East Midlands Clinical Senate

Adult and Older People Community Mental Health Services in Leicester, Leicestershire and Rutland

Report of the Independent Clinical Senate Review Panel (2nd October 2020)

October 2020

Confidential

england.eastmidlandsclinicalsenate@nhs.net

Glossary of abbreviations

A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
AHP	Allied Health Professional
AMH	Adult Mental Health
ASD	Autism Spectrum Disorder
BAME	Black, Asian and Minority Ethnic
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CVS	Community and Voluntary Services
ED	Emergency Department
EMAS	East Midlands Ambulance Service
HOSC	Health and Overview Scrutiny Committee
ICS	Integrated Care System
JSNA	Joint Strategic Needs Assessment
LPT	Leicestershire Partnership Trust
LLR	Leicester, Leicestershire and Rutland
MDT	Multidisciplinary Team
MHIS	Mental Health Investment Standard
NICE	The National Institute for Health and Care Excellence
OT	Occupational Therapy
PCN	Primary Care Network
STP	Sustainability and Transformation Partnership
UHL	University Hospitals of Leicester

Contents

1. Foreword by Dr Julie Attfield, Clinical Review Panel Chair

Clinical Senates have been established as a source of independent and objective clinical advice and guidance to local health and care systems, to assist them to make the best decisions about healthcare for the populations they represent.

Clinical Senates are minimally staffed and built on the voluntary engagement and goodwill of local clinicians and other health and care professionals to ensure that the wider NHS can benefit from this expertise and experience.

We would like to thank Leicestershire Partnership Trust for proactively engaging the Clinical Senate and to the Trust's Executive team and their clinical teams for presenting their system's plans on behalf of Leicester, Leicestershire and Rutland and for the time they afforded the Clinical Senate both on the panel day itself and in preparation for it.

It is with thanks to our clinical review team for their participation and commitment to this clinical review as the panel offered a breadth of expertise and experience as well as broad geographical representation to ensure a comprehensive clinical discussion ensued.

We would like to wish Leicestershire Partnership Trust good luck on its transformation journey.

Dr Julie Attfield
Clinical Senate Vice Chair

2. Clinical Senate Review Panel summary and key recommendations

Leicestershire Partnership Trust on behalf of the Leicester, Leicestershire and Rutland system described to the clinical review panel a coherent offer and articulated its aspirations well. Credible presentations were supported by a number of clinicians and Trust Executives throughout the day. The Trust seems to be able to deliver its proposed changes countywide and their recent reduction in length of stay for inpatients is impressive. It was clear to the panel that the proposed model is superior to the historical way of operating and the Trust was open in its communication about the historical challenges and particularly around quality and performance of a largely fragmented service.

The panel felt that the overarching plan and strategy was positive. Co-production with service users was a clear strength and clinical leadership within the Trust was evident coupled with an organisational commitment to cultural change, which was positively articulated by the presenting clinicians. Whilst the Trust recognised that a huge amount of work was needed and will take time, the organisation's change messaging is consistent, and the panel were informed that Trust clinicians are hearing this from the leadership which is combined with a powerful message that the new model is what service users want and need. The panel acknowledged that a lot of work had been undertaken to date and that the LLR system had acknowledged their difficulties and developed a new model of care to address historical challenges and shortcomings, which was considered commendable by the panel.

The panel however were not sighted on any detailed plans and would have welcomed the opportunity to be shown the overarching strategy connection with the local population and demographics, improved clinical outcomes, and a demonstration of how the system will secure their intended impact. The panel acknowledged in its limitations that this work may have been undertaken but the panel could not acquire a view of the population aspects, detailed delivery plan and clinical outcomes, as only two of the four elements of the total transformation programme were contained within the scope of the Terms of Reference. The panel felt that a continual sense of

progress being measured will be important as well as more detail around the Urgent Care Hub to demonstrate its effectiveness given the primacy of this in the model.

The key recommendations made by the panel concerned five main areas.

1. The panel recommend that a health equity assessment is undertaken in order to ensure that systematic action on health inequalities and equalities are embedded in the proposed model. The panel have signposted the Trust to resources which could help with this in Appendix D.

2. The panel recommend that the system's proposals are made clearer in terms of data, performance, current measures, intended outcomes (and how the new model is going to deliver) and the evaluation strategy.

3. The panel recommend that much clearer capacity and demand modelling is undertaken (by linking referral rates data to the future workforce required) and made available which would ensure the system has sufficient capacity to meet future demand for its Integrated Community Services model, with an overarching plan which clearly demonstrates exactly how the existing quality and performance challenges will be addressed and additionally, has the ability to deliver a wide range of interventions including those with service users who pose significant clinical risk (e.g. Assertive Outreach Team service users).

4. The panel recommend a coherent prevention focus is required covering upstream, midstream and downstream approaches from raising awareness, tackling stigma and parity of esteem between mental and physical health, health literacy, to early diagnosis, evidence-based interventions to recovery and resilience.

5. It is recommended to model a range of scenarios to meet future demand, and for the Trust's own assurance to consider fully the measures to take to make the change process itself safer.

3. Background and advice request

3.1 Description of current service model

Urgent and Emergency Care

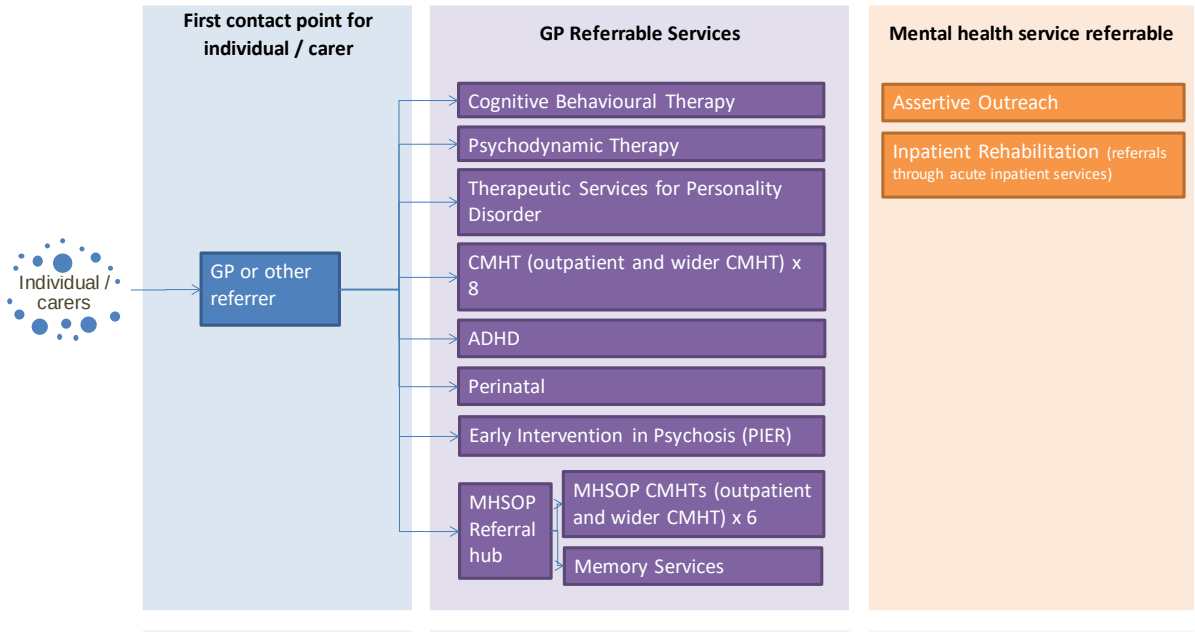
For Urgent and Emergency Care, the Leicester, Leicestershire and Rutland (LLR) system plans are to invest in a proper urgent and emergency care pathway that provides earlier support to patients, proactively manages vulnerable people, provides planned support outside of the criminal justice system and acute emergency departments.

The NHS Long Term Plan sets an ambition for more comprehensive crisis pathways in every area that are able to meet the continuum of needs and preferences for accessing crisis care, whether it be in communities, people's homes, emergency departments, police or ambulance services. It also frames that there should be 'no wrong door' approach to supporting people so that they can get or be supported to the right help to meet their needs irrespective of the point of access.

The LLR system will work with its partners to increase capacity, improve traditional models of crisis care and deliver comprehensive accessible local crisis care pathways by working with the voluntary and community sector, police, ambulance service and A&E departments.

