London Clinical Senate

Advice on proposals for inpatient mental health services in South West London

Report of the London Clinical Senate:

Clinical Review Team

CONTENTS

The Clinical Senate Council approved this report on 1 December 2014

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1. Foreword

As an appointed member of the London Clinical Senate Council I was asked by the Chair of the Council to bring together a team of experts with experience and understanding of mental health services to provide independent advice on proposals for inpatient mental health services in south west London. The proposals underpin a substantial development programme to modernise facilities provided by South West London and St George's Mental Health NHS Trust.

I established a multi-disciplinary group which brought together health and care professionals with a wide range of experience in mental health care and the wider health and social care system and representatives of service users and carers. Some members brought expertise from across the country. The extent of the Team's knowledge and expertise was substantial and included first-hand involvement in leading service change to deliver improvements for users of mental health services. This enabled a series of challenging and constructive discussions that are summarised in this report.

We support the overall goals of improved hospital accommodation, alignment of services, and transfer of activity from hospital to community where appropriate. To achieve these goals, we believe that the clinical model across the pathway of care needs to be further developed. The plans for community services that will complement the changes to inpatient care do not currently achieve sufficient overall capacity and capability in the system to meet the needs of people who will increasingly be cared for, and supported at, or close to, home. The proposals are generally consistent with commissioning plans and have the potential to reduce the equality gap that far too many mental health patients currently experience.

The team recognises the challenges (economic, financial, political, social and clinical issues) posed by any service change proposals expected to span a 10-year period. However, the Clinical Review Team would have liked to see clearer transition and clinical strategies and plans, particularly for community-based services.

I would like to thank all the Clinical Review Team members for their energy, commitment and focus, and for their contributions to this final document. I would also like to thank the representatives from South West London and St George's Mental Health NHS Trust, the South West London Clinical Commissioning Groups and the service users and carers whom we met, as well as the representatives from other organisations who gave up their time to discuss the proposals with the Clinical Review Team

Dr Adrian Bull

Chair, Clinical Review Team; Managing Director, Imperial College Healthcare Partners

2. Summary of findings and advice

This section of the report presents a summary of the London Clinical Senate's findings and advice in relation to proposals for inpatient mental health services in south west London[1]. It reflects the overall conclusions of the Clinical Review Team which the Clinical Senate Council established to formulate advice requested by Kingston Clinical Commissioning Group (CCG), on behalf of Kingston, Merton, Richmond, Sutton and Wandsworth CCGs and NHS England (London) Specialised Commissioning

1. The **case for modernising mental health inpatient facilities in south west London is well made and based on clear evidence**. The case for change reflects national and local policy and guidance, and is based on good principles.

   There is a clear **correlation between the Trust's plans, the South West London Collaborative Commissioning *Five Year Strategic Plan*, the commissioning intentions of the five south west London CCGs which commission mental health services from the Trust and NHS England specialised commissioning**. The Clinical Review Team found commissioners to be very supportive of the proposals.

   The **high level principles underpinning the proposals are sound,** i.e:

   - increased, enhanced and more integrated community provision with integrated recovery-focused models
   - more care at home for service users of all ages
   - a drive to reduce variation and enable equitable provision across each of the five boroughs
   - consolidation of some skills and specialties across the pathways
   - consolidation and reduction of inpatient beds in response to developing community-based care.

   However the Clinical Review Team would have liked to see **clearer evidence of how the proposals meet the stated consultation principles (Chapter 5, Proposals for Consultation) and a model of care** that covers the whole spectrum of mental health services. It did not see an overarching clinical strategy which presents the totality of plans for developing the Trust's services, the key changes proposed over the next few years, how these relate to each other and the quality improvements they aim to deliver. Whilst the proposals are predominantly about inpatient services they must be considered in the context of the overall pathway. In particular ensuring sufficient capacity and capability within community services will be a prerequisite to implementing changes in inpatient care.

2. **Benefits** (for service users, carers and staff) anticipated from the improved built environment for inpatient care **are generally described in terms of a better experience** and more **effective, and efficient, care processes**.

   Whilst these are undoubtedly important benefits the **improvement in clinical outcomes that the changes aim to deliver are not currently well-defined**.

[1] Consultation documents available at www.kingstonccg.nhs.uk/have-your-say/inpatientmentalhealthservicesinsouthwestLondoproposalsforpublicconsultation (extracted 20 Nov 2014)

The Trust does not currently comply with CQC standards for mixed sex accommodation because of limitations in the physical environment and the proposals will address this. However the CQC standards focus on maintaining a satisfactory and high-quality model of care within a physical environment, not just the physical environment itself and greater assurance that the proposals will enable compliance cannot be confirmed until that model is better described.

3. Whilst the **inpatient model of care is supported**, aspects of the model require more attention to ensure they are evidence-based, in particular ensuring:
    - the needs of older people who do not have dementia, including frail elderly people, would be met if they are treated in all-age wards.
    - that the risk relating to nasogastric feeding that would result from the proposed separation of child and adolescent and adult eating disorders' services onto different sites i.e. the risk of children and adolescents having to be transferred to the adult service to access specialist skills is effectively mitigated, so that quality and safety of care is maintained
    - the proposed model of a flexible PICU ward for women is safe, assessed to meet existing and future needs and is compliant with National Association of Psychiatric Intensive Care Units (NAPICU) standards,
    - there is sufficient expertise in the wider workforce to care for people with learning disabilities if they are located on a number of general wards
    - the anticipated increased acuity of patients admitted to inpatient wards and any potential impact on low secure capacity, arising from an increasingly community-focused model with a reduced bed base, is understood, planned for and appropriately resourced
    - that robust workforce development and staffing plans are in place to manage any impact on community teams, including crisis and home treatment
    - further opportunities to apply innovations and technological improvements in the delivery of services are considered to improve quality and outcomes and enable easier channels of access.
4. The **Trust and CCGs need to do more to specify whole patient pathways and clarify details on integration** with other services, in particular:
    - how capacity would change to ensure provision of safe, sustainable high-quality care along different care pathways as they develop, with greater emphasis on community-based provision. The robustness of assumptions underpinning the modelling of future community teams is not clear enough at this stage to give confidence about deliverability and resilience of proposals
    - how the physical health care needs of inpatients, including emergency care, would be assessed and met in a timely way as part of a wider strategy to address the inequalities in outcomes that exist in relation to physical health care for people with mental problems, and how services will interface with general hospitals to enable this
    - whether workforce plans are aligned to the capacity modelling. Whilst the team was given assurances by the Trust and commissioners that there would be appropriate quality gateways prior to any reduction of inpatient capacity, it is important that agreed plans are in place to mitigate and manage risks

- how the local and specialist inpatient services would integrate with community mental health and social care services.

5. The importance of partnership working to effectively deliver the proposals, especially enhanced and more integrated community-based care, has been acknowledged. However the **robustness of partnership arrangements is not clear**. There was a strong indication that social care partners have not been sufficiently involved and that they do not yet have a sufficient understanding of the resourcing plans for community-based services.

   The Trust and commissioners need to **explain their overall plans better by continuing, and in some cases strengthening, engagement** with:

   - **patients and carers**. There is evidence that the Trust and CCGs have used a variety of channels to engage service users and carers in the development of the proposals

     The Trust plans to engage service users in the design of the community hub and spoke model in each borough. Commissioners recognised a clear narrative is urgently required to be able to describe what community services might look like in future to enable this to happen

     There was a lack of clarity regarding whether patients had been engaged early enough in the process and involved in the co-design of options. This particularly appeared to be the case with respect to older people's services, and the team heard mixed views from stakeholders about engagement with CAMHS
   - **local authorities** (beyond those involved in joint health commissioning). There is strong evidence that local authorities feel insufficiently informed about, and involved in, the Trust's plans to the extent that this could undermine the current s75 agreements
   - **providers**. There is a lack of clarity on engagement with other providers, particularly in the development of the physical health care model.

   Without engaging better, stakeholders are unable to contribute fully, and risks and opportunities that might accrue may be missed.

6. A **transformation programme has been established** (focusing on acute care, the community model, older people and CAMHS), though each element of the programme is at a different stage. **There is a need to be clearer about the overall plan**, key milestones, decision gateways, dependencies, risks, mitigations and contingencies to deliver the overarching objectives. Whilst the Clinical Review Team recognises the proposals presented will be delivered over a 10-year period and therefore accepts that some uncertainties exist and some detail may not be clear at this point, it was not assured that the Trust and commissioners had sufficiently clearly defined when key decisions need to be taken, nor established clear 'gateway' decision points to govern the progress of the changes subject to key dependencies.

Summary of advice

Advise on whether the clinical case for change and proposed model of care for inpatient mental health services:	The Clinical Review Team's summary advice:
1. **are underpinned by a clear clinical evidence base (where this exists)**	• The case for modernising inpatient services is clear. The model of care and underpinning clinical assumptions are based on clinical evidence. However the team feels there needs to be more detailed consideration of the community services and overall clinical and patient pathways
2. **are informed by best practice**	• Yes, although the team recognises that there are many examples of best practice and specific details of the proposal are not yet confirmed
3. **will enable improvements in quality**	• Yes, in terms of the accommodation/ environment and the patient experience. However the team has concerns, for example, regarding the lack of focus on clinical outcomes, and level of resourcing in the community
4. **align with national policy and regional and local commissioning intentions**	• Currently yes. However the team recognises that not all commissioning intentions are clear (and may change); the Trust will need clear plans as to how it mitigates any changes to commissioning intentions
5. **will, if delivered, enable compliance with CQC standards**	• Yes, as they relate to the physical environment e.g. compliance in relation to mixed-sex accommodation. However, it is important to emphasise that improved accommodation alone will not ensure compliance with CQC standards. Processes of care must also be compliant.
6. **demonstrate parity of esteem (compared with physical healthcare).**	• Yes, as far as it is possible to assess this within the terms of the review. However the team recommends greater patient, public and stakeholder engagement in future.

3. Advice requested

Kingston Clinical Commissioning Group (CCG), on behalf of Kingston, Merton, Richmond, Sutton and Wandsworth CCGs and NHS England (London) Specialised Commissioning, asked the London Clinical Senate to provide independent clinical advice on proposals for inpatient mental health services in south west London (Appendix B) which underpin a substantial development programme to modernise facilities provided by South West London and St George's Mental Health NHS Trust (Appendix C).

3.1. Scope of advice requested

The London Clinical Senate was asked to provide advice on whether the clinical case for change and proposed model of care for inpatient mental health services:

1. Are underpinned by a clear clinical evidence base (where this exists)
2. Are informed by best practice
3. Will enable improvements in quality
4. Align with national policy and regional and local commissioning intentions
5. Will, if delivered, enable compliance with CQC standards
6. Demonstrate parity of esteem (compared with physical healthcare).

4. Formulation of advice

The London Clinical Senate Council agreed to establish a multi-professional Clinical Review Team, including members with mental health services expertise from London and outside London, balanced with members representing the wider health and social care system, service users and carers, and primary and emergency care. (Appendix E). To ensure a fresh and impartial view, care was taken in recruiting the Clinical Review Team members to ensure they had no involvement in any of the work to develop the south west London proposals and had not been involved, or were likely to be involved, in any other part of the NHS England assurance process in respect of this scheme (Appendix F). Two-thirds of the Clinical Review Team are experienced health and social care professionals who work in mental health services.

