Appendix F

NHS
Bedfordshire
Clinical Commissioning Group

Mental Health, Learning Disability and CAMHS Procurement Review

ENGAGEMENT REPORT

A summary of stakeholder engagement activities with service users, providers and other key stakeholder groups

27th January 2014

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1.0 Background

On 1st April 2013, as part of the national NHS reforms, the responsibility for commissioning a range of health services transferred from NHS Bedfordshire (also previously known as Bedfordshire PCT) to NHS Bedfordshire Clinical Commissioning Group (BCCG). Responsibility for commissioning certain other local health services was transferred either to Bedford Borough Council, Central Bedfordshire Council or NHS England (Hertfordshire and South Midlands Area Team).

'The Bedfordshire Plan for Patients' is BCCG's operational plan for the delivery of health services, and has been developed by local clinicians, working with its partners, to deliver improvements in the quality (experience, safety and outcomes) of care and life for the residents of Bedford Borough and Central Bedfordshire.

BCCG acknowledges the need to take a longer term view of the planning of services to reflect the significant changes required to tackle the unprecedented Challenges facing the public sector. The operational plan details the local ambitions for improving outcomes within the funding available to BCCG.

In February 2014, BCCG published its Mental Health Strategic Objectives which describes its commitment to the improvement of Mental Health services within Bedfordshire. These can be found at:
https**://www.bedfordshireccg.nhs.uk/page/?id=3713**

Within the Mental Health Strategic Objectives, BCCG have committed to a programme of transformation which has already started; to redesign and integrate mental health services, to improve quality, improve health outcomes, increase Capacity and reduce gaps in provision. BCCG is keen to increase the volume and range of services for people with mild to moderate mental health issues, which are provided within primary care, enabling people to receive help earlier, improve their recovery and should reduce the number of people developing more severe problems.

Changes also need to be made to secondary care services. This will ensure that Services for people with more serious or complex needs, and for people with Dementia, are more accessible and responsive. Generally, there is a need for greater access to psychological therapies across the whole mental health pathway.

The Commissioning Organisations (including BCCG, Bedford Borough Council and Central Bedfordshire Council) are committed to the development of Mental Health services and have developed the model for delivery of care across both the health and social care systems that will be high quality, safe, fit for purpose and sustainable.

In order to achieve the necessary transformation, and secure a strengthened,

integrated framework for Mental Health services, the BCCG Governing Body gave its approval for a formal procurement process. In addition, both Bedford Borough Council and Central Bedfordshire Council have formally agreed that those services commissioned through Section 75 arrangements would also be part of this procurement process.

Local Context

BCCG, Bedford Borough Council and Central Bedfordshire Council work together in the commissioning of Mental Health and Learning Disability Services, and in monitoring existing services to ensure the best outcomes are delivered for their respective populations.

There are challenging financial targets for all Commissioning Organisations over the coming years and this must be considered alongside an increased demand for services.

The Commissioning Organisations have worked hard over the last eighteen months to engage all of their stakeholders and to develop service models which will transform local Mental Health and Learning Disability Services.
BCCG's Strategic Objectives for Mental Health describe how Mental Health services will be developed within Bedfordshire. These were developed following stakeholder engagement, using public health data and reviewing national best practice.

BCCG will continue the work it has already started with its partners to redesign all of its mental health services, to improve quality, improve health outcomes, increase capacity, reduce gaps in provision and remove duplication. This will require services to be integrated and commissioned jointly with the Local Authorities
whenever possible.

Within this 3-year plan, BCCGs key priorities are:

- Prevention and early intervention
- Improving quality in general practice
- Steps 1 – 3 of the Stepped care model
- Steps 4 – 5 of the Stepped care model
- Complex needs
- Rehabilitation and Recovery
- Dementia
- Liaison Psychiatry
- Transition to adult services
- Services for children and young people
- Preparing for the full introduction of the new Payment System for Mental
- Health Services

Engagement Report Summary for the Mental Health Projects

2.0 Specialist Learning Disability Service Review

A stakeholder event was held in July 2012 where the following areas were discussed:

1. Eligibility criteria
2. Arts Psychotherapies
3. Health Facilitation Service
4. Physiotherapy
5. Occupational Therapy
6. Specialist Medical Team
7. Sensory

Overview of the feedback received from this event is outlined as follows:

What people would like to keep?