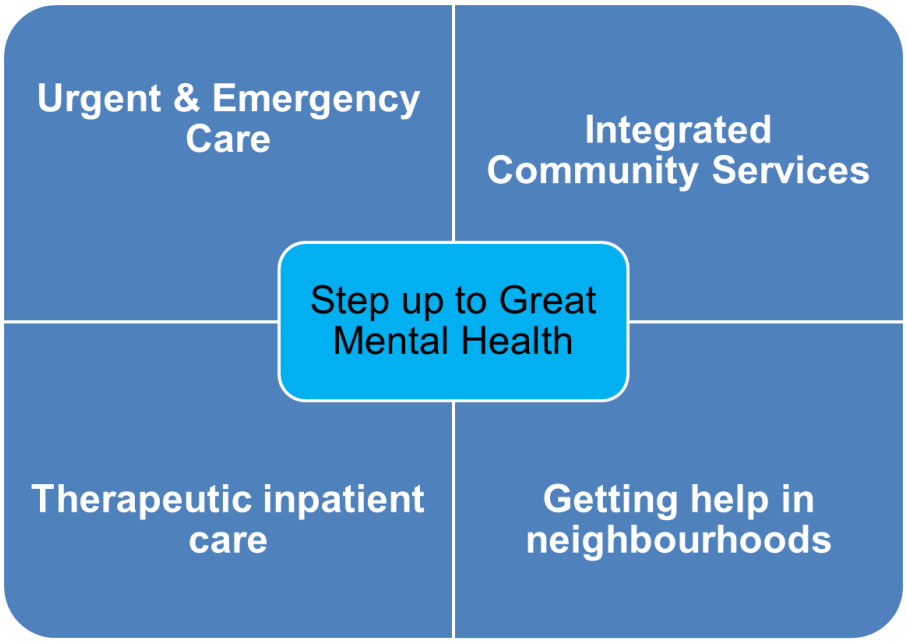
Integrated Community Services

The existing configuration for community services was provided in advance to the panel and can be seen in the diagram below. The present configuration is largely based on the previous national service framework with psychological therapy services and capacity largely out with the main stay of clinical teams.



The Trust described the performance of its mental health urgent and emergency care pathway historically as “clunky at best” which had contributed to long lengths of stay and an absence of admission prevention.

The case for change was split into two key foci, urgent and emergency care and integrated community services. These two aspects were described as part of the system’s Step up to Great Mental Health which contained four programmes overall and is laid out in the diagram below.



This review did not consider the areas of Therapeutic inpatient care and Getting help in neighbourhoods but does touch on the implications of this in the limitations of the review.

3.2 Case for change

Step up to Great Mental Health

Step up to Great Mental Health is the Leicester, Leicestershire and Rutland (LLR) STP programme designed to improve mental health services in the region. The Step up to Great programme is led by the LLR STP through their Mental Health Partnership Delivery Board which is chaired by the Chief Executive of Leicestershire Partnership NHS Trust.

The programme has four key elements:

- Neighbourhoods
- Integrated community services
- Urgent and Emergency Care
- Inpatient

This review did not focus on inpatient mental health services or the neighbourhood plans. The inpatient services will be the subject of a separate Outline Business Case for capital funding. The neighbourhood plans will be piloted in a small number of Primary Care Networks (PCNs) prior to wider roll out. This Clinical Senate review therefore focused on Integrated Community Services and Urgent and Emergency Care Mental Health services. The service changes are focused on improvement and investment and not on service reduction or closure.

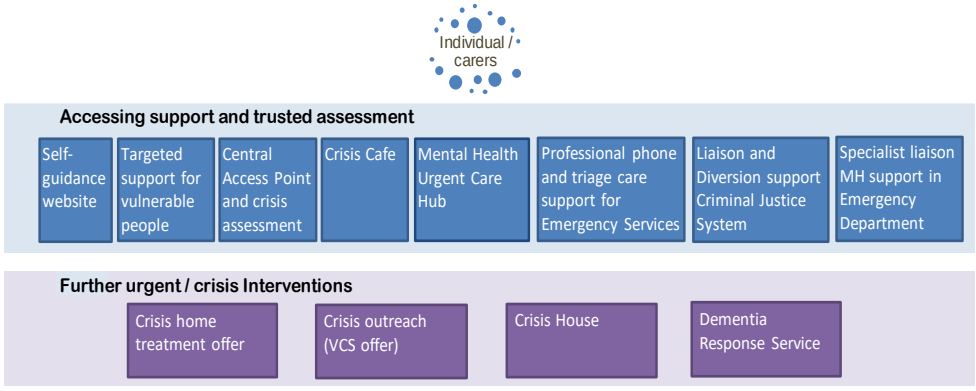
Leicester, Leicestershire and Rutland shares many of the challenges seen across the country in terms of fragmented community services and a disjointed Urgent and Emergency Care pathway. LLR is an outlier in terms of long access waits for services. LLR underperforms against key national and local mental health standards.

Service users tell the system that their services are fragmented, difficult to access and not always available within the community. Service users also express that they want to see services that are integrated, that they can access locally, to receive the right support first time, move between services without starting again, and step up and down as needed. Service users are also often waiting in some services to be accepted by another due to long internal transfer waits. They often have to tell their story many times.

Some of the Trust's staff voice that they feel overwhelmed by their high caseloads and that the system needs to improve flow to help to reduce caseloads and eradicate the lengthy internal waits for some patients. Staff also express that the distribution of caseloads are linked to historic service and team boundaries and structures rather than on real need. This leads to unfair and sometimes wasteful resource management. The regulatory bodies convey that the system is an outlier in terms of long access waits and the Trust underperforms against national targets.

The system has applied learning from the temporary service changes made in response to COVID-19. A number of service changes were mandated by the national team under command and control arrangements. These included a 24/7 Central Access Point, an Urgent Care Hub, a community Rehabilitation team and increased use of digital platforms. These changes were all part of the system's longer-term plans and it is proposed to make them permanent having applied the learning from service users and staff feedback.

<u>Urgent and Emergency Care pathway</u>



For Integrated Community services, the plans in LLR are to deliver the national Community Mental Health Framework and in so doing address the underlying and longer-term problems within current delivery. The LLR system faces the same challenges as those set out in the national framework document and seeks to deliver the same benefits. The performance of the current provision and its limitations were described by the Trust in its submission to the Clinical Senate and on the day of the review. The national framework published in late 2019 by NHS England and NHS Improvement and the National Collaborating Central for Mental Health, sets out a case for change, describing a range of common issues with community mental health services, which are all present in LLR.

The national framework sets out a number of goals for the introduction of a new model of community mental health services. These align closely with the goals of Step up to Great Mental Health:

- Access to mental health services where and when people need it
- Individualised approaches to managing conditions and recovery
- Breaking down barriers between mental and physical health
- Integrated care
- Place and neighbourhood-based service offerings
- Increased roles for the voluntary and community organisations and social enterprises
- Local collaboration
- Working together to maximise the support offered to people when and where they need it
- Meeting people's needs in the community
- Reinvigorating and simplifying community mental health provision

The main focus of the service changes the LLR system plan to make are to better integrate teams that currently work in separate silos resulting in handovers, sometimes lengthy waits and extended journeys when patients pass between teams. The LLR system also plan to change the offer to service users in terms of the support that they can expect to receive and by improving local access to more integrated

services. Community mental health services need to be simpler and with a stronger psychologically driven focus on care and treatment. Within a model that can allow flexibility and that uses best practice from the learning of the past, service users should be cared for without hard onward internal referral and the inevitable delays and push back.

The system will bring together its Assertive Outreach support, Community Mental Health Teams and Psychological services into a more integrated and aligned offer and establish eight Community Treatment and Recovery Teams linked to Primary Care Networks. The focus will be on supporting people to live well in the community through the provision of joined up services where people need them. The system will use team assessment, team caseloads and multi-disciplinary approaches in the new community provision, in line with The Community Mental Health Framework for Adults and Older Adults.

3.3 Scope and limitations of review

The clinical review team were specifically asked to consider:

- The integration of UEC (Urgent and Emergency Care) offering for people presenting in a mental health crisis or with other urgent (and possibly undiagnosed) needs with other UEC services, including alternative pathways to emergency attendances at A&E which may lead to poor patient experience
- How teams come together around patients across different geographical settings and by working with community GPs to reduce waits and unnecessary handoffs and in partnership with the third (voluntary) sector
- The proposal to implement a single point of telephone access for referrers into the service
- The Trust's ambition to implement the Community Mental Health Framework for Adults and Older Adults in LLR

Due to the current COVID-19 pandemic it was agreed with the sponsoring organisation on 10th July that a clinical review would be conducted on Microsoft Teams and although there were no real concerns at the outset about the potential reduced value of a MS Teams conducted review, the panel felt that a virtual event

does stymie the natural flow of both informal and formal discussion that a face to face clinical review usually affords.

