



Health Overview and Scrutiny Committee

Date: Wednesday, 26 June 2019
Time: 10.00 am
Venue: Committee Room 1, County Hall, Dorchester, DT1 1XJ

Membership: (Quorum 3)

Jill Haynes (Chairman), Andrew Kerby (Vice-Chairman), Rebecca Knox, Robin Legg, Jon Orrell, Emma Parker, Bill Pipe, Byron Quayle, Nick Ireland and Ryan Holloway

Chief Executive: Matt Prosser, South Walks House, South Walks Road, Dorchester, Dorset DT1 1UZ (Sat Nav DT1 1EE)

For more information about this agenda please contact Denise Hunt 01305 224878 - denise.hunt@dorsetcouncil.gov.uk



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Members of the public are welcome to attend this meeting with the exception of any items listed in the exempt part of this agenda. **Please note** that if you attend a committee meeting and are invited to make oral representations your name, together with a summary of your comments will be recorded in the minutes of the meeting. Please refer to the guide to public participation at committee meetings for more information about speaking at meetings.

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A G E N D A

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1 APOLOGIES

To receive any apologies for absence.

2 DECLARATIONS OF INTEREST

To receive any declarations of interest.

3 TERMS OF REFERENCE

To note the Committee's terms of reference:-

Overview and scrutiny is a statutory activity of the Council, its powers and responsibilities are set out in detail in the Council's Constitution. The Council will appoint members to 4 Overview and Scrutiny Committees:- **Health, People, Place and Resources**.

Each Overview and Scrutiny Committee will perform all those functions conferred on it by the Local Government Act 2000 and each committee can review and scrutinise decisions and actions made by the Council, relevant to their area.

In the absence of any alternative joint arrangements having been entered into, the Health Scrutiny Committee shall be the Council's Overview and Scrutiny Committee for the purposes of fulfilling the Council's statutory powers in relation to health scrutiny.

4 MINUTES

5 - 12

To receive the minutes of the meeting held on 7 March 2019 (signed by the previous Chairman).

5 PUBLIC PARTICIPATION

To receive questions or statements on the business of the committee from town and parish councils and members of the public.

- 6 MENTAL HEALTH REHABILITATION REVIEW** 13 - 80
- To consider a report by Elaine Hurl, Principle Programme Lead, NHS Dorset Clinical Commissioning Group.
- 7 BRIEFINGS FOR INFORMATION** 81 - 112
- 8 URGENT ITEMS**
- To consider any items of business which the Chairman has had prior notification and considers to be urgent pursuant to section 100B (4) b) of the Local Government Act 1972. The reason for the urgency shall be recorded in the minutes.

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Dorset Health Scrutiny Committee

Minutes of the meeting held at County Hall, Colliton Park,
Dorchester, Dorset, DT1 1XJ on Thursday, 7 March 2019

Present:

Bill Pipe (Chairman)

Bill Batty-Smith, Kevin Brookes, Ray Bryan, Beryl Ezzard, Nick Ireland, Alison Reed,
Peter Oggelsby, Tim Morris and Peter Shorland

Officers Attending: Ann Harris (Health Partnerships Officer), Denise Hunt (Senior Democratic Services Officer) and Helen Coombes (Transformation Programme Lead for the Adult and Community Forward Together Programme).

Other Officers in Attendance:-

NHS Dorset Clinical Commissioning Group (CCG):- Diane Bardwell (Dementia Services Review Project Manager), Dr Paul French (Clinical Lead for Mental Health and Dementia); Eaine Hurl (Senior Commissioning Manager (Mental Health), Vanessa Read (Director of Nursing and Quality)

Dorset County Hospital (DCH) - Neal Cleaver (Deputy Director of Nursing and Quality); Sophie Jordan (Divisional Manager, Family Services and Surgical Division);

Dorset HealthCare University NHS Foundation Trust:- Jane Elson (Service Director for Integrated Community Services)

(Notes: These minutes have been prepared by officers as a record of the meeting and of any decisions reached. This is the last planned meeting of this Committee before the start of the new Dorset Council on 1 April 2019. The minutes will therefore be confirmed and signed by the Chairman prior to 31 March 2019.

Apologies for Absence

1 An apology for absence was received from Councillor David Walsh.

Code of Conduct

2 There were no declarations by members of disclosable pecuniary interests under the Code of Conduct.

Councillor Peter Shorland declared a general interest as a Governor at Yeovil Hospital.

Councillor Ray Bryan declared a general interest as a Partner Governor of the Dorset Healthcare University NHS Foundation Trust.

Minutes

3 The minutes of the meeting held on 29 November 2018 were confirmed and signed.

Public Participation

4 Public Speaking

There were no public questions received at the meeting in accordance with Standing Order 21(1).

There were no public questions received at the meeting in accordance with Standing Order 21(2).

Petitions

There were no petitions received at the meeting in accordance with the County Council's Petition Scheme.

Clinical Services Review (CSR) - Update regarding the Referral to the Secretary of State and the Joint Committee scrutiny of the South Western Ambulance Service NHS Foundation Trust (SWAST)

- 5 The Committee received an update report by the Transformation Programme Lead for the Adult and Community Services Forward Together Programme.

The report was introduced by the Health Partnerships Officer who informed the Committee that the Referral to the Secretary of State remained under consideration and that the timescale for a response was not yet known. The letter of support for the referral by the Borough of Poole had been attached as an appendix to the report.

She reported that the Joint Health Scrutiny Committee for SWAST had met on 24 January 2019. The Joint Committee had been hosted by the Borough of Poole and had been a positive meeting with openness by SWAST about performance, particularly in relation to category 3 and 4 incidents. The actions taken to improve performance in this area were also highlighted, including a risk stratification tool to support despatch decisions; the roll-out of a community responder falls scheme; a more effective incident stacking system, the recruitment of additional Paramedics from New Zealand and improved use of the vehicle fleet. The Joint Committee recommended that ambulance performance continued to be monitored whilst recognising the potential difference in approaches that might be taken by the new councils.

Councillors Brookes and Oggelsby offered personal perspectives of the meeting and highlighted in particular that it had taken over a year to convene this meeting which had led to a delay in debating the issues.

Members discussed whether it would be appropriate to specify the number of meetings and the way in which terms of reference and the type of issues might influence the frequency of meetings.

Whilst it was acknowledged that a minimum number of meetings might be appropriate for a deep dive into a specific issue, it was noted that a Joint Committee would set its own terms of reference and meet as and when required and have regard to officer capacity.

Following the discussion it was agreed that ambulance times would be incorporated into the Committee's forward plan for consideration in 6 months' time. The view was also expressed that it would be favourable to have a pan Dorset committee in future as health issues affected Dorset as a whole.

Members asked about the definition of the categories and relayed accounts of long periods before ambulance arrival in respect of category 3 and 4 type incidents and a 1 hour 45 minute wait in respect of a category 1 call which was unacceptable. It would be equally important to understand the reasons for prolonged call out periods which included 2-3 hour delays in handing over patients at hospitals. A daily report from SWAST which provided numbers and duration of handover delays at individual hospitals was available.

Concern was expressed regarding the closure of local hospitals in advance of the implementation of the community hubs that had most likely increased pressure on the ambulance service. However, the Chairman reminded members that some of the changes had not been progressed due to the referral of the CSR proposals to the

Secretary of State and that the Committee must wait for the response.

Resolved

1. That the support of Members from the Borough of Poole in relation to the referral to the Secretary of State for Health and Social Care be noted;
2. That a review of the delivery and performance of the new Integrated Urgent Care Service in six months' time, as suggested by the Joint Committee for the scrutiny of SWAST be agreed; and
3. That the slide presentation for the Joint Committee (SWAST) is circulated to the Committee.

Reason for Decisions

The recommendations were in recognition of the need for on-going scrutiny by the Dorset Committee and both Joint Committees for the Clinical Services Review and the performance and capacity of local ambulance services.

Update regarding the Repatriation of Specific Activity from Bridport Community Hospital

- 6 The Committee considered a report that provided an update regarding the ongoing consultation with stakeholders for proposals to relocate specific services from Bridport Community Hospital to Dorset County Hospital (DCH) and Blandford Community Hospital.

The report was introduced by the Divisional Manager, Family Services and Surgical Division (DCH), who explained that the primary reason for the changes was to have a specialist team on a Dorset Healthcare site with the ability to see additional patients, rather than for financial reasons.

The first public engagement event on 5 March 2019 had gone reasonably well with 35 members of the public in attendance. The main concerns expressed were in relation to travel, parking at DCH and transport arrangements for frail elderly patients. Further engagement events were planned on 20 March and 11 April 2019 and would include third sector providers.

Members were provided with an overview of the reasons for clustering services together and the permanent relocation of gastroscopy services to DCH, to increase staffing resilience and clinical oversight.

The Committee was assured that Bridport Hospital would continue as a thriving hospital with further services being developed during the past year. Musculoskeletal services would continue to be provided locally at Bridport, however the monthly pain list would transfer to a weekly list at Blandford Hospital as a more central location for patients who currently travelled from across Dorset. This would also ensure adherence to national best practice which had changed, as patients needed intervention quickly and it was found that the monthly list at Bridport could not be filled effectively.

Members asked about the impact on jobs and were informed that staff consultation was currently taking place, however, staff losses were not anticipated due to opportunities arising from the development of services at Bridport as well as job vacancies at DCH. The Committee was also informed that the proposals had the support of the governors, although an issue had arisen due to the late notification given in relation to the recent engagement day that had now been resolved.

Members also drew attention to the impact on staff travel by providing care in people's homes and were informed that care would be provided closer to home in community hospitals and that work with primary care colleagues would continue in respect of the early identification of risk of the frail elderly and proactive work in the community to

support people at home.

Members were supportive of the proposals as a way of balancing capacity with patient satisfaction and sensible travel distances.

Resolved

That information provided at the recent engagement event is circulated to members.

An update on the availability of the Freestyle Libre® Device on the NHS in Dorset

7 The Committee considered an update report that was introduced by the Director of Nursing and Quality (CCG) who explained that since the previous report in October 2018, the CCG had refreshed availability of the device and associated formulary based on revised guidance. A further announcement was awaited on its clinical suitability from April 2019 that would determine whether the device could be made accessible to more people.

Members were aware that Dorset was one of the few areas that had not provided this device more widely and it was confirmed that, although the current access criteria had been developed locally, the CCG would follow national guidance which would standardise the approach taken. This information would be available at the next committee meeting.

Members highlighted that the 6 month trial timeframe would not be sufficient to assess whether the device was making a difference given that some diabetic patients were only monitored by GPs once every 6 months.

The Director of Nursing and Quality confirmed that there would be greater levels of monitoring to assess the effectiveness of using the system under a specialist rather than a GP and that the length of monitoring could be included under the refresh of the guidelines at the point at which the trial cohort changed.

The Chairman stated that he had been pleased with the response to this issue by the CCG as a direct result of recommendations made by the Committee. However, further clarity would be helpful concerning how this was going to be monitored in the longer term.

Resolved

1. That the contents of the report be noted; and
2. That a further update be provided at the next meeting of the Committee.

Reason for Decisions

The Committee had expressed concerns about the availability of Freestyle Libre® monitoring devices in Dorset. As it was not possible for the CCG to provide a full update at this stage, the matter should be added to the Committee's Forward Plan for future review.

NHS Dorset CCG - Dementia Services Review and Consultation Update

8 The Committee considered an update on the Dementia Services Review containing co-produced model options and sought support for public consultation in June/July 2019.

An accompanying presentation to the report was provided by the Dementia Services Review Project Manager (CCG) who outlined the objectives, outcomes and services in scope that had been included in the report. She explained the future stages in the process as follows:-

- review stages and view seeking - completed in March 2017
- model options development - completed in September 2018

- NHS Assurance - March 2019
- sense check meeting with NHS England
- Clinical Senate - March 2019
- Strategic Outline Case (synopsis contained in report)
- Consultation - June/July 2019
- Implementation as soon as possible following the public consultation

The preferred model, Option B had been outlined in the report and resulted in a cost variance of £669,000 and it was felt that this additional cost could be identified within mental health budgets.

A co-production approach had been taken in terms of the consultation with advice and guidance from key stakeholders on the materials and wording. The consultation would be for a minimum period of 8 weeks.

The Chairman asked whether the 40 specialist beds at Alderney Hospital in Poole had increased to reflect the loss of beds in the other hospitals that had been closed.

The Project Manager advised that this was not the case as steps had been taken in East Dorset to introduce an intensive support service that had resulted in a decline in the need for hospital admissions. The money from the closure of the Chalbury Unit had been used to develop a similar service in West Dorset that would see reduced hospital admissions in future so that 40 beds was likely to be too many in 2-3 years' time.

Members heard that beds were becoming more relevant to the needs of the individual (rather than bed category) and that current demand was being met. The day hospitals would support individuals and prevent the need for inpatient stays unless absolutely necessary.

Members asked about the analysis behind the 4 options and the rationale for discounting the most expensive option. They were informed that this was not a CCG decision and that the other options had been discounted through a co-production process whereby stakeholders had considered the different options, recognising the budget limitations, staff resources and measuring against critical success factors. The strategic outline case would provide the analysis and the final decision would take into account the consultation outcome.

In response to further questions in relation to Dementia Friendly groups and Admiral Nurses, the Project Manager explained that such groups had been funded through the Alzheimer's Society, but due to budget cuts, could no longer be funded. Local communities were becoming increasingly involved, resulting in dementia friendly towns. It was hoped that the Dementia Co-ordinators would be able to help people to take advantage of this resource.

Admiral nurses had been discounted in the long list of options as it was felt that nurses were costly to provide and would not add value to what was to be provided in Dorset. In addition, the intensive support service supported individuals without families which was not covered by the Admiral nurses.

Resolved

1. That the progress of the review be noted;
2. That the proposed consultation plan be supported; and
3. That a link to the consultation documents is sent to members of the Committee when available.

Reason for Decisions

The report provided the Committee with an opportunity to be updated and to

contribute to the consultation plan for the Dementia Services Review.

Review of Mental Health Rehabilitation Services

9 The Committee received a presentation by the CCG Senior Commissioning Manager (Mental Health) concerning rehabilitation services provided to people with serious enduring mental illness.

Since November 2018 work had continued with a needs analysis for a challenging cohort of 600 people; benchmarking with other areas including Oxford and Taunton; a Dorset Healthcare engagement day with staff, patients and managers in December 2018 and modelling and shortlisting from 18 options which had been a challenging exercise.

The preferred option included the following elements:-

- high dependency unit that was NHS owned and delivered
- community recovery units delivered by NHS/third sector partners
- supported housing with a range of providers
- community team with rehabilitation, assertive outreach and homeless health

The next steps involved:-

- development of the strategic outline case
- development of service specification for the whole pathway
- development of a housing solution plan including service specification
- presentation of findings to the project group (including the strategic outline case and housing offer)
- Mental Health Integrated Programme Board / Governing Body /
- NHS Assurance and consultation if required, as this represented service improvement
- Implementation in stages with community offer as the first stage

The Senior Commissioning Manager was asked whether the housing element had been integrated with the local authority Building Better Lives Programme and she confirmed that local authority colleagues had been involved in the early stages, but had not been maintained due to changes in personnel.

The Transformation Programme Lead for the Adult and Community Services Forward Together Programme said that she would take this forward as a matter of urgency to facilitate a whole estates approach and linkage between the two projects.

Resolved

That a report on the Strategic Outline Case is provided at the next meeting.

Dorset County Hospital Care Quality Commission Inspection 2018

10 The Committee received a presentation by the Deputy Director of Nursing and Quality (DCH), a copy of which had been included as part of the agenda. The presentation outlined the outcome of an inspection by the Care Quality Commission in the summer of 2018 and included an inspection of 'use of resources' which had been undertaken by NHS Improvement and formed part of the overall rating. The Hospital had achieved an overall rating of Good.

Following the presentation, the Chairman asked when the Safe Domain rated as "Requires Improvement" would be inspected again and was informed that this was likely to be at the end of 2019 as there was a 3 year gap in between inspections.

Attention was drawn to anomalies in the report in relation to this area as the CQC had commented on the Board's strong focus on patient safety. The Deputy Director informed the Committee that some elements of the report had been contested, but that the final report had remained unchanged.

Members asked when inspection of Maternity and Gynaecological Services as separate services would take place. The Deputy Director explained that the latter did not have the benefit of a rating due to its previous inspection linked to maternity and it was not known when a separate inspection would take place.

The Committee wished to congratulate DCH on its achievements in care quality and asked for this message to go back to hospital staff.

Noted

Dorset Health Scrutiny Committee Forward Plan

- 11 The Committee noted its forward plan for the next meeting in June 2019 that would also include an update on the Freestyle Libre device.

Noted

Liaison Member Updates

- 12 Dorset County Hospital NHS Foundation Trust - Peter Shorland
No update available.

Dorset Healthcare University NHS Foundation Trust - Nick Ireland
Councillor Ireland reported the following items arising from a meeting held on 30 January 2019:-

- the capital investment programme was £90m short of funding
- Portland Hospital was still shown as closing, but there seemed to be some uncertainty about this and further demonstrations were planned by the "Keep Portland Hospital" group.
- an increase in vacancy levels for the third month for integrated care and children's services.
- the funding of apprenticeship level advanced practitioner role had commenced in February 2019.
- a planning application for Pebble Lodge child mental health facility had been refused by Bournemouth Borough Council.

NHS Dorset Clinical Commissioning Group - Bill Pipe
A meeting had been held in January 2019 that Councillor Pipe had not been able to attend.

South Western Ambulance Service NHS Foundation Trust - Beryl Ezzard
A meeting was to be confirmed.

Questions from County Councillors

- 13 There were no questions submitted under Standing Order 20(2).

Glossary of Abbreviations

- 14 The glossary was provided for information.

Closing Comments

- 15 As this was the final meeting of the committee, Councillor Bill Batty-Smith conveyed that he had been a member of the committee for 16 years and thanked officers and fellow councillors on the committee. The Chairman also thanked councillors and officers for their support and wished everyone all the best for the future.

Meeting Duration: 10.00 am - 12.20 pm



Date of Meeting: 26 June 2019

Lead Member: Cllr Jill Haynes – Chair, Dorset Health Scrutiny Committee

Lead Officer: Mathew Kendall, Executive Director of People – Adults

Executive Summary:

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

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

- Access the support and treatment required in settings other than inpatient units
- Have a much better experience of treatment and support in community settings with much better outcomes
- Avoid being placed out of area and avoid losing contact with people and communities and avoid spending more time in hospital than is absolutely necessary
- Access treatment and ongoing support in a variety of different settings in the community.

Proposals are anticipated to provide benefits through:

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

The review was carried out in stages and so far stages 1 and 2 have been finished:

1. Needs analysis and View seeking
2. Modelling
3. NHS Assurance
4. Consultation (if required)
5. Implementation

The coproduction groups agreed objectives, critical success factors and constraints and came up with a proposal for what services should be included in Rehab or complex care pathway, and these broadly align with national guidance and general direction of travel for complex care pathways. The following components were agreed from a long list:

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

There are several possibilities in terms of how these components can be configured. The proposal is for a blended model that is delivered by a mix of NHS and Third sector providers which means the proposal includes using non NHS providers to deliver some of the bed spaces or accommodation units.

The Health Scrutiny Committee is asked to approve the paper and the review findings and to provide advice concerning the need for public consultation.

Equalities Impact Assessment:

CCG completed

Budget:

CCG Budget

Risk Assessment:

Having considered the risks associated with this decision, the level of risk has been identified as:

Current Risk: NA for Dorset Council
Residual Risk: NA for Dorset Council

NA

Other Implications:

NA

Recommendation:

The Health Scrutiny Committee is asked to note the paper and provide a recommendation about the requirement for Public Consultation in relation to this review.

Reason for Recommendation:

1. The review and outcomes are coproduced and in line with national direction of travel for mental health rehab services.
2. NHS England value Health Scrutiny Committee advice concerning the requirements for public consultation.

Appendices:

- 1 NHS Dorset CCG Mental Health Rehabilitation Review for People with a Serious Mental Illness: Data Needs Analysis Report
- 2 NHS Dorset CCG Mental Health Rehabilitation Service Review: View Seeking Report

Background Papers:

None.

Officer Contact

Name: Elaine Hurlll, Principle Programme Lead, NHS Dorset Clinical Commissioning Group

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1. Introduction

- 1.1 Dorset Clinical Commissioning Group (CCG) and Dorset HealthCare (DHC) launched the Mental Health Rehabilitation Review. Rehabilitation (Rehab) provision is for people who have severe enduring mental illness. The review has been co-produced from the outset with Dorset Mental Health Forum (DMHF), Local Authorities and other stakeholders that have an interest in mental health rehabilitation and complex care pathways such as homelessness and mental health assertive outreach (AOT).
- 1.2 The strategic context is framed by the national NHS mandate which outlines the objectives for the NHS as a whole:
 - Preventing people from dying early
 - Enhancing quality of life for people with long-term conditions
 - Helping people to recover from episodes of ill health or following injury
 - Ensuring that people have a positive experience of care
 - Treating and caring for people in a safe environment and protecting them from avoidable harm.
- 1.3 The case for change is that people who require rehab or complex care should be able to:
 - Access the support and treatment required in settings other than inpatient units
 - Have a much better experience of treatment and support in community settings with much better outcomes
 - Avoid being placed out of area and avoid losing contact with people and communities and avoid spending more time in hospital than is absolutely necessary
 - Access treatment and ongoing support in a variety of different settings in the community that do not currently exist for this client group.

Proposals are anticipated to provide benefits through:

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

2 Background

- 2.1 Dorset CCG is committed to reviewing and transforming all mental health services across the Integrated Care System (ICS) to improve mental health care for people who need to use mental health services. The Mental Health Rehabilitation Service is a key element of delivering against that commitment.
- 2.2 The Rehab review is led by Dorset HealthCare and Dorset CCG as part of their programme of transformational work. The governance of the project sits with the mental health Integrated Programme Board (MH-IPB) which has oversight of all the programmes of transformational work and the MH-IPB feeds up to the Integrated Community and Primary Care Services Portfolio Board.
- 2.3 The CCG's mental health commissioning team and Dorset HealthCare teams are working together with Dorset Mental Health Forum and all three partners in the review share the responsibility for the design and delivery of the review and form the core part of the project team.
- 2.4 The review's objectives are to improve services for people who access the Inpatient rehabilitation services, Assertive Outreach Teams, Homeless Health Service and Out of Area locked rehab. The only mental health rehabilitation currently available in Dorset is in one of three inpatient settings.
- 2.5 Inpatient provision on its own is not the national direction of travel for MH Rehab. Community rehabilitation and assertive outreach models are much more central to the way the services are to be delivered in the future. Inpatient facilities are to be part of a whole pathway and will help support people who require containment and treatment in a safe, calming inpatient setting.
- 2.6 The aim is to provide MH Rehab in the most appropriate place possible for the individual and for some that will be in hospital for a time and for others Rehab and / or other long-term support will be provided in the community by community teams.
- 2.7 The review is being carried out using a tried and tested format and has the following stages:
- Stage 1 Needs analysis,
 - Stage 2 View seeking,
 - Stage 3 Model development,
 - Stage 4 Assurance and consultation

- Stage 5 Implementation.

