1. Feedback on Overall Model.

We welcome and support the overall model of care, recognising that it has been designed by and for the many stakeholders involved in mental health care delivery in the city. Our local clinicians have valued detailed discussions recently with Commissioners on aspects of the model and individual pathways, and would appreciate further opportunities to continue such discussions where that is possible in terms of future recommissioning processes.

Staff and services in the city recognise that there will need to be significant change in order to guarantee sustained delivery of the model, and the advantage of our recent local clinical process to review the Pathways is that we can say with confidence that there is an eagerness to make these changes, amongst Consultants and other Senior Clinicians, amongst front line Team / Ward Managers and Senior Practitioners, and amongst local Operational Managers. We recognise that this change needs to be as much cultural as operational, and as we move into a locally managed service we are already starting work on both cultural change and local service model development.

Many aspects of the model have been highlighted in the Pathway Documents already sent to you from the work of clinical groups led by Dr Catherine Thompson, Dr James Eldred, Dr Will Hall and Dr Sarah Price. In addition to these, we would like to highlight the following as main themes:

a. **Primary Care and Recovery** - The move towards primary care, with community provision being based around defined numbers of GP Practices, is strongly supported, offering as it does a far closer relationship, and therefore continuity of care, between traditionally more separated primary and secondary care staff. We have some concerns regarding the viability of enough small teams across the city to ensure real localness, but believe that the sort of hub and spoke model outlined by Dr Catherine Thompson in her Recovery Pathway Document could offset these concerns, with at times some more central highly specialised city-wide provision to back up local delivery

b. **Severe Mental Illness and Agelessness** - Within the local community model we would raise two significant concerns: firstly that many of our clinicians in the current Recovery teams have voiced worries that there needs to be a heightened awareness of the “harder end” of community mental health work, and the support for complex needs of hundreds of service users who may not usually come into contact with primary care; secondly that all clinicians in our later life Complex Intervention Teams have expressed concerns that a fully genericised ageless approach would prove problematic when those with later life psychiatric illnesses, and their carers, need specialised support, recognising that with many referrals into our services there is a
co-existence of cognitive impairment and depression/anxiety which would not be helped by a full separation of dementia care from functional treatment.

c. Diversity – Our recent local discussions with Commissioners, with Partner Agencies, with Service Users, and with local Community Groups, have indicated to us that there are sections of the local communities who feel distanced from mental health provision in the city, and not confident that they can receive sufficient local support when in mental distress. We are currently reviewing our own service responses in these areas, and staff who have worked in areas such as the inner city for many years have reinforced to us that there has been gradual erosion over many years of targeted staff and services within our own provision. We are now starting work to address that internally and in liaison with local partner agencies, but would suggest that a greater commissioning as well as provider focus on diversity would be beneficial to ensure the best targeting and balance of provision to meet needs across the city. A shared approach across all providers to meeting the requirements of the NHS Equality Delivery System would also seem essential in any recommissioning specification.

d. Localness – Following changes in the Trust in recent months, there is now strong support at all levels, from local clinical teams up to and including the Trust Board, for a fully locally managed and clinically led service. This will be instituted before the end of 2012. We recognise that there may be parts of this service, along some Care Pathways, which could more effectively be delivered by other providers, particularly local non statutory services, and we are already having conversations with a number of Bristol based organisations to this effect. Our clinicians have though expressed some concerns that a recommissioning process which strongly separated the delivery of care between separately tendered Pathways could place barriers to effective treatment, such as if the Dementia pathway became too separated from functional care for older people, or Crisis delivery became too separated from Acute in-patient and PICU (Psychiatric Intensive Care) or equally too distant from Recovery Teams.