The Clinical Senate review team in its preparation requested:

- Case for change and a summary of the current position and proposed alternative service/care model
- Impact of withdrawing/reconfiguring services, including risk register and mitigations
- How proposals reflect clinical guidelines and best practice (NHS Long Term Plan and The Community Mental Health Framework for Adults and Older Adults), the goals of the NHS Outcomes Framework and Constitution
- Alignment with local authority joint strategic needs assessments and a narrative around health inequalities and demographics
- Evidence of alignment with STP plans
- Evidence of how any proposals meet future healthcare needs, including activity modelling, pathways, and patient flows
- Demonstrate how patient access and transport will be addressed
- Demonstrate how any implications on the Ambulance Service will be addressed
- Consideration to a networked approach
- Education and training requirements
- Implications on workforce (to be able to demonstrate alignment to new ways of working, and to describe how the future workforce will look to support any new models of care/reconfiguration proposed)
- Implications for the workforce (to describe how the workforce will be engaged, supported and motivated to work in new ways and in new places that support any new models of care/reconfiguration proposed)
- Implications for the clinical support services and those staff (e.g. clinical engineering, radiology, pharmacy)
- SHAPE (Strategic Health Asset Planning and Evaluation) Place Atlas, which helps organisations to consider the evaluation of the impact of service configuration on proposals and assess the optimum location of services
- Core service inspection report (i.e. CQC)

- Public, patient and staff engagement plans

Further to the Clinical Senate review team's pre-panel call on 16th September, the following additional information was requested from Leicestershire Partnership Trust (to be provided in advance or to be covered in the presentations on 2nd October):

- How the new service model will solve some of the quality problems in the acute care pathway (i.e. long waits)
- The culture and engagement aspects of the transformation plan (both staff and patients)
- Services footprint
- Workforce plan and programme of educational work
- Phase 3 mental health plan
- Any examples of patient pathways
- Mental health services benchmarking report
- Plans around neighbourhood teams and Community Mental Health Teams
- Demographic figures related to current activity (patients LLR is serving and needs of assessments) and the Trust's understanding of inequalities
- Any audits against clinical guidelines/NICE

The panel received a further evidence submission ahead of 2nd October:

- Phase 3 Planning Support template for Leicester, Leicestershire & Rutland
- Phase 3 Mental Health Finance Template for Leicester, Leicestershire & Rutland
- NICE Epilepsy Audit
- NICE Vitamin D Testing / Prescribing Audit
- POMH-UK Report on Monitoring of Patients Prescribed Lithium
- Action Plan for Monitoring of Patients Prescribed Lithium
- Benchmarking - Inpatient and Community Mental Health (Registered Population)
- Benchmarking - Inpatient and Community Mental Health (Weighted Population)
- Integrated Community Team – Workforce model

The panel acknowledged that it did not have sight of the operating procedures for the Urgent Care Hub or the Central Access Point or service evaluations which articulated the outcomes of these recently made changes. It was acknowledged that the absence of more detailed information about these two key developments is a limitation, which would likely have been overcome by site visits – that were not possible.

It was also acknowledged that the panel did not receive a delivery plan of the proposed transformation or a strategy to evaluate the service changes or proposed impact measures, as they are still to be fully completed by the Trust. Therefore, the methodology of this review was largely limited to an MS Teams based discussion and accompanying presentations. The panel would emphasise that as there were some deficits in the information available to support the clinical review, the implications of this are highlighted.

4. Methodology and governance

4.1 Details of the approach taken

The sponsoring organisation (Leicestershire Partnership Trust) formally engaged the Clinical Senate on 10th July 2020 (Gordon King, Medical Director and Jo Kirk, Associate Director – Mental Health NHS England and NHS Improvement – Midlands was also present on the call). It was agreed that a long half day's review (10am – 3.45pm) would be required, and 2nd October 2020 was identified for the clinical review panel. A subsequent teleconference call took place between the Head of Clinical Senates, John Edwards, Associate Director for Transformation and Graeme Jones on 30th July.

Panel members and a patient representative were identified from the East Midlands and West Midlands Clinical Senates to ensure appropriate representation of clinical roles. In addition, other regional Clinical Senates outside of the Midlands were approached and particular effort was made to secure representation from the twelve Early Implementer sites.

A draft report was sent to the panel members and the sponsoring organisation to check for matters of accuracy.

The final report was submitted to the Senate Council (and ratified on 22nd October 2020).
This report was then submitted to the sponsoring organisation, Leicestershire Partnership Trust, on 23rd October 2020.

The East Midlands Clinical Senate will publish this report on its website once agreed with Leicestershire Partnership Trust. The anticipated publication date is 31st January 2021.

4.2 Original documents used

The full list of documents provided by the sponsoring organisation for the clinical review panel can be found in Appendix B. The main submission included:

- Clinical Senate presentation
- Summary of the plans
- Summary of challenges in the current state and features of new approach for integrated community services
- National Community mental health framework for adults and older adults
- Core 24 Bid (Wave 2 Liaison Mental Health Transformation Funding)
- Liaison and Diversion – national specification
- Liaison and Diversion Business Case
- Summary of the Leicester JSNA
- AMH Board Performance Report July 2020
- Inpatient flow data
- Activity and investment Integrated Community Services
- CQC Inspection June 2019
- STP and CCG presentation to HOSC
- Mental Health Urgent Care Hub Evaluation
- Central Access Point Summary of survey findings

5. Key findings from the clinical review

The panel heard at the start of the day from the Executive team at Leicestershire Partnership Trust (LPT) who explained that this is a new model of integrated community mental health and urgent care for adults and older people. The model had been developed with high levels of clinical input in the system, and the Clinical Senate had been approached because of the importance of clinical validation from external regional colleagues as part of the Trust's wider engagement to ensure the model is informed by independent and external clinical input and expertise.

The panel heard that the Trust had for the past 18 months been working through challenges from regulatory bodies around quality and partly performance (being an outlier in terms of long access waits and underperformance against national targets). The Trust had also been a laggard in terms of introducing new modern models of integrated care. Co-production of the new model of care had been a strong guiding principle and 50 workshop days involving service users, Trust clinicians and staff, EMAS, UHL, police, CCG and GP colleagues had been held. Central to the development of the new model of care was to ensure service users and carers had a better experience and their voice and particularly through Healthwatch colleagues had helped to drive the work forwards.

The Executive explained to the panel that a significant lack of joined up crisis services and community pathways was a historical challenge. The referral routes for GPs included 9 or 10 different routes to access services which had led to patients bouncing back to primary care and multiple handoffs within services. The other main area of concern was around quality and performance and particularly waiting times (some waits were around the 3 or 4 year mark), quality of access (to Personality Disorder pathways and trauma and psychological support) and speed of service in addition to historical siloed services. This was combined with a challenge in managing caseloads and a traditional consultant led outpatient model (rather than an MDT model) which did not feel supportive to either service users or consultants. Parts of the community services are not able to offer a breadth of psychologically informed interventions. The panel also heard that out of area flow and many of the bed stock had become blocked.

The Executive explained that their new model of adult and older people mental health care was aligned to The Community Mental Health Framework and the NHS Long Term Plan. The governance structure for the programme was explained to the panel who heard this is a system owned piece of work by LPT and its partners. The governance and oversight from a system stance suggested buy in from partners and a Mental Health Clinical Reference Group that is embedded. Step up to Great Mental Health encompasses four workstreams – Urgent and Emergency Care and Integrated Community Services, which the panel would hear about and also Therapeutic inpatient care (up to 50 LLR patients had been placed out of their local area) and Getting help in neighbourhoods which had looked at how services are built up locally and can be structurally sustained and embedded. The panel heard that tremendous support to date for the transformation had been received from local authority and GP colleagues.

It was explained to the panel that due to the Infection Prevention and Control challenges of the COVID-19 pandemic, the Trust had reduced its bed stock by 48%. The Executive explained to the panel that the Trust intends to apply the learning from the temporary service changes made in response to COVID-19. A number of service changes were mandated by the national team under command and control arrangements. These included a 24/7 Central Access Point, an Urgent Care Hub, a community Rehabilitation team and increased use of digital platforms. These changes were all part of the Trust's longer-term plans and it is proposed to make them permanent having applied the learning from service users and staff feedback. This meant that early in April, a Central Access Point had been implemented for the first time in the system which provided a single point of access for GPs and service users to ensure the right support is provided at the right time. Feedback had been received from both the CQC and service users around the removal of organisational boundaries in order to provide timely and supportive clinical care. Finally, it was explained to the panel that new investment had been received (>£5mn MHIS in 2020 and further monies in 2021-2024) which would be combined with re-organising existing LPT resource.

Urgent and Emergency Care

It was explained to the panel that service users had experienced inconsistency in approach across different points of access combined with poor and variable response times and an unclear offer of crisis support across the Emergency Department pathways and a lack of focus on early help or support. Service users were being reassessed repeatedly which is both inefficient and leads to poor patient experience. The ambition therefore is to implement a more coherent and accessible Urgent and Emergency Care Pathway using the same trusted assessment model.

Earlier support in the community

The system's plans to strengthen earlier support in the community will improve the offering to their local population in LLR ahead of an emergency or criminal justice scenario. The Crisis Home Treatment offer will be more consistent and offer greater continuity of care and link with a broader range of support services including those provided by the Voluntary and Community Sector (VCS) to develop a range of options for people in the community to be supported through crisis and to respond to the need in a timely manner. Through these actions the Trust plans to reduce the number of people unnecessarily entering secondary mental health services. It was explained to the panel that the Trust already has a strong partnership with Turning Point, a service delivered by Leicestershire County Council who provide substance misuse services and crisis support as an alternative to admission to hospital. The system also is planning to invest £145k into expanding crisis cafes and a further investment planned each year for the next four years to increase the number of crisis cafes to stretch across large parts of the LLR geography.