The Clinical Review Team agreed a framework, drawing on:

- available guidance[2] on the provision of independent clinical advice to inform NHS England's service change assurance process
- national and local policies, standards and guidance (Appendix D)
- professional and personal knowledge and experience of improving the quality of health services and care.

The Clinical Review Team is accountable to the London Clinical Senate Council, through Dr Adrian Bull, a member of the Clinical Senate Council, who chaired the team and led the process.

[2] *Clinical Senate Review Process: Guidance Notes,* NHS England, August 2014

4.1. Terms of reference

Terms of reference setting out the scope, approach and timescale for the review were developed and agreed with Kingston CCG and then approved by the London Clinical Senate Council. (Appendix G).

4.2. Limitations

A significant amount of supporting information was provided by the CCGs and the Trust to inform the review. Wherever possible the Clinical Review Team has triangulated information from many different sources including through discussion with stakeholders who participated in the review process.

The Clinical Review Team would have liked to have heard a greater range and number of stakeholders e.g. health and social care providers.

The team therefore felt that these placed limitations on the advice it was able to give.

4.3. Meetings and hearing session

The Clinical Review Team met three times during the course of the review. Separate briefings were held for members unable to attend particular meetings.

- **16 October** – Members shared preliminary views on the proposals from the desk-top review of documentation, agreed a framework to formulate the advice requested and key issues to explore at a full day meeting with stakeholders in south west London (Appendix H).
- **29 October** – The Clinical Review Team held a 'hearing session' to discuss identified issues with stakeholders involved in the development of the proposals. At the end of this session the Review Team agreed provisional findings and advice and identified the need for further information about proposals for development of community services which was requested from the Trust.
- **11 November** – The Clinical Review Team met to consider the additional information received from the Trust and to discuss and finalise its findings and advice. The information received did not fully meet the Review Team's request and a further request was made after this meeting which was subsequently received.

5. Clinical Review Team detailed findings and advice

5.1. The clinical case for change and proposed model of care are underpinned by a clear evidence base

The Clinical Review Team notes the Trust's stated alignment with best available evidence, which is detailed in its *Strategic Outline Case for investment in redevelopment of campus-based mental health services in south west London and St George's* (Nov 2013, updated March 2014).

This states that the **case for change** is based on:

- modernisation of services
- standardisation and consistency in the delivery and quality of care provided
- promotion of greater partnership and integration of services
- appropriate and flexible service capacity
- appropriate, high-quality accommodation
- better use of resources and achieving financial targets
- improved recruitment and retention.

The Clinical Review Team has considered the evidence (including guidance, standards etc) that underpin the proposals and agrees that these are relevant and up to date. The stated **standards** to which the Trust aspires are detailed in its consultation document: *Inpatient mental health services in south west London; Proposals for public consultation* (Sept 2014). These are:

- access to outside space for everyone
- separate accommodation for men and women with appropriate standards for privacy and dignity avoiding inappropriate use of mixed-sex accommodation
- access to natural light
- meeting modern guidelines for staff to be able to monitor and observe patients by 'line of sight and to support appropriate levels of staff cover
- provide single bedrooms with ensuite facilities for all patients
- a maximum of 18 beds per ward – (Royal College of Psychiatrists*: Do the Right Thing, How to Judge a Good Ward*, 2011)
- at least three mental health wards on each site to ensure cross cover for any emergencies (Royal College of Psychiatrists: *Not Just Bricks and Mortar*, 1988)
- compliance with the Equality Act 2010.

The Clinical Review Team heard that the Trust and health services commissioners had researched what has worked at other locations/trusts and made visits to a number of other trusts in London and elsewhere in the UK. The Trust and health services commissioners stated that this work has strengthened their working relationship.

The team notes the key findings in the *Assessment of South West London mental health inpatient needs* undertaken by Beacon UK and Maudsley International (revised March 2012) which underpin the case for change and proposed standards:

- There has been a significant reduction in average length of stay for inpatients over the last three years, without a corresponding increase in the readmission rate.

- There is variation in the threshold for old age care across south west London.
- Based on retrospective review of patient notes by NHS psychiatrists, up to 50 per cent of inpatients could have been treated effectively in a community setting if appropriate support was available.
- Only 13 per cent of GPs were contacted during the first week of hospitalisation, according to patient notes.
- Half of all inpatients were readmissions. However, communication with the community mental health team occurred in just 35 per cent of admissions.
- One in four patients were not documented to be seen by a consultant psychiatrist during the first seven days of inpatient admission. 58 per cent of patients were seen only once in the first seven days of admission.

Specialist commissioners explained that current services meet existing standards.

The Trust explained to the Clinical Review Team that it intends to **develop inpatient facilities** that: provide the best possible experience for patients, carers and staff; meet national and local standards; are purpose-designed; enable staff to provide high-quality care; and are sustainable.

Findings and advice

The Clinical Review Team considered the **case for change**. Current arrangements make it challenging to provide consistent high-quality and safe services from Victorian buildings where most accommodation is not fit for purpose to deliver modern-day mental health care. The design of these old buildings means additional staff are needed to maintain a safe service on some wards to resolve line of sight issues and the proximity of male/female accommodation on the CAMHS wards is unsuitable; it is difficult to deal with crisis incidents; more people could be treated in the community, closer or in their own home; and length of inpatient stay could be reduced by meeting peer/best-in-class performance. The team heard that therapeutic activities, patient, carer and staff experience were being impacted negatively.

The team notes that the proposals demonstrate links to relevant JSNAs and consider the current and future need of service users. The team heard that demand for mental health care is rising and will continue to rise. The SOC sufficiently describes the local population, the demographics, and assesses the mental health needs expected in future.

The team heard that there is a significant differential regarding admission rates between different boroughs – this was attributed to different distribution of resources between acute and community services and between mental health and other services. The team accepts that the existing estate is not fit for purpose, that it would be difficult to adapt existing facilities and that upkeep costs are not sustainable or best value.

The team considered the proposals against best available clinical evidence and standards. The team acknowledges that the **standards** provide a good foundation on which to develop proposals. The proposals meet many of the Trust's stated standards.

The Clinical Review Team notes the improvements that the local NHS and the Trust have achieved regarding **clinical models, the environment and mental health pathways** e.g. the Wandsworth Recovery Centre, the recovery college and the Prosper

network[3] for service users and service user groups across south west London. However the team did not feel that there has been sufficient consideration of:

- a number of specific pathways (see points below)
- other innovations and technological improvements that would further improve quality and outcomes, e.g. the use of multimedia to provide education for children, assisted technology for older people, and activities for people in the PICU ward.

The team would have liked to see clearer evidence of the principles and model of care that cover the whole spectrum of mental health care services and the lack of a clear clinical strategy has made clinical appraisal of the proposed options more difficult.

Whilst we accept that some of the detail of the model of care can be agreed at a later date (a point made by the Trust and CCGs), some elements should be addressed earlier to ensure the proposed service change successfully meets the stated aims e.g.:

- how patients will be ***triaged*** *and how* ***emergency mental health care*** will be provided. The Trust agreed that the model had not been decided
- ***eating disorders service***. If the CAMHS moves to Tolworth then the eating disorders team is split. Children requiring nasogastric feeding would need to be transferred to Springfield hospital, and the team is unclear if they would be located with the adult specialist team at Springfield
- ***acuity of patients.*** There is a recognition by the Trust and commissioners that, with more patients being treated in the community, the acuity of inpatients and patients in the community will be increased and that investment will be required. However mitigations and plans to manage this issue are unclear
- the ***PICU for women*** is proposed to be a flexible space partitioned from the rest of the women's ward. The Clinical Review Team could not envisage how this would work effectively and safely
- ***access for emergency physical care***. Neither of the proposed inpatient sites in the preferred option are co-located on acute hospital sites (whereas Queen Mary's Hospital is) and the Clinical Review Team saw no evidence for a clear pathway for patients needing physical care
- the proposals ***separate the treatment of functional and organic illness e.g. dementia***. Whilst this is generally supported, older people who do not have dementia, including frail elderly patients are proposed to be treated:
    - in all-age wards (from 19 years old). This is of some concern and a mixed approach based on need and frailty is recommended by, for example, the Royal College of Psychiatrists and the Joint Commissioning Panel for Mental Health[4]
    - by in-reach specialist and generalist services (such as faith communities). Whilst this plan has some merit, it is not clearly defined in terms of service and capacity
    - In addition, the ***proposed acute care pathway for older patients*** is to admit them to a general ward. Whilst this requirement may be rare, the team is not convinced that the plans (and mitigations) had properly considered this point

[3] A mutual support group independent of the Trust
[4] *Joint Commissioning Panel for Mental Health guide for commissioning old age services*, June 2013.

- the proposed ***pathway for learning disability patients*** (to general acute wards) requires further thought. There appears to be no clear benefit to patients and the Clinical Review Team felt it would be difficult to maintain the staff skills and knowledge required unless one ward takes a specific focus on this.

The Clinical Review Team investigated whether the plans met the **likely capacity requirements and ambition for the facilities**

- The team noted that whilst there are pressures in CAMHS Tier 4 beds across London, around 50 per cent of beds are occupied by children and young people from outside London; therefore there is sufficient capacity in London to meet London children's and young people's needs. The team was advised work is taking place to look at the procurement process for Tier 4 CAMHS across England with the aim of redressing the balance. The Trust proposes an increase in CAMHS bed capacity though this is not yet agreed with commissioners. Information provided by the Trust stated that their business case for CAMHS PICU is being considered by NHS England. In the light of the recently published health select committee review into the provision of CAMHS[5], the team feels that the Trust should, together with specialist commissioners, consider the development of Tier 3.5 services, i.e. more assertive outreach for CAMHS rather than an increase in the CAMHS bed base as it has proposed
- The Clinical Review Team heard that there is financial and bed capacity/configuration flexibility in the plans. For example, there is opportunity to add extra beds on additional levels on the proposed Springfield development. However the team noted that final bed numbers in any new build were still to be agreed and could be amended. We heard that assessments were based on previous experience (e.g. Sutton's decommissioning of long-stay beds) and comparisons with other systems. We heard that bed occupancy is currently low and falling. The team accepts that, with good out-of-hospital services, the need for inpatient beds will reduce. However some of the assumptions (e.g. for community CAMHS services) are based on productivity and efficiency improvements with no guarantee that these can be achieved; the team heard from commissioners that the Trust is not currently hitting some community CAMHS targets. Additionally, the team feels that the proposals do not take account of the national strategy to develop community rehabilitation[6], which would reduce inpatient rehabilitation beds, nor of community forensic services to do likewise

The team heard from the Trust, commissioners and other stakeholders (for instance providers, some service users and carer representatives, and social care) that there was **support for the proposed two-site option over the status quo**, and that there was an acceptance that the Springfield and Tolworth sites provided the best configuration. The team heard that the Queen Mary's Hospital site at Roehampton is considered to be too small for significant development i.e. as part of a two-site option.

[5] *Children's and adolescents' mental health and CAMHS.* Third Report of Session 2014–15. House of Commons Health Committee, 5 November 2014

[6] *Guidance for commissioners of rehabilitation services for people with complex mental health needs, volume two, Practical mental health commissioning.* Joint Commissioning Mental Health Panel, November 2012

The Trust has used a variety of methods to develop and assess the site options – set out in the consultation document[7]. The team considers that the options offered for consultation are reasonable and have some clear benefits that address the stated criteria.

