engagement on criteria for option appraisal**

In January and February 2019 we commissioned Evolving Communities, who run Healthwatch Somerset, to facilitate three focus groups, two with members of the public and one with staff, to facilitate discussion and seek views on a 'straw man' list of criteria. The staff focus group was especially well attended, with a broad cross-section of clinical and commissioning staff from the CCG, the county council, the acute hospitals and Somerset Partnership.

On the whole there was good support for the list of potential criteria. Additional criteria, and suggestions from the participants to refine the existing ones, included:

- Greater digitalisation
- Consideration of how each criterion performs in integrating organisations, services and teams alongside an alignment of needs, outcomes, responsibilities and use of resources
- Separate criteria to assess how each option promotes whole system planning, whole system and cultural change, and how each option promote the alignment of cultural differences across organisations and of organisational objectives
- Affordability and value for money must be aligned to effectiveness / quality
- Prevention of ill health

- Under the criteria relating to travel times, consider the impact on each option of local authority transport plans
- Impact on carers; it was suggested that this should be a consideration under the criteria concerning the impact on equalities
- Impact of proposals on organisations / services such as police / ambulance / GP practices / local authority and other sectors including community / voluntary organisations
- On workforce sustainability, consider how the options perform in integration of workforce, enabling the sharing of skills and a 'one team' culture

#### How we have responded

We have responded in the following ways to the feedback from the engagement on option appraisal criteria:

- The central importance of digitalisation was recognised by the Fit for my Future Programme Board who refined the vision for the programme to incorporate digitalisation (see Vision infographic on page 19)
- Membership of the deliberative workshop to appraise the mental health model was extended to include police, ambulance and primary care
- Rurality and access are significant issues in Somerset; we have taken advice from Dorset and Weston about how best to consider these in our modelling, including community transport
- Prevention is considered to be one of the underpinning ambitions of the entire programme and therefore not a criterion
- Consideration of the impact on carers of proposed changes to services has been captured in the equality impact assessment and will be a consideration under the impact on equalities criterion

The feedback was considered when the evidence collation for the option appraisal was taking place, so that these factors appeared relevant in terms of differentiating between options they could be taken into account.

#### **9.3.3 Engagement on option appraisal for acute mental health inpatient beds for adults of working age**

We commissioned Participate, a company with a great deal of national experience of engagement and consultation in the health and care sector to provide external support, independence and expertise for our option appraisal and consultation processes. We wished to ensure that the reports on the findings from the engagement were produced independently so that the findings were not in any way influenced by the programme team or provider staff.

Based on Participate's advice we decided to have a stakeholder workshop to help us consider and appraise our options. This took place on 12<sup>th</sup> July 2019. The outcome of the workshop is covered in section 8.4 of this business case. Participate's report of the workshop is attached at Appendix 6.

### 9.3.4 Co-design of consultation strategy for public consultation

On 31<sup>st</sup> July, the same group of people were invited to a further workshop to co-design the consultation strategy for public consultation, attached at Appendix 7.

The same group of people were invited to continue as a reference group throughout the remaining engagement and consultation activity through to conclusion and reporting.

### 9.3.5 Working with the Somerset County Council Adult and Health Overview Scrutiny Committee and the Somerset County Council Health and Wellbeing Board

From an early stage in the development of the overall Fit for my Future programme we have been regular attendees at Somerset County Council's HOSC, keeping members abreast of developments in the case for change and the evolving shape of the programme. We have worked closely with Somerset County Council officers who have also been integral to this as work has progressed.

In addition to the details of the programme, we have engaged and informed HOSC members of our plans for engagement and reported back to them on the results.

In September 2018, prior to the public launch of Fit for my Future we attended the HOSC. The Committee received a report about the development of the Somerset Health and Care Strategy. Members were informed that work was underway to develop proposals which will address the challenges identified in the draft case for change, focused on a series of themed workstreams; urgent and emergency care, proactive care, long term conditions and frailty, mental health and learning disabilities, children's and maternity services, planned care and cancer. Members noted that a multi-agency group had also been established to work together in developing and delivering a communications and engagement strategy."

On 5 December 2018, a further report to the HOSC updated members of the continuing progress of Fit for my Future. The Committee considered the report which included an update on the Somerset Health and Care Strategy, commented on the proposals and noted the overarching strategy, and the autumn public engagement.