Intensive support to vulnerable groups

The presenting clinical team explained to the panel that their ambition to join up and integrate services to support the most vulnerable people in the community would happen by building on the well-regarded local services that are already in place. For example, a well-established homeless service and investment at Police Custody Suites and Crown and Magistrates Courts. The system will build on work that is underway to ensure that services are working for all of their communities and, in particular, that service users from BAME backgrounds have equality of access and outcomes by investing £540,000 into this pathway in LLR. The system plans to

develop a more rounded dementia support service by bringing together the dementia in reach team so that those people living with dementia can stay living in a familiar environment. It was not clear to the Clinical Senate how the Trust had positioned these important developments in aligning to joint strategic needs assessments and broader joint health and wellbeing strategies.

Self-referral and Central Access Point

As part of the system's response to COVID-19, the Trust introduced a Central Access Point to provide a more co-ordinated response guiding people to the right service the first time for routine and for crisis support. An existing helpline with Turning Point was merged into the Central Access Point. This has begun to reduce handovers and hand-offs within the Trust and has provided a place for individuals to directly refer themselves for mental health help, signposting and advice. This could be a brief intervention or further assessment, or a patient could be handed over to the community team. The early stage evaluation suggested that this development had been well received by patients and provides a way back into crisis services through a direct route if necessary. The full operating details of the Central Access Point and any quantitative details of impact were not available to the Clinical Senate and a visit was not practicable.

Making the Urgent Care Hub permanent

The Trust was one of the first systems in the country to introduce a Mental Health Urgent Care Hub set up initially to divert people away from A&E in response to the COVID-19 pandemic. The Hub covers the LLR area and is based on the inpatient site at The Bradgate Mental Health Unit on the Glenfield site of University Hospitals of Leicester. It was described to the panel that this then blossomed, and the Hub now takes referrals from the police and East Midlands Ambulance Service who can bring people in crisis to the Hub. The Hub also provides expert advice to other health professionals. The Hub runs on a 24/7 basis and it is intended that the system will make it a key permanent feature of their Urgent and Emergency Care pathway, with full assessment taking place within two hours of arrival in the Hub which is delivered by a mixed discipline of mental health colleagues, nurses, and AHPs. The principle that has been adopted by the Hub is that if the service user does not need crisis support then they do not need another assessment. The Hub has been very

successful and feedback from service users, partners and staff has been overwhelmingly positive. The full operating details of the Urgent Care Hub and any quantitative details of impact were not available to the Clinical Senate and a visit was not practicable.

Working with the emergency services

The panel heard that the system will expand their police triage car support to work with East Midlands Ambulance Service as well. The system will also expand the hours that the service is available. This will be achieved by releasing triage team time through the redirection of advice, guidance and queries to the Central Access Point as part of joining up the different services.

Delivering Core 24 standards in ED

The system described how it will develop their specialist liaison mental health teams working in emergency departments and general hospital wards to provide 24/7 support and to meet the Core 24 service standard for adult liaison mental health services (1 hour and 24-hour target delivery).

Finally, the principles underpinning implementation were highlighted by the Trust:

- Putting patients and carers at the heart of initiatives
- How the system's resources can be used efficiently including its local authority and CVS partnership
- Embedding further positive steps such as the Central Access Point and Urgent Care Hub

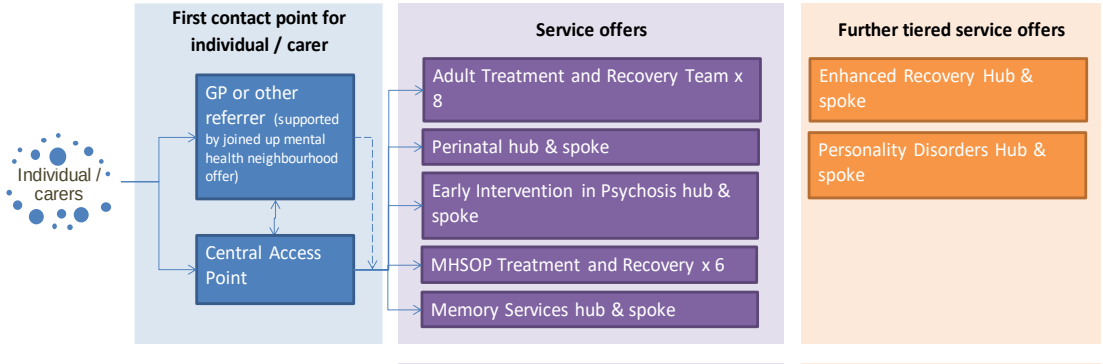
Integrated Community Services

It was explained to the panel that service user experiences and system challenges had informed the new model of care. Similar to the morning's presentation on Urgent and Emergency Care, service users had a strong voice in the development of the model. The Trust had been on the receiving end of challenging CQC, regulatory and wider system critique and challenge. Some of the challenges go back 20 years with fragmentation of different specialist teams, duplication, and silos, and this was not just present in a single trust. This was combined with multiple assessments for the same service user, rigid service specifications, poor flow and very large caseloads

throughout the system, inconsistent practice across teams and considerable bounce backs to GPs and around the system. GPs were faced with a bewildering set of services, some of which had extremely long waits, and had to make decisions about which pathway would be most appropriate to refer a patient onto and the Trust understood that anecdotally, sometimes GPs would take the line of least resistance in order to get a patient into a service as quickly as possible. All of these factors combined led to unnecessary deterioration of patient's mental health and the historical model had not taken account of the pace and service change needed. The Trust explained to the panel that whilst this piece of work is not as developed as the Urgent and Emergency Care model, GPs and Primary Care Networks (PCNs) had been brought into the new model of care in a more integral way.

It was reiterated that the Central Access Point had meant that people can now self-refer and that the system was trying to simplify pathways and meet the needs of The Community Mental Health Framework and the NHS Long Term Plan.

The proposed Integrated Community Offer was shown to the panel as below.
The future state integrated community service configuration brings together the system's Assertive Outreach support, Community Mental Health Teams and Psychological services into a more integrated and aligned offer and will establish eight Community Treatment and Recovery Teams linked to the County's three Primary Care Networks:



The system has adopted four key principles when developing the new model of care which better focuses on supporting service users and their needs and recovery and

has real flexibility to rapidly step up and step down intensive and assertive approaches. By incorporating psychological therapies and the principles of the assertive outreach team and applying a whole team MDT approach to develop and deliver a clear treatment plan and removing inter-team barriers; a strong formulation based (single) assessment right at the beginning of a patient's care in collaboration with service users can be undertaken and the offer can extend further to a broader number of patients, and by ensuring specialist knowledge is brought in and interventions are offered locally by local services and teams.

Hub and spoke model for targeted community services

The system will build on the success of its Perinatal hub and spoke model (this was described to the panel by highlighting a patient story) to develop similar arrangements for other community services including Early Intervention in Psychosis (EIP), Enhanced Recovery, Personality Disorder support and Memory services.

The system will place the majority of service delivery into community settings with a central expert resource to provide support, training and step up expertise and targeted interventions. The focus will be on recovery and supporting the majority of people in a community setting. There will be access to more intensive and specialist support for a smaller number of people (based on acuteness or targeted needs), with a step-down community recovery focus, as per the national framework.

Wider Therapy services

The system's separate Cognitive Behaviour Therapy (CBT) and Psychodynamic teams will come together into the Community Treatment and Recovery Teams. The system's goal is to increase the psychologically informed ways of working across its community teams and increase the number of people in LLR accessing therapy support. The Community Treatment and Recovery Teams will manage their caseload as a whole team, working as an MDT to formulation of need, care planning, review and treatment. The role of the psychological worker will include a greater focus on supporting staff to deliver psychologically informed care in the Community Treatment and Recovery Teams, participating in the initial integrated assessment and formulation alongside specific therapy activity.

Much improved initial integrated assessment and formulation will identify with the service user the best pathway for patients and reduce the number of ineffective treatments by better understanding individual needs and circumstances. The system also aims to have less siloed services with a significant reduction in handovers and restarts for patients and associated internal waits. There will be a much greater focus on individual care and having expertise focused on the service user.

Personality Disorder Services

Some of the system's longest internal waits are in the Personality Disorder (PD) service as it receives 1,000 referrals per year from GPs and IAPT (Improving Access to Psychological Therapies) which is not a sustainable model. A whole system approach will be adopted by raising awareness and training in order to support individuals with personality disorder and to provide a more transparent offer of tiered provision:

Tier 1a – A significant number of service users fall between IAPT and secondary mental health services and this tier aims to bridge the gap

Tier 2 – Offer Structured Clinical Management in Treatment and Recovery Teams

Tier 3 – Offer delivered by the Hub to address the small percentage of individuals presenting with the highest levels of risk

The Enhanced Recovery Pathway

The Enhanced Recovery Pathway (ERP) will aim to support the rehabilitation of people with complex psychosis and other severe and enduring mental health difficulties. The pathway will have both a hub and spoke function which will allow individuals to step up and step down as per their recovery journey. As per NICE guidelines for the rehabilitation of adults with complex psychosis the pathway will offer recovery interventions in the least restrictive environment for service users and aims to help people progress from more intensive support to greater independence. The team started in April and staff are making a transition to a community setting and building a hub team. The spoke elements will be delivered by planned Treatment and Recovery Teams in trusts and staff skills will be developed so that alternative provision to inpatient rehabilitation can be delivered and by strengthening links with Adult Social Care and CVS.