2.8 The outputs of the review are:

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

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

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

3 Project stages

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

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

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

- There is rising demand and current services are not set up in the right way to manage the demand in the least restrictive, recovery focussed way.
- There is little community provision and few supported housing options at the moment, which leave inpatient services being the primary rehabilitation and complex care option.
- It is likely with targeted reshaping of the current services that the offer for people who require ongoing rehabilitation or assertive support could be improved and enhanced.

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

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

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

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

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

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

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

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

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

4 Model Options

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

for complex care pathways. The following components were agreed from a long list:

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

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

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

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

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

- Supported to have the life they want to live in a place they want to live

- Able to live as independently as possible
- Able to live outside of hospital settings
- Supported in the least restrictive way possible

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

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

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

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

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

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

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

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

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

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

4.11 The costs will be based on all the modelling work and will be finalised for the Strategic Outline Case.

5. Interdependencies

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

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

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

6 Conclusion and recommendation

- 6.1 The preferred model of mental health rehabilitation is to be much more community focussed with inpatient provision being part of the whole pathway rather than the pathway. The beds provided will be the right number to meet the needs of the Dorset population but will be delivered by a mix of NHS and other providers.
- 6.2 A Strategic Outline Business Case is being developed to support the NHSE Assurance processes. The SOC will be presented to the Health Scrutiny Committee as required.
- 6.2 The NHS Assurance will follow on from the Health Scrutiny meetings in Dorset and Bournemouth, Christchurch and Poole. It will be done in this order because NHSE values and relies on the view of the Health Scrutiny Committees in relation to the review's robustness and future consultation requirements.
- 6.3 In preparation for NHSE assurance and possible consultation it is also the intention to develop the housing options with LA colleagues and local developers, landlords and providers, to ensure a mix of accommodation that meets the proposed model requirements and adds to the already existing provision and enhances those services.
- 6.4 The requested recommendations (of the CCG) are that:
- I. Dorset Health Scrutiny Committee endorses the review findings and proposals to develop a more community based Rehab model of care
 - II. Dorset Health Scrutiny Committee supports the intention to go through NHS Assurance with the proposed model including the proposed bed changes
 - III. Dorset Health Scrutiny Committee makes a recommendation about the need for public consultation on the proposals in the paper.

Elaine Hurll

Principle Programme Lead, NHS Dorset Clinical Commissioning Group

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Mental Health Rehabilitation Review

For People with a Serious Mental Illness

Data Needs Analysis

28th August 2018



DOCUMENT TRAIL AND VERSION CONTROL SHEET

Heading	Review of the Mental Health Rehabilitation Pathway Mental Health Rehabilitation- Data Needs Analysis
Project Sponsor	Colin Hicks
Purpose of document	Present an outline and analysis of available data to inform the Mental Health rehabilitation review case for change
Date of document	28 th August 2018
Authors	Melissa Scott Julie Brown Elaine Hurll Suzanne Green Lisa Spriggs Melissa Paxton
To be Approved by	Rehabilitation Services project board MH - IPG
Date approved	
Effective from	
Status	For comment
Version	V6.0

Supporting people in Dorset to lead healthier lives

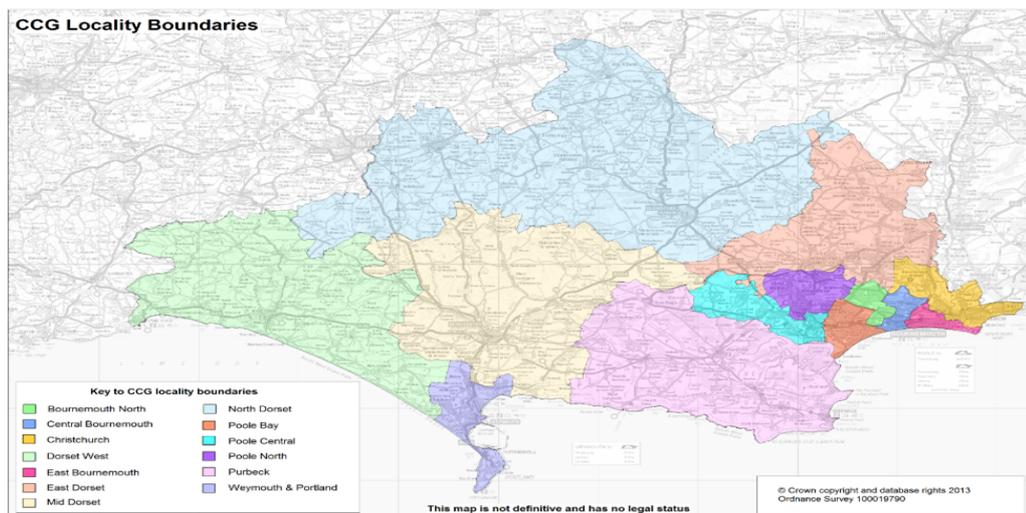
1. INTRODUCTION

- 1.1 NHS Dorset Clinical Commissioning Group (CCG) and Dorset HealthCare NHS University Foundation Trust (Dorset HealthCare, DHC) are undertaking a review of adult mental health rehabilitation services for people with a serious/severe mental illness (SMI) in Dorset, the review focusses upon functional mental illness and excludes organic conditions such as dementia. Serious mental illness includes psychosis, severe depression, bipolar disorder, personality disorder, schizophrenia and schizoaffective disorder.
- 1.2 This report aims to identify the needs and demand profile of the local population of people who have a SMI and use rehabilitation or complex care pathways. This will enable an evidence based business case to be developed.

2. DEMOGRAPHIC PROFILE OF DORSET

- 2.1 Dorset covers an area of 1,024 square miles and is bordered by Devon to the west, Somerset to the south west, Wiltshire to the north-east and Hampshire to the east.
- 2.2 The county town is Dorchester which is in the south-west of Dorset. The largest urban areas are Poole, Bournemouth, Christchurch and Weymouth & Portland. Around half the population lives in the south east area, while the rest of the county is largely rural with a low population density.
- 2.3 NHS Dorset Clinical Commissioning Group operates on the basis of a locality model with the geography of Dorset divided into 13 GP localities (Diagram 1 below). All 86 GP practices are sub-grouped into these locality groups (or geographical areas). Each locality has a Locality Chairperson (a local GP), who is also a member of the CCG's Governing Body which ensures CCG decisions are clinically-led.

Diagram 1. Dorset CCG GP localities



- 2.4 The county of Dorset has a resident population of 776,304 (all ages) and is served by three local authorities comprising the Borough of Poole (151,300, 19.7% of pan Dorset population), Bournemouth Borough Council (194,800, 25.7% of the pan Dorset population) and Dorset County Council (424,700, 54.6% of the pan Dorset population). To note the councils are due to merge into 2 unitary authorities during 2019. (ONS mid -year population 2017)
- 2.5 Table 1 below indicates the Dorset Registered GP Practice Populations (December 2017), accessed from NHS digital (2018).

Table 1. Dorset Registered GP Population

Urban/Rural	CCG Locality	Male					Female					Grand Total (18+ yrs)	Grand Total (All ages)
		0-17 yrs	18-64 yrs	65+ yrs	Total (18+ yrs)	Total (All ages)	0-17 yrs	18-64 yrs	65+ yrs	Total (18+ yrs)	Total (All ages)		
Urban	Bournemouth North	5,409	22,445	5,108	27,553	32,962	5,123	22,560	6,085	28,645	33,768	56,198	66,730
	Central Bournemouth	6,025	19,583	4,368	23,951	29,976	5,642	18,714	5,244	23,958	29,600	47,909	59,576
	Christchurch	4,726	14,438	7,562	22,000	26,726	4,372	14,327	9,350	23,677	28,049	45,677	54,775
	East Bournemouth	6,692	25,555	6,053	31,608	38,300	6,593	22,841	7,146	29,987	36,580	61,595	74,880
	Poole Bay	6,625	23,467	7,713	31,180	37,805	6,120	22,096	9,242	31,338	37,458	62,518	75,263
	Poole Central	6,090	18,889	6,109	24,998	31,088	5,829	18,949	7,335	26,284	32,113	51,282	63,201
	Poole North	5,172	15,272	5,613	20,885	26,057	4,953	15,441	6,639	22,080	27,033	42,965	53,090
	Weymouth & Portland	6,883	21,819	8,665	30,484	37,367	6,687	21,609	9,933	31,542	38,229	62,026	75,596
Urban Total		47,622	161,468	51,191	212,659	260,281	45,319	156,537	60,974	217,511	262,830	430,170	523,111
Rural	East Dorset	6,342	18,061	9,777	27,838	34,180	6,120	18,405	11,684	30,089	36,209	57,927	70,389
	Mid Dorset	4,145	12,341	5,371	17,712	21,857	3,875	12,456	6,424	18,880	22,755	36,592	44,612
	North Dorset	8,700	22,959	10,560	33,519	42,219	8,527	23,752	12,519	36,271	44,798	69,790	87,017
	Dorset West	3,299	10,481	6,231	16,712	20,011	3,120	11,061	7,048	18,109	21,229	34,821	41,240
	Purbeck	2,847	9,315	4,744	14,059	16,906	2,668	9,336	5,425	14,761	17,429	28,820	34,335
Rural Total		25,333	73,157	36,683	109,840	135,173	24,310	75,010	43,100	118,110	142,420	227,950	277,593
Grand Total		72,955	234,625	87,874	322,499	395,454	69,629	231,547	104,074	335,621	405,250	658,120	800,704

- 2.6 The population table above illustrates that approximately 35% of the population are located in the rural areas of Dorset and 65% are in the urban areas, primarily in Poole and Bournemouth. This broadly reflects the rest of the country.
- 2.7 It must be highlighted that there is no singular definition of rurality but rather a number of different approaches to it. This encompasses spatial classification (based on population density, distance to cities and urban centres); a socio economic classification (based upon principle forms of employment in an area) and more complex definitions combining both of the above. (Nicholson, 2008 in Advances in psychiatric treatment).
- 2.8 Table 2 below is the predicted Bournemouth, Poole and Dorset local authority (LA) adult resident population figures taken from Office National Statistics (2018).

Table 2. Predicted Adult Local Authority Population

Local Authority	Age Group	2016	2018	2023	2026
Bournemouth	18-64	123,220	124,844	126,193	127,708
	65+	35,121	35,705	38,372	40,739
Bournemouth Total		158,341	160,549	164,565	168,447
Poole	18-64	87,093	87,101	86,812	86,815
	65+	33,438	34,182	36,422	38,272
Poole Total		120,531	121,283	123,234	125,087
Dorset	18-64	226,076	224,983	221,802	220,038
	65+	119,700	123,546	134,210	141,904
Dorset Total		345,776	348,529	356,012	361,942
Pan Dorset	18-64	436,389	436,927	434,807	434,561
	65+	188,259	193,433	209,004	220,915
Pan Dorset Total		624,648	630,360	643,811	655,476

Data source - ONS, Population projections - local authorities SNPP Z1 (May 2018)

There is a predicted 4.9% increase in the overall Pan Dorset adult population year on year from 2016 to 2026. This increase is almost exclusively in the over 65 age group. The 18 to 64-year-old age group population is expected to reduce slightly within Poole and Dorset local authorities from 2019.

- 2.9 Projected changes to the population profile of the county are not expected to alter the existing prevalence of serious mental illness locally but there will be a slight increase in numbers of people potentially requiring services in line with the overall growth.

3. LOCAL CONTEXT

- 3.1 Table 3 below shows the current prevalence and projected prevalence increase in Dorset for people with a serious/severe mental illness.

Table 3. Projected Increase for SMI

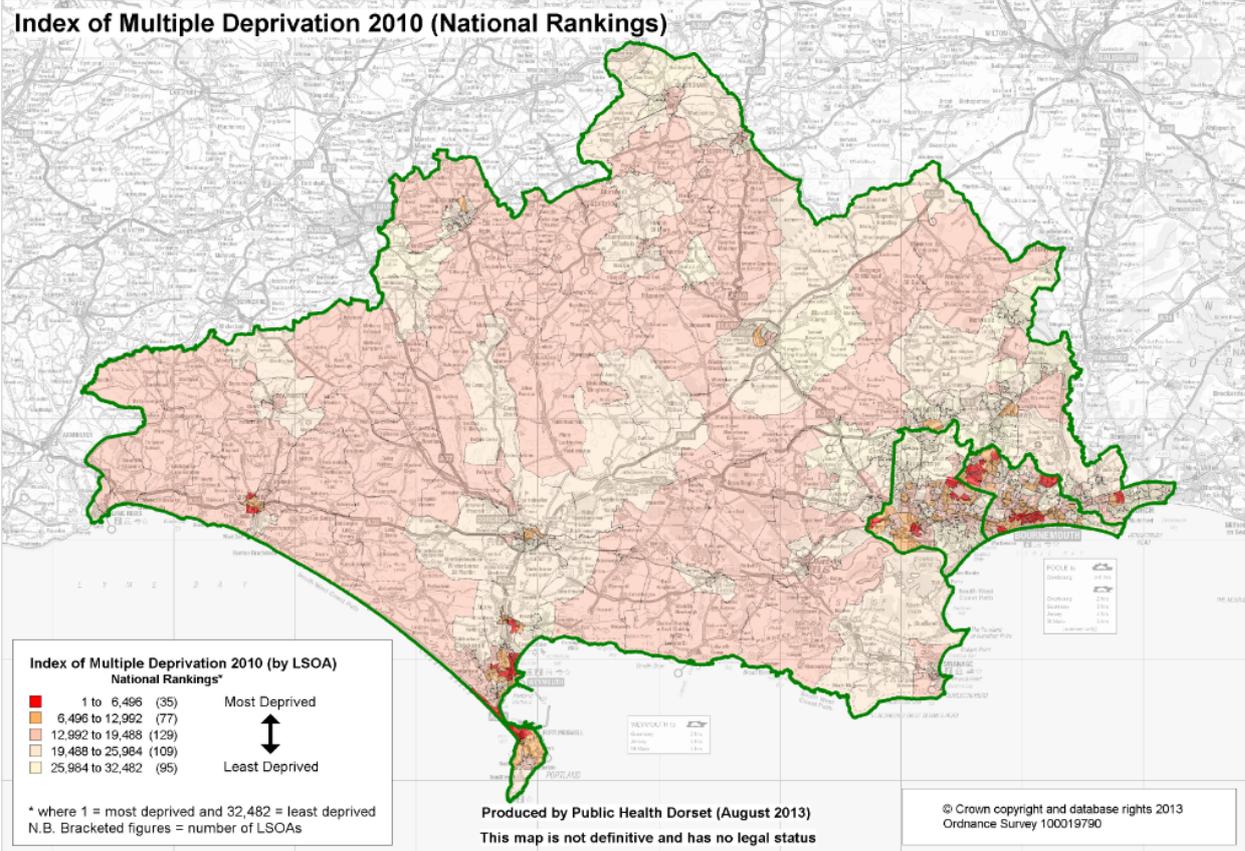
CCG Locality	2016/17			2021/22			2026/27		
	Practice List Size	Practice Register SMI	SMI Prevalence	Practice List Size	Practice Register SMI	SMI Prevalence	Practice List Size	Practice Register SMI	SMI Prevalence
Bournemouth North	66,832	627	0.94%	68,437	642	0.94%	70,079	657	0.94%
Central Bournemouth	57,904	612	1.06%	59,294	627	1.06%	60,717	642	1.06%
Christchurch	54,627	399	0.73%	55,939	409	0.73%	57,281	418	0.73%
East Bournemouth	74,312	1,172	1.58%	76,097	1200	1.58%	77,922	1229	1.58%
Poole Bay	74,572	897	1.20%	76,363	919	1.20%	78,195	941	1.20%
Poole Central	62,773	548	0.87%	64,280	561	0.87%	65,822	575	0.87%
Poole North	52,708	418	0.79%	53,974	428	0.79%	55,268	438	0.79%
Weymouth & Portland	75,170	856	1.14%	76,975	877	1.14%	78,822	898	1.14%
Urban Sub-total	518,898	5,529	1.07%	531,359	5,662	1.07%	544,105	5,798	1.07%
East Dorset	69,911	410	0.59%	71,590	420	0.59%	73,307	430	0.59%
Mid Dorset	44,308	373	0.84%	45,372	382	0.84%	46,460	391	0.84%
North Dorset	86,928	648	0.75%	89,015	664	0.75%	91,151	679	0.75%
Dorset West	41,070	444	1.08%	42,056	455	1.08%	43,065	466	1.08%
Purbeck	34,044	293	0.86%	34,862	300	0.86%	35,698	307	0.86%
Rural Sub-total	276,261	2,168	0.78%	282,895	2,220	0.78%	289,681	2,273	0.78%
Grand Total	795,159	7,697	0.97%	814,254	7,882	0.97%	833,786	8,071	0.97%

Population figures for 2021/22 and 2026/27 are based on Dorset CCG population increases taken from ONS, Population projections - CCG SNPP Z2 (May 2018)

Projected SMI practice register figures assume SMI prevalence percentage for each locality remains stable over time

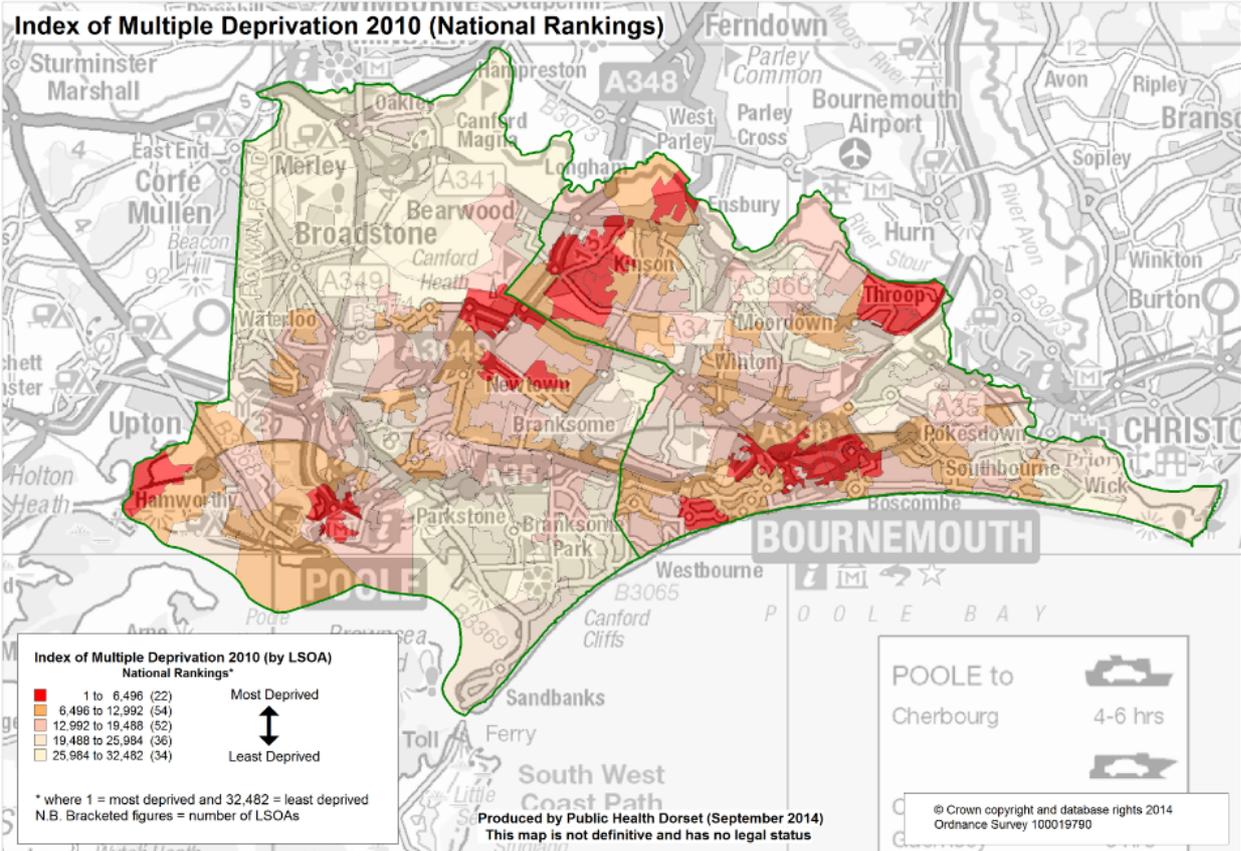
- 3.2 The table above shows how the current SMI prevalence varies across the county with the highest prevalence in the East Bournemouth CCG locality (1.58%) and the lowest in the East Dorset CCG locality (0.59%). Further analysis by practice shows how SMI prevalence varies significantly within CCG localities. Prevalence is higher in the urban areas of Dorset (1.07%) compared to the rural areas (0.78%) with the exception of West Dorset.
- 3.3 The table above also shows a projected additional 185 patients (2.4%) on the Dorset CCG SMI practice register between 2016/17 and 2021/22. By 2026/27 an additional 374 patients (4.9%) are expected on the Dorset CCG SMI practice register. The projections are crude and don't take into consideration the age and sex difference in population projections and whether certain groups (age and sex) of people are more likely to experience SMI.
- 3.4 Public Health England (PHE) has outlined numerous factors to inform local profiles of severe mental illness which link to socioeconomic deprivation: this was recommended to be used as the key determinant of Serious Mental Illness. The Index of Multiple Deprivation (IMD) 2015 is a composite of the following factors and weightings:
- Income (22.5%)
 - Employment (22.5%)
 - Health and Disability (13.5%)
 - Education, Skills and Training (13.5%)
 - Barriers to Housing and Services (9.3%)
 - Crime (9.3%)
 - Living Environment (9.3%)
- 3.5 The maps included below outline Index of Multiple Deprivation (IMD) 2010 national rankings. These demonstrate a wide variance in the levels of deprivation across the geographical boundaries of Dorset CCG ranging from some of the poorest areas in the country to those that are more affluent.

