Mental Health Rehabilitation Webinar – 10th December 2020

Questions and Answers

1. **What are the plans for future follow ups like this? - FT**

   We plan to hold around three more follow up rehab webinars to cover other key areas that might be useful to people.

2. **Do we have a nationally agreed 'rehab training' package for community MDTs? – PB**

   We're working on this with HEE. In the interim, do use the Higher Trainee Rehab curriculum as a guide.

3. **Is there information with regard to rehab competencies? - CO**

   This is being developed currently, using the competency framework from the psychiatry Higher Trainees. It will have MDT input and has been through the Rehab-AIMS quality forum once already for this reason. We are in discussion with HEE about the potential for support from them this, including potential for funding for MDT / multi-agency rehab training in the next year's Spending Review.

4. **If local authorities are responsible for housing/sheltered accommodation, how will lack of funding to LAs be overcome? - MW**

   There is an appetite from the Department of Housing, Communities & Local Government and the Department of Health & Social Care to address the issue of the need for supported housing/housing for those with mental illness, to optimise their ability to live well in the community. There is an expectation from the GIRFT mental health rehab team that all local Integrated Care Systems will understand the local housing needs and develop plans to provide the right complement of housing to meet those needs – in the knowledge of the evidence of how the right supported housing reduces relapses of illness, reduces admissions to hospital, reduces Out of Area Placements and reduces the proportion of people spending longer on inpatient wards than is necessary.

5. **Interested to know about any HEE plans around supporting provider trusts to develop staff skills and knowledge and skills with accreditation around this for all MDT in MH rehab? Is this something that is being explored? – KO'S**

   GIRFT and the NHSEI MH policy team are in discussions with HEE about developing staff skills and knowledge in rehab. We are optimistic that we may be able to.

6. **I am curious to see the strong emphasis on whole system approach in this model. But where does social work / social care pathway sit with Clinical Leaders that are Psychiatrists in such models? - AC**

Social work is integral to rehabilitation and integrated social workers in multi-disciplinary teams will lead on many of the social issues, including benefits, housing, safeguarding, social care packages, placement funding, Approved Mental Health Practitioner issues etc. However, all team members have these skills to some degree and take advice and support from social work colleagues as and when necessary.

7. **It was stated earlier that the Rehab model nationally would be based on the three pilots stated. How does that relate to the design work currently going on locally under the Community Framework? - MB**

Local design based on best practice and evidence base (NICE Guidance 181) and other key documents, such as the JCP-MH rehab guidance and GIRFT rehabilitation national report and recommendations (which have now been out for consultation) is good. The learning that comes from the pilot sites will further inform and support local design.

8. **Can we obtain more information on the three implementer sites? - MM**

There is a further meeting this month (January) of the implementer sites and we will add key learning on to the GIRFT website.

9. **When according to the Stevenson & Farmer 2017 reports estimates between £74bn and £99bn lost due to MH issues each year. What investment do the panel believe is required to significantly reduce this figure? Do the panel believe by placing investment in prevention processes this can assist in this number reducing?**

Yes. Prevention is essential and is incorporated into the NHS Long Term Plan, in order to reduce absenteeism and presenteeism due to mental illness. Currently public mental health budgets are mainly held by local authorities and not health commissioners.

10. **Rehab is important and needs to be in area but do the panel believe a specialised care system where the patient may have to be out of the immediate area would be beneficial? Why is mental health not treated with specialisation in the same way as physical health? - AD**

Mental health rehabilitation care and services must be available locally. Where there is additional need for highly specialist care, this may be provided on a more regional or even national basis in some instances. This provision does already exist and is described in terms of typology of unit in the Joint Commissioning Panel for Mental Health, Rehabilitation commissioning guidance.

11. **Any discussions with DASS nationally around the development of whole system approaches for rehab where they are encompassing supported housing/regulated social care activities and the commissioning arrangements around those to ensure that LAs are supported financially**

to engage with these new pathways and do not view these developments as pressures? – KO'S

There has been close collaboration with both Stephen Chadler (president of ADASS) and Mark Trewin (mental health social work lead at the Department of Health and Social Care). Good models of rehabilitation, which include community rehabilitation teams, support cost savings year on year for health and social care funded placements. Some areas have formed alliances, where budgets are pooled and used in the best possible way for personalised and least restrictive care for patients eg; the Lambeth Rehabilitation Alliance.