Finally, it was explained to the panel that in order to tackle existing challenges, the system was undertaking a review of all patients as there is a big caseload currently especially for outpatient clinics and by bringing in a targeted offer for long waits. The system is looking at a patient's diagnosis and their current treatment plans and what future treatment and therapeutic intervention might be needed and what else could be offered to support social isolation, housing, and employment, by working with the community and voluntary sector. The panel heard that the system is in its early stages of a robust plan which is governed by programme boards through to the STP and structural plans are due to take place next year.

6. Conclusions and advice

The panel thanked the Trust for inviting the Clinical Senate to review their plans, for the presentations and all the preparation work in advance of the panel. The panel acknowledged that systems and mental health providers are all grappling with similar issues as part of their transformation journey and the learning is a shared experience. The panel also acknowledged the fleeting nature of the exercise and whilst high level detail had been explored, due to the scope of the review and the limitations of Microsoft Teams, the panel had not explored what is a very wide ranging transformation programme fully in great detail and recognised that there was a broader strategy (including inpatient services and neighbourhood working) and the panel was limited to look at two parts of a four part programme which are intrinsically linked.

The panel therefore could not see the whole programme and how it all fitted together and particularly see how the proposed changes make that link with primary care. The panel acknowledged that this may well have been covered by the Trust in its programme development work although the panel felt this was a limitation of the review as its views had been influenced by the parts of the programme that had been presented. The panel also acknowledged the limitations of its advice in the context of not being able to visit the new Central Access Point or the Urgent Care Hub or examine their operating procedures or speak to the Trust's staff on the ground delivering these changes.

The panel felt that the Trust had presented a positive and coherent overarching strategy with real strengths. These plans are evidently based upon national guidance. In terms of the broad direction of travel the Clinical Senate supported the Trust's proposals whilst it highlighted some concerns, having heard both of the presentations throughout the day, but it could not comment on the delivery plan, demand and capacity scenario modelling and the Equality Impact Assessment, as these pieces of work are still to be fully completed by the Trust. Whilst the panel acknowledged this, it could not clearly see the alignment with a broader needs assessment and community strategy as the work is still underway.

It was also difficult for the panel to determine how the strategy had been shaped by the needs of the local population and it was hard to be fully assured because the

Equality Impact Assessment and the Quality Impact Assessment underpinning the evidence base is work yet to be completed by the Trust. Evidence of alignment with local authority joint strategic needs assessments and narrative around health inequalities and demographics was requested by the panel as part of the supporting information submission, and it had received the Leicester City Joint Strategic Needs Assessment (2016). Therefore, the panel could not conclude how the needs of the local population had been considered in the modelling given the work is still underway locally.

Whilst the clinical changes had been coherently described, the panel felt it did not have a clear picture as to how the strategy had been adjusted to consider the demographics of the local population and more local evidence to ensure inequalities are not inadvertently increased. The presentations seemed to be driven by the Trust's own clinical narrative, co-production (which is of course positive) and the national direction. Further work will need to be undertaken (and was acknowledged by the Trust on the day) to be able to illustrate the population considerations, outcomes, and a demonstration of how the system will secure their intended impact.

Whilst it was suggested that activity modelling had been developed to ascertain the safety and robustness of the transformation plan, this detail was not available to the panel. There was a heavy focus on co-production which is of course laudable although the panel could not see triangulation of approaches due to the previously described limitations of the review. For example, Public Health input and taking a population perspective approach was mentioned, although the panel could not corroborate this with supporting written evidence as the work is still to be finalised by the Trust. As a full consideration of population demography was also not provided for the same reasons described, the panel would emphasise that the Equality Impact Assessment when completed will need to demonstrate – how has the system considered cultural perceptions about mental health – how has this affected access to, and experience of, services? Has the system identified issues of access and outcomes for other minority communities for example transgender people? Has the system considered health literacy needs and issues for staff, patients and the population (in all its subsections)? Has under-diagnosis in the population been considered?

Strong partnership working was mentioned with CVS and local authority services which again is positive, although the three large local Universities (University of Leicester, De Montfort University and Loughborough University) which have a significant student population and possibly have hidden secondary mental health needs amongst the student population will also need to be considered in the modelling as this was not covered specifically on the day itself due to the time constraints. The panel were not clear if a health equity assessment on the model had been undertaken.

The benefits of the Urgent Care Hub around avoiding unnecessary A&E admissions had been described to the panel although more detail about how it operated and outcomes to date would significantly strengthen the underpinning clinical evidence base. The panel acknowledged it would have been helpful to have visited the Hub. The proposals should be explicit about what the Hub has delivered for the Trust, its impact and effectiveness on the system's overall operating model. How will the system know the model is clinically and cost effective?

The Integrated Community Services strategy articulated well the whole scale changes with a compelling vision, the panel felt that the system's aspirations are the right ones and the model was understandable, although it was not always clear to the panel how far in each stage of the transformation the system was at. The panel felt that clear communications with stakeholders was required in order to elucidate which elements of the model they will receive, and at which point, and additionally, what benefits will be realised should be made clear from the outset. The system described a model that seeks to release capacity by building community capability and releasing flow although the panel were concerned that capacity should be developed before the model is pushed too hard otherwise the system could get into difficulties with an increased number of referrals. As the demand and capacity scenario modelling had not yet been finalised by the Trust, this level of detail around planning and capacity was not available to the panel for comment and it suggested that detailed plans around what had already been delivered and what do those detailed plans look like into the next financial year and beyond would strengthen the clinical evidence base. The panel suggested that basic data around referral rates (how referrals and/or outcomes of referrals might change) should be used for predicted modelling and then the system can work out the workforce and capacity required.

This will be important going forward to link the capacity available to meet the demand and the system will need to be able to demonstrate how it can flex its capacity otherwise there might be a risk that the system will be overloaded and will not be able to deliver. Moreover, the system will also need to show how it will flex the level of intensity to enable them to deliver the core principles of Assertive Outreach as well as those with higher levels of clinical risk. It was unclear to the panel how the system would drive down waiting times – what are the exact details of what the system needs to do and when? Moreover, the panel felt that assumptions which appeared to have been made in the COVID period may not be generalisable going forward in terms of activity or funding.

The panel felt that the formulation-based approach was laudable. Whilst digital platforms may be planned within the Trust's proposed improvements this level of detail was not discussed on the day due to the time constraints. The perinatal patient story provided was a good example although the panel were concerned that the model was more of an enhanced secondary care offer than an integrated model due to the panel not being able to see the link with primary care strongly enough and how the system will build primary care capacity and how it all dovetails together (the Trust had explained that the intention was for the historical boundaries between primary and secondary care to become seamless). The panel felt that describing the membership engagement and management of the transformation programme going forward beyond a high-level governance structure may help to embed this into the evidence base. It was felt that a greater level of integration could be achieved beyond local authority Approved Mental Health Professionals and that the physical health care of patients with a Serious Mental Illness appeared to be missing in the primary care component. Furthermore, recovery was mentioned throughout the presentations but is there a focus on developing and supporting resilience, which should be part of the wider secondary prevention offer and what is the focus on upstream prevention and links with lifestyle services? The panel felt that a coherent prevention focus is required covering upstream, midstream and downstream approaches from raising awareness, tackling stigma and parity of esteem between mental and physical health, health literacy, to early diagnosis, evidence-based interventions to recovery and resilience.

As the clinical review team were specifically asked to consider a number of questions in the scope of the review, in addition to the conclusions and advice provided above, each issue is addressed in turn below.

The integration of UEC (Urgent and Emergency Care) offering for people presenting in a mental health crisis or with other urgent (and possibly undiagnosed) needs with other UEC services, including alternative pathways to emergency attendances at A&E which may lead to poor patient experience

The panel did not have access to a more detailed plan around either of the models presented to the clinical review team, which raised questions for the panel about capacity and demand and how certain of delivery the Trust was. The panel highlighted this as a safety consideration and proposed that the Trust need to be able to provide assurance that it can meet the onward activity demands through the transformation and can provide the capacity needed to improve and not deteriorate the safety concerns associated with poor access and long waits.

It is recommended to model a range of scenarios to meet future demand, and for the Trust's own assurance to consider fully the measures to take to make the change process itself safer. In order to consider reducing future demand, there should also be a focus on prevention and early diagnosis before adulthood and therefore mental health promotion and mental health services should be seen as a continuum.

How teams come together around patients across different geographical settings and by working with community GPs to reduce waits and unnecessary handoffs and in partnership with the third (voluntary) sector

The panel could not see clear links being made with primary care and the PCNs appreciating this was not a workstream that was under review and that the access changes described would appear to have distinct benefits to primary care. That said, the panel did expect greater clarity in the linkages between PCNs and the reengineered new core service offers. Accordingly, the panel did not see the linkages with building resilience in communities and primary care.

