NHS DORSET CLINICAL COMMISSIONING GROUP

GOVERNING BODY MEETING

MENTAL HEALTH REHABILITATION REVIEW

Date of the meeting	17/07/2019
Author	E Hurll, Principle Programme Lead
Sponsoring Clinician	Dr P French, Clinical Lead for Mental Health and Learning Disabilities
Purpose of Report	To update on the Mental Health Rehabilitation Review.
Recommendation	The Committee is asked to **note** the report.
Stakeholder Engagement	Stakeholder Events 11 July, 5 September 2018, 17 January 2019
Previous GB / Committee/s, Dates	20 March 2019

Monitoring and Assurance Summary

This report links to the following Strategic Objectives	• Prevention at Scale • Integrated Community and Primary Care Services • One Acute Network • Digitally Enabled Dorset • Leading and Working Differently		
	Yes [e.g. ✓]	**Any action required?**	
		Yes Detail in report	**No**
All three Domains of Quality (Safety, Quality, Patient Experience)	✓		✓
Board Assurance Framework Risk Register	✓		✓
Budgetary Impact	✓		✓
Legal/Regulatory	✓		✓
People/Staff	✓		✓
Financial/Value for Money/Sustainability	✓		✓
Information Management &Technology	✓		✓
Equality Impact Assessment	✓		✓
Freedom of Information	✓		✓
I confirm that I have considered the implications of this report on each of the matters above, as indicated	✓		

Initials :EH

1. Introduction

1.1 Dorset Clinical Commissioning Group (CCG) and Dorset HealthCare (DHC) launched the Mental Health Rehabilitation Review. Rehabilitation (Rehab) provision is for people who have severe enduring mental illness. The review has been co-produced from the outset with Dorset Mental Health Forum (DMHF), Local Authorities and other stakeholders that have an interest in mental health rehabilitation and complex care pathways such as homelessness and mental health assertive outreach (AOT).

1.2 The strategic context is framed by the national NHS mandate which outlines the objectives for the NHS as a whole:

- Preventing people from dying early
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

1.3 The case for change is that people who require rehab or complex care should be able to:

- Access the support and treatment required in settings other than inpatient units
- Have a much better experience of treatment and support in community settings with much better outcomes
- Avoid being placed out of area and avoid losing contact with people and communities and avoid spending more time in hospital than is absolutely necessary
- Access treatment and ongoing support in a variety of different settings in the community that do not currently exist for this client group

Proposals are anticipated to provide benefits through:

- Reduced number out of area placements and associated costs
- Better use of in county inpatient facilities with shorter inpatient stays and appropriate exit routes into a range of other types of accommodation
- Blended model of bed provision that is more cost effective than just NHS bed provision

2. Background

2.1 Dorset CCG is committed to reviewing and transforming all mental health services across the Integrated Care System (ICS) to improve mental health care for people who need to use mental health services. The Mental Health Rehabilitation Service is a key element of delivering against that commitment.

2.2 The Rehab review is led by Dorset HealthCare and Dorset CCG as part of their programme of transformational work. The governance of the project sits with the mental health Integrated Programme Board (MH-IPB) which has oversight of all the programmes of transformational work and the MH-IPB feeds up to the Integrated Community and Primary Care Services Portfolio Board.

2.3 The CCG's mental health commissioning team and Dorset HealthCare teams are working together with Dorset Mental Health Forum and all three partners in the review share the responsibility for the design and delivery of the review and form the core part of the project team.

2.4 The review's objectives are to improve services for people who access the Inpatient rehabilitation services, Assertive Outreach Teams, Homeless Health Service and Out of Area locked rehab. The only mental health rehabilitation currently available in Dorset is in one of three inpatient settings.

2.5 Inpatient provision on its own is not the national direction of travel for MH Rehab. Community rehabilitation and assertive outreach models are much more central to the way the services are to be delivered in the future. Inpatient facilities are to part of a whole pathway and will help support people who require containment and treatment in a safe, calming inpatient setting.