5.2. The clinical case for change and proposed model of care will deliver real benefits to patients

The Clinical Review Team notes the Trust's focus on quality, outcomes and benefits (SOC, Appendix M) and the improvement goals set out in the CCGs' five year strategic plan. The team heard evidence that the existing inpatient facilities are not conducive to high-quality care. It also heard evidence that the proposed changes would benefit the majority of inpatients, for instance through:

- a more pleasant, modern environment
- a safer environment when there is a crisis
- more care in the community.

The guiding principles and the benefits for each service are set out in the consultation document (chapter 5).

Specialist commissioners explained that clinical outcomes are (and would be) included in service specifications and would be monitored accordingly.

Findings and advice

The options offered for consultation are reasonable and have some clear benefits (for instance a better environment, more suitable wards better functional relationships and the ability to staff more efficiently) that address the stated standards (see page 9). The Clinical Review Team acknowledges the Trust's and commissioners' commitment to improving the quality of services and addressing inequalities. Fit-for-purpose and therapeutic wards are critical to the health, wellbeing and effective treatment and recovery of patients[8]. For specific groups of patients, the team recognises:

- the improvement to patient experience that would accrue if the adult inpatient service for deaf people moved from the poor accommodation at Springfield to a new purpose-built facility at the Tolworth site
- the potential improvement to patient experience that would follow if the CAMHS service moved into new accommodation as a single campus: for instance better access to outdoor space; a better separation of educational facilities from wards; and a more homely environment
- the advantages of the proposed accommodation for carers.

However the Clinical Review Team notes that in many respects the benefits:

- for inpatients do not appear to be quantified and there is a lack of focus on improvements to patient/clinical outcomes. Will the patient be better able to self-care? Will they be less likely to have an acute episode? Will they be less likely to

[7] *Inpatient mental health services in south west London – proposals for public consultation*
[8] *Do the right thing: How to judge a good ward. Ten standards for adult in-patient mental healthcare* – Royal College of Psychiatrists, June 2011

relapse and need readmission? Will their symptoms be reduced and their physical health improve? Will there be fewer suicides … more adherence to medicine regimes etc

- for other mental health patients and the wider community are unclear.

The team notes the evidence that issues important to service users and carers have been taken into account in the development and appraisal of options.

Service user and carer representatives recognised the benefits of the proposals whilst echoing the concerns of other people providing evidence – for instance that the plans do not address transitions between different services and whole pathways of care. The team notes that there is evidence of the clinical benefits of modernisation in other programmes e.g. the introduction of Home Treatment Teams in Merton and Sutton halved the admission rate between 2007 and 2012. However it cannot be assumed that improved facilities will always lead to improved outcomes (or that all the potential benefits will be realised) unless there is a clear focus on clinical outcomes that any change is intended to deliver an understanding of the baseline against which improvements will be measured and the measures that will be used.

Engagement and consultation

There is evidence that the proposals have been informed by the views of service users and carers' plans (e.g. the service users' reference group and the carers, families and friends reference group) – and is ongoing, by feedback and analysis of complaints, as well as engagement with wider groups. Stakeholders were candid about some of the challenges in engaging the wider community in discussions about mental health care, which meant that much of the involvement focused on service users and carers. Examples of particular efforts to engage some communities were noted e.g. the black and minority ethnic community in Wandsworth.

The team also notes the plans to engage service users and carers in developing community services. For example, during the autumn of 2012, the Trust held a number of listening events to engage stakeholders, and an option appraisal event was held in December 2012. Around 30 individuals attended including service users and carers; members of local LINKs (now Healthwatch); mental health charity Mind; local authority; commissioners; the strategic health authority; clinicians and service managers; trust executive directors. The SOC and the consultation document detail the process.

The quality criteria used (service quality, accessibility of services, optimal service configuration, future flexibility, feasibility and timing) were developed prior to the December 2012 meeting, although it is unclear whether there was user involvement. However the criteria were accepted by the appraisal group in December 2012 and appear to chime with the views of the patients and public representatives that we met in the 'hearing session' on 29 October.

Findings and advice

Involvement of patients, the public and key stakeholders is critical in developing proposals that benefit all patients to the greatest extent. The Clinical Review Team:

- notes that the appraisal of options events involved quite a small group of individuals
- acknowledges there has been quite detailed discussion on the proposals with some groups (including patient and public representatives). There were differing views of the breadth of engagement with some evidence-givers believing that some stakeholders and communities have been less well connected to the development of the plans. The team saw little evidence regarding the input of: older people (particularly those who do not have dementia); social services departments; and carers
- notes in the consultation document that "the proposals were developed with input from clinicians and mental health professionals working in the mental health inpatient services" (chapter 5). However, from the evidence we saw, the team was unclear on the extent to which frontline clinicians have been involved in developing the proposals
- believes that engagement with local authorities has been limited. It is essential to remedy this situation given the importance of s75 agreements and the necessary joint planning of community services.

Equalities

The Trust has completed an equalities impact assessment.

The Clinical Review Team notes current improvements in navigating patient pathways and access e.g. the advisory portal (Kinesis) used by Wandsworth GPs and the developing psychiatric liaison services for mental health patients in A&E.

The team notes that many people admitted to specialist inpatients' services are referred from around the country and thus for these patients the differential in travel times associated with the changes would be minimal.

Findings and advice

The development of an equalities impact assessment is essential to ensure the Trust and commissioners: understand the effect any changes may have on groups of individuals (particularly those with protected characteristics); enhance any positive effects; and mitigate against any negative effects.

The Clinical Review Team:

- notes that the impact on access for service, carers and families (for treatment and visiting), including waiting times and travel times, has been considered. It is clear that the Trust and commissioners recognise the need to improve access arrangements as a whole. However the team was unclear whether the impact on access for local service users granted leave as part of their rehabilitation has been properly assessed.

Planning

To ensure the proposed changes deliver real benefits, a well-resourced and robust plan is required.

Findings and advice

- A transition programme has been established, and risks and consequences of implementation have been identified with mitigating actions and monitoring arrangements.
- Flexible and easy transition was identified as a key criteria in assessing options. There are a number of sections in the SOC that indicate how the transition may progress (e.g. the programme/project management arrangements; the benefits realisation plan; the programme assurance; risk management; and impact assessments). However the Clinical Review Team saw no overarching clinical strategy that succinctly brings together relevant and current plans, risks and mitigations, including decision gateways that is signed up to by all key stakeholders. The Team found that information provided by different stakeholders did not always correlate with each other or with the documentation. For instance the team was told that the new facilities would be operational from 2020, whereas at other times we were told it was from 2024; reductions in beds were indicated by the Trust to start in 2015/16; whereas the five year commissioning strategy indicates 2018 onwards.

5.3. There is evidence that the options considered will be deliverable and sustainable

The proposals reflect the local commissioning intentions of the south west London CCGs, as set out in their draft five-year strategy (May 2014). The strategy (in accordance with national guidance and aligning with recently published documents e.g. the *NHS Five Year Forward View*) indicates:

- a continued trend towards more alternatives to hospital admission (including for mental health issues)
- a reduction in admissions to mental health beds (already being seen and in particular once alternatives are in place from 2018 onwards)
- commissioners have indicated they will not support long-term continued use of buildings for mental health inpatient services which remain non-compliant with quality and care standards.

Commissioners and the Trust discussed the financial context in which the proposals are being developed, with no or minimal growth anticipated. All providers are required to develop cost improvement plans (CIP) whilst maintaining and improving quality. Modernisation of community services appears to form a core element of the Trust's CIP plans. Despite the clear commitment in the CCGs' five year strategy to investing in mental health services, the level of investment is not yet quantified.

The Trust described the first phase of the community modernisation programme which aims to improve productivity by increasing face-to-face contact time to 40 per cent and reviewing skill mix.

Findings and advice

The proposals are based on an assumption that community health and social care services will be sufficiently resourced and of sufficiently high quality to enable a reduction in inpatient capacity. The team has significant concerns about the lack of detail regarding proposed changes and improvements to community services, and how these interface with the proposed changes to inpatient services.

- The team noted that, in the Clinical Commissioning Groups' request for advice from the Clinical Senate, the collective effect of the wider changes to mental health services is expected to reduce the requirement for mental health inpatient beds from the current position by about 10 per cent from 2018.

  Following a request from the Clinical Review Team for clarification about changes in bed capacity and community staffing, the Trust has indicated that it plans a phased reduction of inpatient capacity over the period to 2019/20.

  Data provided by the Trust's (below) only include those changes agreed within the long-term financial model signed off with the south west London CCGs and NHS England. The Clinical Review Team accepts that the figures, particularly relating to CIP impact and community and home treatment services, are subject to ongoing discussion.

  The figures show an overall reduction of 45 (from 153 to 108) inpatient beds for working age adults (29%); and a reduction of 23 (from 41 to 18) older adults beds (56%). The data also indicates that CAMHS and some other specialist services inpatient beds are predicted to increase whilst inpatient beds for forensic services, psychiatric intensive care and hospital hostels are planned to remain as now. These reductions in beds are anticipated to begin in 2015/16.

Inpatient bed numbers[1]	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
CAMHS inpatient services	28	36	36	36	38	38
Hospital hostels	24	24	24	24	24	24
Step-down	33	33	33	33	33	33
Older adult	41	37	35	27	18	18
Psychiatric intensive care unit	13	13	13	13	13	13
Secure services	61	61	61	61	61	61
Specialist services[2]	47	53	53	53	54	54
Working age adult services	153	143	133	126	108	108

1. As of April each year

Commissioners told the team that they recognise the critical role of crisis home treatment teams (CHTT) and that existing teams are under pressure. CCGs have committed to investing in CHTTs, evidenced in the five-year strategy plan and 2015/16 commissioning intensions, however have not yet quantified the level of investment available. The Trust has submitted a business case for an additional 21 WTE.

However the baseline for staff numbers against which this would be measured is unclear. We were assured that there would be investment in additional community-based staff; however we also heard that the number of posts had recently and/or was currently being reduced. Without a capacity (activity and workforce) plan the Clinical Review Team is unable to assess the resilience and sustainability of staffing proposals.

For 2014/15:

- CAMHS Community Team has reduced by 10.5 WTE to 64.5 WTE
- Crisis and Home Treatment Teams have increased with an additional 10 nursing (qualified and unqualified) posts.

For 2015/16 to 2019/20

- No further changes are planned for CAMHS
- Working age adults community teams are projected to reduce from 308 to 171 WTE (-121 non-medical and -16 medical)
- Older adult community teams will reduce by 46 (from 113 to 67 WTE)
- Crisis and Home Treatment Teams are predicted to remain fairly stable (though we note that this excludes Crisis Line and the ACP Co-ordination Centre).