The panel felt that aspects of physical health care, an enhanced digital offer and being clear about how care for complex patients is secured within a compressed model after the disestablishment of Assertive Outreach. The panel were not clear

about the future position in the new model for all patients particularly those with ADHD, ASD and dual diagnosis and how the work of the LLR Neurodevelopmental Transformation Board is considered.

The proposal to implement a single point of telephone access for referrers into the service

The panel felt positive about the Central Access Point facility but without any hard evidence to support this. The full operating details of the Central Access Point and any quantitative details of impact were not available to the Clinical Senate and a visit was not practicable.

The Trust's ambition to implement The Community Mental Health Framework for Adults and Older Adults in LLR

The panel felt that the Trust had presented a coherent overarching strategy and that the co-production model is clearly a strength. The plans are evidently based upon national guidance and the Clinical Senate supported the broad direction of travel. However, it was difficult to understand the connection with the population in terms of needs assessment and local demographics. Furthermore, the available evidence suggests that strategies to improve health literacy are important empowerment tools which have the potential to reduce health inequalities because the most vulnerable and disadvantaged people in society are at highest risk of poorest health outcomes and therefore such strategies aimed at improving mental health literacy should be considered.

7. Recommendations

7.1.1 Recommendation 1

The panel recommend that a health equity assessment is undertaken in order to ensure that systematic action on health inequalities and equalities are embedded in the proposed model. The panel have signposted the Trust to resources which could help with this in Appendix D.

7.1.2 Recommendation 2

The panel recommend that the system's proposals are made clearer in terms of data, performance, current measures, intended outcomes (how the new model is going to deliver) and the evaluation strategy.

7.1.3 Recommendation 3

The panel recommend that much clearer capacity and demand modelling is undertaken (by linking referral rates data to the future workforce required) and made available which would ensure the system has sufficient capacity to meet future demand for its Integrated Community Services model, with an overarching plan which clearly demonstrates exactly how the existing quality and performance challenges will be addressed and additionally, has the ability to deliver a wide range of interventions including those with service users who pose significant clinical risk (e.g. Assertive Outreach Team service users).

7.1.4 Recommendation 4

The panel recommend a coherent prevention focus is required covering upstream, midstream and downstream approaches from raising awareness, tackling stigma and parity of esteem between mental and physical health, health literacy, to early diagnosis, evidence-based interventions to recovery and resilience.

7.1.5 Recommendation 5

It is recommended to model a range of scenarios to meet future demand, and for the Trust's own assurance to consider fully the measures to take to make the change process itself safer.

Appendix A: Clinical Review Panel Terms of Reference

CLINICAL REVIEW TERMS OF REFERENCE

Title: Adult and Older People Community Mental Health Services in Leicester, Leicestershire and Rutland (LLR)

Sponsoring Organisation: Leicestershire Partnership NHS Trust (LPT)

Clinical Senate: East Midlands

NHS England and NHS Improvement region: Midlands

Terms of reference agreed by:

Name: E Orrock/J Attfield **on behalf of clinical senate and**

Name: J Edwards/G King **on behalf of sponsoring organisation**

Date: 10th August 2020

Clinical review team members

Chair: Dr Julie Attfield, Executive Director Nursing, Nottinghamshire Healthcare NHS Trust and Clinical Senate Vice Chair

Panel members:

Name	Role	Organisation
Chris Ashwell	Associate Director	Nottinghamshire Healthcare NHS Trust
Dr Amanda Gatherer	Chief Psychologist and Schwartz Round Clinical Lead	Birmingham and Solihull Mental Health Foundation Trust
Matthew Hall	Chief Operating Officer Mental Health Nurse	Worcestershire Health and Care NHS Trust

Dr Anthony Kelly	GP/Clinical Director for Mental Health and Well-being	Herefordshire and Worcestershire CCGs
Dr Steve Lloyd	GP and CCG Medical Director and STP Clinical Lead	NHS Derby and Derbyshire CCG
Jasmine Murphy	Consultant in Healthcare Public Health	Public Health England - Midlands
Dr Jaspreet Phull	Consultant Forensic Psychiatrist	Lincolnshire Partnership NHS Foundation Trust
Keith Spurr	Patient representative	East Midlands Clinical Senate
Sue Sutcliffe	Occupational Therapist/General Manager (Community Mental Health Teams)	South West Yorkshire NHS Partnership Trust
Dr George Theodoulou	Consultant Older Adult Psychiatrist	Worcestershire Health and Care NHS Trust

Aims and objectives of the clinical review

Step up to Great is the Trust's Quality Improvement Plan in recognition that some significant improvements need to be made to consistently deliver high quality clinical care and move to 'good' and beyond. The East Midlands Clinical Senate has been asked by the Trust to review the system's (LLR's) forward transformation plans (although predominantly relates to changes to the Trust's services) for adult mental health in the community in the context of the two different national drivers (urgent and emergency mental health care and planned community mental health services) as the Trust is working on transforming their services and delivering continuous improvements to meet the needs of the Leicester, Leicestershire and Rutland

population with SMIs (Serious Mental Illnesses). The Trust is proposing to bring a number of largely separate community mental health teams together under a single and more coherent management structure so that there is a clearer secondary care offer. The clinical review team is specifically being asked to consider the proposed clinical model, associated pathways, and alignment to the Community Mental Health Framework for Adults and Older Adults and the NHS Long Term Plan.

Scope of the review

The clinical areas under consideration within adult community mental health services are psychological therapies services, CBT (Cognitive Behaviour Therapy) team, EUPD (Emotionally Unstable Personality Disorder) offer, Assertive Outreach (AO), Crisis Resolution and Home Treatment Team (CRHTT).

The clinical review team is being asked to consider specifically:

- The integration of UEC (Urgent and Emergency Care) offering for people presenting in a mental health crisis or with other urgent (and possibly undiagnosed) needs with other UEC services, including alternative pathways to emergency attendances at A&E which may lead to poor patient experience
- How teams come together around patients across different geographical settings and by working with community GPs to reduce waits and unnecessary handoffs and in partnership with the third (voluntary) sector
- The proposal to implement a single point of telephone access for referrers into the service
- The Trust's ambition to implement the Community Mental Health Framework for Adults and Older Adults in LLR

Mental health beds are out of scope of this review.

When reviewing the case for change and options appraisal the Clinical Review Panel should consider (but is not limited to) the following questions:

- Will these proposals deliver real benefits to patients (access/clinical outcomes/quality[1])? For example, do the proposals reflect:

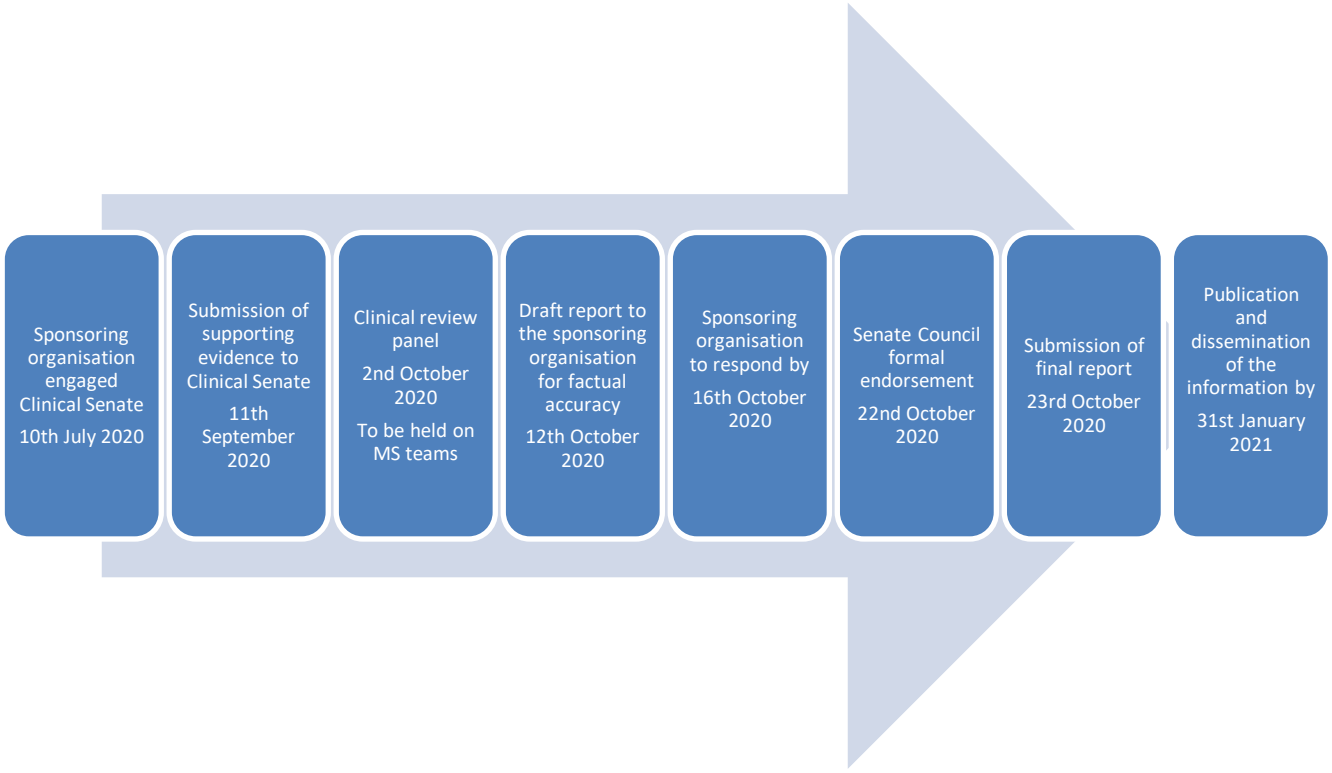
[1] Quality (safety, clinical effectiveness and patient experience)