12. **As part of the CMHF investment in rehabilitation, do the panel think that will translate into the increased availability of specialist services? (and thank you from Rethink for all your great work on this) - JM**

Yes, that's absolutely the plan. The CMHF investment is specifically for community rehabilitation teams and services. Trusts have already put in initial plans in December for how they will use the additional money and more detailed submissions are needed by January 20th. Money that is already being spent on out of area rehab placements must be viewed as Mental Health Investment Standard money and, as people are brought back into local care, that money is to be ring-fenced, for development firstly of the local rehabilitation pathway (both community and inpatient) based on local needs, with remaining funds for other mental health needs locally. They are efficiency savings to commissioners.

13. **How is modelling demand/capacity working out in designed pathways with minimal existing service provision and high demand aligned to increase in recognition of rehab needs? - PB**

NICE rehab guidance describes how to ascertain the local rehab need. This then needs to be commissioned and provided locally.

14. **Will anyone be looking at the rules for a person being entitled to supported/social housing? Currently rules are very tight; for example, if moving to be near family, the family have to have lived in an area for five years - MW**

Currently, official guidance states that people can choose where they wish to live and be housed. Having family in the area adds weight to the case and the local council is obliged to support this request for anyone entitled to council housing. It is up to local authorities to negotiate with the originating local authority on how to best facilitate such a move.

15. **Are there any plans to update guidance on what "community rehab" is - there has been an increasingly worrying focus in some areas towards intensive home treatment/6-8 week rehab potentially with a detriment to those needing longer term rehab support in community. Is this becoming an issue in many areas? - further definition/expectation of breadth of community rehab building on NICE guidance but also across**

"diagnoses" would be useful as we go forwards working with partners linked to CMHF aspirations - AB

The need is to focus on individual patients and provide personalised care. A 6- to 8-week period of rehabilitation will not support sufficient or sustained progress. It is important to direct people to the NICE rehab guidance and ensure that rehab services locally are commissioned to these clear standards, which patients and their families have a right to.

16. **How can the panel address this written by a PICU HSA last week? Psychiatrists have NO answers for the most common problem on a PICU ward of severe intrusive voices and self-harm other than Medication. One could argue that medication is the way that PICU patients are stabilised until such time that they can be treated long-term elsewhere with other methods (and this works well with certain patients such as those experiencing manic or psychotic episodes), however this does NOT represent the large majority of patients. The most common thing we see on a PICU is EUPD (Emotionally Unstable Personality Disorder), which is not something that can be suddenly medicated. Wrong patients for this environment. Begs the wider question of what is Psychiatry doing for those who have experienced complex PTSD and have EUPD? And why are they ending up on a PICU unit? BECAUSE NO-ONE KNOWS WHAT TO DO WITH THEM. This is only one question of many she has - AD**

There is a directive for specialist provision in the Community Mental Health Framework for people with EUPD to be developed locally, to support sustained and successful community living. There is specific funding for this patient group to improve the local offer for them, to avoid hospital admissions and NICE recommended care.

17. **COVID – huge issue for families like mine. Is this something GIRFT will be exploring? [eg JCVI published national COVID vaccine guidance a few days ago - people with schizophrenia included in clin high-risk grp. Role for GIRFT? - DS**

Good thought. Issues arising from COVID-19 in people receiving rehab are incorporated into the national report. I am sure we will learn more as we go along and we need to consider what can be done to ensure learning is translated into practice. There are several links to COVID-19 specific information on the GIRFT MH rehab webpage. There were also two webinars through GIRFT and RCPsych which addressed COVID-19 related issues. We'll get those uploaded on the GIRFT webpage too.

18. **What training did staff have please? - RB**

Work was done to develop a positive identity for rehab services. Staff were trained in comprehensive assessment of patients and delivery of treatment that was based on a biopsychosocial interventions using as much of evidence based

treatment as was available, focusing on developing clear recovery goals for each patient collaboratively.
Peer supervision for senior clinicians is in place.
We had good links with user led WRAP and recovery trainers, and were involved early on in using the DREAM questionnaire to look at the work we were doing in patient units.