- Sensory
- Health Facilitation Team
- Nurses at the hospitals
- Forensic Community Treatment Team
- Going to people's homes
- Providing training and on-going support to staff
- Good access to specialist Medical service
- Good use of community services

What people would like to change

- Hours of work, not just a 9 – 5 service, especially Liaison Nurses and Health Facilitation Team
- Venue
- Waiting times and waiting lists
- Difficulty in getting an appointment
- Having same staff supporting a person
- Better communication
- Shorter referral forms
- More input from Intensive Support Team
- Length of time some people stay in the service

3.0 How the feedback obtained influenced the development of the model of service

Currently the services are located north of Bedford at the Twinwoods site in Clapham. The location has been an issue particular to those who are situated in the south of the county. The proposed redesigned model recommends that the specialist services are based within the Local Authority locality areas. As a result it is anticipated that these services will be more accessible to everyone who resides within Bedford Borough or Central Bedfordshire. Specialist Learning Disability Services will include:

1. Health Facilitation Team
2. Specialist Medical Team
3. Occupational Health
4. Psychology

The Intensive Support Team (IST) and the inpatient unit will remain a county wide service. The health facilitation team and the Liaison Nurses who are located within both Bedford and Luton and Dunstable hospitals will remain the same.

Speech and Language Therapy (SALT) and the Sensory department will transit over to mainstream services. There will be a 6 – 12 month transition from specialist to mainstream services and the transition will be supported by specialist teams who will offer training and advice on making reasonable adjustments for people with a learning disability.

The dietetic service will transit across to mainstream services with a transition period anticipated to be between 6 – 12 months so that staff and service users can be supported through the transition of services.

Arts Psychotherapies will be decommissioned and spot purchased on an individual basis. The current provider (SEPT) have informed us that they have carried out their own review of the service and are planning to stop the Arts Psychotherapies as part of their review. An email was sent to Gary Kupshik requesting an update in relation to this service review.

The role of the health facilitation team is to support service users and their carer's in accessing primary and mainstream services. They also offer support and training to the GP practices and mainstream services in making reasonable adjustments and supporting people with a learning disability.

A further stakeholder event was held in December 2013 outlining the proposed new model. The model and supporting paper was also circulated out to stakeholders for those who were unable to attend the event.

Following the period of consultation, it became apparent that there were stakeholder uncertainties around losing the specialism - SALT and the sensory team. As a result the model has been amended to retain two nursing posts, one from either team to continue to support the development and transition across to

mainstream services. These posts will be reviewed after a two year period, so as to continue to have specialists supporting this arena for a longer time frame.

4.0 Additional Engagement Meetings

Date	Meeting / Event
17/09/2013	Meeting was held with colleagues from Luton Borough Council Adult Learning Disability Team
19/09/2013	Half day workshop with Local Authority leads to discuss the model
09/10/2013	Meeting with the current SPLD manager
11/10/2013	Meeting with the Lead Liaison Nurse at Bedford Hospital
26/11/2013	Meeting with the Luton Clinical Commissioning Lead for SPLD
03/12/2013	Meeting with Diane Meddick to discuss the transition between SPLD and Mainstream services
06/12/2013	Stakeholder event workshop
16/12/2013	Meeting with IST to discuss their project to combine MH and LD crisis service
09/01/2014	Meeting with the East of England Health Education
21/01/2014	SPLD steering Group
21/01/2014	Meeting with Maria Brown to discuss the transition from SPLD to Mainstream services

5.0 Plans for forthcoming meetings / events

- A meeting has been arranged with the current provider for 25/02/2014 to discuss the outcome of the consultation
- Presentation of the proposed model will be held at both the Central Bedfordshire and Bedford Borough Learning Disability Partnership Boards in March 2014
- The SPLD steering group will continue to meet to support the development of the service specifications and the procurement process on a monthly basis
- A further two workshops are being planned for the outcome based service specification for MH and LD services

6.0 Rehabilitation Service Review

A stakeholder event was held in May 2013 where there was representation from a wide audience, including service users, carers, voluntary sector and providers. The workshop was centred on 4 key themes:

1. What should a good Mental Health Rehabilitation Service look like?
2. What should we have in the Acute Sector and Services?
3. What rehabilitation should we have in the community sector and services?
4. What rehabilitation should look like in the future?

