NHS DORSET CLINICAL COMMISSIONING GROUP

GOVERNING BODY MEETING

MENTAL HEALTH REHABILITATION REVIEW

Date of the meeting	13/11/2019
Author	E Hurll, Principle Programme Lead
Sponsoring Clinician	Dr P French Clinical Lead Mental Health
Purpose of Report	To update on the Mental Health Rehabilitation Review.
Recommendation	The Governing Body is asked to **approve** the additional investment as set out in the Strategic Outline Case (SOC) that forms part of the Mental Health Investment Standards (MHIS) priorities and financial planning.
Stakeholder Engagement	N/A
Previous GB / Committee/s, Dates	GB – 20/03/19 and 03/07/19 Dorset HOSC 26.06.19 BPC HOSC 02.09.19 JCB 14.10.19

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) have carried out a review of Mental Health (MH) Rehabilitation and Assertive Outreach (AOT). Rehabilitation (Rehab) and AOT 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.

1.2 The strategic context is the NHS Long Term Plan which highlights MH rehabilitation services and the need for community options plus ensuring that people who experience severe enduring mental illness are able to have the kind of life they want including work and leisure. This 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 proposals will ensure improvement in the care and support of people who have long term mental health needs. The changes will mean access to treatment and support in the community rather than hospital as well as ensuring that when hospital is needed it is available to them. In addition, 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
- Avoid losing contact with people, families and communities and avoid spending more time in hospital than is absolutely necessary
- Access treatment and ongoing support in a variety of settings in the community

1.4 Proposals are anticipated to provide benefits through:

- Reduced number out of area placements
- Better use of in county inpatient facilities with shorter admissions and appropriate exit routes into a range of accommodation
- Blended model of bed provision that is more cost effective

Background

1.5 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.

1.6 The Rehab review has been led by Dorset HealthCare, Dorset CCG and Dorset MH Forum as part of the programme of transformational work. The governance of the project sits with the MH 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.

1.7 The CCG's mental health commissioning team and Dorset HealthCare teams are working together with Dorset Mental Health Forum with all partners in the review sharing the responsibility for the design and delivery of the new model of care.

1.8 The vision and objectives of the rehabilitation review were agreed by the coproduction groups. These are as follows:

- To identify the needs and demand profile of the local population of people who access Rehabilitation, Assertive Outreach, Homeless Health services and are in High Dependency Units (HDU).

- To carry out a review of services that show how rehabilitation service is delivered.

- To review the current services in line with performance requirements, usage patterns, local need, carer and client experience, nationally benchmarked data and services, clinical guidance and usage of the Mental Health Act. The aim of this is to identify best practice, areas for improvement and to identify gaps in service provision.

- To develop through co-production, a clinically informed pan-Dorset Rehabilitation pathway that easily connects with the Mental Health Acute Care Pathway review and care model based on: "A whole system approach to recovery from mental ill health which maximises an individual`s quality of life and social inclusion by encouraging their 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).

- To involve service users, supporters, clinicians and other stakeholders on the development of the options should there be substantial change to the service model, to consult with the Health Scrutiny Committees as required under section 244 in addition to patients and the public.

- To commission an effective Mental Health rehabilitation pathway to improve physical, mental health and social outcomes for people who have or who are at risk of becoming seriously mentally unwell.

1.9 Currently all MH rehab is carried out in Inpatient settings. Rehab in inpatient settings on their own are not reflective of 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.

1.10 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 but only as required and not the default place.

1.11 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.

1.12 The review has adhered to the principles of co-production and consisted of the following stages:

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

2. Report

2.1 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

Project Stages

2.2 **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.

2.3 **Stage 2. View-seeking** led by Dorset HealthCare in partnership with Dorset CCG, Dorset Mental Health Forum and the local authorities. There were in total 144 people that participated and contributed 156 different views. 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.

2.4 **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.

2.5 The modelling and shortlisting work was carried out over approximately 8 sessions over approximately 9 months. In all there were 13 events. The project team consisted of approximately 20 people and the stakeholder sessions involved up to 65 people approximately. They represented housing and social care from the LA, other third sector and voluntary organisations, also people using services were represented. The measured approach enabled background activity such as detailed modelling and costing to be done in the background and between each session.

2.6 **Stage 4. Assurance –** NHS England facilitated a stage one assurance meeting on the 7th October 2019 where the Strategic Outline Case and proposals were presented and reviewed. Formal notification of the outcome is awaited. Indications from the meeting are that formal public consultation on the changes will not be required.

2.7 A full copy of the Strategic Outline Case and related appendices which outline the work undertaken to arrive at the proposed model of care is available on request

Future Model

2.8 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 Units (one east and west of the county)
- Community Team: including a Community Rehab Team, Assertive Outreach teams
- Supported Living/Housing/residential care

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

2.10 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
- Additional resources funded by CCG available in the community such as the Community Rehab Team and enhanced AOT.
- 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.

2.11 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

2.12 The modelling in relation to blend of NHS beds and supported living units has been carried out using predictive tools and by looking at actual demand and use of the current service. This was underpinned by a review of existing patients 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.

2.13 The proposed configuration of elements in the future model is outlined below alongside the existing configuration of bed provision.