On 5 June 2019 the HOSC received a detailed report, updating members on the programme and the developments of work under the three settings of care – acute, neighbourhoods and community, and mental health services. Members considered the report which included an update on the outcomes of the engagement on the selection of option appraisal criteria, our plans for continuing engagement for option appraisal, co-design of programme consultation strategies, and the recruitment of a citizen's panel to assist engagement with hard to reach groups and quiet voices.. On 11<sup>th</sup> September 2019 we reported on the output of the two workshops mentioned above and the next steps. On 2 October we reported further in closed session on the detail of this business case and our consultation proposals

We have also been regular attendees at the Health and Wellbeing Board, updating members of progress and emerging proposals for Fit for my Future, and the detailed plans for engagement.

## 9.4 Public consultation

We have developed

- A consultation strategy (attached as Appendix 9)
- An operational plan for the consultation (attached as Appendix 10)

They are summarised below

### 9.4.1 Consultation strategy

NHS Somerset CCG has been working with independent engagement and consultation specialists, Participate, to develop a strategy to consult with stakeholders and the public. Our aim has been to create meaningful engagement with local people and stakeholders to involve them in deliberations about the future configuration of acute inpatient mental health services for adults of working age. The approach will be responsive and proportionate to the community as a whole.

The consultation strategy has been informed by the members of same stakeholder panel which was involved in our option appraisal. The panel met on 31st July and made suggestions on who should be consulted, and the most effective means of consultation.

In addition to an extensive distribution plan for the consultation document and materials, and a strong online presence, targeted involvement will provide further opportunities for those potentially affected to have their say and share their views with us.

This plan is based on existing pre-engagement work with stakeholders, including:

- Somerset Partnership NHS Foundation Trust (SOMPAR)
- Primary Care Network
- GPs (with an interest in Mental Health)
- Healthwatch
- PPG networks
- Patients and carer representatives
- Mental health organisations

In developing our strategy we have focussed on ensuring adherence 'Gunning Principles' outlined below.

- Consultation must take place when the proposal is still at a formative stage
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response
- Adequate time must be given for consideration and response
- The product of consultation must be conscientiously taken into account

Our aim is to maximise the “reach” of the consultation. We will of course seek the views of people who have used our mental health inpatient services, but we will go much further than this, ensuring we have input from g families and carers of inpatients, staff, stakeholders and the public at large.

A targeted communications campaign will run prior to and over the 14 weeks consultation period to ensure the public are made aware of the consultation; two additional weeks have been included to account for the two week Christmas holiday time. This will include features in the local press, regular press releases sent out to local media organisations and parish & community Facebook pages, and posters in GP surgeries and public venues.

Information will be sent to neighbouring CCGs, and Somerset providers, partners, third sector and voluntary organisations and networks with an interest in Mental Health. The FfMF team will work with local authority colleagues to ensure that materials are circulated via their local channels as well, including libraries and leisure centres.

The methods of consultation will vary, including focus groups and attendance at pre-arranged meetings, and will be targeted to ensure the consultation is inclusive.

#### 9.4.2 Consultation operational plan

##### Responsibilities

Responsibility for the Consultation Strategy lies with the CCG however it is important that we work closely with Somerset Partnership to implement the plan, ensure communications and messaging are consistent and achieve the widest reach of patients and service users.

The Fit for my Future communications and engagement team is responsible overall for the planning and implementation of the consultation plan and approach, working very closely with the NHS Somerset CCG Head of Communications and Engagement and team.

A multi-agency sub-group has been established to drive through the detailed planning, logistics and delivery of the consultation; membership will include the Fit for my Future and CCG teams, and communications and patient engagement colleagues from Somerset Partnership.

We will brief Healthwatch volunteers in advance of the go-live date so they can reach out to they can encourage people to feedback through their network of community contacts.

## Programme

Subject to the necessary approvals being achieved, consultation will commence on 7 November 2019.