Changes in community services staffing[9]

Working Age Adults Community Teams								
		Plan						
	2014/15 Base	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Total WTE Change
AHPs	39	-4	-5	-6	-9	-6	0	-31
Managers	3	0	0	0	-1	0	0	-1
Nursing (qualified)	100	-9	-11	-13	-20	-12	0	-66
Nursing (unqual)	33	0	0	0	0	-3	-3	-6
Psychologists	32	-1	-4	-3	-2	-1	-1	-12
Psychotherapists	13	0	-2	0	0	0	0	-2
Social Workers (Trust)	10	0	-1	0	-1	-1	0	-3
Total non-medical	**231**	**-15**	**-24**	**-23**	**-33**	**-23**	**-4**	**-121**

[9] Figures received from South West London and St George's Mental Health NHS Trust, 19 November 2014

	2014/15 Base	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Total WTE Change
Medical consultants	33	0	0	0	0	-2	-2	-4
Medical Seniors	12	-2	-3	-7	0	0	0	-12
Medical juniors	32	0	0	0	0	0	0	0
Total (medical)	**77**	**-2**	**-3**	**-7**	**0**	**-2**	**-2**	**-16**
AHPs	3	0	0	0	2	2	0	4
Managers	1	0	0	0	1	1	0	2
Nursing (qualified)	1	0	0	0	0	0	0	0
Nursing (unqualified)	4	0	0	0	0	0	0	0
Psychotherapists	0.4	0	0	0	0	0	0	0
Total Recovery College	**10**	**0**	**0**	**0**	**3**	**3**	**0**	**6**

CAMHS Community Teams[10]								
	2014/15 Base	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**Total WTE Change**
Admin	16	0	0	0	0	0	0	0
AHP	2	0	0	0	0	0	0	0
Psychologists	17	-3	0	0	0	0	0	-3
Psychotherapist	12	-4	0	0	0	0	0	-4
Nurse Q	11	-3	0	0	0	0	0	-3
Other	1	1	0	0	0	0	0	1
Manager	5	0	0	0	0	0	0	0
Medical	11	-0.5	0	0	0	0	0	0.5
Total	**75**[11]	**-10.5**	**0**	**0**	**0**	**0**	**0**	**-10.5**[12]

[10] Values based on the costed staffing model and cross referenced with the consultation paper
[11] You mentioned that CAMHS changes had been introduced over the last year therefore assume 2013/14 is the baseline.
[12] WTE changes exclude Medical as the CAMHS medical savings target has not transferred to the Transformation Programme.

Older adult community teams[13]								
	2014/15 Base	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Total WTE Change
Medical Consultants	11.4		-2.4					2.4
Medical Junior	8							0
Medical Seniors	3							0
Ahps	13		-6					-6
Managers	1		-1					-1
Nursing Qualified	52		-22					-22
Nursing Unqualified	19		-12					-12
Psychologists	7		-4					-4
Total	**113[14]**	**0**	**-46**	**0**	**0**	**0**	**0**	**-46**

Crisis and Home Treatment Teams [15]								
	2014/15 Base	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Total WTE Change
Managers	1	0	0	0	0	0	0	0
Medical Consultants	5	0	0	0	0	0	0	0
Medical Seniors	1	0	0	0	0	0	0	0
Medical Junior	3	0	0	0	0	0	0	
Nursing Qualified	47	7	0	0	0	0	0	7
Nursing Unqualified	17	3	0	0	0	0	0	3
AHPs	3	0	0	0	0	0	0	0
A&C	5	0	0	0	0	0	0	0
Total	**81.2[16]**	**10**	**0**	**0**	**0**	**0**	**0**	**10[17]**

[13] This is based on the staffing model included in the business case that went to September Board
[14] The above baseline excludes administration and clerical staff as this is part of a separate review
[15] Includes posts recharged to the Local Authority
[16] The base budget excludes the Crisis Line and ACP Co-ordination Centre but includes posts recharged to the Local Authority
[17] WTE increase due to an investment

- Based on the information available to it, the Clinical Review Team is concerned that the capacity plans to underpin the proposals have not yet been considered sufficiently to give assurance about deliverability and sustainability.
- The Trust and commissioners described a staged approach to implementation, including quality gateways, whereby reductions in inpatient capacity would be dependent on evidence that community teams are able to accommodate increased activity and provide the quality of care required. The SOC also identifies a number of risks. However the arrangements for identifying and monitoring clinical risk linking these to key decision points 'gateways' do not yet seem in place. Existing measures should be identified and new ones defined to enable robust monitoring of impact e.g. community and inpatient incidents, readmission rates and detention rates.
- In addition to agreeing a more detailed transition plan, the Trust and commissioners are encouraged to ensure that plans are regularly reviewed, particularly noting new guidance and thinking. For instance, the recent publications from the London Health Commission – *Better Health for London*, and the National Information Board – *Personalised Health and Care 2020*.

5.4. There is evidence that proposals for inpatient services have been considered as part of broader pathways

The Trust and commissioners are clear that the necessary modernisation of community services is at an early stage. They described the broad approach and the high level model of care e.g. single point of access, improved consistency of service, and a reduction in inequalities.

The consultation document (chapter 3) describes the alternatives to hospital admission and the way in which mental health services are changing. The Trust has stated that the developments in community mental health care, particularly home treatment and the reduction of inpatient treatment is not reliant on the plans to improve inpatient facilities.

The team noted the work to remodel CAMHS – through a single point of access in each borough which combines access to mental health treatment and social support services.

The Trust has a stated aim to focus on recovery thorough engagement with self-management programmes and more support at home around skills to help maintain wellbeing and help prevent crisis and admission to hospital. Each borough will develop an administrative centre which will support the community mental health teams.

Commissioners said they recognised the need for significant improvements in productivity and the changes to community services. The interface between inpatient and community services is critical to the success of the plans.

Findings and advice

- There is a clear commitment by the Trust and commissioners that mental health services should be easily accessible and seamless.
- The Clinical Review Team is pleased to note that the Trust is seeking to integrate NHS services better with social care and provide creative solutions. Two boroughs are currently tendering Improving Access to Psychological Therapies (IAPT) and extended IAPT. There are s75 agreements in place with four boroughs (not Merton) and fledgling plans to look at step up and step down services in the boroughs (e.g. Wandsworth and Richmond).
- The Clinical Review Team found little evidence that the development of community services has been properly considered (other than to broadly assess capacity) in the production of proposals for inpatient services. There appears to be an assumption that because the estate would not be ready until 2020, there would be ample time to ensure community services are improved and relevant interfaces and care pathways determined. The team would like to have seen greater detail about, and ambition for community services and specific indicators/milestones that would be achieved up to 2020 aligned with the inpatient proposals. A more holistic approach would strengthen the likelihood of quality improvements and benefits realisation across the whole pathway, as well as the identification and mitigation of risks.
- The Trust's adult eating disorders service is well-regarded, supporting adults primarily from outside south west London. However the team is unclear on how the Trust is seeking to use its day care programme more flexibly, or how it would utilise the benefits that technology could bring to support patents who are admitted from outside London e.g. tele-psychiatry methods.

5.5. The impact on the wider health and care system has been considered

The case for change reflects national policy and local context (Appendix D), and aligns with commissioners' draft commissioning intentions for the next five years. The Clinical Review Team notes the work that has progressed with local authorities, e.g.: the potential move of the CAMHS school to the Tolworth Hospital site.

The team notes that the Trust has assessed its proposed plans against "The Four Tests":

- service users and the public have been involved in development of the plans. Engagement of service users, members of the public and key stakeholders aids the winnowing out of unintended consequences
- the proposals meet the requirement to ensure consistency with current and prospective need for patient choice. Safeguarding patient choice provides a safeguard to reduce the risk of some unintended consequences
- the proposals take into account national policy, regulation and guidance including *No Health Without Mental Health*; The *Darzi Review*; The *Francis Report*; the *Winterbourne Report*; the *Keogh Report*; the *Berwick Report*; *Closing the Gap*; *Everyone Counts*; Professional guidelines from the Royal College of Psychiatry; and Care Quality Commission standards. Alignment with national policy and regulation will reduce the risk of unintended consequences

- there is support from clinical commissioners. Alignment with the intentions of commissioners to prioritise community mental health services, to provide alternatives to hospital admissions and to reduce hospital admissions reduces the risks associated with a reconfiguration.

The consultation document states that benefits of the proposed model of care include closer links with general hospitals to improve support for people with mental health needs who also have physical health needs.

We noted that arrangements to ensure access to emergency mental health is being planned in line with the Mental Health Crisis Concordat, *Improving outcomes for people experiencing mental health crisis*. This requires services in different parts of the system to be joined up with flexibility across the five boroughs. CCGs advised that they are looking beyond emergency departments to wards and perinatal services so that there is a properly integrated solution in all areas of interface with the acute trusts.

Findings and advice

Engagement (also refer to section 5.2) has been variable across the area, with some boroughs being more involved than others – potentially leading to inequalities of opportunity to consider all points of view across the whole health and care system.

The team notes that the Trust has prepared a risk register (SOC Appendix N). However, while the case for change is strong, the team is concerned that there has been a lack of consideration of both the risks and (just as importantly) the significant opportunities that might accrue for inpatients and for the wider health and care system

Options for the configuration of inpatient services refer to the need for adult eating disorder services remaining at Springfield because of the physical support provided by St Georges'. Whilst it was not clear how wider interfaces have been considered in the development of options, the Trust and CCGs acknowledged the need to align with future patterns of services as strategic plans are developed across SWL.

There is a lack of consideration of community and other pathways (e.g. entry to pathways for acute care for physical health needs). The team feels that the plans as a whole could be strengthened to ensure pathways are simplified and access is improved for all mental health patients.

5.6. Parity of esteem for mental health care is demonstrated

The Trust's consultation document reflects the five year strategy for the local NHS published in May 2014 by south west London commissioners. This emphasises the importance of joined-up health and social care services and of 'parity of esteem' between mental health and other services.

The Trust has considered key documents in preparing the case for change and its proposals e.g. *No Health Without Mental Health* (Department of Health 2011), the national strategy for mental health. The Trust aims to improve the mental health and wellbeing of the population and to keep people physically well; and to improve outcomes for people with mental health problems through high-quality services that are equally accessible to all.

The Trust also acknowledges *Everyone Counts: planning for patients 2014/15 to 2018/19* (NHS England, 2013) which established the principle of parity of esteem to ensure that mental health services and the needs of people who use them are given as much attention as other health services and the needs of other patients.

The CCGs have made a conscious decision to establish a mental health workstream through their collaborative commissioning arrangements. Review of the five year strategic plan shows consistent reference to physical and mental health care and the important interface between the two. The CCGs emphasised that mental health is embedded in all strategy work and this is evidenced in the strategy e.g. through the acute, maternity, children's and integrated care workstreams. The strategy makes a clear commitment to parity of esteem, which is one of three overarching outcomes.

Each CCG has a named mental health clinical lead and there is a mental health lead with responsibility for collaborative mental health commissioning across south west London.

Findings and advice

The CCGs five year clinical strategy reflects a clear commitment to parity of esteem. The commitment by the Trust and commissioners (in the five year strategy) to improve the condition of the estate is welcomed. The proposed reconfiguration, if achieved in full, would significantly improve the estate and environment for mental health inpatients – reducing the equality gap.

The ambition to care for more patients in the familiar setting of their own home, rather than antiquated Victorian buildings, is clear. However the plans to achieve this are not sufficiently described in the consultation document or accompanying literature.

Whilst there is some consideration of holistic services (e.g. plans for in-reach services) the team feels that it is difficult to demonstrate or to test the proposition that mental health is valued equally with physical health because we have no comparator to use. However we were assured that the Trust and commissioners are paying sufficient attention to this aspect of the strategic priorities.

There are no commonly agreed measures of parity of esteem. It would be helpful to consider with stakeholders how this could be demonstrated so that progress over coming years can be monitored and share.