2. Themes from the 2011 Engagement

These were all highlighted in the formal consultation document,

a. A locally accountable Bristol structure – We fully support this as indicated in 1d above, and this will be in place for our current service model from December 2012. Our Recovery Teams are already sectorised to reflect the CCG Clusters and we support a further move to smaller Practice linked teams. Service Users have fed back to us a desire to sectorise the crisis response from our Bristol Intensive Team and we are already looking at strengthening the three cluster model in which the team now operates.

b. Much greater partnership and co-working – We fully support this and believe there are priority areas for this to be addressed, which we are already progressing but would suggest should be strengthened in recommissioning: shared statutory and non statutory delivery of
Recovery Pathway, Peer Support Workers and a Recovery College approach particularly for harder to reach communities, Community Rehabilitation, Crisis Pathway interaction with A&E and Criminal Justice Services, and work across the Chaotic Lifestyles and Complex Needs Pathway.

c. **Clearer and easier access to services** – In recent months the AWP Redesign has aimed to provide this, although we recognise that the current model of care we deliver will need to change to meet the proposed new Pathways and are starting to discuss this internally. Ideally such a discussion would also be held direct with GPs and we would welcome any opportunity to do this which did not compromise any aspect of the recommissioning process for ourselves or the Clinical Commissioning Group. From May to August 2012 we received 1582 referrals of which 1383 were from primary care and we will be seeking to further raise our responsiveness whilst reviewing the longer term service model. Our own clinicians, and community agencies, still believe that there are access issues related to some parts of the city, most specifically for a number of black and ethnic minority communities including for older people in those communities. It may be useful to review the final care destinations for the recent referrals into our services, including the greater proportion who do not get passed through to secondary care, as this may provide some useful insight as to delivery and gaps across the whole mental health system and not just specialised secondary services. We are also aware, as we know Commissioners are equally, that there are access problems to some specialised services in the city, and in particular ADHD. Whilst such services sit outside the remit of your consultation, we are keen to continue to work with you to ensure that ADHD provision, alongside support for other specialised areas such as Autism and Eating Disorders (primary and secondary care), are established at the levels needed in Bristol for the future.

d. **Crisis Services, which are responsive and meet demand** – Our discussions with service users and with carers in preparing this response have indicated that there is still further progress to be made by the current Bristol Intensive Team to meet demand. We hope that our work to support the opening of the Men’s Crisis House will partially address this, as will recent recruitment of 11 further staff. From participation in a number of consultation discussions, we strongly support the proposed Pathway, but have some concerns as to whether all levels of mental distress can be addressed by a Crisis Response. Service User feedback to us recently indicates that issues regarding a “responsive” service also refer to the customer care experience from those who call the service and we have already instituted further training in this area for all staff as from this month. Comments on the Walk In Centre are provided below.

e. **Open and responsive organisational culture** – We agree that this is essential for effective local community mental health care. It is a matter of public record that AWP was seen as an organisation with a less open and responsive culture until recently. This has been addressed as the highest possible priority by the Trust Board, and we believe that the engagement of many clinicians in open dialogue with Commissioners and partner agencies has started to demonstrate such change “on the ground”.
f. **Cultural competency skills for staff** – We support this particularly strongly and have been active in progressing RECC (Race Equality and Cultural Competency) Training for our staff in Bristol. Following recent team changes, we are now looking at a full roll out across the city for this training, and want to ensure it leads to sustainable change by ensuring as a priority a full course for all senior managers in the city as soon as we have agreed our permanent local management team. We would suggest that recommissioning ensures that shared approaches to such training and other work to improve cultural competency should be addressed across agencies, and even between commissioners and providers, rather than just in separate organisations.

g. **Ageless/needs led services** – Our comments on this have been covered in 1b above

h. **Dementia to be distinct from functional mental health** – Again this was covered in 1b. We support a distinct dementia service and pathway but not one that fragments older people’s care where there are concomitant functional mental health issues diagnosed or suspected. In addition we would add that for many later life issues, particularly dementia, there are significant psychosocial issues and we feel it is important that these are not lost if there is a strong physical healthcare focus on the dementia pathway. The current pilot where we are training Memory Nurses working in surgeries to help build skills, whilst maintaining the link to the specialist core team seems potentially viable – it is important to maintain links between mental health for older adult and primary care, as service users function in community settings between these services often with the support also of social services and voluntary agencies. The dementia pathway sounds particularly attractive for many people without complex problems but we are concerned that it may not have enough emphasis on those we currently see in Complex Intervention Teams with challenging behaviour, aggression, psychosis, as well as anxiety / depression, and many who refuse social care needing expert skills to engage and risk management. The pathway is also vague about crisis work for people with dementia. Crisis pathways for people with dementia ideally should be in partnership with social services and dementia specialists.