Diagram 2. Multiple Deprivation National Rankings - Dorset



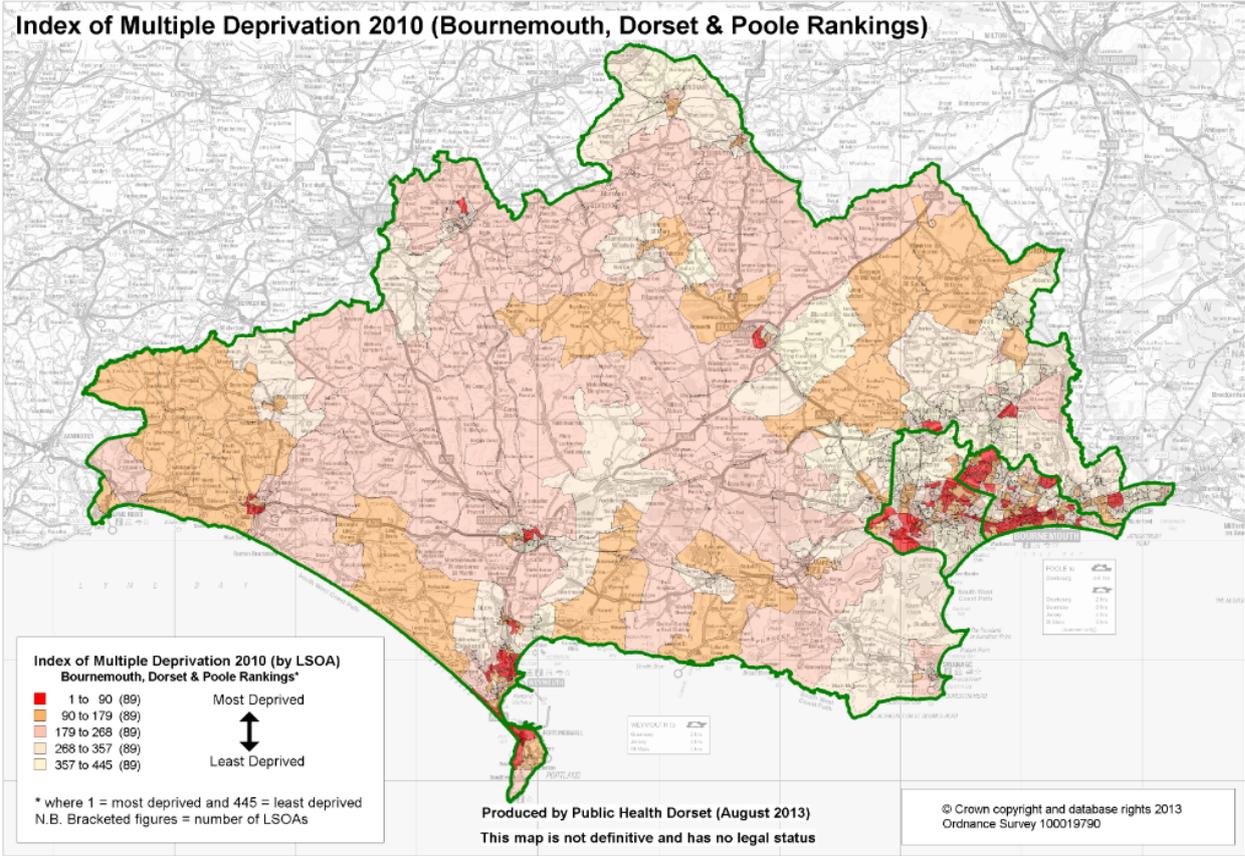
3.6 The maps of deprivation below for Dorset and the Bournemouth and Poole area show differences in deprivation levels in Dorset based on national quintiles (fifths) of the Index of Multiple Deprivation 2010 by area (Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in Dorset. The areas with most significant deprivation are mainly located in the urban areas of Bournemouth, Poole and the Weymouth & Portland locality. There are also some pockets of deprivation in Christchurch and Bridport.

Diagram 3. Multiple Deprivation National Rankings – Bournemouth & Poole



3.7 The map below illustrates a more detailed overview of *relative* deprivation across Dorset. To determine relative deprivation, the level of deprivation in each area is ranked and divided into local quintiles. The relative deprivation shows that in addition to the urban areas, relatively speaking Sherborne, Bridport, Blandford and parts of East Dorset and Dorchester also have relatively high levels of deprivation when compared to other areas in Dorset.

Diagram 4. Multiple Deprivation National Rankings – Lower Support Output Area (LSOA)



Risk Factors

- 3.8 Mental illness has a huge impact on health and wellbeing. People with mental health problems are more likely to develop significant preventable conditions such as diabetes, heart disease, bowel cancer and breast cancer, and at a younger age (King’s Fund, 2014).
- 3.9 People with severe mental illness on average tend to die earlier than the general population and this is referred to as premature mortality. There is a 10-25-year life expectancy reduction in people with severe mental illness (World Health Organisation, 2013).
- 3.10 Life expectancy is even lower for people who are homeless with the average life expectancy for males being 47 and female 43 (Crisis, 2011).
- 3.11 Around 20% of service-users presenting to mental health services for the first time with a psychotic illness will go on to require rehabilitation services and 1% of them may require hospitalisation (Joint Commissioning Panel for Mental Health, 2016). This equates to 1531 people from our current SMI register who may require rehabilitation/assertive approaches to their care and support at times.
- 3.12 On average people referred to mental health rehabilitation care have been in contact with mental health services for more than 13 years and have had repeated admissions (Care Quality Commission, 2018).

Benchmarking

- 3.13 The Academic Health Science Network (AHSN) have produced a profile pack for Dorset CCG in year which figures for Dorset were compared with 10 other similar CCGs. Key highlights are outlined below:
- Although there is a need for local interpretation, the data suggests the estimated number of people with a psychotic disorder in NHS Dorset CCG is nearly 20% higher than other areas.
 - Over 40% more people subject to the Mental Health Act.
 - Dorset CCG has a higher percentage of known service users who have psychosis (30% compared to Wessex average of 26%).
 - A greater number of service users with psychosis reach old age.
 - Higher than expected proportion of psychosis amongst service users of a minority ethnic background.
 - Service users with psychosis in Dorset require three times as many health professional contacts when compared with other mental health conditions.
 - 27% of service users with psychosis get admitted to mental health inpatient wards (less than Wessex average of 30%) but stay twice as long in hospital when compared to others
- 3.14 The NHS Benchmarking Network Inpatient and Community Mental Health Benchmarking Report published in November 2017 shows that in 2016/17 the average length of stay within longer term complex/continuing care beds (excluding leave) for Dorset (covering Dorset HealthCare rehabilitation beds) was 367 days, this is lower than the UK median average of 394 days.
- 3.15 The benchmarking report also shows that in 2016/17 the bed occupancy within longer term complex/continuing care beds (excluding leave) for Dorset (covering Dorset HealthCare rehabilitation beds) was 94.2%, this is higher than the UK median position of 85.1%. There are contributing factors for the higher percentage bed occupancy for Dorset i.e. accommodating overspill from the acute wards during times of bed pressures.
- 3.16 The data suggests that, in Dorset the bed occupancy rates are higher than the national average and that people out of area do less well because they are out of area and disconnected from their peers and families and friends. The national drive is not to use out of area placements and that suggests in Dorset we need additional resource in the community to support exit from inpatient services and to make sure that people do not go out of area.
- 3.17 NICE 2018 highlighted that in areas where there is a lack of local rehabilitation services, people will access 'Out of Area Treatments' (OATS), OATS displace people with severe and enduring mental illness from their communities and families and are 65% more expensive than local placements in England. Around £350 million each year is spent on OATS for people with severe and enduring mental illness. Locally our current spend is approximately £1.5 million.

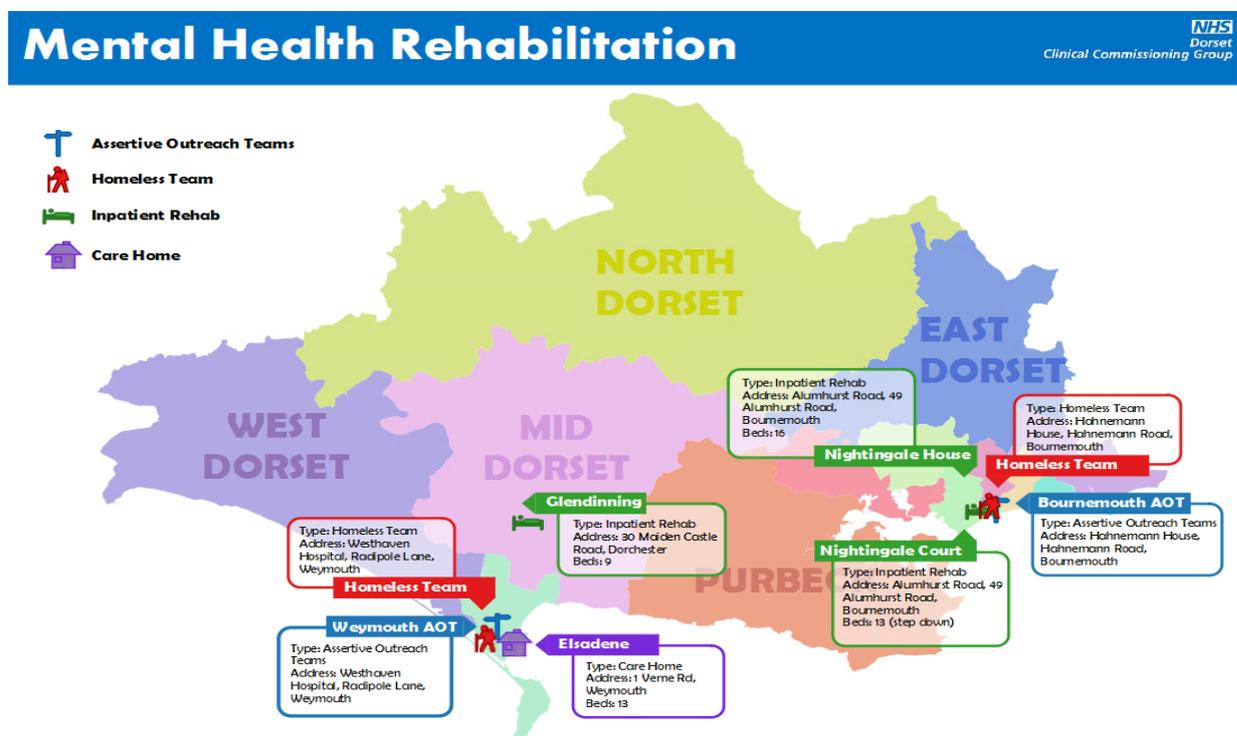
3.18 The Care Quality Commission’s March 2018 report and the Joint Commissioning for Mental Health Panel 2016 report suggests mental health rehabilitation highlighted the concern for the recovery of patients receiving treatment away from their home increasing isolation and building links with services that will support them post discharge.

4. CURRENT SERVICE PROVISION

4.1. Dorset HealthCare is the main provider of specialist mental rehabilitation health services across Dorset. The locations of the various services are shown on the map below.

4.2. The mental health rehabilitation services within Dorset have been in existence for many years but have never been fully reviewed.

Diagram 5. Map of Services



4.3. There are four elements considered within the scope of the mental health rehabilitation review and are as follows:

- Residential Rehabilitation Units – Nightingale House located in Westbourne, Nightingale Court located in Westbourne and the Glendinning Unit located in Dorchester.
- Out of area locked rehabilitation placements which are funded through the named patient budget
- The Assertive Outreach Teams located in Weymouth (including Portland), Bournemouth and Poole
- The Homeless Health Service located in Bournemouth and Poole and West Dorset

4.4 For noting:

- Elsadene is a registered care home located in Weymouth that used to be a private hospital that worked with slow stream rehabilitation patients. The care home has been part of the Dorset rehabilitation service provision to date and this was to be considered as part of the review. However, as part of the background work on the review there are contractual issues that need to be resolved outside of the context of this review and is therefore not in scope of the review.

Residential Rehabilitation Services

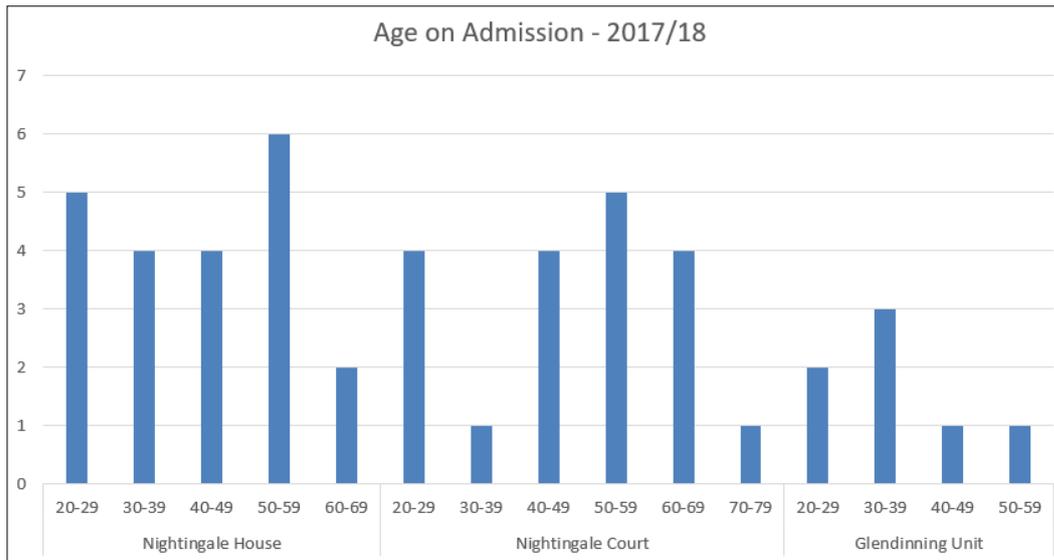
- 4.5 **Nightingale House:** Is a 16 bedded mixed sex unit, providing controlled access (not a 'locked' or 'secure' rehabilitation unit) solely for patients with severe complex care needs that do not require acute psychiatric inpatient admission or their needs cannot be met in an open rehabilitation unit. Nightingale house provides high dependency rehabilitation services to clients with active symptoms of psychosis and other related mental health conditions, complex needs and challenging behaviours. The usual aim of treatment is to prepare patients to step down to other rehabilitation services prior to independent or supported living. Patients can be admitted into these beds from a variety of sources, including secure services, and directly from the community with prior assessment.
- 4.6 **Nightingale Court:** 13 bedded step-down inpatient unit for adults who experience complex, severe and enduring mental illness. A multidisciplinary team comprising of mental health nurses, occupational therapy staff, medics and clinical psychologist work collaboratively to provide a holistic and supportive approach to enable and promote patients on their personal journey of recovery and enhance their quality of life and wellbeing. The patients will often have had previous multiple admissions and unsuccessful discharges from other services and require a longer period of stability to consolidate their recovery and rebuild skills and confidence before moving back out into the community.
- 4.7 **Glendinning Unit:** 9 bedded rehabilitation unit in Dorchester. The patient group predominantly suffers from psychosis often with other related mental health conditions. The main sources for referrals are from other inpatient settings within Dorset HealthCare. The unit helps people develop strategies for living with their health condition, encourage people to take responsibility to self, enable the building of skills and develop confidence through direct experience. This support includes community integration which is delivered in collaboration with allied health, voluntary and third sector agencies.
- 4.8 **Table 4.** below illustrates the inpatient data for admission, discharges and length of stay (LOS) for the 3 inpatient mental health rehabilitation units in Dorset.

Table 4 Inpatient rehabilitation unit inpatient data

Unit		2015/16	2016/17	2017/18
Nightingale House	Admissions	20	21	21
	Discharges	8	6	11
	Min Length of Stay on Ward (days)	1	0	7
	Max Length of Stay on Ward (days)	1007	692	358
	Avg Length of Stay on Ward (days)	252	233	148
Nightingale Court	Admissions	9	10	19
	Discharges	6	8	11
	Min Length of Stay on Ward (days)	3	0	0
	Max Length of Stay on Ward (days)	945	694	417
	Avg Length of Stay on Ward (days)	514	209	164
Glendinning	Admissions	7	11	7
	Discharges	3	8	4
	Min Length of Stay on Ward (days)	0	2	116
	Max Length of Stay on Ward (days)	714	619	415
	Avg Length of Stay on Ward (days)	275	285	290

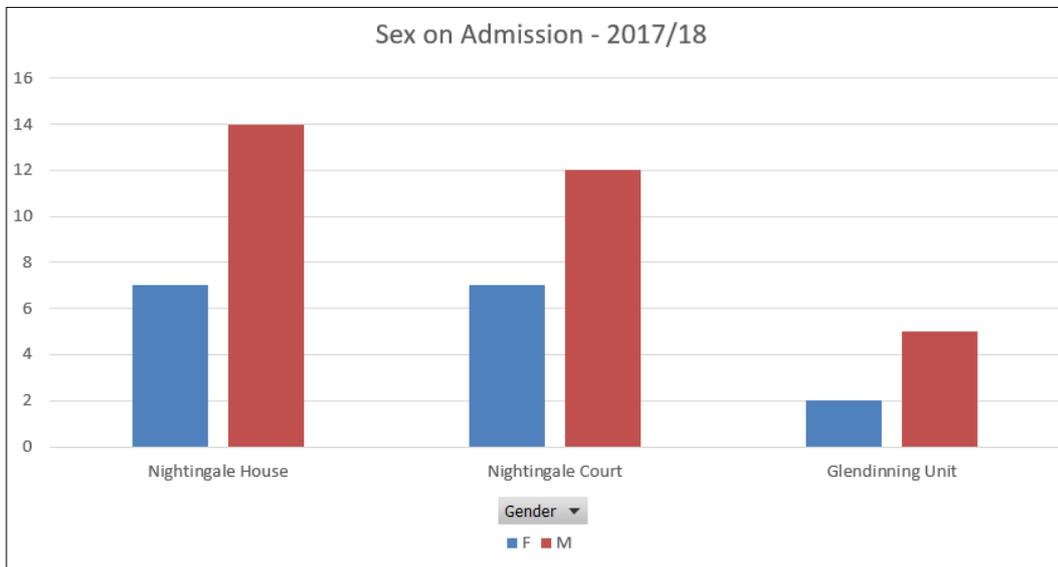
- 4.9 The table above shows admission numbers and length of stay at the three residential rehabilitation units for the past three years. The figures show that admissions are consistent over the 3-year period in Nightingale House and Glendinning Unit however admissions were high in Nightingale Court during 2017/18 compared to the previous two years.
- 4.10 There is a marked reduction in length of stay at both Nightingale Court and Nightingale House over the 3-year period, however Glendinning remains stable. The average length of stay over 2017/18 across the 3 sites is 200 days.
- 4.11 Graph 1 below shows the age range of patients admitted to a rehabilitation bed during 2017/18. The average age of patients admitted to Nightingale House during 2017/18 was 42.9 years, at Nightingale Court it was 47.8 years and at Glendinning the average age was 36.9 years.

Graph 1. Inpatient Age Range



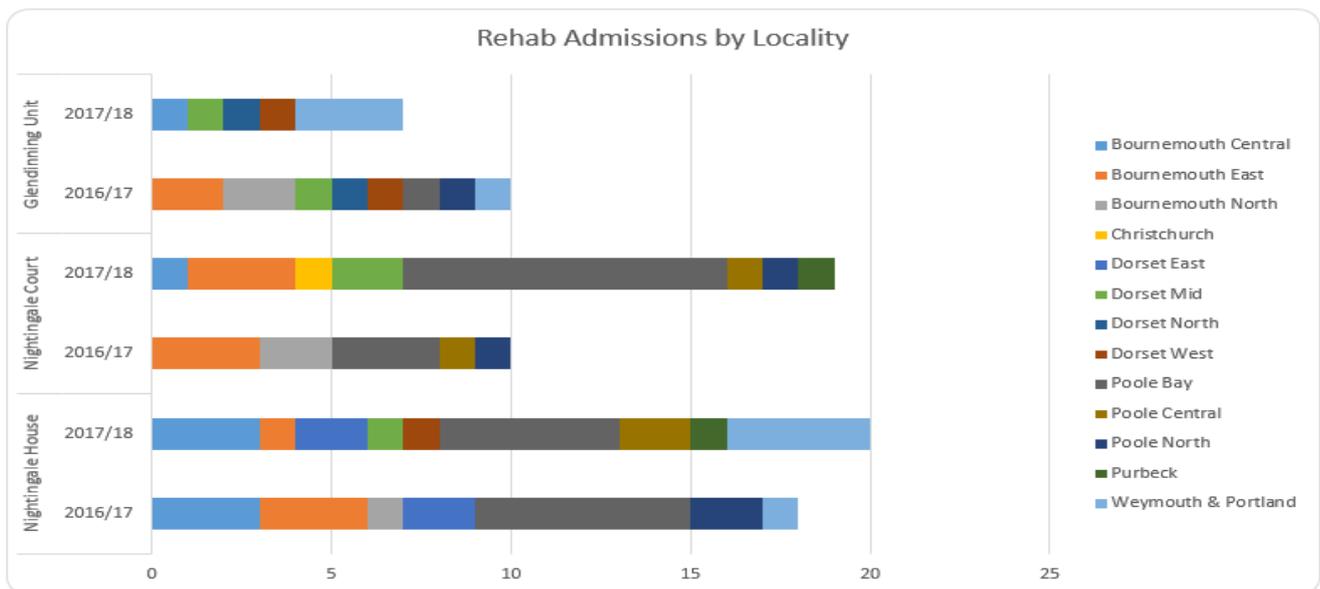
4.12 Graph 2 below shows the number of males and females admitted to the rehabilitation units during 2017/18. Across the rehabilitation service admissions for males were higher than females with 34% of admissions for females and 66% for males. Male admissions were higher within each of the rehabilitation units.

Graph 2. Inpatient Admissions by Sex



4.13 Table 10 is a breakdown of the inpatient admissions at the 3 inpatient rehabilitation units by GP Locality:

Table 10. Rehab Admissions by GP Locality



Source: Mental Health local dataset (RiO)

4.14 The breakdown by locality shows some particular themes; a large proportion of the admissions in the last two years have been from Poole Bay locality. There are also a proportion of the Weymouth & Portland locality utilising East services. Bournemouth Central are showing consistent usage of Nightingale house year on year, whilst Bournemouth East are following a similar pattern but at Nightingale Court. Most of the other localities are remaining fairly static year on year.

Bed Occupancy

4.15 Table 5 below shows a breakdown of the bed occupancy from October 2017 to June 2018.

Table 5. Bed Occupancy Rates

Without home leave

Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
97.0%	96.8%	94.6%	94.7%	89.1%	93.3%	93.8%	95.6%	95.8%

With home leave

Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
100.8%	100.2%	101.6%	99.7%	96.1%	97.8%	97.0%	98.8%	97.8%

4.16 The table above show that the units run to capacity most of the time. It also shows that section 17 leave allows units to use a bed for more than one person i.e. when another patient is on section 17 leave. This indicates units run over capacity as shown between October - December 2017. In addition to this Dorset uses a number of out of area placements because the units in county are running to capacity and has not got a community rehabilitation service. At any time, there is an average of 8 or 9 people in out of area placements.

4.17 Table 7 below shows the community teams that have Care Coordination responsibility for individuals on each unit. The table shows that there is a good spread of teams holding Care coordination responsibility and that the most referrals are from the teams that are in conurbations where psychosis prevalence is generally higher than in the other areas.