2.6 The aim is to provide MH Rehab in the most appropriate place possible for the individual and for some that will be in hospital for a time and for others Rehab and or other long-term support will be provided in the community by community teams.

2.7 The review is being carried out using a tried and tested format and has the following stages:

- Stage 1 Needs analysis,
- Stage 2 View seeking,
- Stage 3 Model development,
- Stage 4 Assurance and consultation
- Stage 5 Implementation.

2.8 The outputs of the review are:

i. The development, through co-production, of a clinically informed pan Dorset rehabilitation and complex care pathway that easily connects with the Mental Health Acute Care Pathway and other parts of the system and is based on:

"A whole system approach to recovery from mental ill health which maximises an individual`s quality of life and social inclusion; done by encouraging skills, promoting independence and autonomy in order to give them hope for the future and which leads to successful community living through appropriate support" (Killaspy et al., 2005)

ii. The dynamic and responsive commissioning of an effective mental health rehabilitation and complex care pathway to improve physical, mental health and social outcomes for people who have or who are at risk of becoming seriously mentally unwell.

3. Report

3.1 The services in scope of the rehabilitation review project are listed below:

- Inpatient units; Nightingale Court, Nightingale House and the Glendinning Unit
- The Assertive outreach teams (AOT)
- The Out of Area Locked Rehabilitation
- The Homeless Health Service

3.2 **Stage 1. Needs analysis** designed and delivered by CCG and Dorset HealthCare and including Public Health and other national and local data. The high level themes are described below:

- There is rising demand and current services are not set up in the right way to manage the demand in the least restrictive, recovery focussed way.

- There is little community provision and few supported housing options at the moment, which leave inpatient services being the primary rehabilitation and complex care option.

- It is likely with targeted reshaping of the current services that the offer for people who require ongoing rehabilitation or assertive support could be improved and enhanced.

- The percentage prevalence of SMI is not expected to change for the foreseeable future however there is anticipated population growth and so the SMI register numbers will proportionately increase.

3.3 **Stage 2. View-seeking** led by Dorset HealthCare in partnership with Dorset CCG, Dorset Mental Health Forum and the local authorities. All views were compiled into a thematic analysis report. The high level themes are described below:

- Mental health issues don't stop at the weekend;

- No one talks about me leaving here;
- Being in hospital for a long time doesn't help;
- Continued support for people who have been inpatients when they leave hospital should include support for getting involved with community activities, paying bills and budgeting, planning GP, outpatient appointments, house hold tasks and volunteer/employment assistance;
- Staff are a good team and are genuinely caring and supportive;
- AOT is quick to help me with housing, always on time for my visits and always turn up. Wouldn't ever have had CBT if not under the team;
- Being in the service makes access to other help i.e. drug and alcohol services easier;
- Encouraged to be more independent to adjust to life outside.

3.4 **Stage 3. Coproduced modelling** of the new pathway and the options for its achievement from the design of the project to the delivery of the modelling work. The coproduction was between people who have lived experience of mental illness and of using services and staff including team managers and clinicians.

3.5 The modelling and shortlisting work was carried out over approximately 8 sessions over approximately 9 months. The measured approach enabled background activity such as detailed modelling and costing to be done in the background and between each session. The sessions are described below:

Project Meetings	
Project team meetings consisting of staff, managers, service user representation	4
Wider stakeholder events including the local authorities, housing and mental health providers and services user. This group sense checked the project team's work and enhanced it	4
Staff engagement events for any one working in any of the services in scope	2
Shortlisting event involving the project team and then sense checked in a wider stakeholder meeting	1
DHC Facilitated session to agree the pathways vision including project team	1
Cross checking with people who use services. This was tailored to the individuals so each person may have been seen more than once.	

3.6 In January 2019 the final stakeholder sessions took place and shortlisting finished with a preferred way forward being clearly identified. Following the stakeholder session further modelling and costing work was carried out. The output of that work will form a significant part of the Strategic Outline Case (SOC) which is near to being finalised. It was presented to the project team on 20 June 2019 and going to the MH-IPB in August.