The key components of the programme will include:

- Wide distribution of the summary consultation document of approximately 12 pages – we anticipate this will be the version most often read – and we will send it to all stakeholders we have identified. It will include a feedback questionnaire. We have asked a lay readers panel to review our consultation materials.
- An easy read version of the consultation document
- Access to all key documents and the questionnaire through the FfMF website
- Active use of digital media (e.g.: Facebook live events)
- A representative group of people who reflect the geography and interests of past and present patients, carers, staff and other stakeholder to consider the transport and access implications of the preferred option and potential mitigation
- Staff briefings
- Attendance at a wide range of public meetings
- “Pop-in” events at each of the three locations currently providing services
- Focus groups and/or 1-1 conversations with current and past service users and carers
- Clinicians acting as key spokespeople for media events

## Consultation responses

All responses will be received and logged by the consultation response officers in the Fit for my Future team. Questionnaires can be completed online, posted or emailed. People may also ask for support in completing a questionnaire.

All questionnaire responses will be fed into the online survey platform, Questback, which will also provide partial analysis. More detailed analysis of the rich qualitative information within text fields of the survey will also take place.

Participate will review and analyse all feedback and write an independent report on the outcome of the consultation.



## 10 ASSURANCE

### 10.1 Compliance with NHS tests for significant service change

This section describes the assurance process and how the work within the PCBC meets the NHS Five Tests and what will be done in the future to continue this work during and after the consultation period.

The five tests set out that proposed service changes should demonstrate evidence of:

1. Strong public and patient engagement;
2. Consistency with current and prospective need for patient choice;
3. A clear clinical evidence base;
4. Support for proposals from clinical commissioners; and
5. Proposals for hospital bed closures should meet specific preconditions

#### South West Clinical Senate

The South West Clinical Senate has considered the Case for Change and held a Clinical Review Panel (CRP) that convened on 5th September 2019 to review the proposals for change. The panel formed an independent clinical review 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. 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. The Clinical Senate Panel supported the proposal to move the location of 14 beds as described, which is supported by clinical evidence and best practice, and confirmed that the bed test is not applicable for this review as there are no plans currently being proposed to reduce bed numbers.

#### NHSE/I Assurance Process

The NHSE/I Assurance process for service reconfiguration has consisted of two checkpoints; a stage 1 strategic sense check and a stage 2 assurance checkpoint. Stage 2 took place on 21st October 2019 and comprised a formal, detailed exploration of the service change being proposed. Following presentation of the draft PCBC and consultation documentation, NHSE/I provided feedback particularly around the consultation document and this feedback has been incorporated.

The NHSE/I Assurance process for service reconfiguration has enabled the regional team to provide broad assurance against the four key tests of service change and the NHS England Beds test and the proposed consultation

### 10.1.1 Strong patient and public involvement

Section 9 demonstrates clearly the extensive patient and public engagement we have carried out to support the proposals within this business case. It also shows our comprehensive plans for the proposed public consultation.

If the proposed option is agreed as the way forward we will work closely with patients and patient representatives to ensure that:

- The transition of the service to Yeovil is managed with least disruption possible to existing patients
- There is good awareness of non-bed based local services in the Wells area
- Patients have input into the design of the upgraded ward facilities at Yeovil
- We do as much as we can to support any patients/carers who have difficulty in travelling to Yeovil

### 10.1.2 Consistency with Current and Prospective Need for Patient Choice

Mental health inpatient services are primarily for patients who are having some form of crisis in their lives; admissions are not planned for some point in the future but need to take place immediately on assessment. As with all emergency services this means that the NHS is not normally in a position to offer a choice of which provider will offer care, nor the location of the service that will be used. This is therefore not a service in which patient choice plays any significant role.

There is often a balance to be achieved between the number of places where treatment is offered to patients and the quality of the treatment. This is shown clearly in this PCBC where the option appraisal demonstrates that the proposed option best supports quality of care, but does not perform as well as the current service in terms of travel times, because instead of three locations the service would have two in the future.

A key element of the consultation will be to obtain feedback from patients and the public on this balance and whether they believe the preferred option is the right way forward in terms of considering both the quality of care and the number of locations.

### 10.1.3 Clear clinical evidence base

The evidence supporting the case for change and why the preferred option offers the best quality is set out in sections Table 5 : 6 and 8.3.1. This has been subject to clinical review at the NHS Clinical Senate in September 2019; the proposals were endorsed by the Clinical Senate with a number of refinements which have been fully incorporated into this document as appropriate [ref Appendix 14]. The Clinical Senate panel supported the proposal to move the location of 14 beds as described, which is supported by clinical evidence and best practice, and confirmed that the bed test is not applicable for this review as there are no plans currently being proposed to reduce bed numbers.