i. **Targeted interventions for younger people** – We have had verbal feedback in the consultation from Commissioners that our Early Intervention in Psychosis Service is highly valued. Discussions with Off the Record indicate a far wider number of young people in need of mental health support than are seen by our services. We strongly support the focus in the consultation on integrated pathways for young people and are currently finalising an Integrated Pathway with NBT CAMHS.

j. **The default position should be prevention and early intervention** – We support this but as expressed in 1b above we feel it is important not to underestimate the need for a focus on providing effective interventions for those with complex and often long term mental health problems whilst developing effective early intervention strategies. In relation to younger people, there are a small number of youth mental health services emerging in England and we would be very interested in working with commissioners and other stakeholders in looking at this approach in Bristol.
k. **The commissioning of mental health services should be integrated** – Probably the strongest concern expressed by our clinicians in teams across the city is the recent impact of disaggregation with social care. Mental Health Recovery is so often about social issues as well as health ones, and we would hope that a more integrated commissioning approach could lead back towards more integrated delivery. We have agreed with colleagues in the Council that we should soon start preliminary discussions as to how we could start to bring health and social care closer together again on the ground, and would welcome a joint commissioning drive in this area.

3. **Key Features of the New Model of Care**

Six key features have been raised for discussion in all consultation meetings at which our staff have been present.

a. **Multiple Access Points** – We recognise that there are individuals, communities and areas of the city for which a single access process or point is unhelpful. We support differentiated access and for example are currently in discussion with two different local BME organisations as to how this could most effectively occur for users of their services. We would however wish to understand further how the local practice linked community teams would manage access before deciding definitively on this. We assume that such teams would pick up much of the primary care facing role in our redesigned PCLS in Bristol, but would want to support some agencies and communities to have city wide access to Recovery Pathways as well as Crisis.

b. **Decreased and refocused in-patient/secondary care element enabling a greatly expanded community/primary care element** – As already stated in this response, we support a stronger community focus and shift of this closer to primary care. However we believe that the consultation document had less information on in-patient care which is still very important within an overall delivery system, which our clinicians think needs to be managed as a whole with specialist community and crisis services. Informal Commissioner feedback after visits to our services during the consultation was very positive about our acute, older people, intensive care and rehabilitation wards, and we would hope that a continued commissioning focus will continue for these areas. We are unclear from the consultation document as to whether the reduction of 10 rehabilitation beds mentioned in the document relates to the 40 beds set out or the current 30 beds. We have also shared with you in your visits to us that there is an increasing trend of admissions of young women with personality disorder, and we would suggest that a greater commissioning focus is needed in this area noting that further bed reductions may restrict the ability to bring more of such service users back from ‘out of Bristol’ placements. In relation to Psychiatric Intensive Care (PICU) we have a nationally recognised Women’s PICU and would hope that recommissioning ensure gender separate PICU provision. Recommissioning would also need to address the need for continued use of Section 136 as well as the provision of Electro-Convulsive Therapy. CCG representatives at recent QIPP Meetings have questioned the number of service users being transferred to beds outside Bristol, and although we have acted
to reduce these we would hope that as the new Men’s Crisis House becomes fully operational there would be a further review of bed capacity which includes PICU as well as Acute provision. Service users and carers with whom we have discussed the consultation have mostly indicated a desire for an increase in beds locally.

c. **Potential for Multiple Providers of Services** - Co-ordination across a broader range or partnerships will require a more focused approach, be that to contracting, governance or care co-ordination, and we are in early discussions with local agencies as to how some of this could be progressed. Equally, we recognise that the roles of service users and carers need strengthening as partners, in individual care and in terms of service delivery, and we are currently discussing the establishment of a local Bristol Management Board for our services which would have a strong clinician voice, a strong service user voice, a strong carer voice, and a strong voice for diversity, as well as also potential input from key partners and primary care. Were we to continue as a provider of services in the city we would be willing to take a lead in many areas of contracting and governance, but equally recognise that relationships with non statutory partners need strengthening in a way in which they feel equal and valued partners when working with us.

d. **Locally focussed services** – As in 1d and 2a above we fully support this

e. **Crisis Walk In Centre** – We have heard views from Carers as well as Service Users that such a centre would be valued. Recognising the need for as high as possible resource investment in the Crisis Pathway, we would suggest that such a centre would be more effectively run in a less medicalised / statutory manner. A number of the Bristol Intensive Team are shortly to visit the DIAL Service in Leeds which may be a useful model to explore further.

f. **Ageless Services** – We have covered this is Section 1b above.