Table 7. Care Co-coordinating teams by Ward

Ward	Team	Total
Glendenning Unit	Bridport CMHT	1
	Poole West CMHT	1
	Shaftesbury CMHT	1
	Weymouth Assertive Outreach Team	3
	Weymouth CMHT	2
	Early Intervention Team	1
Glendenning Unit Total		9
Nightingale Court	Bournemouth East CMHT	2
	Bournemouth West CMHT	4
	Christchurch & Southbourne CMHT Team	1
	Poole Central CMHT	3
	Shaftesbury CMHT	1
	Bridport CMHT	1
	Early Intervention	1
Nightingale Court Total		13
Nightingale House	Bmth & Poole Assertive Outreach Team	4
	Bournemouth East CMHT	1
	Christchurch & Southbourne CMHT	2
	Dorchester CMHT	2
	Bmth West CMHT	1
	Poole Central CMHT	1
	Poole West CMHT	1
	Weymouth CMHT	2
	Wimborne CMHT	1
	Early Intervention Team	1
Nightingale House Total		16
Grand Total		38

4.18 Table 10 below is a breakdown of the Mental Health Act section status of the current inpatients at the 3 inpatient rehabilitation units.

Table 10. Mental Health Act Section Status – Rehab Inpatient Wards

Section	Glendenning Unit	Nightingale Court	Nightingale House	Grand Total
Informal	3	4	1	7
Section 3 - Admission for treatment	6	9	14	26
Section 37/41	0	0	1	1
Grand Total	9	13	16	38

4.19 Table 11 below shows 7 delayed transfers of care (DTOC) for people who are ready to be discharged. There are also 7 people who were delayed between 9 to 89 days from the units. The report indicates that delays are attributable to waiting for placements in the community or packages of care/housing placements.

Delayed discharges/transfers - from June 2017 – June 2018

Table 11. Delayed transfers of care

Applicable Local Authority	Ward	Delay Reason	Total Delayed Days Wait
Weymouth and Portland	Glendenning Unit	Awaiting nursing home placement	22
Bournemouth	Nightingale House	Awaiting care package in own home	89
Bournemouth	Nightingale House	Awaiting further non-acute	25
Bournemouth	Nightingale Court	Patient or Family choice - Community	58
Bournemouth	Nightingale Court	Awaiting public funding	70
Dorset	Nightingale Court	Awaiting further non-acute	9
Weymouth and Portland	Nightingale House	Awaiting care package in own home	33

Out of Area Treatment (OATS)

4.20 Currently Dorset HealthCare has 11 service users placed in out of area locked rehabilitation units. This client group has diverse and complex needs and may have had contact with the criminal justice system. There is no local provision that provides locked rehabilitation and if individuals require out of area locked rehabilitation they are offered services out of area that can accommodate their needs.

4.21 The absence of a dedicated Dorset Community Rehabilitation Services managing out of area placements and actively working towards transitioning individuals back to area is a huge financial and personal cost to individuals placed outside of Dorset.

Assertive Outreach Teams (AOT)

- 4.22 Assertive Outreach Teams (AOT) are specialist community services and part of secondary mental health. AOT work with adults of working age with serious mental illness and particularly complex needs who require intensive support.
- 4.23 Services users within the AOT services have multiple needs. This group of services users require a proactive case management approach. Typical AOT clients may have multiple contacts with police and a forensic history, multiple admissions to inpatient units under the mental health act, high levels of substance misuse and limited insight into their illness. Some service users experience homelessness and some may be unable to maintain housing.
- 4.24 The Assertive Outreach Team operates the following referral criteria:
- A severe and persistent mental illness (i.e. schizophrenia, major affective disorder) associated with a high level of disability.
 - A history of frequent use of inpatient or intensive home based care (i.e. more than two admissions or more than 6 months in inpatient care in the past two years).
 - Detained under Mental Health Act on at least one occasion in the past 2 yrs.
 - Difficulty in maintaining lasting and consenting contact with services.
 - Multiple, complex needs including a number of the following:
 - History of violence or persistent offending
 - Significant risk of persistent self-harm or neglect
 - Poor response to previous treatment
 - Dual diagnosis of substance misuse and serious mental illness
 - Unstable accommodation or homelessness
 - Subject to Care Programme Approach (CPA).
- 4.25 The skill set of the AOT staff centre around the individual to meet their needs and operate a flexible and adaptive approach to engaging with service users. This can include visits being undertaken at a range of locations, supporting with medication compliance, developing life skills, increasing access to opportunities for employment and occupation and monitoring physical health. The current community provision for rehabilitation is partially covered by the Assertive Outreach Teams.
- 4.26 Dorset HealthCare currently has two Assertive outreach teams that operate differently in each area however cover some rehabilitation work in absence of a defined local service. Table 14 below indicates the Assertive Outreach Team Caseloads and the difference in service provision which provides an unequitable service across the county. Table 14a shows the case load split by gender (this table also included homeless service gender split).

Table 14 Assertive Outreach Team Caseloads

AOT – Bournemouth/Poole	AOT - Weymouth
Caseload: 60	Caseload: 32
<ul style="list-style-type: none"> • Dedicated administrative assistant • Social Workers in team • No Occupational Therapist • No psychology input into the team • No dedicated medic based within the team – use locality medics • Primary referrals from rehabilitation services • Overcapacity 	<ul style="list-style-type: none"> • No dedicated administrative assistant • No Social Workers in the team • Has Occupational Therapist in the team • Has Psychology input to the team • Has dedicated Psychiatrist • Primary referrals from Weymouth CMHT and Glendinning • Overcapacity

4.27 By crude comparison it can be seen that the allocation of workforce resources is not consistent. The professional breakdown with each team also differs by way of whole time equivalent (wte) allocation. It is not clear how individual team workforce profiles have been determined with apparent inconsistencies between ratios of administrative and clinical staff.

Table 14a. Gender split on AOT and Homeless Service caseloads

Team	Males on caseload	Females on caseload	Totals
AOT Bournemouth/Poole	47	12	59
AOT Weymouth	24	8	32
Homeless Health Service	35	9	44

4.28 There are a total of 106 males on the caseloads, 29 females equating to 135 people.

4.29 Medical staffing in the team varies with one team having dedicated medical input and another using a variety of medical input from the Community Mental Health Teams (CMHT).

4.30 There are no AOT teams covering Christchurch, Purbeck, North Dorset, Dorchester or Bridport. Individuals who met the remit for care under an AOT are managed within a generic CMHT.

4.31 Table 15. Below shows the number of contacts and DNAs carried out by the Assertive Outreach Teams. It shows that there are a lot of contacts and a lot of cancelled or DNA appointments especially in the follow up contacts.

Table 15. AOT DNAs

Appointment Type	Appointment Status Description	2015/16	2016/17	2017/18
First	Attended	26	10	35
	Did not attend	9	3	8
	Healthcare Provider Cancelled	8	4	7
	Patient Cancelled	0	0	0
First Total		43	17	50
Follow-up	Attended	5,177	4,920	5,217
	Did not attend	934	926	921
	Healthcare Provider Cancelled	197	187	130
	Patient Cancelled	16	18	20
Follow-up Total		6,324	6,051	6,288
Grand Total		6,367	6,068	6,338

4.32 The table indicates the complexity of the AOT client group where there are a significant numbers of DNA's for offered appointments.

4.33 Table 16 below shows the Assertive Outreach Teams caseloads per annum for each year:

Table 16 AOT caseloads

Team	Gender	2015/16	2016/17	2017/18
AMH Bmth & Poole Assertive Outreach Team	F	18	16	11
	M	50	53	49
AMH Christchurch Assertive Outreach Team	M	3		
AMH Weymouth Assertive Outreach Team	F	9	8	6
	M	24	26	26
Grand Total		104	103	92

4.34 In 2017/18 there were 73 males and 17 females on the AOT caseloads. The caseloads remain consistent with a slight decrease in 2017/18 but it is apparent there are more males than females within the service.

4.35 Table 17 below shows the Assertive Outreach Teams Caseload by cluster. Clusters are defined by an identifier and a description associated for reporting purposes.

Table 17 Assertive Outreach Teams Caseload by cluster

Cluster	Cluster Description	2015/16	2016/17	2017/18
P11	Ongoing recurrent psychosis (low symptoms)	6	8	4
P12	Ongoing/recurrent psychosis (high disability)	7	7	8
P13	Ongoing/recurrent psychosis (high symptom & disability)	14	14	15
P14	Psychotic crisis	2		
P16	Dual diagnosis (substance abuse and mental illness)	32	36	24
P17	Psychosis and affective disorder difficult to engage	40	36	26
P99	Un clustered	2	2	15
Total		104	103	92

4.36 Table 17 above indicates that the majority of the AOT caseload are categorised in clusters P16 and P17. This is what would be expected on an AOT caseload where there are high proportions of clients who present with complex needs including drug use and marginalisation meaning that the team work hard to provide care for clients who often do not wish to be under mental health services. There are also a number of people in other cluster groups and it might be argued that people not in clusters 16 or 17 could be managed by the CMHTs potentially.

4.37 Table 19 below data shows the caseload discharges for the Assertive Outreach Teams.

Table 19 AOT caseload discharges

Caseload Discharges		2016/17	2017/18
Bmth & Poole Assertive Outreach Team	F	2	7
	M	5	10
Bmth & Poole Assertive Outreach Team Total		7	17
Weymouth Assertive Outreach Team	F	1	2
	M	2	4
Weymouth Assertive Outreach Team Total		3	6
Total Discharges		13	23

4.38 Table 19 above illustrates the higher number of discharges in 17/18 for both teams.

Homeless Health Service

4.39 Dorset HealthCare currently provides a service via Mental Health Practitioners and Nurse Practitioners working across the Bournemouth, Poole and West Dorset Locality to offer access to mental health service assessments and physical health assessments for those who are rough sleeping.

- 4.40 The Service has an open referral system and anyone can refer to the Homeless Health Service. However, the main referrers are the homeless outreach services. The team accepts referrals from service users who may not have been seen bedded down by the homeless outreach services however are known to be a rough sleeping.
- 4.41 Staff working within the Homeless Health Service carry out street outreach in an attempt to locate service users and provide health support and advice. The team work closely with the street outreach services to joint work service users. Current provision is as below on table 20.

Table 20. The Homeless Health Team provision for Street Outreach

West Dorset	Bournemouth and Poole
Case load: 26	Case load: 18
<ul style="list-style-type: none"> • Full time mental health practitioner • 22.5 hours of Nurse Practitioner • Under capacity • Offers a service under the broad definition of homelessness – rough sleeping, temporary accommodation • Offers a service, consultation and advice to those living in hostel accommodation • No separate commissioned GP in area but single practice with interest in homelessness 	<ul style="list-style-type: none"> • Part time mental health Practitioner covering larger and more populated area with higher prevalence of homelessness • 15 hours Nurse Practitioner in post • Overcapacity • Only offers a service to rough sleepers • No input into hostel units • GP in Boscombe has contract with CCG to provide service to the Homeless

- 4.42 From the above table inconsistencies can be seen in service provision across the 2 areas. The caseload numbers are higher in West Dorset however this is due to higher staffing levels and are not needs related. It must be noted that homelessness is not just a health issue and for the purposes of this review the focus is on homeless individuals who experience serious mental illness.
- 4.43 There is no service covering Christchurch, Purbeck or North Dorset. Currently individuals who meet the criteria for the Homeless Health Service are managed within a generic CMHT, within primary care or have access to no services.
- 4.44 Table 21 below indicates the amount of people rough sleeping broken down by local authority.

Table 21 Street counts and estimates of rough sleeping by local authority district

Local Authority/District	2015	2016	2017	Number of households 2017 ('000)	2017 rough sleeping rate (per 1,000 households)
Bournemouth	47	39	48	90	0.53
Weymouth and Portland	6	11	18	29	0.62
Poole	10	11	13	67	0.19
Christchurch	8	10	5	22	0.22
North Dorset	0	1	3	31	0.10
West Dorset	6	2	2	46	0.04
East Dorset	3	0	1	39	0.03
Purbeck	5	2	1	20	0.05

Data Source - Rough sleeping in England: autumn 2017 (ONS)

Notes - The Autumn rough sleeping counts and estimates were carried out between 1 October and 30 November. A count is a single night snapshot of the number of rough sleepers in a local authority area. An estimate (shown in grey) is the number of people thought to be sleeping rough in a local authority area on any one night in a chosen week.

4.45 Table 21 above shows the number and rate of rough sleeping per 1,000 households for Dorset local authority districts. In 2017 the number of rough sleepers was highest in Bournemouth local authority (estimate of 48). Weymouth and Portland district had the highest rate of rough sleepers per 1,000 households (estimate of 0.62).

4.46 Table 22 and 22a below shows the number of DNAs across mental health services and highlights the homeless services have the highest DNA rate, closely followed by CMHTs and AOT. All three teams are higher than DHC average DNA rates. It is not possible to do a 3 year comparison as data has only been captured in these areas as the team was not created until November 2016. The information below is taken from Business Objects (DHC reporting tool).

Table 22 DNA by the homeless health team

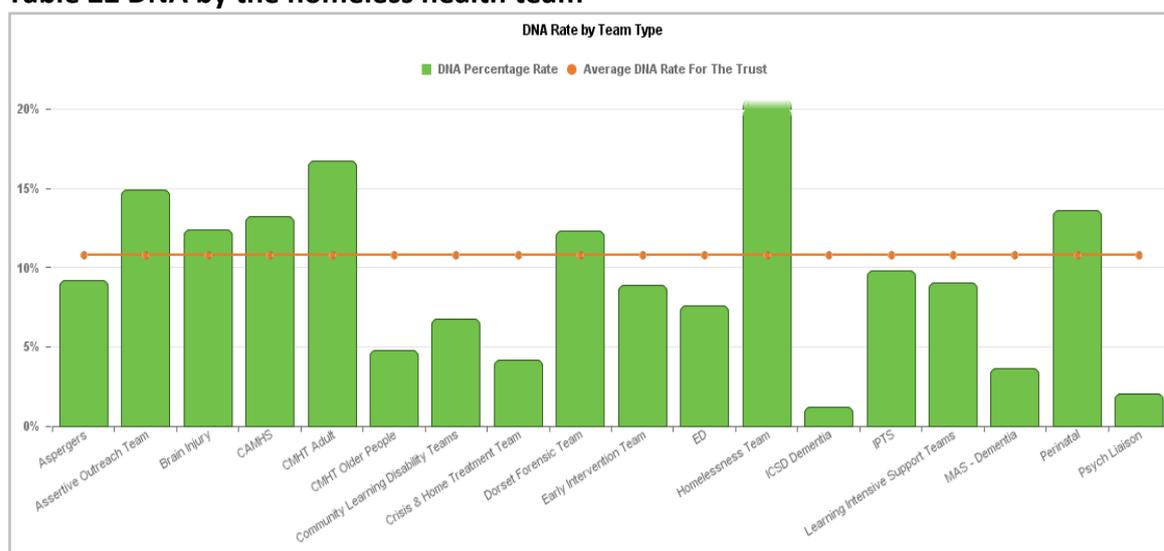
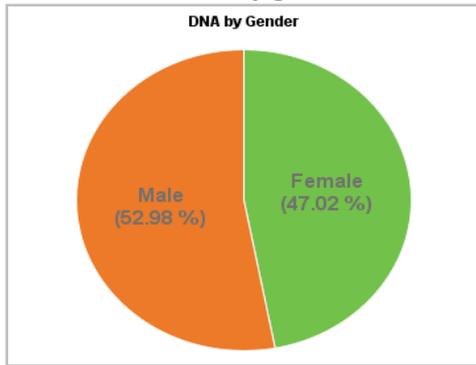


Table 22a – DNA by gender



4.47 Table 22a shows DNA rates by gender across the system and shows that men DNA more than women.

4.48 It should be noted on the homelessness service DNA rates that there is a distinction between did not attend and did not find. The staff assertively look for people sleeping out and if they are not found where they were previously seen sleeping out that cannot be considered to be a DNA.

4.49 Table 23 below shows referral activity for the Nurse Practitioner in Weymouth for 2017/18. Due to a post being only recently being in place for the east of the county there is no comparison to be made for this report.

Table 23 Weymouth Nurse Practitioner referral activity

Weymouth Homeless Service	2017/18
Number of new referrals	32
Number of open referrals	165
Number of contacts	58

4.50 The Nurse Practitioner provides a physical health outreach services to the homeless. The individuals seen do not have to have an SMI and can present with any health need. The role provides assessment and treatment of physical health conditions and supports individuals to access mainstream primary care or secondary care services.

Homeless attendance to A&E

4.51 Homeless people struggle to access health services because they are often asked to provide forms of ID such as proof of address, mobile numbers and addresses. Exclusion from these services puts people’s health at further risk, and places additional pressure on emergency and urgent care services to treat illnesses -- some of which are preventable.

4.52 Homeless people are 5 times more likely to attend A+E (Dr Pippa Metcalf, The Royal College of Physicians presentation 2017)

4.53 Table 24 below illustrates the number of Emergency department (ED) attendances by individuals who are homeless over the last 3 years for the main 3 acute hospital providers.

Table 24 ED attendances by acute provider split

Provider		2015/16	2016/17	2017/18
Poole Hospital	Number of Visits	307	310	259
	Number of Individuals	164	127	122
Royal Bournemouth	Number of Visits	568	509	562
	Number of Individuals	267	250	270
Dorset County	Number of Visits	Not available	Not available	110
	Number of Individuals	Not available	Not available	56

Source: Provider data

- 4.54 This shows there are particularly higher number of homeless individuals attending ED at Royal Bournemouth compared with the other two providers. All three providers are showing that there are multiple re-attendances of the same patients given number of individuals is proportionately half of the number of attendances. For Royal Bournemouth and Poole numbers have stayed fairly static over the 3 years noted.
- 4.55 From Dorset HealthCare Homeless Health Audit (2017) 37% of those surveyed (155) had attended A+E within the last 12 months.

5. CONCLUSIONS AND SUMMARY ANALYSIS

Future Demand

- 5.1 Statistics suggest that by 2020/21 the number of people in Dorset forecasted to have a serious mental illness will increase to approximately 7,882. The number of people who may subsequently require rehabilitation (20%) is approximately 1576 and a further 1% (78.82) of people may require inpatient rehabilitation at some time.
- 5.2 The age of Dorset's population is rising and a greater number with SMI reach older age. This suggests that services need to be all age and not exclusively to adults as the complexity of client group will not usually change with age.
- 5.3 Dorset currently has 38 rehabilitation inpatient beds. During 2017/18 there were 47 admissions to those beds and the average length of stay was 200 days. Based on the forecasted increase there is an estimated 79 people (1% of SMI register) by 2020/21 who may require rehab inpatient beds and if nothing else is done additional beds may be require however with community team and housing provision is in place it is possible that fewer would be required.
- 5.4 Based on population data the higher proportion of services will need to be provided in the conurbation as these have the highest population density and highest SMI rates. The deprivation figures also indicate there are levels of deprivation in Christchurch and Bridport and in the west of the county e.g. Bridport SMI rates are slightly higher than the national average. However the highest rates are primarily in Bournemouth East and Poole. This is also evidenced in the proportion of homeless people in these areas. Furthermore, as the community services in

the review are not pan Dorset this indicates that a population of people who would benefit from these services are currently missing out on the specialist support.

Community Teams

- 5.6 It is apparent that community teams are working at overcapacity at times and resources are not matched to meet demand. Teams may need to work differently to manage the demand and could better meet the need for a pan Dorset service.
- 5.9 The current rehabilitation service in Dorset focusses on inpatient facilities and less on community and supporting people to live as independently and as well as possible in the community. The community offer is currently AOT and the Homeless Health Service and although skill sets of staff are arguably the same, the service remits have a slight difference in terms of responsiveness to treatment through rehab.
- 5.10 The skills of the staff across rehab, AOT and homelessness are broadly the same, staff work assertively, they form and hold the relationship with the person when they are not able or do not want to, they are able to engage with people who do not necessarily want to engage or do not see the value in engaging, they manage risk and work. There is argument in terms of the demand profile that there should be one team that supports people who have complex needs. Bringing the teams together will make them more robust and sustainable and give greater resilience.
- 5.11 Based on the inconsistencies and disparity of service provision and the skill mix within the teams there could be a case developing a for a community team that provides a pan Dorset service to meet the populations needs in a different and more fluid/flexible way.

Inpatients

- 5.12 People with a serious mental illness experience long length of stay during their inpatient admission and can often result in delayed discharges. Possible reasons for this include the limited supported accommodation options locally and a lack of an active and engaging community team supporting discharge with packages of care or waiting for placements.
- 5.13 National research data suggests that that people out of area do less well because they are disconnected from their peers, families and friends. The national drive is to cease out of area locked placements. Dorset will need to accommodate people being repatriated back into the county and provide resource to accommodate them.
- 5.14 There are a higher proportion of males accessing rehabilitation services. This could be for a number of reasons that have not been identified specifically within the analysis. This is consistent within the AOT service, the homeless health team service and the out of area locked rehab units with 7 males and 4 females and inpatient units that have 26 males and 12 females. The future bed provision will need to take this into consideration.

- 5.15 In total there are currently 180 people on the caseloads within our support services including inpatient rehabilitation. The forecast indicates this number will increase and this will need to be taken into consideration with shaping of future rehabilitation services for Dorset.
- 5.16 In summary there is rising demand and current services are not set up in the right areas to manage the demand in the least restrictive way.
- 5.17 There is little community provision and few supported housing options at the moment, which leave inpatient services being the primary rehabilitation and complex care option.
- 5.18 It is likely with targeted reshaping of the current services that the offer for people who require ongoing rehab or assertive support could be improved and enhanced.

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Mental Health Rehabilitation Service Review View Seeking Report



DOCUMENT TRAIL AND VERSION CONTROL SHEET

Heading	Review and Design of the Mental Health Rehabilitation Pathway Mental Health Rehabilitation Service View Seeking Report
Project Sponsor	Colin Hicks
Purpose of document	Present an outline of the view seeking information gathered to inform the MH rehabilitation review case for change.
Date of document	21 st August 2018
Review Date	
Authors	Melissa Scott Elaine Hurl Alissa Tromans Lisa Spriggs Julie Brown
To be Approved by	Rehabilitation services project board
Date approved	
Effective from	
Status	For comment
Version	V2.0

Mental Health Rehabilitation Report

View Seeking Report

1 Introduction

1.2 NHS Dorset Clinical Commissioning Group (CCG), Dorset HealthCare (DHC) and Dorset Mental Health Forum are undertaking a review of adult mental health rehabilitation services for people with a serious/severe mental illness (SMI) in Dorset. This is titled the rehabilitation review.

2. Co-production

2.1 This review is underpinned through co-production with key stakeholders, including people who use services and their families/carers. The aim has been to ensure that patients, carers, public, communities of interest and geography are engaged fully within the different stages alongside the process. As part of the review we felt it was imperative that service users within the mental health rehabilitation hospitals were offered 1:1 support from a peer specialist to ensure that their voices are heard.

3. Services in scope

3.1 There are six services within the rehabilitation review and consist of:

1. Three Inpatient Rehabilitation Units – Nightingale House and Nightingale Court located in Westbourne and the Glendenning Unit located in Weymouth
2. Out of area locked rehabilitation
3. The Assertive Outreach Teams located in Weymouth and Portland
4. The Assertive Outreach Teams located in Bournemouth and Poole
5. The Homeless Health Service

4. Methodology

4.1 There were individual 144 responses to the different view seeking methods. There were 71 attendees at the community events. Sixteen people attended the outreach events and meetings.