Appendices

Appendix A: Glossary

Acronym	Expansion
A&E	Accident and Emergency
AHP	Allied Health Professional
BDD	Body Dysmorphic Disorder
CAMHS	Children's and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CQC	Care Quality Commission
CRT	Clinical Review Team
CYP IAPT	Children and Young People Improving Access to Psychological Therapies
FT	Foundation Trust
GP	General Practitioner
HEE	Health Education England
HENCEL	Health Education North Central and East London
HOSC	Health and Overview Scrutiny Committee
HWB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System
JSNA	Joint Strategic Needs Assessment
LETB	Local Education Training Board
LINks	Local Involvement Networks
NAPICU	National Association of Psychiatric Intensive Care Units
NEL CSU	NEL Commissioning Support Unit
NELFT	North East London NHS Foundation Trust
NHS	National Health Service
NHS England (L)	NHS England (London)
NICE	National Institute for Health and Care Excellence
NTDA	NHS Trust Development Authority
OCD	Obsessive Compulsive Disorder
PHE	Public Health England

Acronym	Expansion
PICU	Psychiatric Intensive Care Unit
PPV	Patient and Public Voice
QMH	Queen Mary's Hospital
SOC	Strategic Outline Case
SUH	Springfield University Hospital
SWLSTG	South West London and St George's Mental Health NHS Trust
TH	Tolworth Hospital
UCLP	University College London Partners

Appendix B: Scope of proposals for inpatient services

The *Strategic Outline Case* (SOC) for these proposals states that the existing mental health inpatient facilities in south west London are old, do not provide a good, supportive environment for patients and carers, and make it harder for frontline staff to deliver high-quality care.

Much of the accommodation fails to meet modern standards and wards are not all fully compliant with CQC standards, especially around best management of mixed-sex accommodation. Some of the wards were built in 1840 and bedrooms are therefore unacceptably small for modern mental health care. Very few have ensuite bathroom facilities and there is limited access to outside space.

The Trust's plans seek to ensure that mental health inpatient services are of high-quality, and are in the right places to support local people in south west London and people from further afield who use the Trust's specialist inpatient services. The Trust proposes that:

- new accommodation will be flexible so that space can be used in different ways as services change and develop in the future
- wards will typically have between 12 and 18 beds, which could be brought into use as appropriate to meet the clinical needs of each service, in line with Royal College of Psychiatrist standards[18]
- staffing ratios will meet the standards set out in the Francis Report
- inpatient accommodation will be designed to dovetail with the community mental health services in each borough to provide a single service for people who need inpatient care and treatment.

The Trust is consulting on two options for the future location of mental health inpatient facilities for people living in the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth, and for a range of specialist mental health inpatient services which have a far wider catchment area – some reaching across England.

The scope of the proposals involves rationalisation and re-provision of services currently located on three campus sites onto either:

- Two sites, at Springfield University Hospital in Wandsworth and Tolworth Hospital in Kingston (identified as the preferred option). Proposals involve investment in new or refurbished accommodation on those sites for the following:
    - Two older adult inpatient wards
    - Four to five working age adult acute inpatient wards
    - Four forensic mental health wards (low and medium secure)
    - One specialist deaf adult inpatient ward
    - One specialist obsessive compulsive disorder/body dysmorphic disorder (OCD/BDD) adult inpatient ward
    - One eating disorders adult inpatient ward
    - A discrete CAMHS campus for provision of tiers 3 and 4 services comprising acute, eating disorders, deaf, and Psychiatric Intensive Care (PICU)
    - Springfield University Hospital (SUH) and Tolworth Hospital (TH) Community hub/outpatient facilities (community mental health team/crisis teams, single and group therapies, clinics, outpatients etc.)

[18] *Do the Right Thing: How to Judge a Good Ward*, Royal College of Psychiatrists (2011)

- Management, administration, hard and soft facilities management etc.
- Three sites at Springfield University Hospital in Wandsworth; Tolworth Hospital in Kingston; and Queen Mary's Hospital, Roehampton with investment in new or refurbished accommodation to provide the same range of facilities as the two site option – but with working age adult acute inpatient wards on the Queen Mary's site rather than at Tolworth.

The Trust and the five CCGs that commission mental health services from the Trust are committed to the principle of providing as much treatment as possible in the community. This is based on national policy such as the *Mental Health Care Crisis Concordat*[19] and local collaborative commissioning work.

The Trust has said that the timescale for community changes is to make improvements by 2018 and the new inpatient facilities would be built after this, opening by 2024, if these proposals are agreed. The Trust proposes to sell some of its land and sites in order to resource the changes.

[19] *Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis* – HMG, Feb 2014

Appendix C: Kingston Clinical Commissioning Group's request for advice on behalf of South West London CCGs

London Clinical Senate

Template to request advice from the London Clinical Senate

Name of the lead (sponsoring) body requesting advice: Kingston CCG (on behalf of South West London CCGs)

Type of organisation: Commissioning

Name of main contact: Dr Phil Moore

Designation: South West London CCGs' Mental Health Lead

Email: phil@philmoore.org **Tel:** 07774 870 130 **Date of request:** 01 September 2014

Please note other organisations requesting this advice (if more than the lead body noted above):

NHS England (London)

Please state as clearly as possible what advice you are requesting from the Clinical Senate

SWLSTG has embarked on plans to develop new mental health inpatient facilities for the south west London sector. The plans propose delivering future inpatient services from two sites rather than three in order to satisfy the latest Royal College guidance on safety and effectiveness for inpatient care and to provide sustainable mental health care in the long term. The plans aim to deliver inpatient care from new estate that is purpose built for the 21st century and be able to flex to accommodate the appropriate number of beds for emerging models of care based more around community than inpatient services. Specialised services for deaf people, eating disorders, secure services and **Obsessive Compulsive Disorder (**OCD**)** services will not move from their existing site while CAMHS will be re-provided in a new location with much increased facilities. The Trust is about to embark on the public consultation stage of this journey following its submission of the Strategic Outline Case (SOC) attached.

The proposals for inpatient services form part of a wider strategy for mental health services in south west London and reflect changes in the development of services closer to home, including alternatives to hospital admission, that have been implemented and which are planned.

In this context advice is requested that the clinical case for change and proposed model of care:

a. are underpinned by a clear clinical evidence base (where this exists)
b. are informed by best practice
c. will enable improvements in quality
d. align with national policy and regional and local intentions
e. should enable compliance with CQC standards
f. demonstrate parity of esteem (compared with physical healthcare)

Given the important interface and pathways between inpatient and community services advice is requested on the overall model of mental health care for the population of south west London.

Please state your rationale for requesting the advice? (What is the issue, what is its scope, what will it address, how important is it, what is the breadth of interest in it?)

It is good practice to seek an independent view that proposals for change are clinically robust and evidence-based and will improve the quality of care for the population served.

The advice is also requested to provide independent clinical advice to NHS England that the proposed case for change meets the test that there is "a clear clinical evidence base", which forms a key part of NHS England's service change assurance process.

What is the purpose of the advice? (How will the advice be used and by whom, how may it impact on individuals, NHS/other bodies etc.?)

The advice will inform NHS England's service change assurance process. It will support commissioners in making the best decisions for the population (subject, as necessary, to the outcome of consultation). In addition it will:

a) ensure best practice has informed the proposals
b) confirm compliance with CQC standards
c) demonstrate to the Trust, NTDA, local commissioners, NHS England and local authorities that proposals have received external scrutiny
d) provide additional assurance for NHSE and CCGs on the service change proposed.

Please provide a brief explanation of the current position in respect of this issue(s) (include background, key people already involved, relevant data and supporting information, views on methodology to be applied).

The Trust is part way through its planning process in relation to the Estates Modernisation Programme to provide state-of-the-art mental health inpatient facilities for the people of south west London as well as for a number of national services.

Inpatient services are currently provided from three sites:

- Springfield University Hospital in Wandsworth (SUH)
- Tolworth Hospital in Kingston (TH)
- Queen Mary's Hospital in Roehampton (QMH).

The Trust currently provides the following inpatient services:

- Psychiatric Intensive Care Unit (PICU)
- Seven adult acute wards
- A number of rehab and supporting people type facilities
- Two older adult wards
- Four forensic wards of both medium and low secure
- A national OCD unit
- A regional deaf adult unit
- A regional eating disorders unit for adults
- A national eating disorders unit for young people
- A regional CAMHS tier 4
- The only national inpatient facility for deaf children with mental health issues.

Much of the accommodation fails to meet with modern standards and wards are not all fully compliant with CQC standards around best management of mixed-sex accommodation. Some of the wards were built in 1840 and bedrooms are therefore unacceptably small for modern mental health care and very few wards have ensuite facilities. The Trust is in a fortunate position to be proposing that it sells some of its land and

sites across south west London in order to resource the largest mental health Capital Programme currently proposed in the country.

A thorough process of evaluation has been completed with local stakeholders on future configuration and this concludes that modernised services provided from two sites (Springfield and Tolworth) would be safer, better and more efficient. The Trust will be consulting with the public on this preferred two-site option.

These proposals for inpatient services have been developed in the context of a broader strategy for mental health in south west London. Over recent years more care has been provided closer to home and this is set to continue. South West London CCGs intend to put in place more alternatives to hospital treatment which will:

- provide better mental health care overall
- reduce the number of people who need to be admitted to hospital, and how long they normally stay in hospital
- put the right care in place outside hospitals to enable people who are admitted to be discharged home sooner, with proper care and support.

The alternatives to hospital admission are set out in the CCG's draft five-year commissioning strategy published in May 2014. The collective effect of these developments is expected to reduce the requirement for mental health inpatient beds by about 10 per cent from 2018 onwards, compared to the position in 2014. The proposals for inpatient services are based on these plans.

When is the advice required by? Please note any critical dates

Advice is requested by the end of November 2014. This is considered a critical due to the required submissions of the Trust's Outline Business Case by March 2015 in order for the TDA to assess the OBC during Purdah and proceed after the election without undue delay.

Subject to agreement amongst key stakeholders public consultation on these proposals will take place as early as possible. The consultation is currently scheduled to start on 15th September and complete by 5th December and if there were any critical messages from the Clinical Senate review that could be shared during the latter stage of consultation that would be most welcome.

Has any advice already been given about this issue? If so please state the advice received, from whom, what happened as a consequence and why further advice is being sought?

The Trust has received legal advice from Capsticks throughout the planning and consultation process and has received guidance at all steps of this journey from the TDA.

NHS England has also provided advice and support on the assurance process for this service change.

Is the issue on which you are seeking advice currently subject to any other advisory or scrutiny processes? If yes please outline what this involves and where this request for advice from the Clinical Senate fits into that process: (*state N/A if not applicable*)

The Public Consultation process required the establishment of a Joint Health Overview and Scrutiny Committee drawn from the five south west London boroughs. NHS England is also in the process of providing scrutiny and assurance before consultation starts.

The Joint HOSC have established a sub-committee to work with the Trust and its commissioners throughout

public consultation and will formally meet at the consultation's conclusion.

Each of the five south west London CCGs and NHS England London will be meeting in by the end of January 2015 to discuss approval of the outcome of the public consultation after which the Trust plans to submit its Outline Business Case to the TDA by the end of March.

If the issue on which you are requesting advice relates to a provider organisation please note: (*state N/A if not applicable*)

(a) **What action the provider Board has already taken to address it?**

The Trust Board supports this request for advice from the Clinical Senate.

(b) **Whether discussions have taken place between the provider Board and CCFG(s) to address the issue and action taken as a result:**

The Trust, CCGs and NHS England have discussed the issues fully.

If the issue on which you are seeking advice relates to the urgent and emergency care pathway please note what action the local Urgent Care Board has taken to address it (*state N/A if not applicable*)

Not applicable

Please note any other information that you feel would be helpful to the Clinical Senate in considering this request.

A copy of the Trust's Strategic Outline Case for Investment in Redevelopment of Site-Based Mental Health Services in South West London & St Georges is attached.