#### 10.1.4 Support from clinical commissioners

These proposals have been developed in collaboration with Clinical Commissioners and have at various points been presented to, and approved by, the Clinical Executive Committee of the CCG, with regular updates to the Governing Body throughout the programme's development.

#### 10.1.5 Appropriateness of bed closures

The proposal does not reduce the number of inpatient beds and therefore this assurance test does not apply.

### 10.2 Quality Impact assessment and Equalities Impact Assessment

From a quality perspective it is considered that this option would bring about a small positive impact overall, across each of the quality criteria of Patient Safety, Effectiveness, Systems and Patient Experience. No negative impacts of the option were identified.

From an equality perspective it is considered that this option would bring about a small positive impact overall with no negative impact being identified across equality criteria of Age, Disability, Gender Reassignment, Marriage & Civil Partnership, Pregnancy & Maternity, Race, Religion or Belief, Sex, Sexual Orientation, Human Rights and Other Groups.

### 10.3 Programme Governance

The Fit for My Future Programme is developing and implementing a strategy for how we will support the health and wellbeing of all the people of Somerset by changing the way we commission and deliver health and care services.

The FFMF Programme is a multi-agency programme which is being delivered within the context of the Somerset Sustainability and Transformation Plan.

The Programme is structured in to three main workstreams;

- Acute Setting of Care
- Neighbourhood and Community Settings of Care
- Mental Health

Groups with key roles in the governance of the Mental Health work stream of the FFMF Programme are set out below with the relationships show in the figure below;

- **Mental Health and Learning Disabilities Programme Board** have developed and shaped the change proposals and will continue to lead their development and delivery. This group includes members such as local clinicians, staff working in services, patients, voluntary and community based organisations.

The Mental Health and Learning Disabilities Programme Board will continue to develop and manage delivery of the implementation plan, resolving issues and manage risks.

The Board will also manage the interdependencies with other projects or areas of work within the Mental Health and Learning Disabilities arena.

- **Fit for My Future Programme Board** - The Health and Care Strategy Development Fit For My Future Programme Board (FFMF Programme Board) has responsibility to provide leadership and oversight for the Fit for My Future Programme. It will maintain oversight across the strategic Settings of Care workstreams within programme, of which Mental Health is one.

The FFMF Programme Board membership incorporates leaders from across the system including Somerset County Council, the Somerset CCG and the main local NHS providers.

The current phase of work to develop strategic thinking about Mental Health services in Somerset and define projects for delivery (as set out in section 11.1 below.) will continue to be delivered by the Mental Health Programme Board and monitored and assured by the Fit for My Future Programme Board.

- **Transformation Board** – the Transformation Board is responsible for ensuring the delivery of the agreed system transformation and service improvement priorities ensuring project design, development and delivery reflects the agreed outcomes and timescales.

Once a Decision Making Business Case has been developed and approved, delivery of the outcome and programme of work set out in the Decision Making Business Case will transfer to the Transformation Programme Board.

- **Partnership Executive Group (PEG)** maintains oversight of all aspects of system reconfiguration and transformation in Somerset, including strategic elements, transformation delivery and assurance across the Somerset system (as set out below in figure 19).

Oversight and accountability will be maintained by the Partnership Executive Group throughout the strategic and the delivery phases of work.