4.2 Views were gathered from 37 service users, 24 carers, 69 staff and 26 other agencies that worked with the services included in the review.

4.3 Please note that some individuals identified as belonging to 2 user groups which accounts for the difference in totals.

Type of Response		Number
Online survey		60
Postcards		79
Emails		5

- 4.4 **Online survey** - The online survey was designed and the web link promoted by NHS Dorset CCG, Dorset HealthCare and Dorset Mental Health Forum.
- 4.5 **Postcards** - The postcards were designed and distributed to all services involved in the review and a number of agencies who work alongside the services involved in the review. The postcards were freepost to NHS Dorset CCG.
- 4.6 **Community events** - NHS Dorset CCG, Dorset HealthCare and Dorset Mental Health Forum held 7 community drop in events across the whole of Dorset and during the daytime to give as many participants as possible the opportunity to attend. These meetings lasted for 2-4 hours and gave information about the purpose of the review and approach. Participants were given the opportunity to discuss issues and were then invited to write their views down with assistance offered if necessary.
- 4.7 **Outreach events** - Five outreach events were held across the county for service users and carers. The information about the purpose of the approach was given alongside the opportunity to discuss issues. Individuals were invited to write their views down by facilitators and note takers from Dorset CCG, Dorset Healthcare and Dorset Mental Health Forum. Alternatively, if individuals preferred they could write their own views.
- 4.8 All three approaches to engagement followed the same process and asking participants a set of 3 broad questions around rehabilitation services and for the purposes of the report the responses are colour coded. The questions are:

From your knowledge/experience of mental health rehabilitation services what currently works well?

From your knowledge/experience of mental health rehabilitation services what doesn't work well?

How can mental health rehabilitation services be improved?

Themes and from people who use services

5. Helpful and dedicated staff

- 5.1 The quotes in 5.3 are from people who use services who responded to the view seeking questions. The quotes are based on common themes emerging from the view seeking sessions. The themes were; helpful dedicated staff, food, workshops, activities, peer support.
- 5.2 Throughout the view seeking staff were generally praised for their commitment to helping the service users in their recovery and for being friendly and easy to talk to. They also said that staff encourage them to focus on their recovery and the future and being able to build positive relationships with staff members. People also said

how well staff worked as part of a team and liaised with other services/family members to ensure the best care was provided.

5.2 Across all groups (staff members, service users and family members) one of the most common themes was that staff members are dedicated, skilled and caring. Multiple service users emphasised that staff offer a lot of support and encouragement and that staff have been helpful in their recovery.

5.3 The following are quotes from people who use services.

- *"I would be a 'wreck' without AOT. Happy staff with a smile."*
- *"Staff are a good team. Genuinely caring and supportive."*
- *"Some of the staff have been really helpful. They listen to me and help me let off steam"*
- *"Staff help me all the time - they are very supportive." "Staff are very easy to chat to. Staff pop in and see me and encourage me when I'm not feeling great. It's very caring and supportive."*
- *"AOT – quick to help me with housing, always on time for my visits and always turn up. Wouldn't ever had CBT if not under the team. Being in the service makes access to other help i.e. drug and alcohol services easier"*
- *"The food is good"*
- *"Food quite nice - A choice of food menu. "*
- *"I like going to the groups, particularly the ones that get me outside."*
- *"Roots is really good group - gets people out and about. Doing activities helps build relationships."*
- *"Lots of different activities on offer."*
- *"OT is good"*
- *"The music group is very helpful"*

- *Not enough variation in weekend activities"*
- *"Sometimes I get bored because there is not enough going on."*
- *"Having to spend so much time on the ward is hard."*

6. Workshops and activities

6.1 Service users spoke about how workshops were helpful, giving them a sense of purpose and having something positive to focus on to aid their recovery.

6.2 Many service users said that they would like more activities and resources to attend activities because it gives them something to do to manage boredom levels.

6.3 Some services have links with RSPCA, Gyms etc. which helps with community integration. Some people said that cooking Groups and moving forward groups are helpful. But they also mentioned that that there is a lack of OT in AOT.

6.4 The following comments address how rehabilitation services can be improved.

- *“More Workshop like groups where I can talk about what’s happening with others”*
- *“More cooking/eating meals together”*

7. Peer Support

7.1 People said that they valued peer support and that they find peer support beneficial in their recovery.

- *“The only people who really understand me is other patients/Peers.”*

8. Time devoted is invaluable

8.1 People said that dedicated time really helps. They said that a real positive of the rehabilitation services is that, there is time devoted to caring for them and that this was really important in helping them to recover and for making them feel worthy.

8.2 People suggested spending time getting to know the service user is more beneficial in helping the individual to recover in the long-term. Devoted time shows that staff truly care about the service users’ individual needs. The following are comments about what works well:

- *“AOT helped me get out. They spend longer with you than other services. See them more frequently. Feel much more supported that way.”*
- *“It’s a specialist service - they understand the service-users; they take time to get to know you. I can talk to the team about anything.”*
- *“Staff talk respectfully to individuals and really take time to get to know people.”*
- *“Staff know individuals very well and are committed to providing support and managing wellbeing”*
- *“Having time spent on an individual to boost their confidence/self-esteem is invaluable. Rushing people into so called mental wellbeing doesn’t work.”*

9. Safe Environments

9.1 People felt that it was important to have a safe environment. People said that they felt safe using the services, where they get support from peers and staff whenever they need it.

9.2 People said that the places of residence are free from judgement and there is a real sense of staff wanting to help promote positivity and recovery.

9.3 People suggested that kindness and compassion helps them to feel safe and supported.

9.4 The following are comments from people about what is working well and what is working less well along with suggestions of improvement:

- *“Place of safety and containment”*
- *“It has been a protective bubble”*

- *“Mental health issues don’t stop at the weekend”*
- *“Having weekend AOT so I can see somebody.”*

- *“Service users would like a 7-day AOT service”*

10. Listening and understanding

10.1 There were other thoughts and views about how important listening and understanding are and some people said that they had experienced negative attitudes.

10.2 Service users spoke about how important it is for their needs and feelings to be listened to by staff members and their peers. Being able to share their problems is fundamental to building relationships and aids their recovery. This is especially important for those who need longer-term treatment. People want to be listened to and generally need more time to recover.

10.3 Even though many service users felt the staff are friendly, a couple of service users felt that staff can be too negative and harsh. They also said that communication can sometimes be poor especially in relation to leave arrangements and medication. The following comments say how things are not working so well.

- *“Doctors don't listen to me. No one talks to me about leaving here.”*
- *“doctors are over cautious, leave can be hard to get as staff don’t trust me”*
- *“A staff member was rude to me. ... Some staff are really harsh.”*
- *“Always telling me what to do. Staff can sometimes be negative and restrictive*
- *Psychology made me pressured and judged.”*

10.4 People suggested that things could be improved and the following are examples about how things could work differently.

- *“Staff to listen to me more about where I want to move to.”*
- *“More talking therapies - counselling services. Stronger advertising campaigns to reach people about MH education.”*

11. Individualised Care

11.1 People had views about individualised care. Service users emphasised how they would like more contact with services on a 1:1 basis. They said how positive AOT

had been in many cases and they felt that they would like more of this service and specifically to support them on an individual basis.

11.2 There were comments about links to the community when people leave the units. People had concerns about the lack of psychology and the over use of medication. Some people also noted that there was a lack of physical healthcare if a person is homeless.

11.3 People said that these things were not working well

- *“Given phone numbers when left unit but felt too afraid to call”*
- *“Don’t normally mix with people, I get told off for not mixing with people here”*
- *“More support when I left”*
- *“Treat humans individually.”*
- *“Rushed into leaving the service/recovery”*

11.4 And suggested these for improving services:

- *“Learning life skills, one to one and group support and social exposure work”*
- *“more personal centred care and 1-1 time.”*
- *“1 to 1 support work when at home.”*

12. Recovery and Future Focussed

12.1 Service users said that recovery should be at the forefront of their whole experience in the service, and that focus on moving forward. They said that rehab should concentrate on the future and leaving inpatient rehab, rather than focus on staying in rehab. People said that this would give individuals a sense of hope that they will get better.

12.2 Multiple service users felt the staff members give them support and encouragement to gain independence, learn skills and to go out in to the community. And that confidence has been built.

12.3 Feedback was given that some people who are ready and able to leave the unit are held back due to lack of suitable housing and they would like more support once leaving units. The following are quotes about what works and what does not and how things can be improved.

- *“Staff are helping me to move on - talking to me about staying motivated.”*
- *“It has helped me look in depth at what will help me, and given me time to look at myself”*
- *“Lots of interest in recovery skills and managing stress and anxiety”*
- *“They (AOT) encourage me to go out – wouldn’t go out if it wasn’t for them.”*

- *“Staff encouragement. Supported with future. Like art and craft groups. The groups that get me out in the community”*

- *“Being in hospital for a long time doesn’t help”*
- *“Doesn’t work in rehabilitating people back to living meaningful lives”*
- *“Feel like I’m just here waiting when I am ready to leave”*

- *“To come from a much more recovery focused stand point”*
- *“Focus on discharge from day 1”*
- *“More community team work when out”*

Themes from NHS Staff

13. Community reintegration

13.1 Staff members spoke about how essential it is to provide service users with the tools needed to be able to get back to living independently in the community once leaving inpatient rehab care. Building relationships with community services is an integral part of the recovery process and being able to get back to ‘normal’ living including more access to volunteering/working when reintegrating into the community.

Comments include:

- *“Recovery hubs/houses, integration in community, less focus on containment and more focus on independent living”*
- *“Funding into supported living with more focus of living a life in the community”*
- *“Involve in community programmes that helps towards confidence progress.”*
- *“Better community support for service users as many declined cares to history (aggression/drugs) so can’t get housing.”*

14. Independence

14.1 People said that they wanted to move away from an ‘institutionalised’ way of living to being independent and this is something that needs to be addressed seriously. Whilst it is good to help service users with daily activities e.g. shopping, going for coffee, more focus needs to be on ways to help individuals gain these skills individually, giving them the confidence and abilities to pursue this more. Some of the views about this are expressed below.

- *“encouraged to be more independent to adjust to life outside i.e. cook for themselves”*
- *“Staff encourage and assist patients to engage in activities they may continue after moving on”*

- *“To come from a much more recovery focused stand point - to teach people much more everyday living skills.”*
- *“getting support with carrying out healthy lifestyle, improve physical wellbeing, learn to budget, improve social interaction, optimise medication with regular reviews.”*

15. Care for the most vulnerable/ill patients

- 15.1 Staff said that the services for those who are most in need and most unwell are essential in helping and providing the best care possible.
- 15.2 The staff were praised for being helpful to individuals who are the most unwell and suggested that more focus should be directed at keeping these facilities running because individuals depend on these services to live.

- *“Having a service that deals with some of Dorset's most vulnerable and poorly patients with no judgement just with kindness and compassion - with the aim of giving them a decent life.”*
- *“Improve access to services for people with long term/severe and enduring mental illness.”*
- *“Ensure that rehab services and the assertive outreach teams continue to provide services for some of Dorset’s very poorly patients.”*
- *“Service managed challenging group balancing risk and recovery.”*

16 Close links/relationships

- 16.1 Staff spoke about how different services have close and well-established links with family members/carers and other community resources. They said that the whole extended team of people involved in the individual’s care works well together.
- 16.2 People said that more work needs to be done to continue this teamwork and strengthen these links especially for more vulnerable groups that need more support.
- 16.3 Staff said that in absence of an AOT in an area the CMHT will cover.
- 16.4 They also highlighted the need for closer relationships with inpatient and addiction services. Comments related to this are seen below.

- *“Good links homeless team – come to team meeting. CMHT cover AOT clients - mixed into caseload and manage AOT approach in absence of a team.”*
- *“There has been good links with assertive outreach teams to help with the transition from inpatient rehab service to independent living in the community.”*

- *“A multi-disciplinary team of dedicated staff to support increases insight, learn and develop life skills.”*

17. Staffing issues such as resources and better use of services

- 17.1 Staff expressed concerns about not having enough staff or staff being under-resourced to be able to cope with the demand of the service users and help people in the most effective possible way. For example, some services e.g. AOT have too many long-term cases which limits their capacity to be able to take on new clients.
- 17.2 There needs to be better communication and integration with other services to work better as a whole term, to take the pressure off some areas, and to help other areas where the patient’s needs may not be met as well as they could be.
- 17.3 More family therapy and more psychological therapy needs to be available.

- *“No structure. No feedback re input to SU. Too many cross over services.”*

- *“Have clear timescales if AOT approach is not working should not keep on caseloads for years - what’s the point”*
- *“AOT may wish to look at their caseload and see those long-standing clients that could be transferred back to CMHT”*
- *“The service is much needed but has to be available to new referrals - perhaps having a time period of 2 years to see if this method of working increases engagement in treatment plans and quality of living for those clients.”*
- *“Referrals take too long to be accepted - they have very limited capacity despite having small caseloads. Keep people for too long - should have clear exit strategy to free up capacity”*
- *“Accessing services difficult as so under-staffed.”*
- *“More admin for AOT”*
- *“More medics”*
- *“Skill mix is not correct - No medic, psychologist or AMHP. These key professions have a role with this client group who often then fail to be able to access medication, trauma focused therapy and co-coordinating MHA assessments in the current climate if difficult and often need to be called multiple times before someone who is homeless is hospitalised. Also, these key professionals help support the team in formulation, reflection and risk management. The team are often dealing with high risk unknown clients and there is no oversight by a medic”*
- *“Specialised worker with skills working with Brain Injury. Estimated 45-55% of homeless have a BI yet there is no service. “*
- *“Creation of an Assertive Contact Team that works with homeless, migrants, gypsy/travellers and underserved communities”*

18. Long term rehabilitation

- 18.1 Staff expressed concerns that some individuals require much longer care than others to facilitate proper recovery to prevent relapse.
- 18.2 There should be more facilities and better-care plans in place to support those that need longer periods of rehab especially for more complex and ongoing issues that cannot be resolved quickly – it takes time for people to recover fully.
- 18.3 It was also noted that staff are sometimes too quick to remove privileges from service users.

- *“Too quick to remove privileges e.g. leave when patients make mistakes.”*
- *“The rehabilitation process can be lengthy and does not always focus on promoting the skills of patients for independent living.”*
- *“Many AOT clients have remained under the team for years with little or no movement. This may have contributed to a loss of independence and autonomy rather than promoted it. The same could be said of inpatient rehab where some patients have been in rehab for many years with no real movement onwards.”*
- *“It can be restrictive and there is always the potential for people to become institutionalised, however for a few people this service is a necessity and has proved invaluable.”*
- *“the waiting times for rehab beds particularly for men is too long”*
- *“Institutionalised care, not recovery focused, poor environment to enable sufficient recovery and care”*

- *“Provide community rehab service to provide long term support. Increase availability of supported housing and care packages.”*
- *“Environment of some inpatient units not conducive to rehab - restricted rehab opportunities. More supported accommodation. More long-term treatment ward.”*

19. Peer Support

- 19.1 Staff felt that peer support in rehabilitation is important in recovery.

- *““Get peer specialists to work on the wards to help with drug and alcohol”*
- *“Having a place for people with complex needs to receive treatment without threat of pre-emptive discharge. Peer support.”*

20. Homeless Service

- 20.1 It was noted that there is a lack of psychiatric help and intervention for homeless people and that mental health act assessments for people sleeping rough are difficult to coordinate.

- *“Mental health act assessments for rough sleepers are not an effective process.”*

- *“homeless practitioner dedicated to support rough sleepers & another MH practitioner to support hostels and housing team. Staff to support their clients as homeless to the council”*
- *“Increase hours of mental health nursing time for Homelessness. Dedicated consultant psychiatric time for Homelessness.”*

20.2 Homeless Health Service data

20.3 The attendance at the view seeking events by homeless clients was inconsistent but there was other recent view seeking done asking the same question with this population of clients and the comments have been included below:

What worked well?

My key workers give me good advice and support
The mental health team is good
Floating support helps, manage appointments with advocacy.
Overall, things are good
1:1 therapy works best
drop in centres and aftercare groups
Every health worker I saw
Having BH1 project to fall back on for every need, support to get back on my feet and get a job
Having daily activities to do during the day
having people who understand your needs who offer correct support
I don't get any support
I receive adequate support for all my health needs
Medication helps me
NHS 111 is helpful. Dorset Mind news leaflet
People that respect me get the most out of me
Practical/emotional help
Talking therapy
Rough sleepers team
Unsure
Total

What could be improved:

A centre where all health professionals are based
Accommodation provided for people who are homeless
Better communication between GP and Hospital. Recording of records
Better intervention service
Health service staff to come onto the streets to see more people
I need a dentist
I need talking therapy
I was misdiagnosed with schizophrenia when I didn't agree with.
Inconvenience of where Drs are for people, people should be able to register wherever they are
More health services and staff available
More support in B&B, more health professionals visiting.
More workshops at my hostel to tackle depression and anxiety
People shouldn't be discharged to the street from hospital, it is not nice coming back out after being indoors, warm and had food
Timely access to health services
Waiting times for appointments
Nurses to check peoples physical health & check wounds & talk about medication
Alcohol and Mental Health services should merge into one
Total

Other comments

Happy with support from housing provider. They helped with anything I need help with and been very supportive and they guided me into the right direction I've needed help with
I have had incidents where medical records have been lost or even not recorded for attempted suicide (very serious).
I think there should be more health support for homeless people. It would be helpful to have a set place where you can go for health workers
I would like to have my own home
more normal places to see people, café type set up and more time so staff can take the time to listen to silly stuff
More outreach from housing services, food banks and rough sleepers team to outreach day and night
Should be more mental health services and a better transition into accommodation
System is crap, resources are wasted on people who I believe do not always need help. More help earlier on in life and if people don't want help then services move on.
The need to feel safe not vulnerable when homeless
Transportation provided to access food and for work
Transportation to get to and from appointments

21. Individualised Care

21.1 Staff were praised for individualised care. Staff said that service users get choices and that the care is person centred.

- *“Collaborative care provided by staff positive risk taking”*
- *“Glendinning has been a creative environment which has improved the quality of life of a patient whom I was allocated cco. It is an upbeat forward-thinking environment which benefits the service users. Their recent experience of two clients being moved to rehab due to bed pressures which has resulted in a much quicker effective route into rehab”*

- *“A separate expert system for those who have severe psychotic conditions and are show to recover is extremely valuable as they need prolonged specialist interest”*
- *“Having a smaller building and team like Nightingale Court, that offers more personal centred care and 1:1 time”*
- *“Regular support tailored to the needs of the individual”*
- *“Help with language needs”*

22. Encouragement and motivation to change

22.1 Staff felt that although it was important to provide the right care and support for the patient’s overall recovery, it was also vital to provide patients with the tools needed to help themselves to get better.

22.2 Staff said patients need to have self-motivation and encouragement from their peers to perform daily activities for example, to make the changes necessary to leave the service and get back into independent living and in the community.

- *“Helping patients to help themselves. Exercise, discussion, monitoring, observation, info, action and encouragement.”*
- *“Staff struggle to motivate residents at times and this can lead to frustration. More talk about recovery skills is missing.”*
- *“More recovery-based conversations and skills groups to engage individuals in thinking about self-management and moving on”*
- *“Focus on people’s lives, their futures and their capacity for change”*

23. Better discharge planning

23.1 Multiple staff members wrote that there is a need for clearer plans at discharge as well as more information about the number and type of services that are available to individuals once they leave a unit.

- *“Care plans that include discharge goals.”*

- *“Continued support for people who have been inpatients when they leave hospital – this will include more support for getting involved with community activities, paying bills and budgeting, planning GP, OPA etc., house hold tasks and volunteer/employment assistance”*

24. Communication between services

- 24.1 Many staff members mentioned the lack of communication between different services. This relates to communication between different in-patient services as well as communication between in-patient services and community services.

- *“The communication links between the Assertive Outreach Team and CMHTs should be strengthened and there should be greater rate of transfer between the services.”*

25. Activities

- 25.1 Some staff mentioned activities as an aspect of support that works well. They mentioned activities that centre on learning skills (cooking, shopping) alongside activities such as art, pottery and music. Multiple service users also mentioned activities such as arts and crafts as a positive thing.

- 25.2 Staff highlighted the importance of physical activity for this client group.

- *“Activities are provided for inpatients”*
- *“Rehab services at Nightingale House are working well. Patients engage in cookery, planning and shopping, art and pottery, gym work, music, relaxation and mindfulness, walks and community trips. It may take a short while to encourage patients to engage with the groups but once a programme is established with individuals it proves to be a success in most cases. Staff encourage and assist patients to engage in activities that they may continue after moving on.”*

- *“Lack of activities - meaningful activities for people who are unable to 'move on' and require long term support.”*

- *“Physical activities which are essential. To keep fit in the wards.”*

26. Safe environments

- 26.1 Staff highlighted that Rehab hospitals can be a restrictive environment and that people can be there too long.

- 26.2 Physical space at both Nightingale house and court are not suitable. Staff feel there should be single rooms.

- 26.3 People with history of Personality Disorder and or self-harm aren't accepted in the unit.
- 26.4 Location of hospitals were noted as positive as they have nice surroundings and are generally close to amenities also people felt that they need to be in units close to where they live.
- 26.5 Staff noted that there is no safe environment for homeless clients. A central base for Bournemouth, Poole Weymouth for multiple agencies to provide adequate services for Homeless would be beneficial.
- 26.7 Finally in this section, the addition of low secure beds in Dorset would be viewed positively.

- *“Residents feel safe here.” “The location of mental rehab hospital is in a building with pleasant peaceful grounds.”*

- *“Sharing bedrooms does not promote dignity and can hamper that person’s recovery”*
- *“People who cannot go to St Anne’s and there are no beds come to us and it is not a suitable environment”*
- *“Keep people for too long”*
- *“Building not fit for purpose”*
- *“Not conducive to a recovery-based environment”*

- *“Single rooms would aid recovery”*
- *“Sex segregation would help”*
- *“Patients with a history of PD or self-harm are not accepted in the unit, but would benefit from a short stay in rehab”*
- *“A safe place for people that cannot get accommodation”*
- *“Safe environment with 24-hour care, able to promote and actively increase community exposure”*
- *“low stress environments for complex individuals who have had multiple placements.”*
- *“they should be a low risk light and airy unlocked facility”*
- *“Provision of inpatient rehabilitation across East and West Dorset. It is important that people are admitted to hospital close to where they will be discharged facilitating social inclusion. Provision of inpatient rehabilitation across East and West Dorset. It is important that people are admitted to hospital close to where they will be discharged facilitating social inclusion”*

Themes from 3rd Sector staff or other agencies

27. Communication

27.1 Third sector staff highlighted that communication can be good but there is room for improvement e.g. link meetings between agencies.