Copies of each of the Transformation Programme briefs are attached.

A copy of the final draft public consultation document is attached.

Appendix D: National and local context for mental health services

The following list provides some context to the discussions of the Clinical Review Team. It is not an exhaustive list, but may provide background to readers interpreting this document.

National context for mental health services[20]

- The *Health and Social Care Act 2012* set out the legal framework for reducing the divide between how mental health is treated compared physical health problems. "Parity of Esteem" is a key priority for mental health services set out in the 'Everyone Counts' planning guidance
- The Department of Health document '*Closing the Gap'*, published in January 2014, sets out 25 priorities for change in mental health services. It details how changes in local service planning and delivery will make a difference to the lives of people with mental health problems in the next two and three. '*Closing the Gap'* supports the government's mental health strategy '*No Health without Mental Health'*.
- Patient choice applies from 1st April 2014. Patients will have more choice about how and where they get treated for their condition in the NHS on equal parity with choice for physical conditions.
- The Better Care Fund allocated money to support the integration of social care and adult mental health and the transfer of health budgets to the local authority.
- There are currently no mental health standards for London however services will need to adapt as these standards are developed
- There is a planned nationwide reduction in the amount of money available for secondary mental health care

Local context for mental health services

- Current services need to continually focus on providing community-based care wherever possible and ensuring patients are treated in the least restrictive setting possible
- Mental health pathways are not integrated with physical health and social care
- Access to psychological services routinely exceeds the target waiting time of one month
- Services that are interdependent with mental health do not have definite working arrangements and developed service protocols
- There are two main mental health providers delivering inpatient care for SWL residents, with an increasingly mixed economy of care provided overall. The models of care in place across the different boroughs of south west London vary in the way they adopt a whole system approach to designing mental health services.

South West London and St George's Mental Health NHS Trust is the main provider of community-based mental health and social care service, acute, step-down and specialist inpatient services, as well as a number of support and day care services for people of all ages living in the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth; serving a population of 1.05 million people in those boroughs. It also provides a wide range of specialist regional and national services.

It proposes to invest in the modernisation of campus-based facilities located in south west London which will rationalise and re-provision services currently located on three sites onto two sites, which

[20] *South West London Five-Year Strategic Plan*, March 2014

will involve “replacing outdated and noncompliant[21] accommodation with modern and compliant facilities from which comprehensive and patient-centred services can be provided.”

In its consultation document, the Trust says that the development of community mental health services means that the traditional pattern of long admissions to mental health hospital services has also changed. People tend to stay in hospital for a few weeks, rather than many months or years. Their care is geared to enabling them to recover their independence so that, with support, they can be discharged as soon as possible.

It states that modern mental health inpatient facilities for south west London are needed that are fit for purpose, give people the best chance to recover in the best environment, support staff to deliver high-quality care, and are sustainable for the NHS in the long term.

Given the important interface and pathways between inpatient and community services, Kingston CCG, on behalf of the five CCGs and NHS England (London) Specialised Commissioning, asked the London Clinical Senate for its advice on the its proposals.

The plans are currently the subject of a public consultation which is running from 29 September to 21 December 2014.

[21] In relation to consumerism standards

Appendix E: Clinical Review Team members

Chair: Dr Adrian Bull was appointed as Managing Director of Imperial College Health Partners in April 2013. He began his medical career by serving for six years in clinical practice in the Royal Navy, qualifying as Member of the Royal College of General Practitioners, before continuing as an epidemiologist and public health consultant in the NHS. He has been Medical Director of an NHS trust and held senior executive positions at PPP Healthcare, Carillion and Humana. From 2008 to 2013 he was Chief Executive of Queen Victoria Hospital NHS Foundation Trust.

Dr Arokia Antonsamy is a Consultant Psychiatrist and Clinical Network Director at Lancashire Care NHS Foundation Trust, and has recently been appointed Clinical Lead for Mental Health at the Greater Manchester Lancashire and South Cumbria Strategic Clinical Network. She teaches on the Medical Leadership in Practice course at the Manchester Business School and supervises higher specialist trainees in their special interest sessions in management. In 2008, she was awarded the 'Rethink Academic prize' by the Manchester Medical Society for her research project at Wythenshawe Hospital looking into patients' satisfaction and unmet needs. She won the 'Trust Innovator' award in 2010 for creating the 'MaZon' tool that helps to evaluate and monitor the patients' progress in inpatient and community settings, and her 'Handshake project' helped to enhance the working relationship between psychiatric professionals and general practitioners.

Antonia Borneo is Head of Policy Development at Rethink Mental Illness, where she has worked since 2007. Particular areas of focus have been early mortality in people affected by severe mental illness, access to evidence-based treatment and therapies (including talking therapies), and early intervention in psychosis; she led the delivery of the first National Psychosis Summit earlier this year. Since the reforms to health and social care, Antonia and her team have focused on implementation of good practice, including co-production approaches to local commissioning and, since early 2014, she has led the delivery of projects within the Rethink Mental Illness' Innovation Network, including intervention level evaluation, and shared learning about services and pathways between Network members.

Clare Duigan is Head of Mental Health Services in the London Borough of Enfield, managing the lead responsibility for social care provision through partnership arrangements with the local Mental Health Trust. With a particular interest in personalised care and partnership working, she has 25 years' experience of local authority social care, 15 of those in mental health multi-disciplinary management. Clare is Chair of Enfield's Mental Health Partnership Board and a member of the London Councils' Mental Health Lead Networks. She is also a member of the regional and national Principal Social Workers' networks and formative member of the North East London Approved Mental Health Professional Training Consortium and peer reviewer for the London Social Care network.

Tracey Edwards has almost 20 years' experience in mental health care, initially as a clinical practitioner in a variety of settings before moving into management and leadership posts. She currently works as the Trust Professional Lead Occupational Therapy for North East London NHS Foundation Trust, with additional strategic responsibility for Recovery and Social Inclusion where she has developed an employment pathway and a recovery college. Tracey is also actively engaged in various London region forums to develop the agenda for these subjects including London AHP forum (HEE), HENCEL AHP forum (LETB) and with the College of Occupational Therapists. She is currently working with UCL Partners to further develop work on the employment pathway in mental health settings.

Dr Rita Harris is CAMHS Director of the Tavistock and Portman NHS Foundation Trust. She continues to work as a Clinical Psychologist and family therapist in a fostering, adoption and kinship

care service within the Trust, specialising in issues of contact for children with parents with whom they no longer live. Rita has a long record of developing community services in partnership with local authorities and the voluntary sector, and involving children and young people in their planning and delivery. She has continued to develop multi-agency services in a partnership with others both locally and nationally for the most vulnerable children, young people, and their families in a range of settings. She also has extensive experience in developing, managing and consulting to a range of services for children and young people and has written extensively in the areas of organisational change, consultancy and working with children in care. She is CYP IAPT Leadership and Management Training Director for the London Collaboration (University College London and Kings College London).

Dr Jayne Hawkins has worked as a psychologist in the NHS in Leeds for over 20 years and is currently head of the psychology and psychotherapy service at Leeds and York Partnership NHS FT, working with those aged 18 years through to late life. Dr Hawkins is also the psychology and psychotherapy strategic lead for the trust, responsible for providing leadership and direction to ensure the successful development, co-ordination delivery and quality of psychological practice across all specialties. Dr Hawkins has trained in neuropsychology and works with people with cognitive impairment, memory difficulties and dementia of all ages; additionally she works clinically with a specialist multi-disciplinary team for younger people (aged under 65yrs) who have dementia. Prior to her current post, Dr Hawkins managed the psychology service for older people (aged over 65yrs) and sat on the British Psychological Society (BPS) National Committee for the Faculty of Older People (FPOP). She is currently a member of the Yorkshire and the Humber Clinical Senate.

Dr Anne Hicks, is Emergency Department Consultant and Trust lead for mental health and liaison services, Plymouth Hospitals NHS Trust. She has been a consultant in emergency medicine at Plymouth since July 2005, is Medical Director for the British Antarctic Survey Medical Unit, and programme lead for the masters in remote and global health. She has had a special interest in mental health since working as a registrar at St Thomas' Hospital, and is the mental health representative for the College of Emergency Medicine. This has included being a member of the Psychiatric Liaison Accreditation Network accreditation committee, sitting on the working group for the Mental Health Concordat and on the NHS mental health patient safety committee.

Sally Kirkpatrick worked in financial consultancy in the City but since retirement she has moved into the NHS related sector on a voluntary basis. She is a Patient and Public Voice member of the London Clinical Senate and is a trustee and company secretary of a mental health charity that gives support to both carers and those suffering from mental ill health. She has participated in several NHS public consultations and reviews giving the viewpoint of patients and the public, and is a member of the South London and Maudsley NHS Foundation Trust involvement register and regularly reviews research proposals before they are submitted to the ethics committee. She works with her local Healthwatch as a volunteer Mystery Shopper and Enter and View visitor in GP surgeries, Care homes etc, and is a member of both the pan-London End of Life Alliance and the steering committee for Smoking Cessation in London.

Dr Raj Kumar is a GP with special interest in mental health and the Clinical mental health lead for Barking and Dagenham Clinical Commissioning Group (BDCCG). He has been a GP since 2006 and enjoys teaching and training in his practice (Having been accredited as a GP trainer, there are medical students, FY2 doctors and GP registrars in his practice). He was the lead clinician in formulating a clinical pathway for depression and anxiety for Barking and Dagenham, Havering, and Redbridge CCGs and involved with contractual negotiations with BDCCG's local mental health provider.

Andy Mattin, is Executive Director Nursing and Quality at Central and North West London NHS Foundation Trust which he joined in 2010. He has worked in the NHS since 1983, holding various nursing and management posts in London and the East of England. He has a wide range of

experience in health and social care organisations and has held roles in the commissioning, providing and performance management of services. He has a particular interest in service user and carer experience and is a Registered Nurse-Mental Health and Registered Nurse-Adult. He holds the post of visiting Professor of Nursing at Buckinghamshire New University, and is a Council member of the London Clinical Senate.

Dr Sylvia Tang joined The Priory Group as Group Medical Director in October 2014 after working for Camden and Islington NHS Foundation Trust where she was Deputy Chief Executive and Medical Director since 2012 and Medical Director since 2006. She has extensive clinical experience working in community teams, crisis teams and inpatient wards as a Consultant Psychiatrist and led the Trust's clinical and quality strategy for the past eight years, leading a redesign of services to a care pathway model with the emphasis on recovery, choice, outcomes and promoting community alternatives to hospital. She was Director of Research and Development and Responsible Officer for revalidation of doctors, responsible for pharmacy, corporate governance, planning and communications. She is a member of the Monitor Mental Health and Community Medical Advisory Group, the Clinical Senate Council for London, and the London Strategic Clinical Network Clinical Leadership Group for mental health.

Appendix F: Potential conflict of interest declarations

In addition to the biographies described above, the following members of the Clinical Review Team have declared the following interests:

Dr Sylvia Tang, Group Medical Director, Priory Group. Priory Group is a provider of tier 4 CAMHS beds, secure services, and eating disorders nationally.