    - The rights and pledges in the NHS Constitution?
    - The goals of the NHS Outcomes Framework?
    - Up to date clinical guidelines and national and international best practice e.g. Royal College reports? (NHS Long Term Plan and the Community Mental Health Framework for Adults and Older Adults)
- Is there evidence that the proposals will improve the quality, safety and sustainability of care? For example:
    - Do the proposals align with local joint strategic needs assessments, commissioning plans and joint health and wellbeing strategies?
    - Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?
    - Is there a clinical risk analysis of the proposals, and is there a plan to mitigate identified risks?
- Do the proposals meet the current and future healthcare needs of their patients?
- Do the proposals demonstrate good alignment with the development of other health and care services?
- Do the proposals support better integration of services?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Do the proposals consider the workforce requirements and transformation required to deliver this new model?

The Clinical Review Panel should assess the strength of the evidence base of the case for change and proposed models. Where the evidence base is weak then clinical consensus, using a voting system if required, will be used to reach

agreement. The Clinical Senate Review should indicate whether recommendations are based on high quality clinical evidence e.g. meta-analysis of randomised controlled clinical trials or clinical consensus e.g. Royal College guidance, expert opinion.

Timeline



Reporting arrangements

The clinical review team will report to the clinical senate council which will agree the report and be accountable for the advice contained in the final report.

Clinical Senate Council will report to the sponsoring organisation and this clinical advice will be considered as part of the NHS England assurance process for service change proposals (if appropriate).

Methodology

The sponsoring organisation has agreed to collate and provide the following supporting evidence to the Clinical Review Panel, and to reference the evidence base wherever possible when drawing on clinical guidelines and national best practice.

- Case for change and a summary of the current position and proposed alternative service/care model
- Impact of withdrawing/reconfiguring services, including risk register and mitigations
- How proposals reflect clinical guidelines and best practice (NHS Long Term Plan and The Community Mental Health Framework for Adults and Older Adults), the goals of the NHS Outcomes Framework and Constitution
- Alignment with local authority joint strategic needs assessments and a narrative around health inequalities and demographics
- Evidence of alignment with STP plans
- Evidence of how any proposals meet future healthcare needs, including activity modelling, pathways, and patient flows
- Demonstrate how patient access and transport will be addressed
- Demonstrate how any implications on the Ambulance Service will be addressed
- Consideration to a networked approach
- Education and training requirements
- Implications on workforce (to be able to demonstrate alignment to new ways of working, and to describe how the future workforce will look to support any new models of care/reconfiguration proposed)
- Implications for the workforce (to describe how the workforce will be engaged, supported and motivated to work in new ways and in new places that support any new models of care/reconfiguration proposed)
- Implications for the clinical support services and those staff (e.g. clinical engineering, radiology, pharmacy)
- SHAPE (Strategic Health Asset Planning and Evaluation) Place Atlas, which helps organisations to consider the evaluation of the impact of service configuration on proposals and assess the optimum location of services
- Core service inspection report (i.e. CQC)
- Public, patient and staff engagement plans

Report

A draft clinical senate report will be circulated within 6 working days of the final meeting - to team members for comments, to the sponsoring organisation for fact checking.

Comments/ corrections must be received within a further 4 working days.

The final report will be submitted to the sponsoring organisation by 23rd October 2020.

Communication and media handling

The clinical senate will publish the final report on its website once it has been agreed with the sponsoring organisation. The sponsoring organisation is responsible for responding to media interest once in the public domain.

Disclosure under the Freedom of Information Act 2000

The East Midlands Clinical Senate is hosted by NHS England and operates under its policies, procedures and legislative framework as a public authority. All the written material held by the clinical senate, including any correspondence you send to us, may be considered for release following a request to us under the Freedom of Information Act 2000 unless the information is exempt.

Resources

The senate office will provide administrative support to the review team, including setting up the meetings, taking minutes and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

Accountability and Governance

The clinical review team is part of the East Midlands Clinical Senate's accountability and governance structure.

The East Midlands Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing with their proposals.

Functions, responsibilities and roles

The **sponsoring organisation** will

- provide the clinical review panel with all relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and Outcomes Framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions)
- respond within the agreed timescale to the draft report on matters of factual inaccuracy
- undertake not to attempt to unduly influence any members of the clinical review team during the review
- submit the final report to NHS England for inclusion in its formal service change assurance process (if appropriate)
- arrange and bear the cost of suitable accommodation (as advised by the senate office) for the panel and any panel members

Clinical senate council and the sponsoring organisation will

- agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements

Clinical senate council will

- appoint a clinical review team; this may be formed by members of the senate, external experts, or others with relevant expertise. It will appoint a chair or lead member
- endorse the terms of reference, timetable and methodology for the review
- endorse the review recommendations and final report

- provide suitable support to the clinical review team

Clinical review team will

- undertake its review in line with the methodology agreed in the terms of reference
- follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies
- submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council
- keep accurate notes of meetings

Clinical review team members will undertake to

- Commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology)
- contribute fully to the process and review report
- ensure that the report accurately represents the consensus of opinion of the clinical review team
- comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally, they will declare, to the chair or lead member of the clinical review team and the Head of Clinical Senate, any conflict of interest prior to the start of the review and /or which may materialise during the review

Appendix B: Summary of documents provided by the sponsoring organisation as evidence to the panel

The following documents were provided as evidence to the clinical review panel:

- Clinical Senate presentation
- Summary of the plans
- Summary of challenges in the current state and features of new approach for integrated community services
- National Community mental health framework for adults and older adults
- Core 24 Bid (Wave 2 Liaison Mental Health Transformation Funding)
- Liaison and Diversion – national specification
- Liaison and Diversion Business Case
- Summary of the Leicester JSNA
- AMH Board Performance Report July 2020
- Inpatient flow data
- Activity and investment Integrated Community Services
- CQC Inspection June 2019
- STP and CCG presentation to HOSC
- Mental Health Urgent Care Hub Evaluation
- Central Access Point Summary of survey findings

Additionally, the following information was provided further to the clinical review team's pre-panel meeting on 16th September:

- Phase 3 Planning Support template for Leicester, Leicestershire & Rutland
- Phase 3 Mental Health Finance Template for Leicester, Leicestershire & Rutland
- NICE Epilepsy Audit
- NICE Vitamin D Testing / Prescribing Audit
- POMH-UK Report on Monitoring of Patients Prescribed Lithium
- Action Plan for Monitoring of Patients Prescribed Lithium
- Benchmarking - Inpatient and Community Mental Health (Registered Population)

- Benchmarking - Inpatient and Community Mental Health (Weighted Population)
- Integrated Community Team – Workforce model

Appendix C: Clinical review team members and their biographies, and any conflicts of interest

Name	Role	Organisation	Conflict of interest
Dr Julie Attfield	Executive Director Nursing	Nottinghamshire Healthcare NHS Trust and Clinical Senate Vice Chair	None
Chris Ashwell	Associate Director	Nottinghamshire Healthcare NHS Trust	None
Dr Amanda Gatherer	Chief Psychologist and Schwartz Round Clinical Lead	Birmingham and Solihull Mental Health Foundation Trust	None
Matthew Hall	Chief Operating Officer Mental Health Nurse	Worcestershire Health and Care NHS Trust	None
Dr Anthony Kelly	GP/Clinical Director for Mental Health and Well-being	Herefordshire and Worcestershire CCGs	None
Dr Steve Lloyd	GP and CCG Medical Director and STP Clinical Lead	NHS Derby and Derbyshire CCG	None
Jasmine Murphy	Consultant in Healthcare Public Health	Public Health England - Midlands	None
Dr Jaspreet Phull	Consultant Forensic Psychiatrist	Lincolnshire Partnership NHS Foundation Trust	None

Keith Spurr	Patient representative	East Midlands Clinical Senate	None
Sue Sutcliffe	Occupational Therapist/General Manager (Community Mental Health Teams)	South West Yorkshire NHS Partnership Trust	None
Dr George Theodoulou	Consultant Older Adult Psychiatrist	Worcestershire Health and Care NHS Trust West Midlands Clinical Senate Council member	None

Clinical Senate Support Team

Ms Emma Orrock – Head of Clinical Senates, NHS England and NHS Improvement

Ms Aly Evans – Clinical Senates Support Manager, NHS England and NHS Improvement

Appendix D: Additional information supplied by the clinical review team

1. Health Equity Assessment Tool: https://www.gov.uk/government/publications/health-equity-assessment-tool-heat

2. Fingertips – This link here is for estimated prevalence of mental health and wellbeing indicators but the Trust can gain population demography indicators as well:

   https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna/data#page/0/gid/1938132922/pat/6/par/E12000004/ati/102/are/E06000016/cid/4/tbm/1/page-options/ovw-do-0

3. Health literacy toolkit:

   https://www.hee.nhs.uk/our-work/population-health/training-educational-resources

Biographies

Chris Ashwell RMN, MSc, LLB (Hons)
Deputy Director of Mental Health Services, Nottinghamshire Healthcare NHS Foundation Trust
Chris has a wide range of experience in mental health service both in forensic secure care and general mental health services.
Chris is interested in transformation of mental health services to ensure greater access for all communities.