• *“Committed Staff, and communication between rehab services and 3rd sector.”*

• *“Not sharing information between agencies and NHS staff”*

• *“Communication could improve between agencies to stop people losing their accommodation”*
• *“A link person to help a person through recovery from unit to community is lacking”*

28 Activities

28.1 Third sector staff view they have different activities on offer at the hospitals but there could be more offered i.e. cooking

• *“Food could be improved - more cooking could be done on site. “*
• *“Engaging with patients in useful occupations e.g. cooking a meal, shopping for meals. Supporting them to placements in the community that are suitable for their wellbeing. “*

29. Staff

29.1 Third sector staff noted that staff can spend too much time in the office and could spend more time with individuals. There should be more “live in staff” in hostels

• *“Staff spend too much time in the office”*

• *“More staff and a mental health worker working in hostels”*

30. Rehabilitation, recovery and discharge

30.1 A more recovery-based approach would be beneficial.

30.2 It was noted by 3rd sector staff that length of stay and discharge times are inconsistent and it seems that some service users are either discharged too soon or stay too long in the unit.

- *“Staff should have more focus on personal recovery strengths and use less negative language”*
- *“Putting too much pressure on people too soon.”*
- *“It appears some patients are in there for a long time”*

- *“More recovery focused work”*
- *“Focus on people’s lives, their futures and their capacity for change”*
- *“Recognition that it not always possible to 'fast track' rehabilitation and recognise that some individuals will reach maximum potential in a 24-hour service.”*

31. Accessibility

31.1 Accessibility to rehab staff could be Improved

- *“Accessibility - Its ok having talented/committed and resourced staff but you need to be able to access them.”*

32. Care pathways

- *“There are unclear rehabilitation pathways associated with the majority of patients I have encountered”*

33. Training and Framework Knowledge

33.1 Rehab staff can be lacking in knowledge of frameworks such as S117. Training that is offered by 3rd sector to staff is not always prioritised or taken up,

- *“Staff have limited to no knowledge around important functions such as S117 framework.”*
- *“Nursing staff must be made aware of the eligibility framework of S117 funding arrangements, and the practicalities associated with this. Far too often I have experienced staff promising packages of care to patients, prior to discharge, where there is no evidence of eligibility”*
- *“Training when offered is not taken up by NHS staff”*

Themes from family members and carers

34. Care and compassion

34.1 Family and carers described how beneficial it was for the staff that staff are compassionate and caring towards the patients. They said this really makes a difference to helping and supporting them, by showing that they truly care about what they do. It also shows that facilitating patient’s recovery was the focus of everything they do. Carers said the support is invaluable, not only to service users

but also towards the families and carers and this helps to build trust and strong relationships.

- *“Form good relationship with AOT as a Carer. They are very caring for my son. They are supportive.”*
- *“The relationship with son's support worker really close and supportive - understand my needs as a carer and my son.”*
- *“Support Worker accepted son and took time to get to know him.”*
- *“The compassionate care that is given to my son in Nightingale by members of staff and the doctors.”*
- *“Staff make family feel welcome”*
- *“Staff can't be faulted, caring, encouraging, support to son seems to be making progress”*

35. Focus on independent living

- 35.1 Family and carers said that it is important for staff to be able to put care plans in place, motivate and assist patients to perform daily tasks independently. Helping patients with these skills with the end view of being discharged into the community is integral part of care that gives patients the hope, skills and confidence they will need to manage independently once they leave the services.
- 35.2 It was noted that there is a lack of privacy for people who are inpatients.
- 35.3 Many service users and family members felt the staff are very helpful in supporting service users in practical matters e.g. finding a place to live or buying a bus pass.
- 35.4 Some family members wrote that there is a need for more activity as patients do not have enough to do to fill their time and are allowed to sleep all day. Carers and families suggested that there should be more activities especially at the weekends with more encouragement to go out. Some people suggested that the activities need to be personalised activities.

- *“Rehabilitation was supported to help my son become more independent. To help with his diet, cooking and shopping and taking him out on regular trips. This doesn't happen very often due to few staff.”*
- *“Proactive with helping my son get a bus pass”*
- *“AOT very good support for my son. Helped him get his own flat and transition worker really helped.”*

- *“Activities offered for my son were not tailored to his interests. Staff lacked time to go out with people and my son wasn't encouraged to go out and was like a zombie.”*
- *“The lack of structure in getting patients up in a morning and having no routine. Allowing patients to stay in bed all day not doing any programs. Rehab should be the next step to moving on in life and it should not be treated like a hotel.”*

- *“Motivating and giving more encouragement to maintain activities. My son gives up too easily – can ‘reward’ be considered?”*
- *“Time to look for job and get creativity which lost in their acute mental health disorder. Involve in community programmes that helps to confidence progress.”*

36. Safe environment

36.1 Some families and carers highlighted that the rehab units are not close enough to family

- *“It is an old cold building and very little happening at the weekends. It is based near Bournemouth with no connection to local/home community in Bridport to facilitate integration within the community. A promise of a more local move has not materialised, and he has been hospitalised / Rehab service for almost 18 months.”*

37. Communication

37.1 It was emphasised that communication should be at the core of everything so that the right decisions are made about care practices and medication etc.

37.2 Some families/carers as well as patients said that more needs to be done to ensure that all parties fully understand and are aware of the patient’s circumstances e.g. in regard to medication, therapy, daily activities, goals for life after discharge.

37.3 Some families/carers and patients may be uncertain about what is happening, e.g. in regard to accommodation or different referrals so this needs to be made clearer for everyone through better communication.

- *“They communicate with me really well”*

- *“Couple of staff 'not on the ball'. Had to fight a couple of battles regarding communication.”*

- *“Families, groups, networks so important and in west need people from this area to have opportunity here.”*
- *“Having conversations about getting better.”*
- *“My son to get more care when he comes home.”*

38. Listening

38.1 Whilst family/carers generally praise staff for listening to their concerns and input to determine the most optimal care for patients, some people said that they sometimes feel a bit neglected. They would like to be made to feel like they are an important part of the team that is made up to support the individual and not seen as a separate support network.

38.2 People said that it is important to listen to views from family/carers as they are likely to know the patients more than the staff so may have valuable input that could strongly help towards their recovery and discharge.

- *“The relationship with son's support worker really close and supportive - understand my needs as a carer and my son”*

- *“Listened to a bit more as a carer. Give family more support.”*
- *“Carers/supporters need to be seen as core part of the team, to understand family support and relationships are a core part of recovery.”*

39. Service takes the pressure off the family

39.1 Family members felt the service takes the pressure off the family.

- *“Having son in rehab inpatient has given me a rest.”*

Themes that were consistent across all the groups

40. Long referral times

41. An area for improvement that was mentioned multiple times in all groups (staff members, service users and family members) was about long referral times. Staff felt the referral process is long and sometimes it is difficult to get a referral accepted. Service users and family members felt that it took too long to get appropriate care.

- *“It took a long time for my son to get into rehab. 6 years of failed attempts in the community.” – A family member*
- *“CMHT not interested, suicidal and had to wait a year. No community support offered.” – A service user*
- *“Referral process appears long and protracted.” – A staff member*

41. More support in the community

41.1 All groups felt there is need for more support in the community. Staff members especially mentioned the need for more support after service users have been discharged.

- *“More services based in the community to enable people to be supported in their own homes.” – A carer*

42. Caring and skilled staff

- 42.1 Across all groups (staff members, service users and family members) one of the most common comments was that staff members are dedicated, skilled and caring.

• *“Staff are a good team. Genuinely caring and supportive.”-A Service user*

43. Specific services

- 43.1 During the course of the view seeking sessions some specific services were mentioned. In compiling all the data in to the report it was considered that it is helpful to include these comments about the specific services. Please note that these comments were made by staff members unless otherwise stated.

Elsadene

“Very good service - with both primary and secondary care input. Holds unwell/vulnerable residents in community environment - where other placements have failed”

“Often facilitates earlier discharge of patients from secondary care settings. Good patient/staff rapport. Homely environment”

“Elsadene vital unit. Please, please, please do not close it and throw out highly vulnerable patients to isolation and anonymity.”

Nightingale House

“The Nightingale House team recognise that the building is not fit for purpose and that high dependency/locked rehabilitation cannot realistically be provided there. The unit is also relatively isolated and so the staff lack back up when dealing with violent situations”

“Staff encourage and assist patients to engage in activities that they may continue after moving on.”

“Patients move on to either independent or supported accommodation with the support of the whole team”

“need to be more dynamic and offer more individualised care to promote recovery.”

Nightingale Court

“It is helpful having a smaller building and team like at nightingale court. Nightingale Court seems to offer more person centred care and 1-1 time.”

Homeless Health Service

"The work I have observed by the homeless health services both directly and in liaison with other agencies is vital for the wellbeing of this vulnerable group."

"I have no doubt that without their essential work the population they serve would suffer and other agencies trying to compensate would do an inferior job, and be costlier and time consuming"

"Homeless Health services are proactive and have excellent skills engaging the client group."

"community based, where the people are. Drop in based so not set appointments making it easier to access for clients, relaxed atmosphere, access to other services based at some of the drop ins."

Assertive Outreach Team

"The Assertive Outreach Team have been dedicated to the rehabilitation services for too long and have been working with clients who do not meet their criteria."

"The Assertive Outreach Team in Bournemouth do an excellent service but are under resourced which creates frustration for CMHT's who wish to refer to AOT."

"AOT team are absolutely superb, the way they connect with clients, non-judgemental approach."

"Some of the most challenging patients are looked after by a dedicated team who can provide out of the box care and treatment as required (AOT)."

"AOT helped me get out. They spent longer with you than other services. See them more frequently. Feel much more supported that way." – a service user

Glendenning

"Glendenning Unit has a great ethos for patient choice and responsibility for their healthcare and responsibility."

"Glendenning – service good. Get to go out. RSPCA Monday, dog walk, charity shops and food shops." – A service user

"The majority of patients who come to Glendenning have been shown to have significant cognitive deficits and have benefited from the highly structured and supported setting there to enable them to function at the optimum potential." – A staff member

- 44.1 During the view seeking session there were also a range of comments that did not fit in with the other general themes but are included because they provide insight to be considered during the review.

Other interesting comments

“Provision for rehabilitation after discharge from hospital for deaf people recovering from major psychosis is woeful. If you look at the Dorset County Council spend for social work for mental illness in adults or sensory impairment, you will find very low spending compared with other counties. So, if you are a deaf person with mental illness you will receive a very inadequate service in Dorset. In fact, no help. Remember the deaf have no voice. I imagine this is why it is possible to ignore them in the provision of rehabilitation and help from psychiatric social workers.” – A staff member and a family member

“It has been a protective bubble. In response to my diagnosis they have behaved appropriately. Has helped me to look in depth at what will help me. It has given me time to look at myself.” – A service user

“Staff help me see what direction I’m going. Help me to gain insight.” – A service user

“I get easily bored. Feel like I’m locked up all day. Sometimes I feel down because I don’t know when I am going to get out of here.” – A service user

“Homeless health service. My clients not being able to access MH support due to substance misuse and when in hostels don’t fall under homeless health and CMHT do not accept – too chaotic and big overall on services. Staff in hostels desperate for MH advice/support/training the team does not support hostels.” – A staff member

45. Conclusions and Summary

45.1 The overarching themes broadly fit in to three categories and for the purposes of summarising the report just the key words or topics from comments in the report have been used.

Staff and people focus	Service and people Focus	Environment and system
Compassion and care	Community reintegration	Safe environment
Team-work	Independence	Expand on current facilities
Better communication	Individualised care	Make better use of services to relieve pressure in system
Devoted quality time	Focus on future	Long waiting times to get into rehab
Support for most vulnerable /ill	Activities	
Listening	Life skills that promote independence and look to the future.	
Psychologist support	Workshops with peers	
	Focus on life outside of the inpatient service	
	More community support	

45.2 Throughout the report and in reference to all the services there are constant references to staff who are perceived to be caring, kind, compassionate and these qualities are really important to people who use services and their families and carers.

45.3 There are references throughout to the need for a focus on moving on from inpatient services, recovery, independence and having life skills that enable people to live as well and as independently as possible. Staff suggested that their focus needs to change from containment to independence.

45.4 In quite a few areas peer support was mentioned as a valuable on wards and in the AOT and people using services said that peers are the people who understand them.

45.5 Throughout the report were comments about life beyond the inpatient settings and the need for staff and patients to work towards as independent a life as possible and in this context there was also a focus on having the right support in the community.

An assertive contact team was mentioned and that raises the question about whether such a team could support the whole range of service users who have a complex range of needs in the community to enable them to live as well and as independently as possible.

- 46.5 In staff comments there was an acknowledgement that the current estate is not right and that to deliver the service they want to deliver estate is important.

47. Conclusion

- 47.1 Overall there were positive views about staff and the care and support they provide. There was also an acknowledgement that resources are tight and that this impact on the type and prevalence of work delivered especially in relation to activities and workshops and limits their ability to focus on future for patients.
- 47.2 The focus on independence and life outside of the units is limited by resources on the units and outside of the units for example a lack of the right type of supported living and so work will need to be done to rebalance that.
- 47.3 The current estate is crucial to delivering the right type of inpatient provision and this was acknowledged by people and this enables conversations in the review to look at what is needed and how much can be redistributed to enable the community aspects of the service to be developed in the way people hope.

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Date of Meeting: 26 June 2019

Lead Member: Cllr Jill Haynes – Chair, Dorset Health Scrutiny Committee

Lead Officer: Mathew Kendall, Executive Director of People – Adults

Executive Summary:

The briefings provided here are primarily for information or note, but should members have questions about the content a contact point for the originator will be available, or questions can be raised with Ann Harris (ann.harris@dorsetcouncil.gov.uk) or Denise Hunt (denise.hunt@dorsetcouncil.gov.uk) prior to the meeting on 26 June.

The following information briefings have been prepared:

1. Freestyle Libre device commissioning arrangements

On 7 March 2019 NHS Dorset CCG provided a report to Dorset Health Scrutiny Committee in response to concerns that had been raised regarding the availability of Freestyle Libre blood glucose monitoring devices for individuals with diabetes living in Dorset.

This briefing provides an update on the current level of availability of the monitoring device, following guidance issued by NHS England.

2. Dorset Suicide Prevention Strategy

A letter was sent to Chairs of Health Scrutiny Committees by Dr Sarah Wollaston, MP, following the conclusion of the House of Commons Health Committee inquiry into suicide prevention and the publication of a final report on 16 March 2017. The letter urged Health Scrutiny Committees to have a role in scrutinising the implementation of local suicide prevention plans.

On 29 November 2018 Dorset Health Scrutiny Committee received a presentation and report regarding Dorset's Suicide Prevention Strategy. This briefing provides an update regarding the progress in implementing the local Strategy.

3. Planned changes to the Dorset Diabetic Eye Screening Programme (Dorset DESP)

The purpose of this briefing report is to inform members of the Dorset Health Scrutiny Committee of the future plans of the Dorset Diabetic Eye Screening Programme (DESP).

The aim of the diabetic eye screening is early detection and treatment of diabetic retinopathy. All people with diabetes (types 1 or 2) are at risk of developing sight-threatening retinopathy and annual screening is a key component of effective healthcare for people with diabetes aged 12 and over.

In April 2017, Health Intelligence (HI) became the new provider for the Dorset DESP. This briefing outlines the current service and sets out plans to provide alternative screening venues in Wimborne and Weymouth.

4. Planned relocation of Moorfields Eye Hospital

NHS Camden CCG and NHS England Specialised Commissioning are leading a public consultation on a proposed new centre for Moorfields Eye Hospital in London. This briefing paper provides details of the proposals and invites the Dorset Health Scrutiny Committee to respond to the consultation.

5. Quality Accounts

This briefing provides a copy of the commentary for annual Quality Accounts which has been provided to the three NHS Trusts with which Dorset Health Scrutiny Committee has the most contact: Dorset County Hospital NHS Foundation Trust; Dorset HealthCare University NHS Foundation Trust; and South Western Ambulance Service NHS Foundation Trust.

NHS Provider Trusts have a statutory duty to provide an annual Quality Account to the Secretary of State for Health and Social Care every year by the end of June. It is a requirement that the Account must be shared with local Health Overview and Scrutiny Committees and they must be given the opportunity to comment.

Equalities Impact Assessment:

N/A

Budget:

N/A

Risk Assessment:

Having considered the risks associated with this decision, the level of risk has been identified as:
Current Risk: LOW
Residual Risk: LOW

Other Implications:

None.

Recommendation:

That Members note the content of the briefing reports and consider whether they wish to scrutinise the matters reported on in more detail at a future meeting.

Reason for Recommendation:

The matters reported on here are of sufficient importance that Members of the Health Scrutiny Committee should be aware of them.

In addition, in the case of the reports regarding the Dorset Diabetic Eye Screening Programme and the relocation of Moorfields Eye Hospital, the providers are legally required to ensure that their proposals have been shared with all stakeholders who may be affected.

Appendices:

- 1 Freestyle Libre device commissioning arrangements – Update briefing on behalf of NHS Dorset Clinical Commissioning Group
- 2 Dorset Suicide Prevention Strategy – Update briefing on progress by NHS Dorset Clinical Commissioning Group
- 3 Report from Dorset Diabetic Eye Screening Programme (Dorset DESP)
- 4 Report from Camden CCG re Planned relocation of Moorfields Eye Hospital, London
- 5 Quality Accounts – Letters on behalf of Dorset Health Scrutiny Committee to local NHS Trusts

Background Papers:

[Report to Dorset Health Scrutiny Committee](#), 7 March 2019 re Freestyle Libre blood glucose monitoring device for Diabetes (see Item 7)

[Report to Dorset Health Scrutiny Committee](#), 29 November 2018 re Dorset Suicide Prevention Strategy (see Item 53)

Officer Contact

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Freestyle Libre device commissioning arrangements – Update briefing on behalf of NHS Dorset Clinical Commissioning Group

1. BACKGROUND

NHS Dorset CCG has previously reported to the Dorset HOSC on the availability of the freestyle Libre monitoring device in Dorset. The purpose of this paper is to provide an update on that position.

2. OVERVIEW

In April 2019 the CCG issued an updated commissioning statement and formulary position for the Freestyle Libre diabetes testing device. This states that it will be made available to type one diabetes patients as set out in NHS England guidance. The full statement can be found here: <https://www.dorsetccg.nhs.uk/Downloads/aboutus/medicines-management/Other%20Guidelines/Freestyle%20Libre%20commissioning%20statement%20419%20March%202019.pdf?UNLID=595029511201952295739>

3. CURRENT POSITION

At a recent meeting of the Diabetes Working Group, a sub-group of the Dorset Medicines Advisory Group, representatives of the specialists for Diabetes in the three acute trusts in Dorset confirmed the following:

- They are supplying the initiation FreeStyle Libre pack to patients with Type 1 diabetes who meet the NHS England criteria.
- All patients are offered and signposted to education before starting the device to maximise the chance that it will be effective in meeting their aims.
- In order to align with the NHS England funding mechanism for this year, GPs are then asked to prescribe the sensors for 6 months until the patient's progress is reviewed by the diabetes specialist team.
- At this review the specialists will assess use of the technology and the added benefit that it has had before making a long term decision on the provision of the technology.

This position is expected to be reviewed in April 2020.

4. CONCLUSION AND RECOMMENDATION

Dorset CCG position on the use of this product is in line with national guidance.

Katherine Gough
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Dorset Suicide Prevention Plan – Update briefing on behalf of NHS Dorset Clinical Commissioning Group

1 Introduction

- 1.1 The Cross-Government national suicide prevention strategy for England was first published in 2012 which incorporated five key recommendations from the Health Select's Committee's (HSC) inquiry into suicide prevention. Since then, the strategy has been refreshed which includes the January 2017 update where an achievement target of a 10% reduction in suicides by 2020/21 was recommended.
- 1.2 In 2015 the Mental Health Crisis Care Concordat (CCC) was established and in Dorset a number of statutory organisations signed up to the CCC. The CCC had two work streams one was to implement the Mental Health (MH) Acute Care Pathway (ACP) and the other to develop and implement the Suicide Prevention Plan (SPP) for Dorset.
- 1.3 Dorset launched the SPP work in March 2018 and each organisation had to develop their own plans. In November 2018 the signed up organisations and other partners and stakeholders met to sense check the progress and agree the way forward for the Dorset wide SPP work for the next year, until December 2019.

2 National Strategy, Target and NHS Long Term Plan

- 2.1 The latest national suicide prevention strategy (2017) outlines two principle objectives; to reduce the suicide rate in the general population and provide better support for those bereaved or affected by suicide. This is to be achieved by addressing six key areas plus two further areas added more recently:
 - To reduce the risk of suicide in key high-risk groups
 - To tailor approaches to improve mental health in specific groups
 - To reduce access to the means of suicide
 - To provide better information and support to those bereaved or affected by suicide (postvention support)
 - To support the media in delivering sensitive approaches to suicide and suicidal behaviour
 - To support research, data collection and monitoring
 - To reduce rates of self-harm as a key indicator of suicide risk
 - To ensure a zero suicide ambition for mental health inpatients
- 2.2 In addition locally it has been agreed that two further areas will be added:
 - To explore digital and innovative opportunities to support reducing suicides
 - Ensuring a Dorset wide leadership approach (leadership, partnership, alliance and co-production) to suicide reduction programme

- 2.4 For noting at this point, nationally the number of suicides has reduced, however there has been a recent increase in the numbers which are thought to be related to changes in criteria for the way Coroners report.
- 2.5 The NHS long term plan has included the following particular areas under the SPP work and these are described below:
- Expanding children’s mental health for 0-25 year olds
 - Improving mental health crisis with a 24/7 new model of care
 - Specialist perinatal services to women who are in need post the birth of their baby
 - Specialist community teams to help support children and young people with autism and their families
 - Integrated models of primary and community mental health care for adults with severe mental illnesses and support individuals who self-harm
 - Post-crisis and bereavement support
 - Quality improvement programme for inpatient zero suicide ambition
- 2.6 The above are to be included in the SPP plan but will be monitored elsewhere in terms of how they are being delivered, for example the 0-25 work will come under CAMHS transformation, the inpatient zero suicided ambition will be monitored through the contract. The updates will come to the SPP Business Meetings so that the group is updated on progress.