Appendix G: Clinical Review Team terms of reference

London Clinical Senate

CLINICAL REVIEW TEAM: TERMS OF REFERENCE

Title: Advice on proposals for inpatient mental health services in south west London

Sponsoring Organisation: Kingston Clinical Commissioning Group (CCG) on behalf of Kingston, Merton, Richmond, Sutton and Wandsworth CCGs and NHS England (London) Specialised Commissioning

Clinical Senate: London

NHS England regional or area team: NHS England (London)

Terms of reference agreed by:

Dr Adrian Bull

on behalf of the London Clinical Senate and

Dr Phil Moore

on behalf of Kingston, Merton, Richmond, Sutton and Wandsworth CCGs and NHS England (London) Specialised Commissioning

Date: 16 September 2014

Clinical review team members

The Review Team will have around 10 members (and a maximum of 12). The aim is to ensure the overall membership includes the following expertise and perspectives and gives a balance of membership from different geographies in London (unrelated to the changes proposed) and external expertise, independent of London:

- Dr Adrian Bull, Clinical Senate Council Member and Managing Director, Imperial College Health Partners (Clinical Review Team Chair)
- Consultant psychiatrists (general adult, forensic services, rehabilitation and out of London perspective proposed)
- A psychiatric nurse
- A psychologist
- A child and adolescent mental health services professional
- Service users and carers
  - Rethink
  - A member of the London Clinical Senate Patient and Public Voice
- A social care member
- A GP
- An emergency medicine consultant.

Advice on membership will be sought from the London Clinical Senate Council members with mental health services expertise, the Clinical Director of the London Mental Health Strategic Clinical Network,

the National Clinical Director for Mental Health and the Royal College of Psychiatrists. At least two members of the Review Team will be from outside of London.

The Review Team will not include any members who have been involved in the development of the south west London proposals or who have been involved, or are likely to be involved, in any other part of the NHS England assurance process in respect of this scheme. All Clinical Review Team members will be required to sign a Declaration of Conflict or Interest and a confidentiality agreement.

Aims and objectives of the clinical review

Kingston CCG on behalf of Kingston, Merton, Richmond, Sutton and Wandsworth CCGs and NHS England (London) Specialised Commissioning has asked the Clinical Senate to provide independent clinical advice on proposals for inpatient mental health services in South West London which underpin a substantial development programme to modernise facilities provided by South West London and St George's Mental Health NHS Trust.

The Clinical Senate has been asked to provide advice on whether the clinical case for change and proposed model of care for inpatient mental health services:

1. are underpinned by a clear clinical evidence base (where this exists)
2. are informed by best practice
3. will enable improvements in quality
4. align with national policy and regional and local commissioning intentions
5. will, if delivered, enable compliance with CQC standards
6. demonstrate parity of esteem (compared with physical healthcare).

Scope of the review

South West London and St George's Mental Health NHS Trust provides a range of local and specialised mental health services commissioned by CCGs and NHS England respectively. The Trust has developed proposals to modernise its inpatient facilities, which comprise:

- Psychiatric Intensive Care Unit (PICU)
- Adult acute wards
- A number of rehab and supporting people type facilities
- Older adult wards
- Forensic wards of both medium and low secure
- A national OCD unit
- A regional deaf adult unit
- A regional eating disorders unit for adults
- A national eating disorders unit for young people
- A regional CAMHS tier 4
- The only national inpatient facility for deaf children with mental health issues.

Much of the accommodation fails to meet modern standards and not all wards are fully compliant with CQC standards for best management of mixed-sex accommodation. Some wards were built in 1840 and bedrooms are therefore unacceptably small for modern mental health care and very few wards have ensuite facilities.

An evaluation process involving local stakeholders, has concluded that modernised services provided from two, rather than the current three sites would be safer, better and more efficient. The Trust will be consulting with the public on this preferred two-site option. The plans aim to deliver inpatient care from

new estate that is purpose built for the 21st century and is able to flex to accommodate the appropriate number of beds for emerging models of care based more around community than inpatient services. Specialised services for deaf people, eating disorders, secure services and OCD services will not move from their existing site while CAMHS will be re-provided in a new location with much increased facilities.

The proposals for inpatient services have been developed in the context of a broader strategy for mental health in south west London. The necessity of inpatient care is fully acknowledged and the CCGs are keen to see the provision of safe and compliant accommodation that will also enhance the patient experience. The CCGs are also in the process of reviewing, improving and extending community services to provide a much more comprehensive service, including enhanced crisis intervention and home treatment, aimed at maintaining more patients safely in the community and relying less heavily on inpatient care.

The alternatives to hospital admission are set out in the CCG's draft five-year commissioning strategy published in May 2014. The collective effect of these developments is expected to reduce the requirement for mental health inpatient beds by about 10 per cent from 2018 onwards, compared to the position in 2014. The proposals for inpatient services are based on these plans.

The scope of this review will therefor consider inpatient and community-based services. Specifically, proposals for inpatient services will need to be considered in the context of plans for community-.

Methodology

This process adheres to the recently published guidance[1] on the role of clinical senates in providing clinical advice to inform NHS England's service change assurance process. It will involve the following key steps:

Step 1: Establish the Clinical Review Team (see proposed composition on page 1)

Step 2: Brief the Clinical Review Team and circulate documentation for desk-top assessment (see proposed schedule of documentation on page 4)

Step 3: Hold a meeting/teleconference with the Clinical Review Team to:

a. agree the overall methodology that will be applied in formulating the advice
b. share desk-top assessment findings,
c. identify issues that need to be explored, clarified or validated to assist in formulating the advice
d. agree any further information/documentation that Clinical Review Team members wish to request to inform the review

Step 4: Hold a Clinical Review Team "hearing session" (1 day) to undertake the following:

e. Meet, hear from and discuss issues identified with stakeholders involved in development of the proposals to seek responses to key lines of enquiry
f. Debate and finalise conclusions
g. Agree the process for following up any outstanding issues

Step 5: **(a)** Prepare a report setting out overall findings, conclusions and any recommendations and circulate to the Clinical Review Team

(b) Hold a meeting/teleconference with the Clinical Review Team to discuss the draft report content and agree any amendments

Step 6: Once agreed by the Clinical Review Team**,** share the report with the Senate Council which will:

- Ensure terms of reference have been met
- Comment on any specific issues where identified by the Clinical Review Team
- Agree that the report can be issued

Step 7: Issue the report and advice to the sponsoring organisation.

It is proposed to hold the "hearing session" in step 4 at one of the current inpatient sites.

The Clinical Senate Council and Clinical Review Team will draw on the following, which includes guidance on testing an evidence base, in framing the approach and formulating advice:

- *Clinical Senate Review Process: Guidance Notes*, NHS England, August 20142
- NHS England's *Service Change Toolkit*
- *Planning and delivering service changes for patients, guidance*, NHS England, December 2013.

The Clinical Senate Council has also agreed a set of principles which it believes are essential to improving quality of care and outcomes. The Council will seek evidence of, and promote, these principles in the issues it considers and the advice that it provides. They are:

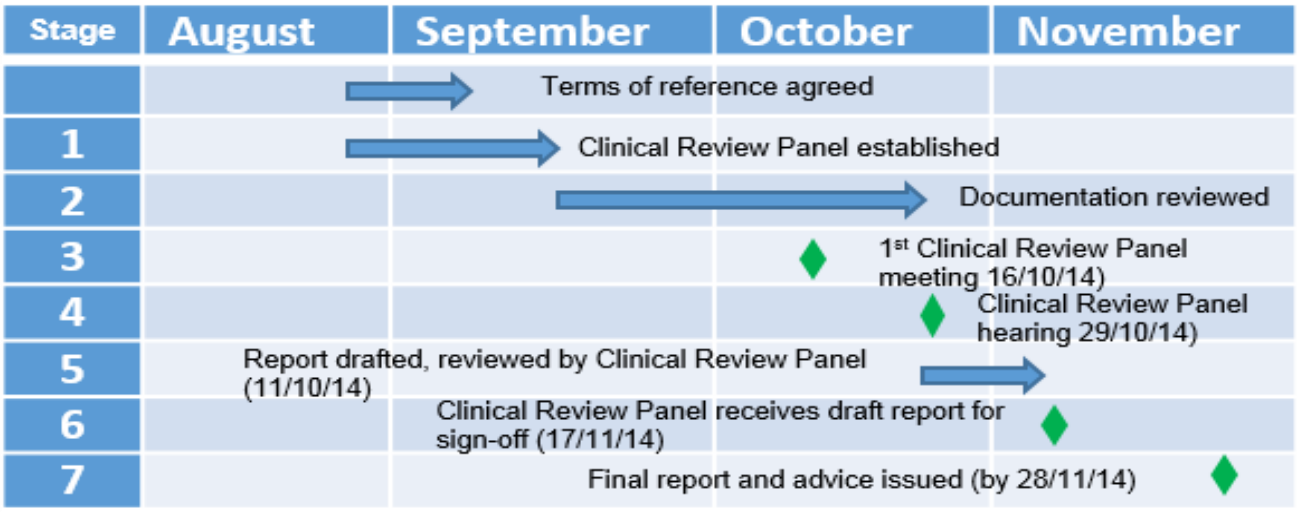
- Ensuring a **seamless patient journey**
- Being **patient-centred** (this includes patient experience, tackling inequalities – in
- access and outcomes – and being responsive to the diversity within London's population)
- **Supporting self-care**
- **Improving standards** (these include use of evidence and research, application of
- **Improves outcomes** national guidance, best practice and innovation)
- Ensuring **value** (this includes issues such as long-term sustainability, implications for the clinical workforce, consideration of unintended consequences).

The documentation requested for this review (to be confirmed following establishment of the Clinical Review Team) is:

- Case for change
- Model of care/proposed clinical models (including transformation programme outputs)
- Quality strategy/quality account/CQC inspection report(s)
- Activity modelling/patient pathways/quality indicators benchmarking data
- Strategic Outline Case
- Transformation programme and associated service development plans
- Improving inpatient mental health services in South West London consultation document
- Equality impact assessment
- Schedule of evidence and best practice that have informed the proposals
- CCG five year commissioning strategies
- JSNAs
- Other relevant/local strategies/service reviews/service redesign.

Timeline

South West London CCGs have requested the advice by the **end of November 2014**.



The Clinical Review Team will formulate advice requested based on consideration and triangulation of documentation provided, discussion with key stakeholders and members' knowledge and experience. The advice will be provided as a written report.

Risks

It is essential that the process through which the Clinical Senate formulates its advice is robust and the approach outlined is designed to do this. Recruiting appropriately experienced Clinical Review Team members who are available on the key dates set for the review and ensuring adequate time to prepare for key activities are the most critical elements and pose the greatest risks. The lead time for this review is designed to mitigate these risks.

Reporting arrangements

The Clinical Review Team will report to the Clinical Senate Council which will agree the report and be accountable for the advice contained in the final report.

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

Report

A draft report setting out the advice will be made to the sponsoring organisation to check for any factual inaccuracies prior to publication. Comments/correction must be received within three working days.

The final report will be submitted to the sponsoring organisation by 28 November 2014.

Communication and media handling

Kingston CCG will be responsible for publication and dissemination of the report. The expectation is that it will be publicly-available as soon as possible following completion. The Clinical Senate will post the report on its website (when in place) at a time agreed with the sponsoring organisation.

Communication on issues other than the clinical review and all media enquiries will be dealt with by the sponsoring organisation.

If helpful, the Clinical Senate will support the sponsoring organisation in presenting the outcome of the review and explaining the rationale for the advice provided e.g. at a key stakeholder meeting subject to discussion and availability of Clinical Review Team members.

Resources

The Clinical Senate will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.

The sponsoring organisation will identify a named contact to assist in provision of the information and to assist in coordinating stakeholders' participation in the review at a local level.