An overview of the feedback has been set against each of the themes –

- What should a good Mental Health Rehabilitation Service look like?
  - A step up or Step down Care
  - High package delivered at start then reduced as required (Review process having a way back up stepped up care again if needed)
  - Expanded variety of third sector provider services
  - On-going pathway of recovery (not stopping at service user entry to community)
  - Personalised care based on person recovery aspirations
  - Adaption of the Learning Disability model with residential supported living (Carer extra care model 1:1 hours to suit need in community house and flats).
  - Day Centre access (with options around)
  - Rapid response to communications for help with
  - Appropriate workforce and staffing levels to cover work in urgent situations
  - Access to employment support
  - Access to association with peer (facilitating peer to peer support)

- What should we have in the Acute Sector and Services?
  - Service user involvement
  - Initial Assessment of service user needs
  - Multi-disciplinary communication from point of referral
  - Early discharge planning (with care package, regular reviews and monitoring)

- What rehabilitation should we have in the community sector and services?
  - Service user at the centre of care
  - Service user leads (where possible .i.e. recovering service users help new service users)
  - Service not time limited (Sessions will be time limited but the number of sessions will not)
  - Service re-enactment (Two way recovery to start at the beginning or go back to where the user is right now)
  - More choice of services

- What rehabilitation should look like in the future?
  - Better supporting information

- Supported housing
- Wider choice - more options keeping people local
- Wellbeing centres (Hub + Spoke buildings)
- Recovery focused on-going support - not time limited (to maintain recovery)
- Process to ‘Step up’ – urgently or quickly
- Access impact of DWP and Job centre on patients (Training need for day opportunities)
- Resource enough qualified staffs to deliver
- Care pathway (where everyone understands how to go up and down)
- Short term rehab beds (without going through multiple referrals and long waits)
- Community Rehab Team (Multi-disciplinary community team)

7.0 How this influenced the development of the Community Mental Health Rehabilitation and Recovery Service

The model concentrates on a Community team that will cover Bedford Borough and Central Bedfordshire locality areas. The team will have a therapeutic focus and will link in with the Local Authorities in relation to supported housing, employment, leisure, education and peer support.

The team will consist of specialist recovery support workers, occupational therapy, specialist intervention nurses and psychology.

The team will work with people who present with enduring mental health and will support people to either step up or step down through service provision. There will be a SPOA and the service will accept referrals from a range of sources including self-referrals.

This service will be person centred and will aim to support people through a 3 tiered approach –

1. Complex Needs – High Support
2. Complex Needs – Medium Support
3. Complex Needs – Standard Support

It is anticipated that this service will support people within inpatient settings who are preparing for discharge, people residing in residential care homes, supported living and people who live in their own homes.

The service will aim to support people who present with an enduring mental health condition who require support to keep them well through therapeutic intervention, who may require support to regain living skills, social inclusion and physical health needs.

This service will work in close partnership with secondary mental health services so that if a person has more serious and complex needs then the individual is supported to step up to a more appropriate level of support. The service will also

be expected to work in close partnership with the Local Authorities so that peoples recovery is enhanced by linking with supported housing schemes, tenancy sustainment support, support around accessing education, voluntary work and employment, support accessing leisure activities and peer support.

Currently there are Support Time and Recovery workers (STR) who work within both the Assertive Outreach Teams (AOT) and the Community Mental Health Teams (CMHT) within SEPT. Through the procurement process these posts will not continue within Secondary Mental Health Services and instead will be replaced with the new model.

MIND is currently commissioned by the BCCG, CBC and BBC to deliver a recovery focused service for people with a MH condition. Their contract is due to be reviewed on 31/03/2014 and notice has been served to the provider. Moving forward through the procurement process, this service will be delivered through the new proposed model that is subject to the procurement process. Likewise the Bedford Resource Centre will also be combined within this new model of service.