3 Progress to date

	Key Area Aim	Actions Completed
1.	Reduce suicide in high risk groups	<p>Children and young people Schools have been awarded funding to support a health and wellbeing programme. Promotion to families and children around use of green spaces has been ongoing. Dorset Council introduced a new education psychology service, set up as part of crisis response unit to schools.</p> <p>Substance Misuse Public Health completed a review of substance misuse; actions now being developed to improve the pathway and support for service users.</p>
2.	Tailor approaches to improve MH in specific groups	<p>Staff MH First Aid Train the Trainer programme rolled out across Dorset, mainly aimed at frontline staff but training now being rolled out to wider system. Wellbeing Groups set up for staff covering mental health support. BCP, training on going for managers in mental health. The Fire Service has implemented TRIM – Trauma Risk Management, a support service for staff who are exposed to traumatic events as part of their role.</p>

		<p>Adults with LTC/mental health problems Dorset Council developing more appropriate accommodation as part of building better lives for those in need.</p> <p>Retreat was opened in Bournemouth as part of mental health acute care pathway; all staff in receipt of assist training which focusses on how to discuss suicide with people.</p> <p>Steps to well-being have been running and expanding the long term conditions pathway, specifically supporting people with chronic pain and fibromyalgia.</p> <p>Police have just gone through process of looking at personal factors, what makes people more vulnerable to crime, unsocial behaviour, looking at threat of harm to individuals and looking at resources. Mental health runs through vulnerable people. September to January talking about mental health. Incorporated into mental health first aid training. Strategy in draft format and delivery plans in draft waiting to be signed off.</p>
		<p>Contracts Public Health National contracts – inclusion of suicide prevention as a responsibility of providers.</p> <p>Dorset Council social care looking at service specifications and quality standards; self-evaluation looking at risks associated with services as part of contracts.</p>
3.	Reduce access to means	Door sensors now in Dorset HealthCare children’s unit, with plan to extend wider to adults.
4.	Postvention support	Poole Hospital Mental Health Group set up specifically for survivors of suicide to support and signpost.
8.	Zero suicide ambition for MH inpatients, which is linked to the national strategy	<p>Dual diagnosis training has been rolled out across the CMHTs and agreed further roll out shortly to inpatient staff.</p> <p>Hosting My Wellbeing Plan launch, which is new care plan in place looking at a crisis and a personal health plan. Looking at the RIO risk proforma along with this as a prediction tool to ensure staff spend less time filling in tick boxes and spending more time with person.</p> <p>Training 45 people looking at early warning signs, specifically car parks in Poole having a big impact on people.</p> <p>Working with families linking with local authorities having a more formalised plan between families and CMHT to</p>

		<p>have a link worker for every CMHT, cross working and joining up the child aspect.</p> <p>Review of our clinical environments for ligature risk and have issued ligature release equipment to our high risk wards.</p>
10.	Leadership	<p>Poole hospital set up a mental health steering group with suicide prevention as a standing item and work programme.</p> <p>Public Health Leadership – Caoimhe O’Sullivan, Public Health Consultant, identified and now chairing steering group meetings.</p>

4 Forward Planning

- 4.1 The SPP meetings will be held every 3-4 months over the year. The meetings will be split into part 1 business and part 2 partnership meetings. The business meetings will take forward the statutory organisation requirements linked to the crisis concordat, the SPP national strategy and NHS long term plan.
- 4.2 The partnership group is a wider network of partners and stakeholders that support the development and delivery of the Dorset plan whilst sharing knowledge and expertise across Dorset. Each partnership event will be themed and the themes identified by the partnership group, and by the end of the year most of the strategy areas will be covered.
- 4.3 The most recent suicide prevention event was in April 2019. The business meeting covered prevention plan updates and then addressed three key themes of the strategy; communications and media, data and hot spots. The partnership meeting focussed on people and their personal experiences with four speakers sharing their stories. This was followed by group discussions.
- 4.4 The next business meeting will focus on high risk groups, e.g. agriculture workers, and focus specifically on post suicide bereavement support. The next partnership meeting will focus on children and young people. The aim of the approach as said, is to ensure that all the agreed areas in the SPP are covered during the course of the year.
- 4.5 At the end of each year a review session will be held to confirm what has been delivered against the plan and what is to be delivered over the following year.
- 4.6 At the last meeting it was agreed that a detailed analysis of suicide activity in Dorset would be developed and this work will enable prevention work to be targeted in the right places to make a tangible difference. This will be a turning point in the progress of the SPP because there will be understanding about people who have ended their own lives including how, where and when and this will enable targeted work pan-Dorset.
- 4.7 Currently each organisation signed up to the CCC and SPP has their own plan. Over the year the intention is to bring all the individual plans into one Pan Dorset Suicide Prevention Plan. This will highlight all the progress and put the spotlight on future work that will be developed and delivered.

5. Conclusion and recommendation

- 5.1 The SPP is gradually taking shape and all involved in the work are committed to ensuring that there will be a reduction in the number of deaths by suicide across Dorset.
- 5.2 The detailed analysis of suicide activity will be completed by September 2019 and this will give focus and drive on specific locality areas. The understanding about how, where and when will give the business and partnership groups a real opportunity to target resources and focus attention based on fact rather than prediction.
- 5.3 Dorset Health Scrutiny Committee is asked to note the paper and approach to the Suicide prevention work.

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Report to be considered by the Dorset Health Scrutiny Committee: planned changes to the Dorset Diabetic Eye Screening Programme

1 Purpose

- 1.1 To advise of planned changes to the Dorset Diabetic Eye Screening Programme (Dorset DESP).

2 Summary

- 2.1 This report is to inform members of the Dorset Health Scrutiny Committee on the future plans of the Dorset DESP.

3 Classification

- 3.1 For information.

4 Background

- 4.1 The aim of the diabetic eye screening is early detection and treatment of diabetic retinopathy. All people with diabetes (types 1 or 2) are at risk of developing sight-threatening retinopathy. Annual screening for diabetic retinopathy is a key component of effective healthcare for people with diabetes aged 12 and over. Diabetic eye screening involves examining the back of the eyes and taking photographs of the retina by a specially trained screener. The photographs are then examined and graded to identify any damage to the retina. Depending on outcome people will be placed back on annual recall or referred for more specialist treatment.
- 4.2 In April 2017, Health Intelligence (HI) became the new provider for the Dorset DESP. The previous provider ran an optometrist model with limited screener/grader venues. At tender stage it was clearly communicated that Health Intelligence would continue with the sub-contracted Optometrist model in some areas, with a strategy to move to the preferred employed screener/grader model, once this model was properly established with sufficient venues in place to improve access with staff recruited and trained. The Public Health service specification (Appendix) is that diabetic eye screening can be delivered by different models and it is expected that the provider will operate a model that will maximise the informed uptake of the screening offer in a safe and cost-effective manner, and this is the benefit of the proposed screener/grader model in this report.
- 4.3 The Programme has become well established in the last 2 years and is performing well against Key Performance Indicators, with patient uptake having increased from 79.6% (Quarter 1 2017/18) to 92.8% (Quarters 1 and 2 2018/19) and a recent successful national screening quality assurance service review. Patient feedback is collated monthly using Friends and Family cards and obtains consistently good results with over 94% of patients extremely likely or likely to recommend the service during Quarters 1 and 2 2018/19. Patient comments and forums help to shape the service provision. The Programme is now ready to proceed to the preferred

employed screener/grader model, reducing some of the sub-contracted optometrist practices and extending HI's direct provision via community venues.

- 4.4 Experience over the last 18 months has shown that, in general (with some exceptions), Optometrist practices do not perform as highly for overall patient satisfaction, attendance or quality of digital photography. Optometrist practice based clinic cancellations, at short notice, are more regular than for Dorset DESPs direct community clinic provision, resulting in inconvenience to patients, the reputation of Dorset DESP which may mean patients losing confidence in the Programme and not attending, and could result in delayed screening without the close management of the patient pathway by the Programme.
- 4.5 There are currently 17 Dorset DESP community clinics and 16 optometry practices providing digital photography. This proposal will increase the Dorset DESP clinics to 18 and reduce the optometry practices to 11. However, with the increase in the Dorset DESP clinics there will also be an increase in appointment availability at these dedicated clinics.
- 4.6 There are two areas in which Dorset DESP are now looking to provide or increase community clinics: Weymouth and Wimborne, and several optometrist practices where Dorset DESP are looking to phase out use, as there is sufficient capacity at our own venues in these areas.
- 4.7 A Health Equity Audit of the service has highlighted the areas where venues need to be located to ensure an accessible service for all. The overall aim of the Health Equity Audit was to assess whether there are groups of patients within the Dorset DESP that are being treated less favourably than others through analysis of qualitative and quantitative evidence and data held by the Programme. As a result of this analysis and the inequities identified through the evidence provided, an improvement action plan was devised ensuring resources are effectively targeted towards the areas of need currently underserved.
- 4.8 Analysis of the patient data, highlighted some actual and potential inequities in uptake and exclusions, depending on where a patient lives and to which GP Practice they are registered with. This included patients in the 20 -59 age groups; those who are female and those in some ethnic groups. Inequity is particularly marked in patients with Learning Disabilities and those who live in areas within the bottom three Index of Multiple Deprivation deciles.

5 Plan

- 5.1 The plan is to provide alternative community screening venues in both the Wimborne and Weymouth areas by phasing out both of the current sub-contracted optometry practices in Wimborne, and 3 out of 4 of the Weymouth sub-contracted optometry practices. All of the new and existing community venues will be located close to where the existing sub-contracted provision is and will consider patient travelling and transport options. These will be dedicated screening clinics and there will be an increase in appointment capacity, not only giving patients more choice but also aids planning for future service provision, as the diabetic population increases by approximately 5% per year.

Wimborne

- 5.2 There are currently two Optometrist practices in Wimborne that the programme is looking to phase out. The Allendale Community Centre has been sourced as a new venue and is within the vicinity of the two practices, is 0.1 miles away and less than a five minute walk. There is capacity for evening bookings at this venue if further analysis shows this is required. The centre has been assessed and provides

excellent parking facilities, is on a public transport route and accessibility is good throughout the building. The Dorset DESP has recently spent time gathering patient feedback from those attending screening in the Wimborne area and 92% were receptive to the new venue proposal and clinics have commenced at this venue in addition to the current optometry practices.

Weymouth

- 5.3 The plan is to increase the number of clinics at the Programme's existing Weymouth venue and therefore the Programme would not require screening at all 4 Optometrist practices which are in close proximity to each other in Weymouth town centre. The programme is looking to phase out three practices, one of which has not provided any screening clinics during 2018 / 19.
- 5.4 Dorset DESP's health equity audit highlighted Dorset as a prosperous area, ranked one of the 20% least deprived counties in England. However, this masks inequalities and twelve areas are within the top 20% most deprived nationally for multiple deprivation. Nine of these are within Weymouth and Portland. The Melcombe Regis and Weymouth areas have also been described as being areas with greater deprivation and poorer health outcomes.
- 5.5 The Programme has an established venue, currently open 2 days a week but with flexibility (and agreement in place) to increase this, plus an availability to accommodate evenings and Saturday appointments if required. This venue is ideally placed between Melcombe Regis, Weymouth East and Littlemoor areas. Considering there are other areas in Weymouth highlighted in the Health Equity audit, one optometry practice in Weymouth town centre will be retained. The Programme's venue is 1.6 miles from the town centre, has parking including disabled spaces and on a public transport route.
- 5.6 The Programme would opt to keep one of sub-contracted Optometrist practices in the town centre, who provide evening and weekend screening, this practice has 3 staff members with a recognised screening qualification to ensure business continuity with cover for sickness and holiday.
- 5.7 The benefits for the patients on moving to this model will be:
- Reduction in clinic cancellations and rearranging appointments for patients
 - New venues have been assessed in conjunction with the Health Equity Audit to ensure venues are in the right area and have good accessibility for patients reducing inequalities and inequities
 - Greater numbers of patients will attend and be screened resulting in preventing of sight loss through Diabetic Retinopathy
- 5.8 The benefits for the Programme on moving to this model will be:
- Improved patient satisfaction and less complaints
 - Improved direct management and greater oversight of the quality of service delivery through direct management of the service
 - Greater resilience with an inhouse developed team of screener graders and flexibility to manage screening demands working with our own Bookings teams and venues.

6 Conclusion

6.1 The Dorset Health Scrutiny Committee is asked to note the content of this report and support the proposal which will improve and continue to deliver eye screening to the diabetic population of Dorset. There will be no impact on patient access to the service as:

1. The new venues are very close the existing venues.
2. There will be more appointments available overall in the area and greater choice. Whilst the actual location of the screening venue will change patients will still receive the same level of screening service and will not be inconvenienced through having to travel much greater distances for their screening appointment.

7 Recommendation (from DESP)

7.1 This paper is presented for information purposes. The Panel Chair is asked to support these proposals as they do not represent a material change in provision, this was covered by the tender patient consultation arrangements and the decisions surrounding that and therefore no further patient consultations are required at this time, although the Dorset DESP has actively sought patient feedback.

Author

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18 April 2019

Appendix: Public Health functions to be exercised by NHS England

Service Specification No.22 – NHS Diabetic Eye Screening Programme



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REPORT FOR DORSET HEALTH SCRUTINY COMMITTEE – Proposed move of Moorfields Eye Hospital’s City Road services

A report from NHS England Specialised Commissioning and NHS Camden Clinical Commissioning Group (CCG) on behalf of all commissioners of Moorfields’ services.

Purpose

NHS Camden CCG and NHS England Specialised Commissioning are leading a public consultation on a proposed new centre for Moorfields Eye Hospital.

This paper invites the Dorset Health Scrutiny Committee to respond to the consultation.

It provides:

- A summary of the proposal
- An update on discussions so far, and
- An outline of the consultation plan for the period 24 May to 16 September 2019.

The Health Scrutiny Committee is asked to:

- **Note this update**
- **Advise and make suggestions for further action to ensure a meaningful consultation process**
- **Provide an indication of the committee’s views on the proposal.**

For further information and consultation documentation, please refer to the consultation website www.oriel-london.org.uk where you can read or download the consultation document and other background information.

Summary of the proposal

Moorfields Eye Hospital NHS Foundation Trust and its partners, UCL Institute of Ophthalmology and Moorfields Eye Charity, are proposing to build a new centre bringing together excellent eye care, ground-breaking research and world-leading education in ophthalmology.

This centre would be a multi-million pound development on land that has become available on the site of St Pancras Hospital, just north of King’s Cross and St Pancras stations in central London.

Services would move to the new centre from the current hospital facilities at City Road in Islington, along with Moorfields’ partner in research and education, the UCL Institute of Ophthalmology. Subject to consultation and planning approvals, it is envisaged that the proposed new centre could be constructed and operational by 2026.

If the move were to go ahead, Moorfields and UCL would sell their current land on City Road and all proceeds of the sale would be reinvested in the new centre.

The proposed move from City Road to St Pancras does not include changes to Moorfields' services at its 30 other sites, although over time these will be considered as part of a wider review of the ophthalmology model of care across London.

NHS Camden CCG, on behalf of all Clinical Commissioning Groups, and NHS Specialised Commissioning, in partnership with Moorfields Eye Hospital, are consulting people between 24 May and 16 September 2019 to inform a decision that will consider whether the proposed move is:

- In the interests of the health of local and national populations
- In line with long-term plans to improve health and care
- An effective use of public money.

The outcome of this will influence a decision-making business case, which will be presented to NHS England and Improvement for assurance and, for decision-making, to the CCGs and NHS England Specialised Commissioning.

In line with scrutiny regulations, the North Central London Joint Health Overview and Scrutiny Committee is leading a joint scrutiny process for the consultation and proposed move.

Background to the proposal

Moorfields is the leading UK provider of eye health services to more than 750,000 people each year attending a network of around 30 sites across London and the south east. Moorfields' main site is located at City Road in Islington, and has a 24-hour A&E, and provides a range of routine elective care for London residents and specialised services for patients from all over the UK.

The hospital's partnership with UCL provides a world-class centre of excellence for ophthalmic research, education and training. Examples of research include gene therapies for inherited eye conditions and stem cell treatments for age-related macular degeneration, which is part of the London Project to Cure Blindness.

The case for change

A detailed pre-consultation business case (PCBC) was approved by NHS England Specialised Commissioning and the CCGs' committees in common in April 2019. The PCBC is available from the consultation website at <http://oriel-london.org.uk/pre-consultation-business-casedocuments/>.

The current facilities at Moorfields Eye Hospital on City Road date from the 1890s. There is very little space to expand and develop new services; the lay-out of the buildings affects efficiency and patient access, and the age of the estate creates difficulties for installing new technologies. Similarly, UCL's education facilities adjacent to the hospital are outdated and unsuited to modern methods of hands-on training

This ageing estate creates impractical and uncomfortable conditions for patients, staff and trainees. There is poor climate control, a lack of privacy in some areas, and challenges in terms of meeting modern standards of disability access and health and safety.

The number of people likely to suffer from common eye conditions such as cataracts, glaucoma, macular degeneration and diabetic eye disease is expected to rise rapidly over the next 15 years.

Our ageing population means greater and more complex demand for eye services as almost 80% of people aged 64 and over live with some form of sight loss.

The proposed new centre not only offers better care for future patients but would significantly improve our ability to prevent eye disease, make early diagnoses, and deliver effective new treatments for more people at home or locally in primary care, as well as in specialist hospital clinics.

It would bring together excellent eye care with world-leading research, education and training with the following benefits:

- Greater interaction between eye care, research and education – the closer clinicians, researchers and trainees work, the faster they can find new treatments and improve care.
- More space to expand and develop new services and technology to improve care, including care that could be available at home or locally, without the need for a hospital visit.
- A smoother hospital appointment process, particularly where there are several different tests involved.
- Shorter journeys between test areas and instantly shared results between departments, which would reduce waiting times and improve communications between patients and staff.
- Modern and comfortable surroundings that would provide easier access for disabled people and space for information, counselling and support.
- The independent London Clinical Senate has stated its support for the pre-consultation business case and, in discussions with patients and public leading up to the consultation, people were supportive of the proposed new centre, which would greatly improve care and the patient experience.

The preferred way forward

The main consultation document explains how Moorfields and its partners have considered various options for developing a new centre, including rebuilding and refurbishment at the City Road site.

A brand-new building is preferable as this would offer:

- The optimum size for an integrated centre.
- The potential to build with minimal disruption to current services, which would continue until the new centre was open.
- The creation of funds to invest in the proposed new centre from the eventual sale of the city road site.
- Estimated costs over the next 50 years that are lower than the costs of maintaining the current site.

The main advantage of staying at the City Road site is that people are familiar with the route to the hospital, which has relatively easy access by bus and underground, with a short walk to the hospital.

The main disadvantages of staying at the City Road site are:

- Limited space and scope for development, even with the possibility of demolishing some of the current buildings and building new ones.
- Rebuilding and even refurbishment would involve major disruption to services requiring some services to move out and then move back in again when the work is completed.

- Staying in the same place means that money would need to be spent on new buildings, but there would be no proceeds from a land sale to pay for the development.
- Our estimate of costs over the next 50 years shows that it would cost more to maintain the existing site than to build a new centre.

Options for the proposed new site

For specialised services, London is the most accessible UK location for patients and for recruiting and retaining specialists, technicians, researchers and students. There are critical benefits from close links with other major specialist centres, research and education facilities.

Of eight potential sites on the London property market that are close to public transport hubs, the proposal for consultation puts forward the view that land available at the current St Pancras Hospital site has greater potential benefits, including:

- Enough space for the size required and potential for future flexibility.
- Proximity to two of the largest main line stations in London, King's Cross and St Pancras, with Euston station also in the area.
- Proximity to other major health and research centres, such as the Francis Crick Institute, the main campus of UCL, and leading eye charities, such as Guide Dogs and the Royal National Institute of Blind People (RNIB).

Insights from patients and public so far have highlighted potential challenges in terms of the change of journey to the proposed new centre for people who have used Moorfields services for many years.

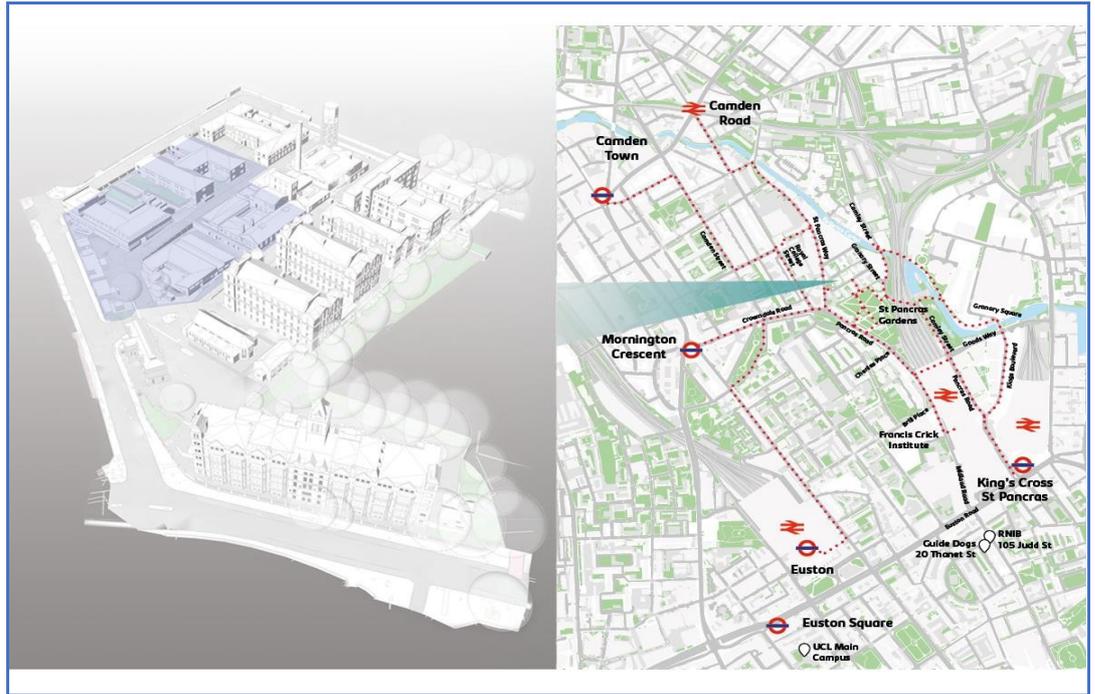
Access to the proposed new site would involve a longer route for some people via bigger and more complicated rail and underground stations than Old Street, which is the nearest underground station to Moorfields at City Road.

We recognise the need to engage widely with our patient community in respect of patient access and wayfinding to and from the proposed site at St Pancras. Moorfields will engage with patients, carers, Transport for London, Network Rail, the Local Borough of Camden and other stakeholders as it progresses designs for the new site.

There are a number of principal routes to and from the site, each of which will need to be explored further as part of an integrated design access statement, to form a key component of future planning proposals.

For more information on access and travel times to the proposed location at St Pancras, please visit <http://oriel-london.org.uk/public-consultation/travel-and-access/>.

The following illustration shows the current St Pancras Hospital site. The blue shading indicates the proposed land purchase for Moorfields. The map shows the local area with mainline rail stations, underground stations and other key establishments, such as RNIB, Guide Dogs and the Francis Crick Institute.



Alternative options.

While the current preferred option is to build a new centre at the St Pancras Hospital site, we remain open to other potential locations and are seeking suggestions as part of the consultation process.

Any new locations would be subject to the same appraisal process and all options (including any new ones) would be re-appraised after the consultation as part of the decision-making business case.

Estimated cost to the NHS

The pre-consultation business case shows that there is an affordable and robust financial plan to support the development of the proposed new centre, which would support the long-term financial position of Moorfields Eye Hospital.