3.7 Crosschecking with patients and their carers enabled them to comment on the proposals. It was important that people who use services were able to comment on the proposed model and for them to see how their initial views and comments helped to shape the new model: The following provides a snapshot of cross check comments: A full report summarising all the cross check views will be completed by Bournemouth University Market Research department and presented along with the SOC but the following are a flavour of some of the comments:

- The community rehab team development is welcome because people said that their rehab should be continued outside of hospital
- A team that follows them into different types of accommodation settings is viewed positively
- The reduction in Out of Area placements is seen as good especially by people who had been required to travel miles to visit the people they care for.
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4 Model Options

4.1 The coproduction process addressed several questions about what a good rehab/complex care pathway would look like. The coproduction groups agreed objectives, the critical success factors and constraints and came up with a proposal for what services should be included in rehab/complex care pathway and these broadly align with national guidance and general direction of travel for complex care pathways. The following components were agreed from a long list:

- High Dependency Unit (70% male 30% female)
- Community Rehab beds (the preferred option is a blended model of NHS and third sector bed provision)
- Community Team: including a Community Rehab Team, Assertive Outreach and Homeless Health Service
- Supported Living/Housing/residential care

4.2 There are several possibilities in terms of how these components can be configured. The proposal is for a blended model that is delivered by a mix of NHS and Third sector providers.

4.3 There are examples across the country where services are delivered in this way by NHS and third sector providers working in partnership. The aim is to support people in the least restrictive setting. The benefits of the approach are:

- More options for rehabilitation and other support in the community rather than in hospital.
- Financial benefits to CCG or ICS in relation to bed numbers, usage and length of stay for patients and a reduction in the use of out of area placements.
- Additional resources funded by CCG available in the community such as the Community Rehab Team and AOT will go some way towards offsetting the notion of cost shunting i.e. Health to Local Authorities – both can benefit from this proposed model
- The introduction of additional community resources will enable support to be provided to people in already existing support services such as supported housing provision or registered care.
- Recovery and strengths focussed treatment and support at home rather than in hospital where ever possible.
- Repatriation of people currently placed out of area. The general principle to be applied as soon as the pathway is implemented is that out of area placements will not be used unless there are exceptional clinical reasons.

4.4 The proposed pathway will ensure where possible, that people who present with a complex range of needs are:

- Supported to have the life they want to live in a place they want to live
- Able to live as independently as possible
- Able to live outside of hospital settings
- Supported in the least restrictive way possible

4.5 Rehab and complex care delivered by a mix of NHS and Third sector providers should enable the reinvestment of funds into the system. For example: cost savings from out of area placements could be reinvested in the development of the HDU and money saved by developing supported housing as an alternative to NHS provided inpatient provision could be reinvested to develop a robust flexible responsive community team.

4.6 An example of the saving potential is seen in the table below. In this example supported housing is funded, through Housing Benefit, service charges including utilities etc. and section 117 after care.

NHS Beds	**Based on Staff Costs**	
Nightingale House 16 beds	£ 1,038,353	
Nightingale Court 13 beds	£ 668,615	
Glendinning Unit 9 beds	£ 535,156	
	£ 2,242,124 per annum	
Supported Housing	**£575 PPPW**	**£975 PPPW**
Supported Housing 16 beds	£ 478,400	£ 811,200
Supported Housing 13 beds	£ 388,700	£ 659,100
Supported Housing 9 beds	£ 269,100	£ 456,300
	£1,136,200	**£1,926,600**
	Potential saving based on £575 per week	**Potential saving based on £975 per week**
Saving	**£1,105,924**	**£ 315,524**

Supported housing cost included in the table above charge a weekly rate between £575 and £975 dependent upon an individual's needs. DHC costs are based on staffing costs only and based on bed day costs the savings are increased.

4.7 The modelling in relation to bed numbers and potential level of blend between NHS and other providers has been carried out using predictive tools and by looking at actual demand and use of the current service. As part of the review the project team also carried out a patient review.