Dr Julie Attfield RMN, BSc (Hons), MSc, MA, PhD
Executive Director Nursing, Nottinghamshire Healthcare NHS Trust
Clinical Senate Vice-Chair
Julie is the Executive Director of Nursing for Nottinghamshire Healthcare NHS Foundation Trust. The Trust is a major provider of mental health, intellectual disability and community healthcare services for the people of Nottinghamshire. It sees in the region of 190,000 people every year and its 8,800 staff carry out a wide range of roles; working together to provide integrated and coordinated care. Julie began her career as a Registered Mental Health Nurse, and has since worked as a clinician, senior manager and director within mental health services in the East Midlands. Between these appointments, Julie spent time as a lecturer in Nursing at the University of Nottingham, before returning to the NHS. Julie's role prior to taking up this position was Director of Nursing and Operations at Lincolnshire Partnership NHS Foundation Trust and the Executive Director of Forensic Services in the Trust. Julie has made a number of professional contributions and gained accolades including holding the title of Queen's Nurse, being a Senior Fellow of the Institute of Mental Health and company secretary for the National Mental Health Nurse Directors Forum. Julie is professionally known particularly for her research into the use of care pathways in mental health, service redesign, quality improvement and governance.

Dr Amanda Gatherer, PhD, C.Psychol.
Birmingham and Solihull Mental Health Foundation Trust
Amanda has worked as the Chief Psychologist at BSMHFT since September 2011. Amanda is also the NHSE Clinical Network Lead for the Midlands for Psychological

Therapies and Severe Mental Illness. Outside of the NHS Amanda is a member of the English Institute of Sport Mental Health Expert Panel set up to provide clinical advice and consultancy to elite athletes across all sports on the Olympic programme and is Consultant Clinical Psychologist to Paralympics GB. Amanda has worked for over 25 years as a clinician and manager in the NHS and has held numerous training and research posts at Birmingham and Coventry Universities. She is Chair of the multiagency committee Mental Health through Sport which brings together mental health, local authority, academic and sports organisations to explore how sports can be more accessible to patients with severe and enduring mental health difficulties to aid their recovery.

Matthew Hall

Matthew is Chief Operating Officer of Worcestershire Health and Care NHS Trust – who provide Community and Mental Health services in Herefordshire and Worcestershire. Matthew is a Registered Mental Health Nurse who has worked in the NHS since 1990. He has a particular interest in patient flow and capacity improvement in acute services.

Dr Anthony Kelly

Anthony is a GP at SPA Medical Practice in Droitwich, Shareholder of Droitwich Healthcare Ltd, Director of Spa Premises Ltd, Shareholder of South Worcestershire Primary Care Ltd T/A Staywell Healthcare, a West Midlands Clinical Senate Council Member and an NHS Clinical Commissioning Board Member.

Dr Steve Lloyd

GP and NHS Derby and Derbyshire CCG Medical Director and STP Clinical Lead

Steve has a wide medical background, originally a maxillofacial surgeon, he has been a GP principal in North Derbyshire for 15 years and is Derby and Derbyshire CCG Executive Medical Director. He is co-chair of the Derbyshire STP clinical and professional reference group and Joined Up Care Derbyshire Board member.

Jasmine Murphy BDS(Hons), MSt (Camb), MRes, MFGDP, MFDS RCS(Eng), MFDS RCS(Edin), FDS(DPH)RCS(Eng), FFPH

Jasmine is a Consultant in Dental Public Health at Public Health England. Jasmine has previously worked in Public Health in a variety of organisations including: Primary Care Trusts, Health Protection Agency, Strategic Health Authority and local government. Her current role includes leadership on dental public health, children and young people and health inequalities where she provides commissioning advice and support to NHS England on NHS dental services, specialist dental public health advice and support to public health colleagues working in local authorities, healthcare public health advice for services affecting children and young people and also has an advocacy role for wider aspects of Public Health. Jasmine is involved with the Local Dental Network and also the East Midlands Maternity and Children's Clinical Network in supporting the public health agenda through the delivery of commissioned services. Through her focus on population public health, she seeks to raise the profile and awareness of how strategic decisions can impact upon health inequalities. Jasmine is also a core member on the NICE Public Health Advisory Committee and has been appointed as an Expert Adviser for the NICE Centre for Guidelines. Working with the Postgraduate Dental Dean, she also leads on the Public Health training programme for Foundation Dentists in the East Midlands and has established the innovative Volunteering Scheme in partnership with local authorities.

Dr Jaspreet Singh Phull

Jaspreet is a consultant forensic psychiatrist, honorary senior lecturer and clinical director based at LPFT NHS Trust. Jaspreet has been involved in authoring National CCQI Royal College of Psychiatrists quality standards; has published a number of articles on service improvement in peer reviewed journals and a book on diagnosis in mental health.

Locally, Jaspreet has been involved in developing new clinical services, clinical pathways, quality improvement practice and new digital healthcare approaches using technology and apps.

Keith Spurr

Patient representative

Keith is a retired experienced HR Advisor/Business Partner providing generalist HR support to organisations of varying sizes, within all types of industry for 40 years. He was an accredited Trade Union Representative when he represented ex-employees at Tribunals liaising with solicitors, courts, CMDs, PHRs and Full Hearings. Therefore, he has experience as both a manager and as a Trade Union representative and can appreciate both sides of the "table" whilst at the same time represents individuals and groups as required. He has worked with organisations as part of their change programme. He is diabetic Type 1 and had a TIA 25 years ago. He is the Diabetes UK Champion for the South Lincolnshire Area and a diabetic "voice".

Sue Sutcliffe

General Manager for Adult Community Mental Health Services, Calderdale and Kirklees, South West Yorkshire NHS Partnership Trust

Sue started training as an Occupational Therapist in York in 1985 and qualified 3 years later. Her first post as a Basic Grade O.T was in a Day Hospital attached to the Mental Health Unit in Halifax. She worked alongside a range of therapists whilst in this role and learnt a lot about Art, Drama and Psychotherapy.

In 1990, Sue secured a Senior O.T post in a new Mental Health unit that was due to open in Dewsbury which was later named as the Priestley unit. She became Head O.T in 1995 and then was asked to undertake the Professional lead post for O.T alongside her Day Services Manager post which covered the Kirklees area.

After a short while and service reconfiguration, she decided to move along a service manager route and started to manage a range of Community services which included IAPT, EIP and CMHTs. After further Transformation of services, she moved 4 years ago into her current role as General Manager of Community services across Kirklees and Calderdale. This is a diverse role (22 teams) and includes the management of a service line which in the main contains Integrated Health and Social Care teams. She is passionate about Integration in Mental Health and have used these principles (and successes) to guide a number of integrated care pathways including those that link physical and mental Health e.g. IAPT Long Term Condition pathways.

Sue is currently leading on the development of a Trauma Informed Personality Disorder Pathway for Kirklees which will be operational later this year.

Dr George S Theodoulou

West Midlands Clinical Senate Council member

George was a panel member for the WM Clinical Senate Walsall Stroke review services 2018. He has worked as a substantive consultant psychiatrist since 2008; working in community, inpatient and acute hospital liaison settings. He completed his psychiatric training in the West Midlands gaining specialist registration in old age and general psychiatry. He is currently section 12(2) approved, an MHA Approved Clinician, a Deprivation of Liberty Safeguards mental health assessor, an Honorary Senior Lecturer at the University of Worcester and sits on the Midlands and East of England Section 12(2)/Approved Clinician approval panel. George has also been the clinical director for older adult mental health services in Worcestershire Health and Care NHS Trust (2013-2016). He has considerable clinical experience in applying the Mental Health Act and the Mental Capacity Act as well as dealing with the interface of the two Acts. He regularly carries out Mental Health Act assessments, DoLS assessments and mental capacity assessments for the Court of Protection. George lectures and teaches widely on all aspects of psychiatric practice.