The estimated capital cost for the NHS is £344 million. Funding sources include:

- The sale of the City Road site
- Funds from Moorfields Eye Hospital NHS Foundation Trust
- Moorfields Eye Charity's support for research
- Central government funding for transformation.

Public and patient involvement so far

Four phases of engagement

Public and patients have been involved in four phases of engagement since 2013. The most recent engagement phase, from December 2018 to April 2019, gathered over 1,700 responses from people via the following activities:

- Four surveys covering travel, care, patient priorities and initial views on the proposed move

- 11 drop-in events
- 18 discussion groups
- One themed workshop to inform the options appraisal
- 12 discussions with patient and public representative groups
- Seven discussions with people with protected characteristics (as outlined in the Equality Act 2010).

A comprehensive summary of these activities and feedback is published on the consultation website at <http://oriel-london.org.uk/patient-views-documents/>.

One of the outcomes of engagement was the establishment of an Oriel Advisory Group with public and patient representatives to help steer the consultation process.

The main themes of feedback

Most people who participated in discussions indicated strong support in principle for a new purpose-built centre of excellence for eye care, with the potential benefits of combining research and education with frontline eye care.

Most people in discussions highlighted the following as critical to success:

- The current level of hospital services should continue, with an expectation of improvements in both clinical care and patient experience.
- Any change should be managed with minimal disruption, smooth transition and continuity of service.
- Accessibility is a high priority, both in terms of getting to and getting around the new centre.

The following main themes highlight what matters to patients, carers and their families:

- Clinical expertise above all else, even if this means travelling further to receive the highest quality specialist care.
- A smooth clinical pathway through the whole system from getting the first appointment to follow-up care and support.
- Getting to the hospital, including in an emergency.
- Efficient and caring experience at the hospital.
- Good communications and information.
- Person-to-person support, when needed.
- Proximity to public transport hubs.
- Manageable and obstacle-free journey from transport hub to the hospital.
- Provision for access by ambulance and motor vehicles.
- Interior design to support access and navigation for people with sight loss.

Accessibility

Views varied according to where people live and their service needs. People living in areas to the north and west of London, for example, felt the proposed St Pancras Hospital site location offered better access for them. Some people in east London were concerned about a possible extended journey and costs.

Travel times were frequently considered (by people with sensory impairment and disabilities) less important than the journey from transport hubs and bus stops to the front door of the proposed new centre. Old Street tube station to Moorfields Eye Hospital on City Road is a

relatively short and simple route. For some people, King's Cross/St Pancras or Mornington Crescent to the proposed new site remain a high priority for consideration of the following:

- Large and complex stations with several exits
- Road crossings
- Cycle lanes
- Cluttered or uneven pavements
- Steep hills
- Vulnerability to street crime and harassment.

People were open to ideas to deal with accessibility concerns e.g. shuttle service for those with limited mobility, efficient drop-off and pick-up at hospital, use of navigation technology. We are holding a themed workshop during consultation to explore in more depth these wayfinding issues and potential solutions, with the aim of scoping what would eventually be an accessibility strategy and implementation plan.

Patient experience

People hold strong faith in clinical excellence at Moorfields, but patient experience in the current facilities does not always live up to same high standards.

The expectation is that the proposed move to a new centre could and should improve not just physical aspects, but the whole culture of eye care – a real opportunity to achieve world-class standards in all aspects of care for patients.

Views on improving patient experience were consistent throughout the discussion sessions. We gathered a wide range of details, but the following were common themes:

- Awareness of the needs of people with sight loss: the proposed new centre is an opportunity to design better accessibility into facilities and ensure more staff training – Moorfields should be a national exemplar in accessibility.
- Communications and person-to-person support: People have spoken about the need for flexibility and a range of communications to meet different needs and abilities. Many acknowledge the potential advantages of new technology, which could improve access for some people, but that there is a risk of excluding some minority groups for whom technology could prove a barrier. Even those who are keen supporters of new technology place a high value on personal support being available to meet the diverse needs of patients and carers, particularly children, frail older people, people with multiple disabilities and people who do not have English as their first language.
- Managing stress: A recurring theme in feedback from discussions is stress and anxiety associated with a visit to the hospital and the anticipation of receiving eye treatment. The more that can be achieved to build patient confidence, particularly for people with protected characteristics, the more we can achieve with equal access to care quality, self-care and improved clinical outcomes.

Impact on equalities

We understand from listening to people that they are apprehensive about how any change would be managed with minimal disruption, smooth transition and continuity of service. To make sure that we address these concerns we have considered how issues of equality affect service users in the proposed changes. We have undertaken an initial equality impact assessment and will continue to gather views and data during the consultation to inform this assessment.

You can find our initial equality impact assessment on the consultation website at <http://oriellondon.org.uk/equality-impact-documents/>.

The population demographic data suggest that the proposed move has a potential impact on equality for people in areas to the north east of London. We will continue to investigate this and consider the issues as part of the decision-making business case following consultation.

The consultation process

The consultation process runs from 24 May to 16 September 2019, during which we are seeking views on:

- The proposal and how people may be affected.
- What matters to patients, their carers and families, and how this could influence decisions, designs and plans.
- The wider implications of the proposed change, its impact on healthcare, social care and environmental issues.
- Alternative proposals and suggestions.

Our approach has an emphasis on active participation and not just a request for written responses to the proposals. The programme of consultation activities includes open discussion workshops, discussions with key groups and meetings on request. People can give their views through several channels, including an online feedback survey, via social media, email and post and through face-to-face discussions.

A dedicated Oriel website provides access to consultation documents and supporting materials, background information and relevant reports. Information is offered in accessible formats, including large print, audio versions, Easy Read summaries and languages on request.

For further details on how people can participate in the consultation, please visit <http://oriellondon.org.uk/get-involved/how-to-give-your-views/>.

Aims for involvement and consultation

	Evidence of achievement
Overall aim – To implement best practice involvement and consultation to influence plans in 2019, and to embed involvement for future implementation.	<ul style="list-style-type: none"> • Outcome reports • NHS England assurance • JHOSC response • Accreditation by The Consultation Institute
Five specific aims	
1. To improve our understanding of the diverse interests and perspectives of people who may be affected by the proposed move – and consider issues in proposals and decisions.	<ul style="list-style-type: none"> • Stakeholder analysis • Engagement log • Consultation documents and accessible versions
2. To expand the range of people and groups involved, including action to reach minority and protected groups.	<ul style="list-style-type: none"> • Outcome reports and influence on plans • Engagement log

	Evidence of achievement
3. To ensure sufficient information is made available during consultation for intelligent consideration and response.	<ul style="list-style-type: none"> • Background information available as well as main consultation document –to include outcomes of pre-consultation engagement
4. To improve public awareness and confidence in change.	<ul style="list-style-type: none"> • Survey results and feedback
5. To build a framework for sustainable involvement from early discussions into future planning and implementation.	<ul style="list-style-type: none"> • Established involvement mechanisms and updated strategy and action plan

Reaching our audiences

The consultation team is working with a detailed list of audiences, groups and organisations to be contacted and consulted. We are also requesting that those we contact share information with their networks and via their websites, newsletters, social media and other channels.

In summary, the main audience groups are as follows:

Main audience groups	Channels for publication and feedback
General public, local residents and all audience groups	<ul style="list-style-type: none"> • Oriel website, social media, news coverage • Cascade distribution and publicity via CCGs, NHSE Specialised Commissioning, local authorities, voluntary sector and other partners
Service users, carers and representatives	<ul style="list-style-type: none"> • Collaboration with eye charities and Healthwatch • Involvement of networks and forums e.g. Trust members, CCG patient participation groups, voluntary sector forums and social media
Minority interests and protected groups	<ul style="list-style-type: none"> • Direct contact with identified groups and tailored workshops • Information in range of formats and language versions • Collaboration with Healthwatch and voluntary sector partners
Voluntary sector and advocates	<ul style="list-style-type: none"> • Collaboration with Healthwatch and councils for voluntary services (CVS) • Direct contact with identified advocacy groups and forums

Main audience groups	Channels for publication and feedback
Local authorities, wards and neighbourhoods, partner agencies: planning, transport health and wellbeing, scrutiny	<ul style="list-style-type: none"> • Direct contact with relevant bodies e.g. planning partners, scrutiny and other committees • Collaboration with relevant neighbourhood forums and other local representatives
CCG, NHSE Specialised Commissioning and Trust staff	<ul style="list-style-type: none"> • Existing channels of internal communications e.g. intranets, briefings, development sessions • Collaboration with Clinical, Workforce and HR functions
Primary care contractors	<ul style="list-style-type: none"> • Existing forums and channels via CCGs and NHS England
MPs and government ministers	<ul style="list-style-type: none"> • Existing Trust and CCG briefing arrangements • Briefings via NHS England
Unions, Royal Colleges and professional representatives	<ul style="list-style-type: none"> • Via Trust and CCG HR forums and local representative committees • Direct contact with Royal Colleges, BMA, RCN, Unison
Press and media: local, national, trade	<ul style="list-style-type: none"> • Existing channels via Trust, CCGs, Specialised Commissioning and NHS England communications teams
Neighbouring trusts, wider geography of CCGs and other interests	<ul style="list-style-type: none"> • Direct contact using distribution channels of CCGs, NHSE Specialised Commissioning and NHS England
Partners in research and education	<ul style="list-style-type: none"> • Direct involvement of the Oriel Management Executive • Cascade to research and education staff and external networks
National regulators	<ul style="list-style-type: none"> • Direct contact and assurance process

Open workshops for deliberative discussion and feedback

Dates of discussion sessions open to all audiences are published on the Oriel website at <http://oriel-london.org.uk/get-involved/events/>

Building on what we have learned during previous engagement, the most effective discussions come from smaller groups of up to a maximum of 20 people (although we would not limit attendance at an open discussion, except for health and safety reasons). We have found the best approach is to offer sessions in association with community and representative groups and eye care charities, using venues where these groups already meet.

Deeper-dive discussions on key themes identified in engagement

In addition to general discussions, we are inviting people to participate in five themed workshops with subject matter experts. These will cover the following key themes:

- Options review and refresh
- Accessibility and wayfinding
- Patient experience
- Innovation
- Design.

Proactively arranged discussions with key groups

As part of our direct contact with representative groups of both professionals and public, we will be requesting discussion and feedback via items on the agenda of meetings. We are also offering meetings on request.

Consulting people with protected characteristics

We are writing directly to national, regional and local advocates for people with protected characteristics as identified in the Equalities Act 2010 to consult their views on issues of equality in relation to the proposed move.

We are also proactively seeking person-to-person discussions with a range of community groups of people with protected characteristics to listen to their experiences and issues that may impact on equality.

Feedback from this part of the consultation process will inform the equality impact assessment, which will be included in the decision-making business case.

Staff and clinical involvement

The consultation process outlined here is open to all, including staff and clinicians within Moorfields Eye Hospital, UCL and the commissioning organisations. It links to other workstreams to ensure more specific and continuing staff and clinical involvement which will guide and influence the design, development and implementation of proposals over the next five years and beyond.

Management of feedback

There is a single system for receiving, acknowledging and recording feedback from multiple channels. Feedback reports and notes of meetings will be available via the Oriel website. The final collation of responses will be passed to an independent organisation for analysis and evaluation at the end of consultation.

Beyond this phase of consultation

As a result of previous engagement work, we have already built relationships that provide a foundation for continuing involvement and co-production with eye charities and other patient and public representatives. This will embed strong patient and public involvement to inform our longer-term strategies for participation in design, development and implementation.

Timeline of next steps

24 May to 16 September 2019

Public consultation, led by NHS Camden CCG and NHS England Specialised Commissioning on behalf of all NHS commissioners.

September to November 2019

Draft report of the feedback from consultation and a review of the equalities impact assessment, to influence a final review of options and completion of a decision-making business case.

November 2019

Camden CCG, Moorfields and NHS England will provide an update to the North Central London joint health overview and scrutiny committee.

December 2019

Decision-making business case (DMBC) and final consultation outcome report assured by NHS England.

January 2020

DMBC reviewed by CCGs' Committees in Common and NHS England Specialised Commissioning.

January 2020

Announcement of decisions of Committees in Common and NHS England Specialised Commissioning.

Early 2020

If the DMBC is approved, Moorfields would then submit an outline business case for national approval to NHS England and Improvement to commit public funds to the development of a new centre.

By autumn 2020

Moorfields would submit a planning application to the relevant local authority. If the plan is agreed to build a new centre at the St Pancras site, this would involve a master plan for the site, in partnership with the current landowners, Camden and Islington NHS Foundation Trust. The local authority would hold a public consultation on the planning application.

Spring 2021

Moorfields would submit a full business case for national approval to commit public funds to the development of a new centre.

Spring 2022

Subject to national approval of the full business case and local authority planning approval, construction would begin.

By 2025-2026

Completion of new build. Start to move services from City Road to the new centre.

ENDS

Letter to Neal Cleaver, Deputy Director of Nursing, Dorset County Hospital regarding commentary for inclusion in their Annual Quality Account, May 2019

Dear Neal

Quality Account and Report 2018/19

On behalf of the Dorset Health Scrutiny Committee, please find attached the commentary that we would like to submit for the Dorset County Hospital NHS Foundation Trust Quality Account and Report 2018/19.

Dorset Health Scrutiny Committee commentary for Dorset County Hospital NHS Foundation Trust, May 2019:

Each year Dorset Health Scrutiny Committee appoints a Task and Finish Group of three Members who meet twice per year with representatives of Dorset County Hospital NHS Foundation Trust to review quality and performance. These meetings provide an opportunity for informal discussion and challenge, giving a helpful insight into the priorities of the Trust and the progress in achieving improvements. With respect to the Quality Account and Report 2018/19, the following matters were of particular interest:

- The continued progress made by the Trust this year with regard to reducing the number of falls resulting in severe harm or death is welcome; Members acknowledge the balance that must be struck between risk and rehabilitation.
- The on-going work to understand the Trust's position as an outlier with regard to mortality surveillance is noted. It is to be hoped that the issues around recording of diagnosis and coding can be resolved over the coming year and that assurance can be provided as to the Trust's true position.
- It is disappointing that progress in the early identification and treatment of sepsis has not been sustained, given the efforts that are clearly being made in this area of work. However, Members recognise that not all delays are significant, and that some can be attributed to recording practice.
- The development of the volunteer programme, particularly for younger people, and the planned expansion of this work, is to be congratulated. The research-based approach that is being taken and the linkages being made with communities and the CCG will no doubt derive tangible benefits for the Trust and will provide added support to patients, staff and the volunteers themselves.
- The lack of substantial progress in sending discharge summaries to GPs within 24 hours is disappointing, particularly as this was an area of concern last year. Members understand that there is on-going work to improve performance and hope to see the results of this later in 2019.
- The development of the Frailty Service and the Dementia Specialist roles will hopefully have a positive impact on the Trust's targets for dementia screening and onward referral. The Quality Account illustrates the range of initiatives that are supporting this work, and particularly highlights the importance of an educational focus.
- Improvements in the management of complaints are to be welcomed; Members hope that this can be sustained going forwards and that the commitment to an open and accountable process will provide assurance to patients and their families.

Finally, the Dorset Health Scrutiny Committee would like to congratulate the Trust on achieving a rating of 'Good' from the Care Quality Commission in late 2018, having previously been rated as 'Requires Improvement'. The continued cooperation of the Trust in providing information and actively participating at both formal and informal meetings with the Committee is much appreciated, and we look forward to the continued progress of quality and services in the coming year.

Yours sincerely,

Ann Harris

Health Partnerships Officer

On behalf of Dorset Health Scrutiny Committee

CC:

Patricia Miller, Chief Executive, Dorset County Hospital NHS Foundation Trust

Mark Addison, Chairman, Dorset County Hospital NHS Foundation Trust

Cllr Bill Pipe, Chair Dorset Health Scrutiny Committee

Mathew Kendall, Executive Director of People – Adults, Dorset Council

Nicola Lucey, Director of Nursing and Quality, Dorset County Hospital

For information: The most recent Care Quality Commission report for Dorset County Hospital can be accessed here: <https://www.cqc.org.uk/location/RBD01>

Letter to Hazel McAtackney, Head of Quality Assurance and Compliance, Dorset HealthCare University NHS Foundation Trust, regarding commentary for inclusion in their Annual Quality Account, May 2019

Dear Hazel

Quality Account and Report 2018/19

On behalf of the Dorset Health Scrutiny Committee, please find attached the commentary that we would like to submit for the Dorset HealthCare University NHS Foundation Trust Quality Account and Report 2018/19.

Dorset Health Scrutiny Committee commentary for Dorset HealthCare University NHS Foundation Trust, April 2019:

Each year Dorset Health Scrutiny Committee appoints a Task and Finish Group of three Members who meet twice per year with representatives of the Dorset HealthCare University NHS Foundation Trust to review quality and performance. These meetings provide an opportunity for informal discussion and challenge, giving a helpful insight into the work and aspirations of the Trust. With respect to the Quality Account and Report 2018/19, the following matters were of particular interest:

- The progress made by the Trust in increasing patient and family/carer involvement, including the Triangle of Care initiative, demonstrates a high level of commitment to this priority. Dorset Health Scrutiny Committee recognises the importance of this work and looks forward to the further development of feedback opportunities for children and young people accessing CAMHS over the coming year;
- The Trust's achievements with respect to patient safety are to be congratulated, particularly the work around sepsis identification. It is hoped that the training programme associated with this will continue to develop, including the work to involve care homes;
- Suicide prevention has been a topic of interest for Dorset Health Scrutiny Committee in 2018/19, so it was encouraging to note the successful actions that have been undertaken by the Trust over the last year, in addition to the future work, going forwards. In particular it is hoped that the Retreat and Community Front Rooms planned for rural Dorset will provide much needed support for individuals at times of distress or crisis, and the Committee looks forward to hearing more about these resources once they have been established;
- The Parliamentary Award given to the Dorset Armed Forces Community Health and Wellbeing Team demonstrates the excellent work that has been undertaken to support local veterans and their families. This accolade, along with the award given to the Criminal Justice Liaison and Diversion Service and the recognitions of achievement for a number of other teams and services, provides assurance to the Committee that the Trust strives to improve;
- The publication of an inspection report by the Care Quality Commission in April 2018 provided further reassurance, with the Trust's rating increasing from 'requires improvement' to 'good' overall. The Committee hopes that the areas highlighted for improvement will be actioned quickly and that the on-going recruitment of staff can benefit from the positive outcome of the inspection;
- It was disappointing to note that, whilst comparing favourably with similar Trusts, performance in a couple of key indicators (patient safety incidents and people

experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral), have shown little or no improvement up to the point at which data for 2018/19 was available. It is acknowledged that the Trust will continue to monitor these indicators and seek to improve performance.

Overall, the Dorset Health Scrutiny Committee welcomes the progress of the Trust and the continued cooperation in providing information and actively participating at both formal and informal meetings.

Yours sincerely,

Ann Harris

Health Partnerships Officer

On behalf of Dorset Health Scrutiny Committee

CC:

Eugine Yafele, Chief Executive, Dorset HealthCare University NHS Foundation Trust

Cllr Bill Pipe, Chair Dorset Health Scrutiny Committee

Mathew Kendall, Executive Director of People – Adults, Dorset Council

Cara Southgate, Deputy Director of Nursing, Therapies and Quality, Dorset HealthCare

Dawn Dawson, Director of Nursing, Therapies and Quality

For information: The most recent Care Quality Commission report for Dorset HealthCare can be accessed here:

<https://www.cqc.org.uk/provider/RDY?referrer=widget3>

Letter to Jenny Winslade, Executive Director of Nursing and Governance, South Western Ambulance Service NHS Foundation Trust, regarding commentary for inclusion in their Annual Quality Account, May 2019

Dear Jenny

Quality Account and Report 2018/19

On behalf of the Dorset Health Scrutiny Committee, please find attached the commentary that we would like to submit for the South Western Ambulance Service NHS Foundation Trust Quality Account and Report 2018/19.

Dorset Health Scrutiny Committee commentary for South Western Ambulance Service NHS Foundation Trust, May 2019:

On an annual basis, Dorset Health Scrutiny Committee appoints a Liaison Member as a point of contact with South Western Ambulance Service NHS Foundation Trust. In addition, the Trust may be invited to Committee meetings to present reports regarding any substantial changes to services or any concerns that Members may have regarding performance or quality of services. The Trust has been cooperative and helpful where requests have been made for input and it is hoped that this will continue in the coming year.

With respect to the Quality Account and Report 2018/19, the following matters were of particular interest:

- The Committee congratulates the Trust on progressing from 'Requires Improvement' to 'Good' ratings with respect to the CQC inspections of the NHS 111 service, Emergency and Urgent Care and Emergency Operations Centre. The 'Outstanding' rating for the Caring domain is particularly noteworthy.
- The developments in clinical triage and risk stratification demonstrate a clear focus on best use of resources. It is hoped that the evaluation of the Enhanced Hear and Treat process will provide evidence of improved outcomes and high levels of patient satisfaction over the next year.
- The work to improve the experiences of mental health patients is welcomed, particularly the engagement with stakeholders and the support for more appropriate conveyance. The Mental Health Nurse Specialist role should also provide a valuable additional resource in this sensitive area of service provision.
- The Committee recognises the importance of the quality priorities agreed for 2019/20, with the focus on mortality reviews, always events and cardiac arrest. In particular, the aim to 'improve survival to discharge following out of hospital cardiac arrest' resonates with the largely rural localities across Dorset. The performance against this priority will be awaited with interest.
- The Trust is to be congratulated on its continued achievements in relation to non-conveyance of patients to hospital and appropriate admissions when they are conveyed. The extensive use of staff feedback to support the approach being taken is acknowledged.
- With regard to complaints and compliments, the Committee notes that there has been a reduction in the former and an increase in the latter, which is to be welcomed. It was also encouraging to see that learning from incidents and complaints is regularly reviewed and disseminated to staff. The identification of delays due to demand being the principal theme arising from incidents and complaints is noted, and, given that this

has been a specific concern for Dorset Members, the Committee would urge that this matter be further addressed in the coming year.

- With regard to performance indicators, it is encouraging to see that ambulance response times have generally improved over the last year, particularly for Category 1 calls. It is to be hoped that this improvement can be sustained and that in due course the National Standard may be achieved for all Categories.

The Committee looks forward to the continuation of a constructive dialogue with South Western Ambulance Service NHS Foundation Trust and we thank you for the opportunity to comment on this Quality Account.

Yours sincerely,

Ann Harris

Health Partnerships Officer

On behalf of Dorset Health Scrutiny Committee

CC:

Ken Wenman, Chief Executive, South Western Ambulance Service NHS Foundation Trust

Sharifa Hashem, South Western Ambulance Service NHS Foundation Trust

Beryl Ezzard, Dorset Health Scrutiny Committee

Cllr Bill Pipe, Chair Dorset Health Scrutiny Committee

Mathew Kendall, Executive Director of People – Adults, Dorset Council

For information: The most recent Care Quality Commission report for South Western Ambulance Service can be accessed here:

<https://www.cqc.org.uk/location/RYF45?referer=widget3>

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