4. **Links to Other Services**

Whilst recognising that a number of services have been omitted from the consultation, we would emphasise the need for any recommissioning approach to strengthen links in a number of areas. These include the following:

a. **Psychiatric Liaison** for links to the Crisis Pathway, and for a greater integration of physical and mental healthcare, particularly for the Dementia Pathway

b. **Criminal Justice Liaison** including closer working with the Police noting their recent reduction in FME cover locally and also recent local investment for mental health work in Custody Suites. We believe that more training support and more regular service links are required with the Police, particularly in relation to the use of Places of Safety and admissions under Section 136 of the Mental Health Act.

c. Clarification of links with **IAPT** Services for all the Any Qualified Provider services
5. Further Important Themes in Local Mental Health Service Provision

We would wish to highlight the following:

a. The need for strong employment provision, including the Bristol Vocational Service as addressed through the joint response to yourselves on Specialist Mental Health Employment Provision by our Bristol staff Sarah Fairham and Matt Trerise and other local services

b. The value of the Bristol Active Life Project, as fed back to you though our Bristol Head Physiotherapist Helen Abbott

c. The need for a secondary care focus, as well as primary care, in Psychological Therapies, as discussed with you by our Bristol leads Shane Matthews and Liz Curtis

d. The value in adult and older people's services of the broad range of Therapies that we provide, whilst recognising that some of this work may need to become more locally focused

e. The need to ensure a range of specialist Physical Intervention Skills within local mental health services as fed back to you for example by our Bristol Lead Dietician Natalie Clarke

f. There also needs to be a closer link with drug and alcohol commissioning regarding Dual Diagnosis. This is nationally recognised as a challenging area, but we believe that that challenge should remain one at the forefront of commissioners’ and providers’ priorities

6. Issues for Recommissioning

Whilst we recognise that the exact detail of recommissioning plans will be determined after the consultation, we have heard a timetable for a full tender and would wish, in a spirit of openness and collaboration to raise the following issues with you as being essential to take into account in any tender process.

a. Payment by Results Management - One of the features of PBR is that any cluster care pathway can straddle a number of different services. In a multi provider environment, a single cluster care pathway can also straddle different providers. This could provide some difficulty in determining how to split up payment on the basis of that cluster episode. Our research into this problem would suggest that commissioners might best be served by allowing one specialist Mental Health provider to be responsible for the whole pathway, whilst at the same time sub contracting to other providers for some of the care at points within the episode. We would also have concerns about how open caseloads impact upon the management of PBR care cluster reviewed episodes and therefore cost to commissioners.

b. TUPE – Whilst recognising that this is mainly a risk for Providers, although that can have a wider impact on local health communities, it is important that in a consultation of this scale that as a
Trust we highlight the risks that exist in relation to TUPE and the further complexities of transfer of pensions if receiving organisations do not have admitted body status

c. **Service Infrastructure** – As well as the standard organisational back office functions, we would particularly highlight issues regarding Safeguarding, Mental Health Act expertise, Pharmacy, On Call, Medical and other Training, Patient Transport, and Facilities Management – all of which we believe are more effectively and certainly more cost effectively provided at scale rather than through separate organisations

d. **Governance** – As stated in 1a above we fully support a move towards primary care recovery Teams linked to local Practices, but would suggest that this raises wide ranging issues of governance, particularly in relation to proposals we have heard for holding caseloads without discharge. We are interested in exploring such models but do not under-estimate their complexity. Further, whilst understanding and supporting the move for greater service user control over their care through the proposal that only a user can actually discharge themselves, we have some concerns that at times those at high risk may discharge themselves from care whilst those at lower risk would stay on caseloads, and this reinforces the concern that some clinicians have regarding a reduced focus on longer term needs of the severely mentally ill.

e. **Information Systems** – In a wider system of care with more Providers, the ability to share information between many agencies can be more difficult and costly. Integrated case and pathway management would seem to us to be an essential element of a modern Mental Health system, which can provide timely and accurate information to aid commissioning decisions.