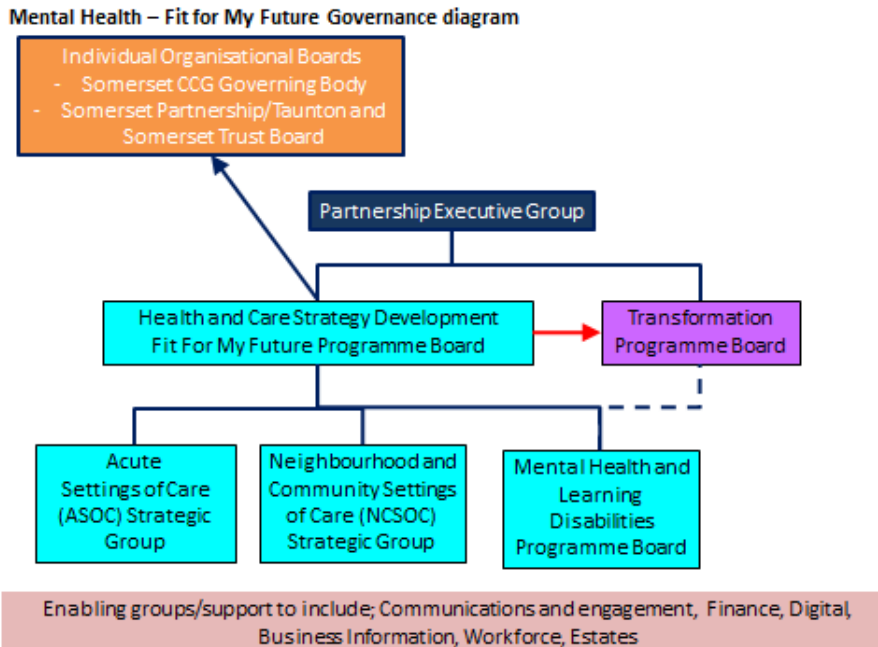
- **Somerset CCG Governing Body** retains ultimate responsibility for considering and making final decisions about the Health and Care Strategy and its implementation. The Governing Body will receive recommendations from the FFMF Programme Board.

Key decisions which will be considered by the CCG Governing Body are;

- ~ Approving the PCBC and the option appraisal within it, and agreeing to commence consultation
- ~ Receiving and taking account of the feedback from the consultation
- ~ Approving the Decision Making Business Case which will make a proposal on whether to go ahead with preferred option and on what basis

- **Somerset Partnership Board** – Somerset Partnership provides Mental Health services in Somerset and would need to consider some specific organisational decisions as part of delivery of the proposal. Somerset Partnership Foundation Trust are in an alliance with Taunton and Somerset Foundation Trust and hold joint board meetings.

**Figure 19 : Fit for My Future Governance Structure**



The detailed work of developing the PCBC and all the elements necessary for a programme of this nature has been led operationally by the Fit for My Future Programme team which include:

- FFMF Programme Director
- FFMF Clinical Director
- FFMF Mental Health Workstream lead
- FFMF Mental Health Clinical Lead
- Programme and Project Management support – programme and project management resource to plan and control delivery, as well as coordination of the relevant specialists to provide input required to deliver the proposed change.
- Communications and Engagement Lead
- Financial Lead.

The implementation of the CCG final decision on the way forward will be the responsibility of the Somerset Partnership NHS Foundation Trust.

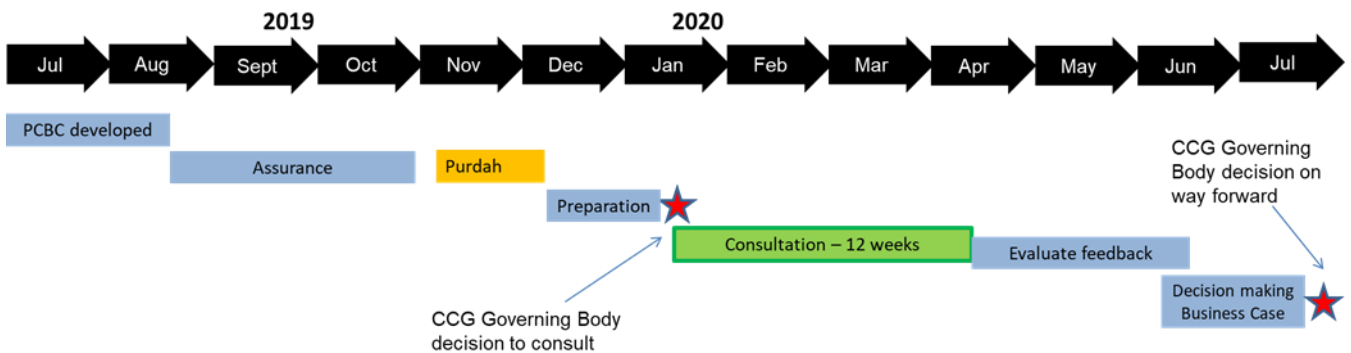
## 11 NEXT STEPS AND IMPLEMENTATION

### 11.1 Process for decision making

Following assurance of the draft PCBC by the Clinical Senate and NHS England, the Somerset CCG Governing Body will consider the PCBC at its Extraordinary Governing Body meeting on 16th January 2020 and will be asked to approve the document for public consultation on the preferred option.