4.8 All patients in all inpatient settings were reviewed to understand who a) might have benefited from rehab and b) might have not required a hospital admission were a community Rehab team in place. This patient review is being validated and the findings will be compared with the estimated numbers. This validation work will help to determine the final level of investment required and optimal level of the blended mix of beds.

4.9 The current investment in mental health rehabilitation and complex care is shown in the table below and is one of the constraints of the project.

Service	**Total Budget (£)**
AOT	289,378
AOT Weymouth	220,815
Homeless Health Service	127,140
Glendinning	535,156
Nightingale Court	668,615
Nightingale House	1,038,353
Out of area	1,800,000
	4,679,457

4.10 The modelling and pricing has been done as far as possible within the existing budget. The assumptions for this are that:

- Some of the pathway will be delivered by third sector organisations at a lower cost
- Savings from the above could be reinvested in the community teams if agreed
- Repatriating people from out of area placements may reduce CCG expenditure in relation to the named patient budget
- Some of the above named patient savings could be reinvested in the rehab pathway

4.11 A project group meeting took place on the 20th June 2019 where the co-produced preferred model option was agreed collectively by the group to take forwards:

The preferred option means:

- Developing a 14 bed High Dependency Unit
- Having community Rehab Units in the west and east of the county likely to be Glendinning and Nightingale House (23 beds in total)
- The closure of Nightingale Court
- The development of Supported Housing option (20 beds)
- Beds or accommodation would not just be provided by NHS provider but by 3rd sector
- The number of beds or accommodation would increase
- The development of Community Rehab Team and enhancement of the Assertive Outreach Team and Homeless Health Service

4.12 The costs will be calculated to reflect the preferred model and will be finalised for the Strategic Outline Case. The preferred model will require additional financial investment. This will be considered by the MH Programme Board and be included in the Mental Health Investment Standard planning.

5. Interdependencies

5.1 There is an interdependency with Dorset HealthCare estates review: Dorset HealthCare is looking strategically at all their estate in relation to the amount and quality and particularly in relation to all the transformational work that has arisen from the MH Acute Care Pathway Review (ACP) and other transformation programmes. The changes include:

- 12 new MH Acute beds at St Ann's

- 15 beds moving to St Ann's from the Linden Unit.
- Relocation and development of the perinatal service (proposed expansion to 8 beds)
- The development of a female low secure ward (currently Twynham low secure is male only)
- Children and young people's Psychiatric Intensive Care Unit being planned.

5.2 The programme of work linked to the estates review has implications for the rehab provision but not for the review itself. The estates work does not pre-empt the outcomes of the review.

6. Conclusion

6.1 The preferred model of mental health rehabilitation is to be much more community focussed with inpatient provision being part of the whole pathway rather than the pathway. The beds provided will be the right number to meet the needs of the Dorset population but will be delivered by a mix of NHS and other providers.

6.2 A Strategic Outline Business Case is being developed to support the NHSE Assurance processes. The SOC will be presented to HOSC as required.

6.2 The NHS Assurance will follow on from the HOSC meetings in Dorset and Bournemouth, Christchurch and Poole. It will be done in this order because NHSE values and relies on the view of the HOSC in relation to the review's robustness and future consultation requirements.

6.3 An update was presented to the Dorset HOSC on the 26th June 2019. HOSC were asked about the need for consultation. Their view on this occasion was that, since there has been a considerable amount of coproduced view seeking and cross checking with service users/carers/ staff/public to date; for this small cohort further consultation may not be required. The future model of care is supported by Dorset HOSC.

6.4 In preparation for NHSE assurance and possible consultation it is also the intention to develop the housing options with LA colleagues and local developers, landlords and providers to ensure a mix of accommodation that meets the proposed model requirements and adds to the already existing provision and enhances those services.

6.5 The recommendations are that Bournemouth, Christchurch and Poole HOSC:

I. endorses the review findings and proposals to develop a more community based Rehab model of care
II. supports the intention to go through NHS Assurance with the proposed model including the proposed bed changes
III. makes a recommendation about the need for public consultation on the proposals in the paper.

9.6

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