### 7. Conclusion

In summary the Trust as a whole, and in particular local clinicians in Bristol, have welcomed the active discussions on future services which have occurred during this consultation. There is now a far greater understanding in our local services as to the reasons leading up to the consultation and proposals for a full tender of services. It would be unfair to our staff to not express the concerns that many of them have expressed to senior clinicians and managers in the city about the process and potential outcomes of any full tender, particularly when teams are now aiming in a local structure to commence many of the changes that have been highlighted as required through recommissioning.

### 8. Endorsement of this Response

This Response has the full endorsement of the Trust Board and the Trustwide Management Group. It has been built upon the active involvement of the following Bristol Clinicians and Managers, all of whom fully support it.

Helen Abbott, Head of Physiotherapy and Exercise, Callington Road Hospital

Dr Pradeep Agrawal, Consultant Psychiatrist & Senior Lecturer, Bristol North, Southmead Hospital
Dr Ovais Badat, Consultant Psychiatrist, Bristol ADHD Clinic

Jaci Bennett, Lead ECT Nurse, Callington Road Hospital

Dr Jochen Binder-Dietrich, Consultant Psychiatrist Bristol Early Intervention for Psychosis Service and Medical Lead Bristol Community

Dr Charlotte Boyer-Millar, Senior Registrar, Bristol Central, Brookland Hall

Mark Bunker, Consultant Nurse, Adult In-Patient, Callington Road Hospital

Natalie Clarke, Lead Dietician, Callington Road Hospital

Liz Curtis, Chartered Clinical Psychologist, Bristol Liaison and Later Life Service, Callington Road Hospital

Jane Corney, Senior Practitioner, Support and Recovery, Bristol South, Petherton Resource Centre

Annie Deamer, Team Leader, Bristol Complex Intervention Teams, Central and East

Dr Brian Dunkley, Specialty Doctor in Psychiatry, Support and Recovery, Bristol Central, Brookland Hall

Dr Rebecca Eastley, Consultant Psychiatrist and Medical Lead Later Life, Callington Road Hospital

Darren Eaves, Team Leader, Bristol Care Liaison Team

Sohail Elahi, Senior Practitioner Support and Recovery, Bristol Central, Brookland Hall

Dr James Eldred, Consultant Psychiatrist Silver Birch Ward and Medical lead Adult In-Patients, Callington Road Hospital

Chris Ellis, Consultant Nurse Bristol Intensive Team, Colston Fort

Sarah Fairham, Manager Bristol Vocational Service, Brookland Hall

Dr Kristina Gintalaite, Consultant Psychiatrist and Medical Lead PICU, Callington Road Hospital

Katherine Godfrey, Head of Occupational Therapy and Chair of Professional Council, Callington Road Hospital

Dr Lucy Griffin, Consultant Liaison Psychiatrist, BRI

Leslie Grundy, Service Manager Rehabilitation and PICU, Callington Road Hospital

Dr Will Hall, Consultant Psychiatrist, Support and Recovery, Bristol Central, Brookland Hall

Dr Rachel Harland, Consultant Psychiatrist and Medical Lead for Rehabilitation, Callington Road Hospital

Rowena Hastings, Area Manager Bristol Adult Community Services, Petherton Resource Centre

Martin Hember, Clinical Development Lead, Bristol Early Intervention in Psychosis Service, Colston Fort

Dr Dan Hodgson, Consultant Psychiatrist, Support and Recovery, Bristol North, Southmead Hospital

Dr Basit Hussain, Consultant Psychiatrist, Southmead Hospital

Dr Arun Kaul, Consultant Psychiatrist, Bristol Memory and Acute Liaison Service, Callington Road Hospital

Nikki Kehoe, Team Manager, Bristol Early Intervention Team, Colston Fort

Faiza Khaliq, BME Development Worker, Bristol Central, Brookland Hall

Gina Lang, Community Service Manager Bristol Liaison & Later Life Services

Emma Lovell, Ward Manager, Elizabeth Casson House PICU, Callington Road Hospital

Shane Matthews, Head of Bristol Psychological Therapies Service

Christine Miller, Therapies Manager, Bristol Liaison and Later Lifer Service, Callington Road Hospital