It is anticipated that the timetable will be as shown in the diagram below.

**Figure 20 : Timetable for business case development**



Note: PCBC = Pre Consultation Business case, DMBC = Decision Making Business Case

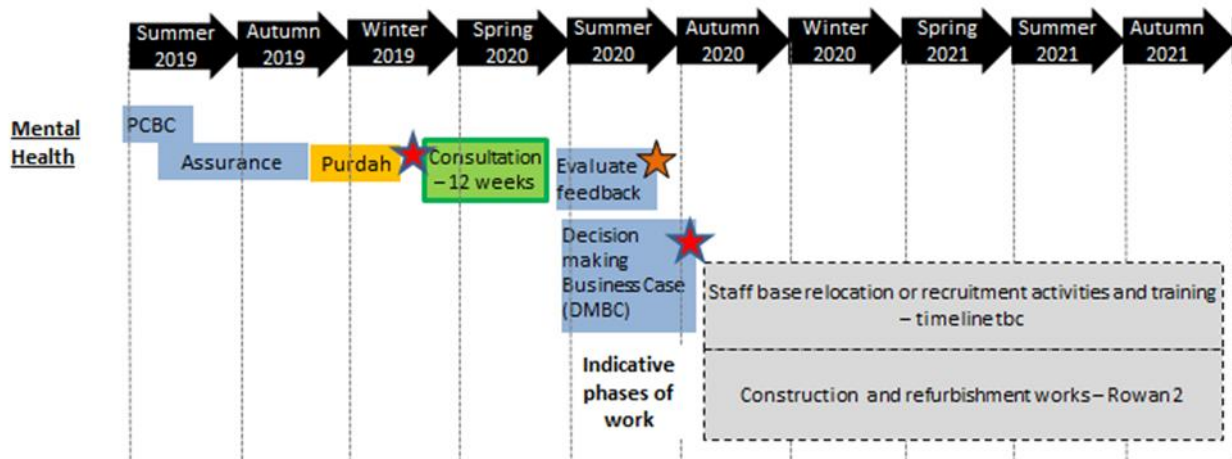
Key points to note are:

- A period of a month is allowed to ensure that all the feedback from the consultation can be taken fully into account in the CCG Governing Body's final decision

### 11.2 Potential implementation plan and timetable

The draft implementation programme is shown in the diagram below.

Figure 21 : Timetable for implementation of preferred option



Note - delivery of the community model aligns with proposed changes. These changes will be supported by the expansion of community mental health services which will help to avoid unnecessary admissions.

The plan above focusses on the main milestones driven by the construction and refurbishment programme.

Our plan also addresses the need to ensure that the enlarged service at Yeovil will be fully and safely staffed. We recognise that the implementing the preferred option will bring a short term risk to staffing the larger unit at Yeovil. It is likely that some of the Wells staff will not wish to transfer to Yeovil. There will be a period of nearly two years for us to manage this risk. The key considerations in terms of risk management are:

- There is a national recruitment challenge: Somerset is not exempt from this. Whichever option is selected – including no change – there will continue to be workforce pressures
- Consolidating resources on a single site will create more attractive options for recruitment
- A workforce review has already been undertaken, and will be repeated, assessing where existing staff currently live, where they currently work, and how the workforce can be better aligned Trust-wide
- We anticipate providing support to assist staff in transferring to the new location
- There is no expectation for compulsory redundancies and staffs who do not wish to transfer will be offered alternative roles within community mental health services
- Active recruitment programmes are already underway for all mental health services, including proactively approaching universities and other recruitment supply routes, including the Nurse Associate training programme which is active on all the inpatient wards Trust-wide

- Rowan Ward in Yeovil has historically not had difficulty recruiting staff members: it is not expected an expansion to the inpatient facilities on that site will create excessive pressures to recruit
- Given both St Andrew’s and Rowan Wards are stand-alone units their respective staffing numbers are higher than they would otherwise be under ‘Safer Staffing’. Therefore if they were co-located the total number of staff could be reduced alleviating some of the recruitment pressures that otherwise would be present