The Clinical Review Team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

Accountability and Governance

The Clinical Review Team is part of the London Clinical Senate accountability and governance structure.

The Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation. The sponsoring organisation remains accountable for decision making, however the review report may draw attention to specific issues, including any risks that the sponsoring organisation may wish to fully consider and address before progressing the proposals.

Functions, responsibilities and roles

The **sponsoring organisation** will:

i. provide the Clinical Review Team with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance and other documentation requested. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions). The sponsoring organisation will provide any other additional background information requested by the Clinical Review Team (see requested documentation scheduled on page 4 of the ToR)
ii. respond within the agreed timescale to the draft report on matters of factual inaccuracy
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review
iv. submit the final report to NHS England for inclusion in its formal service change assurance process.

Clinical Senate Council and the sponsoring organisation will:

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

Clinical Senate Council will:

i. appoint a Clinical Review Team, this may be formed by members of the Senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member,
ii. endorse the terms of reference, timetable and methodology for the review,
iii. consider the review recommendations and report (and may wish to make further recommendations),
iv. provide suitable support to the team, and

v. submit the final report to the sponsoring organisation.

Clinical Review Team will:

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

Clinical Review Team members will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, panels etc that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it.
v. declare, to the chair and the clinical senate manager, any conflict of interest prior to the start of the review and /or any that materialise during the review.

Key points of contact

For the London Clinical Senate
Sue Dutch, Clinical Senate Programme Lead

For South West London CCGs
Dr Phil Moore or named nominee

For South West London and St George's Mental Health NHS Trust
Dawn Chamberlain, Director of Operations or named nominee

Appendix H: Clinical Review Team hearing session

London Clinical Senate

HEARING SESSION PROGRAMME – 29 OCTOBER 2014

Time	Activity	Purpose
9.00 – 10.15	Clinical Review Team preparatory session	• Finalise areas of enquiry • Finalise format – e.g. which Review Team members lead questions on key issues
10.15 – 11.45	Interview with senior members of **South West London and St George's Mental Health NHS Trust** *Andrew Dean, Director of Nursing and Quality* *Dr Emma Whicher, Medical Director* *Dawn Chamberlain, Director of Operations* *Dr Mark Potter, Clinical Director Wandsworth* *Dr Diana Cassell, Clinical Director CAMHS* *Sharon Spain, Head of Nursing*	• Trust to present an overview of the case for change and proposed model of care; how the model of care and options for delivery were developed; how evidence has been used to inform the proposals; quality and outcomes improvement goals • Review Team to explore the case for change, model of care, overall coherence and strength of evidence, alignment with best practice, clarity of quality goals and deliverability , involvement of key stakeholders and fit with the wider system
11.45 – 12.15	Interview with **NHS England (London) Specialised Commissioning** *Caroline Reid, Regional Lead (London) Mental Health Programme of Care* *Patrice Beveney, Commissioning Manager* *Brent Pirie, Commissioning Manager*	• Understand commissioners' priorities for specialised mental health services, views on the case for change, model of care , evidence base and quality goals
12.15 – 13.00	Interview with representatives of **service users and carers** *Four service users* *A carer* *A representative from Wandsworth Healthwatch*	• Explore the case for change, model of care and quality goals from the perspective of service users and carers
13.00 – 13.30	Lunch break	• Take stock of progress – review/reaffirm areas of enquiry for afternoon session

Time	Activity	Purpose
13.30 – 14.30	Interview with representatives from **South West London CCGs** *Dr Phil Moore, South West London Mental Health Clinical Lead)* *Tonia Michaelides, Chief Officer, Kingston and Mental Health Lead for South West London* *Sylvie Ford, Mental Health Commissioner, South West London* *Stavroula Lees, Mental Health Clinical Lead, Richmond CCG* *Lucie Waters, Director of Commissioning, Wandsworth CCG* *Adam Doyle, Director of Commissioning, Merton CCG* – apologies *Dr Chris Elliott, Clinical Chief Officer, Sutton CCG*	• Understand commissioners' priorities for mental health and how the proposals align to these plus wider commissioning intensions across the health economy • Explore commissioners' views on the case for change, model of care, evidence and quality goals • To make best use of time we would like to spend some time exploring GPs views as health care providers as well as commissioners.
14.30 – 15.15	Interview with representatives of the five **Local Authorities** *Rob Percy, Head of Joint Commissioning, Wandsworth Council* – unable to attend *Simon Williams, Director of Adult Social Services* (by phone)	• Understand Local Authorities' priorities for mental health services and views on the case for change, model of care, evidence base and quality goals
15.15 – 16.00	Interview with **other providers** (hospital, community services. NB primary care will be covered in the CCG session) *Dr Jane Evans, Consultant in Acute and Respiratory Medicine, St George's Healthcare NHS Trust* – unable to attend *Dr Dan Harris, Lead Consultant in Emergency Medicine, Kingston Hospital NHS Foundation Trust* – unable to attend *Dr Chris Keers, GP involved in developing the dementia pathway* – unable to attend *Adrian Davey, Joint Commissioning Manager, Sutton CCG* *Jonathan Hildebrand, Medical Director, Your Healthcare* (by phone)	• Understand other providers' relationship with the services subject to review, how they interface in delivery terms and how this has been considered. • Explore the extent of overall cohesion, physical/mental health interface, current challenges (quality, service) and impact of proposals
16.00 – 15.15	*Carol Payne, Head of Special Needs and Disabled Children's Services*	• Explore partnership working in relation to CAMHS and views on the case for change, model of care, evidence base and quality goals (unable to attend until 4.00pm)
16.15 – 17.30pm	Clinical Review Team debates and finalises conclusions	• Sum-up judgement and agree evidence for this • Agree the process for following-up any outstanding issues/queries – and timeline • Confirm arrangements for sharing and signing off the report from this session
17.30pm	Session ends	• Estimated – exact time depends on extent of discussion required

Appendix I: Reference documentation

Documentation submitted to the Clinical Review Team

DOCUMENT TITLE	AUTHOR
Documentation submitted to the Clinical Review Team	
Inpatient mental health services in South West London – proposals for public consultation, September 2014	Kingston Clinical Commissioning Group Merton Clinical Commissioning Group Sutton Clinical Commissioning Group Richmond Clinical Commissioning Group Wandsworth Clinical Commissioning Group NHS England South West London and St George's Mental Health NHS Trust
Strategic Outline Case for investment in redevelopment of campus-based mental health services in South West London & St George's plus appendices – November 2013 (Updated March 2014) Volumes 1 and 2	South West London and St George's Mental Health NHS Trust
Adult community modernisation (productivity project): stage report	South West London and St George's Mental Health NHS Trust
South West London 5-year Strategic Plan, June 2014	NHS South West London Commissioning Collaborative
South West London Mental Health Commissioning Intentions 2015/16 v. 012	NHS South West London Commissioning Collaborative
South West London (acute) Commissioning Intentions 2015/16 v0.18	NHS South West London Commissioning Collaborative
Draft Estates Modernisation Programme consultation communications delivery plan (v003, 04 July 2014)	South West London and St George's Mental Health NHS Trust
Developing mental health services in South West London Consultation Plan v7 (September 2014)	South West London and St George's Mental Health NHS Trust
Communications and engagement strategy, June-September 2014	NHS South West London Commissioning Collaborative
Adult Community Modernisation Stage Report (Productivity Report) 22/09/14 v0.2	Adult Community Modernisation Stage Report (Productivity Report) 22/09/14 v0.2
Community Modernisation Business Case Presentation	South West London and St George's Mental Health NHS Trust
South West London and St George's Mental Health NHS Trust quality report, June 2014	Care Quality Commission

DOCUMENT TITLE	AUTHOR
CQC Quality Report for South West London and St George's Mental Health NHS Trust (June 2014)	Care Quality Commission
Current and proposed bed numbers for South West London and St George's Mental Health NHS Trust estates modernisation programme	South West London and St George's Mental Health NHS Trust
National Policy, Guidance and Best Practice underpinning the Community Modernisation Programme	South West London and St George's Mental Health NHS Trust
Older people's community care pathway modelling – October 2014	South West London and St George's Mental Health NHS Trust
Older people's community service transformation – briefing to joint management group – October 2014	South West London and St George's Mental Health NHS Trust
South West London mental health inpatient needs assessment March 2102 (Rev) and Executive Summary (June 2012)	BEACON UK and Maudsley international
Equality Impact Assessment of SWLSTG Inpatient Service Changes	South West London and St George's Mental Health NHS Trust
Internal papers setting out workforce information for community teams and projected changes	South West London and St George's Mental Health NHS Trust
A schedule of evidence that informed the proposals (evidence cited is listed below)	
Accreditation for inpatient mental health services	Royal College of Psychiatrists
Best Practice Guidance – Specification for adult medium-secure services, July 2007	Department of Health
Children and young people in mind: The final report of the National CAMHS Review, November 2008	Department of Health
Children's and adolescents' mental health and CAMHS – Third Report of Session 2014-15, November 2014	House of Commons Health Committee
Clinical Senate Review Process: Guidance Notes, August 2014	NHS England
Quality Network for inpatient CAMHS	Royal College of Psychiatrists
Dementia – Commitment to the care of people with dementia in hospital settings, January 2013	Royal College of Nursing
Do the right thing: How to judge a good ward. Ten standards for adult in-patient mental healthcare, June 2011	Royal College of Psychiatrists

DOCUMENT TITLE	AUTHOR
FACT: A Dutch Version of ACT; Community Mental Health Journal, 2007	Remmers van Veldhuizen (2007)
Helping People through Mental Health Crisis: The Role of Crisis Resolution and Home Treatment Services, 2008	National Audit Office
Inpatient mental health services in South West London – proposals for public consultation, September 2014	South West London and St George's Mental Health NHS Trust
Joint Strategic Needs Assessment – Royal Borough of Kingston	Royal Borough of Kingston
Joint Strategic Needs Assessment – London Borough of Merton	London Borough of Merton
Joint Strategic Needs Assessment – London Borough of Richmond	London Borough of Richmond
Joint Strategic Needs Assessment – London Borough of Sutton	London Borough of Sutton
Joint Strategic Needs Assessment – London Borough of Wandsworth	London Borough of Wandsworth
London takes action to become world's first dementia-friendly capital city, September 2013	Alzheimer's Society
Low Secure Services – Good practice commissioning guide, January 2012	Department of Health
Mental Health and the productivity challenge, 2010	The King's Fund
Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis, February 2014	Department of Health and Concordat signatories
'No health without mental health': a cross-government mental health outcomes strategy for people of all ages, February 2011	Department of Health
Putting dementia on the map and driving up standards of care, November 2013	Department of Health
Quality standard for supporting people to live well with dementia, April 2013	NICE
Standards for low secure units, June 2012	Royal College of Psychiatrists
Standards for medium secure units	Royal College of Psychiatrists
Talking therapies: a four-year plan of action, February 2011	Department of Health

DOCUMENT TITLE	AUTHOR
The Dementia Challenge: fighting back against dementia, March 2012	Department of Health
The Prime Minister's Review on Dementia. Delivering major improvements in dementia care and research by 2015: Annual report of progress, May 2013	Department of Health
The Operating Framework for the NHS in England 2012/13, November 2011	Department of Health
The right care – creating dementia friendly hospitals, 2012	Dementia Action Alliance
UK health performance: findings of the Global Burden of Disease Study 2010, March 2013	The Lancet Psychiatry