Current Bed Numbers	Future Model
9 Community Rehab Unit beds (west of county)	9 Community Rehab Unit beds (west of county)
29 Community Rehab Unit Beds (east of county)	13 Community Rehab Unit Beds (east of county)
	21 Supported Housing Units
OOA placements (currently 12)	14 HDU beds
50 in total	**57 in total**

**supported housing exists at present across Dorset but is not aligned to the Rehabilitation pathway*

2.14 Implications with the proposed future model include:

- Provision of a Community Rehab Unit in the west and east of the county
- The development of Supported Housing option plans (part of a wider piece of work)

- Beds/accommodation being provided across different settings such as registered care or supported housing and by 3rd sector partners
- Closure of one of the existing community rehab units in the east of the county (13 beds) in order to reconfigure the inpatient part of the service
- The provision of 21 dedicated supported housing units alongside 22 community rehab beds
- The development of Community Rehab Team and enhancement of the existing Assertive Outreach Team and enhanced Homeless Health Service will provide additional community support and treatment to clients already in the MH system
- The development of a 14 bed High Dependency Unit

Financial Impact

2.15 The current investment and out of area expenditure for mental health rehabilitation and complex care is shown in the table below:

Service (based on 19/20 operational budget)	**£Budget**
AOT Poole/Bournemouth	342,472
AOT Weymouth	254,754
Joint Homelessness Team	170,882
Glendinning Unit	558,993
Nightingale OT	344,195
Nightingale House	1,102,472
Nightingale Court	777,756
Service Manager	58,196
Medical Staff	264,698
Total	**3,874,418**
Out of Area Placement Costs (based on 18/19 named patient expenditure)	1,586,596
Grand Total	**5,461,014**

2.16 Although efforts were made to manage within the existing envelope, the preferred model of care will require additional investment.

2.17 The following tables show the costs of the new pathway and the current investment shortfall.

Proposed Service Element	Costs	Totals
9x NHS Beds (West)	£860,320	
13x NHS Beds (East)	£1,317,823	
Community Teams (CRT, AOT and HHS)	£2,710,379	
New Community Rehab Pathway Total		**£4,888,522**
Less current DHC operational budget	£3,874,418	
Budget Shortfall		**£1,014,104**

2.18 The cost implications below are based on inclusion and exclusion of existing out of area expenditure within overall budget.

2.19 The costs of the HDU is separated from the table above to account for a phased implementation.

HDU	Costs
14x HDU beds	£1,214,063
Existing OOA spend	£1,586,596
4 OOA (People unable to be repatriated)	£565,954
Shortfall in budget	**£193,421**

*based on current OOA expenditure (£1,586,596) less need for 4 beds remaining OOA (£565,954)

2.20 It is anticipated that the shortfall in funding will be met through additional funds allocated as part of the Mental Health Investment Standard.

2.21 A high level summary of the costs and mechanism for supported housing is provided below. A separate but interdependent joint health and local authority work stream is being initiated to develop these options.

	Supported Housing
Revenue Streams	Housing benefit covers rent Section 117 covers care and support costs NHS and Local Authorities share responsibility for Sec117 costs
Development options	Developer, Housing Association and Care and Support Provider (Private or Third sector)
Average costs of care and support	Between £350 and £950 per week
Cost to 117	Based on 21 Supported Housing places the predicted cost to Section 117 budget averages: £382,200 per annum (lower range of costs) £1,037,400 per annum (higher range of costs)

Risk	Risk of rising Section 117 costs may be mitigated by other work to reduce the use of Mental Health Act. This is also mitigated by the fact that the number managed in this pathway is also predicted to remain relatively stable.

Implementation Timeline

2.22 The outcome of the NHS England Stage 1 Assurance meeting was there is no requirement for any further assurance/public consultation and the rehab review business case to be presented to the CCG Governing Body in November for a final decision on the model of care.

2.23 A report will also be submitted to the two local HOSC boards outlining the result of the stage 1 assurance process and proposed engagement throughout the implementation process.

2.24 In lieu of the final governing body decision work on the following will be progressed throughout the period Dec 2019 – April 2020 to:

- Develop the Community Rehabilitation Team (CRT)
- Enhance Assertive Outreach Team (AOT)
- Develop supported housing plans with LA partners
- Existing workforce consultation

2.25 Implementation of the new service elements and configuration will then proceed post April 2020.

3. Conclusion

3.1 The preferred model of mental health rehabilitation is to be much more community focus with inpatient provision being part of the whole pathway rather than the pathway. A key aspect of this will see the development of a new Community Rehab Team.

3.2 The pathway will be formed of a blended a mix of NHS beds complimented by supported housing units that have been modelled to meet the predicted needs of the Dorset population.

3.3 The Governing Body is asked to support the development of the proposed future model of care and **approve** the additional investment as set out in the SOC that forms part of the Mental Health Investment Standards (MHIS) priorities and financial planning.

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APPENDICES	
Appendix 1	**The Mental Health Rehabilitation Review Strategic Outline Case (please note, the Appendices/Annexes in the SOC itself are not included as part of the report itself and can be accessed via this link).**