### 11.3 Potential risks and their management

ID	Risk	Consequence	Mitigation
1	Risk of challenge to the final decision on which option to implement	Unable to implement proposal if challenge successful. Delay in implementation even if challenge is unsuccessful.	Follow due process throughout the consultation process. Fully consider all relevant issues raised in consultation prior to CCG Governing Body Decision making.
2	Transitional risks - short term impact on workforce for instance if staff at a ward that is relocating cannot or will not relocate to a new workplace	Impact on workforce could impact on quality or safety, or could mean that the capacity for mental health inpatients is reduced	Effective communication, engagement and support for the workforce to minimise impact on them. Minimise the likelihood of losing staff. Early identification of numbers of staff who will not wish to transfer and clear recruitment plan to address potential vacancies. See section 11.2 for more detail on this issue
3	Clinical risk at the point of transition of services	Impact on inpatients at the point in time when transition occurs	Ensure to seek significant and ongoing clinical involvement in transition planning and delivery – then ensure to manage the transition plan effectively  Clinical managers and staff to maintain focus on provision of clinical services in the existing state as well as the post-implementation state, throughout the transition period
4	Risk of implementation timescales slipping due to estates changes – extended timescales for	Impact on the timescales for delivering the improvements set out	Produce realistic and achievable plans for implementation, and manage delivery effectively to reduce the likelihood of slippage



ID	Risk	Consequence	Mitigation
	obtaining planning permission or completing building works	in the case for change	
5	Risk of cost overrun	Budget is consumed before changes have been implemented. Delivery of improvements is not achieved, or is delayed	Manage the implementation plan effectively to minimise potential budget overruns. Cost estimates to include appropriate contingencies.
6	Risks associated with Operational Management Teams capacity to support and contribute to the implementation and transition	Risk to the pace at which implementation and transition can be delivered. Risk to timescales	Effective liaison between Implementation and operational managers, to ensure that time and resources are available to support the implementation timeline, without impacting on delivery of services

## 12 GLOSSARY

Acronym or Initialism	Meaning
AEDB	Accident & Emergency Delivery Board
AMHP	Approved Mental Health Practitioner
ASOC	Acute Setting of Care
ASOC	Acute Settings of Care
AWA	Adults of Working Age
BAU	Business As Usual
CAMHS	Children and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CEC	Clinical Executives Committee
CMHS	Community Mental Health Services teams
CQC	Care Quality Commission
DGH	District General Hospital
ECDB	Elective Care Delivery Board
ED	ED
EOT	Enhanced Outreach Team
FFMF	Fit for My Future
FYFV	Five Year Forward View
GIRFT	Getting It Right First Time
GP	General Practitioner
HOSC	Health Overview and Scrutiny Committee
HTT	Home Treatment Team
IAPT	Improving Access to Psychological Therapies
ITU	Intensive Care Unit
LD	Learning Disabilities
LMC	Local Medical Committee
LTC	Long Term Condition
LWAB	Local Workforce Action Board
MDT	Multi-Disciplinary Group
MHIS	Mental Health Investment Standard
MPH	Musgrove Park Hospital
NCSOC	Neighbourhood and Community Settings of Care
NCSOC	Neighbourhoods Community Settings Of Care
NHSE	NHS England
NHSI	NHS Improvement

Acronym or Initialism	Meaning
PALS	Patient Advice Liaison Service
PCBC	Pre Consultation Business Case
PEG	Professional Executive Group
PMO	Project (or Programme) Management Office
PPG	Patient Participation Group
SALT	Speech & Language Therapy
SCC	Somerset County Council
SEAG	Somerset Engagement & Advisory Group
SOMPAR	Somerset Partnership NHS Foundation Trust
SPA	Single Point of Access
SPMH	Specialist Perinatal Mental Health
SSHG	Somerset Strategy Housing Group
SSHP	Somerset Strategic Housing Partnership
STEP	Somerset Team for Early Psychosis
STP	Sustainability & Transformation Plan
SUEG	Serve Users Engagement Group
SWAHSN	South West Academic Health Science Network
SWAST	South West Ambulance Service Trust
SWQN	South West Quality Network
TST	Taunton and Somerset Foundation Trust
VCSE	Voluntary, Community and Social Enterprise organisations
YDH	Yeovil District Hospital Foundation Trust