8.0 Additional Engagement Meetings

1. *Central Bedfordshire Mental Health Partnership Board in January 2014*. The proposed model was discussed with members of this group.
2. *Meetings with Bedfordshire Housing Link during January and February 2014*. Where the housing links have been discussed in terms of linking into this model of service.
3. *Meeting with MIND (current provider) in January 2014.* In relation to serving notice on the current contract and highlighted the procurement of this service.
4. *Meeting with the YMCA (Provider) in January 2014*. The model and the procurement of this lot were discussed.
5. *Meetings have taken place with the 'Supporting People Directorate' in Bedford Borough throughout January 2014*. Bedford Borough are contributing to the budget for this service to include support around day resource, employment and tenancy sustainment support.
6. *A meeting was held with the Richmond Fellowship (provider) in January 2014*. This was discussing their current areas of responsibility and how they may link into the proposed model of service.
7. *On-going Rehabilitation steering groups are held monthly*. The membership of this group includes colleagues from both Local Authorities.
8. *A meeting was held with the current provider SEPT at their Rehabilitation service in Luton in December 2013.* The current model and the proposed model were discussed.
9. *There were two workshops held in November 2013 in relation to outcome based service specifications.* The outcomes of these workshops are on-going and the work is continuing.

10. *A* meeting was held with the AD of SEPT to discuss the current and proposed model in November 2013.

9.0 Plans for forthcoming meetings and events

- 17/02/2014 – Meeting with Bedfordshire Housing Link, Bedford Borough Council and Central Bedfordshire Council.
- 18/02/2014 – An outcome based service specification steering group meeting.
- 25/02/2014 – Meeting with the SEPT to discuss the model.
- A further two workshops are being planned based on the outcome based service specification.
- A stakeholder event is being planned for March 2014.

10.0 Dementia

How patient and carer engagement has shaped the project

Patient and carers engagement has resulted in various changes to the project. This includes:-

- Ensuring that the memory assessment service contacts people with dementia and their carers prior to their appointments
- Allowing patients to be seen in whichever clinic best suits them
- To consider the use of admin staff and volunteers as well as dementia nurses.
- Staffing to be based on skills required to achieve the outcomes
- Provision of emotional support as well as practical assistance

Patients and carers felt the following areas were important:-

- Single point of contact
- Proactivity of the service
- Two way communication
- All the updated information in one central point
- Home visits
- Dementia nurses
- Timely information and support

How clinical engagement has shaped the project

Clinical engagement has resulted in various changes to the project. This includes:-

- Screening carers for depression
- Basing the speech and language therapy dementia specialist within the memory assessment service
- Banding of the nurses at Band 6
- Dementia medicine reviews element to be removed from the role of the nurses.

Clinicians felt the following aspects of the project were important

- Someone to be there through the journey of dementia
- Proactive telephoning especially for those patients living alone
- Two way channel of communication to deal with issues as they arise rather than at a crisis point

11. Stepped Care Model 1-5

A stakeholder event and workshops were held in October 2012, May 2013, October 2013 and January 2014, where there was representation from a wide audience, including local service users, carers, voluntary sector and service providers.

The final workshop was centred on the Stepped Care model where the following areas were discussed:

1. Mental Health Care Step Care 1 - 5
2. Stepped Care Model Presentation
3. Assessment and Single Point of Access Team (ASPA)
4. Crisis Team
5. In-Patient Beds
6. NSF Teams (National Services Framework)
7. Link Workers

These are an overview of the questions and feedback received from this event:

11.1 Mental Health Care Steps 1-3

a) What level of triage and Multi-Disciplinary Team do we need in practice?
It was noted that there should be a level zero, which should focus on self-help, signposting and advocacy particularly as a preventative/early intervention measure. There should be a single tool (possibly IT based) for triage with links to services which are available and information/self-help leaflets. People were concerned about transition across services now and wanted assurance that's this would be addressed.

b) Can a Single Point of Access work across Steps 1 - 5?
This will need to work in partnership across all steps of the model (1-3 and 4-5) and not in silo with speedy referrals as appropriate between both. It was important to note that in the overall model, the patient journey needs to be as seamless as possible and based around the patient. People wanted to understand how many referrals there would be but supported the idea.

11.2 Health Assessment and Single point of Access teams (ASPA)

a) Can there be one ASPA for steps 1 – 5?
Stakeholders felt that this would not be appropriate as we need to keep steps 1-3 and 4-5 separate but need to have good communication and links between the two levels across provider services.

11.3 Mental Health Crisis Team

a) Should home treatment function be split from the Crisis Team and incorporated into the locality integrated Mental Health teams?
There was a difference of opinion across the groups about whether Crisis Team and Home Resolution Team should be split or stay together. This is still being considered in the proposal.

Stakeholders wanted a clear pathway for people to access the Crisis Team, especially out of hours and at weekends and that the patient journey needs to be as seamless as possible.

11.4 Crisis Team

a) Should there be a separate Older People in Crisis Team?

It was agreed the Crisis Team should not be separate due to equalities legislation and a single service should cover all adults.

b) Should the Crisis Team work more closely with the ambulance service and police when they request help?

It was agreed that there were often a good relationships between the Police and SEPT/other agencies. However it was also felt that there could be improved communication between agencies in responding to emergency situations especially where the police are called out to respond.

It was agreed that good communications/working relationships across agencies was vital to the effective implementation of the Stepped Care 1-5 model.

c) Is A&E right place to wait for assessment?

It was agreed A&E environment is not pleasant. Stakeholders felt that there needs to be an appropriate and safe environment within A&E that people can have immediate access to immediately on arrival.

d) What should be the appropriate length of time to wait for assessment?

Stakeholders had different views about length of times but four hours was too long.

e) Older Age Services; how would it be best managed?

It was agreed the importance to keep functional and organic illness separate for example as Dementia has a high social element to the support required and there needs to be a focus on crisis prevention.

f) Do we need a MAS in each locality supported by an old age psychological team covering both functional and organic problems – Based where?

It was agreed to keep the organic services (e.g. Dementia) separate as these have different treatment/options model. However there needs to be one in each locality. They could be based in the same 'hub' but appointments offered on different days and there are good examples elsewhere of these services being kept separate.

g) Are we doing enough for functional illness in older services?

It was agreed more need to be done for functional illness in older services once people have been assessed and that this would benefit from stronger integration between health and social care.

11.5 Mental Health Inpatient Beds

a) Can we manage demand?

It was agreed more need to be done as we cannot manage the demand and people are currently going out of county due to lack of beds. The Crisis Team currently manage a process to avoid delayed discharges including to commissioned private sector beds when available.

b) Does short stay assessments and treatment work?

Stakeholders felt this did work, however we need to ensure that we have sufficient beds. Redesign the service to have Acute Assessment Units in inpatient wards which has a consultant on ward rounds twice a day and Consultant available 24/7.

c) Strengths and benefits of Psychiatric Intensive Care Unit (PICU) and are there additional needs?

It was agreed there were additional needs for high risk patients. The group did not have the occupancy rate/numbers of those using the service or beds commissioned. However transporting patients (particularly those who may be aggressive) to the unit has been an issue. Stakeholders wanted local services.

d) Strengths and benefits to Detox Beds and are there any additional needs?

Stakeholders agreed that in patient admission wasn't best place for detox and was unsettling for some mental health needs patients.

11.6 Mental Health National Service Framework (NSF) Teams

a) What functions and outcomes should remain within teams?

It was agreed services should be based around the patient and not the other way round. It was felt that the Assertive Outreach workers could be part of the CMHT and that this would improve access.

b) What are the risks of remaining specific teams?

It was agreed there is a risk of silo working. It was agreed that we need to maintain the responsibilities of these services, but didn't need separate teams.

c) What are the benefits of remaining specific teams?

It was agreed it enables and supports specialist skills which can sit within the teams, but can mean people are not getting best support.

11.7 Mental Health Link Workers

a) Should the role be developed to include supporting service users stepping up and stepping down?

Stakeholders weren't sure bout role. It was agreed CPN's could have direct access (rather than service users going through another layer) but the role could involve care management/working with GPs, plus being a link with locality Mental Health Teams.

b) What role should they play in therapy?

Stakeholders felt that currently some Mental Health Link Workers offer step 2 level assessment and treatment already and that this could further developed.

How the clinical feedback and engagement influenced the final development of the Stepped care model to integrate:

1. **Step Care 1 – 5**
    - Locality based services provision
    - Use of information Technology; social media and marketing
    - Focus on Early intervention
    - Reduction of NSF Teams to create locality teams
    - Waiting times for Crisis Service

2. **Single Point of Access**
    - Referral/GP early signpost and details on assessment
    - Triage service/ Triage tool; risk assessment to ask relevant questions
    - Streamlined and aligned steps 1-3 and steps 4-5
    - Support to prevention and signpost to social care services