19. **Do Cumbria, Northumberland and Tyne/Wear have Section 75 agreement in place with the local authority? - RR**

CNTW does not have S75 agreements with any local authorities as it isn't something we have devolved financial responsibility for. Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. In some cases, such as Section 117 of the Mental Health Act 1983, legislation requires that joint funding be administered by councils and CCGs. In our patch all CCGs and LAs have an agreement for a 50/50 financial split for S117 packages. However, this is becoming more of an issue as financial belts tighten and LAs in particular consider the 'fairness' of a package split i.e. what constitutes a health responsibility versus social care.
Some of our CCGs do have S75 agreements in place with their respective LAs, especially around Learning Disabilities and ASD – an example being pooled budget in North Cumbria.

20. **"Do the community rehab teams follow the assertive outreach model? - JR**

Some community rehab teams have AOT function embedded with appropriate clinical time allocated. We are currently reviewing our rehab pathway, which includes where AOT function should sit.

21. **Has anyone developed good practice models around agreements at point of referral (and at review stages) with CMHTs around expected goals of inpatient/community rehab and at what stage patients move back into CMHT pathway? – KO'S**

Yes, and we will share them on the GIRFT webpage when these good practice models have been written up and confirmed. Of note, for many community rehab teams the point of entry is being placed in 24-hour supported accommodation (could be residential care or supported housing, or very occasionally a very highly intensive and high cost package of care in the community in their own flat) or inpatient out of area rehab. Transfer back to generic CMHTs tends to be once stepped down to a 9-5pm staff-supported setting or own flat with a lower level of care going in, when the rehabilitation outcomes set with the patient have been largely achieved.

22. **Is the community rehab pathway ward based or a supported housing model with clinical team? - SW**

The rehab pathway has both the inpatient and community functions. We have high dependency inpatient units, complex care inpatient units and move on units, which are inpatient units. The move on units are based within hospital sites and community.
The community rehabilitation team (named as step up hub) in the trust are community-based and provide input to patients placed in various community settings.

23. **How many Rehab beds do you have within your trust? - RH**

We have 137 beds. Out of these, 54 beds are HDU beds (2 male units, 1 female unit, 18 beds each = 54)
The rest of the beds are between complex care and move on units, which are based in different localities. The complex care beds are on hospital sites. The move on units are on hospital sites and in the community. The trust covers a population of 1.7 million at present.

24. **What does long term rehab mean? - SW**

Long term rehab, when referring to inpatient rehab, means services for those who require more than one year of inpatient rehabilitation. People in this group tend to have challenging behaviour on top of the other characteristics of those needing rehab and often have a forensic element to their presentation. I'd direct you to the inpatient rehabilitation guide from RCPsych Rehab & Social Psychiatry Faculty. It is also on the GIRFT MH rehab webpage.

25. **We have difficulty recruiting consultants. Are there examples of non-medical Approved Clinicians in rehab services? - TP**

There is a nurse Approved Clinician in rehab on the Isle of Wight. Workforce planning in rehabilitation is an area where we need to ask for support from HEE and RCPsych and other relevant professional colleges.

26. **What happens to GIRFT team post March 2021? very useful programme, how will it continue? - RR**

Thank you for the positive feedback. The plan is to continue the GIRFT programme as the methodology for clinical improvement in the NHS.

27. **Does this review of service delivery also include examination and value of the role of AHPs; Occupational therapy, Speech and language therapy in particular. The specialist skills set can be a different perspective to managing complex presentations alongside medical management - KW**

Rehabilitation is only as strong as the MDT input received. The GIRFT review fully recognises the centrality of MDT working for good care and outcomes. The review is not able in this first iteration to look specifically at individual

professions' input. The programme does recognise the strength of every profession - including AHPs, OTs and SALTs. This is highlighted in the NICE rehab guidance, which is encompassed in the GIRFT national report recommendations. AHPs - including Suzanne Rastrick and her deputy on her behalf - have been consulted on the recommendations ahead of them being sent out for formal consultation.

28. **AIMS helps quality of provision certainly. I find that it would be good to promote it as a specialism and are there guidelines and or a skill set beyond those of the MDT that might support a coordinated approach - CO**

GIRFT definitely promotes AIMS rehab as a means to reach a good standard of care and also for continual improvement from that point.

29. **Speech Therapy in particular allows for any communication needs to be identified from the START of the patient journey and result in more effective treatment. - KW**

SALT is included in the NICE rehab guidance and there is very much an expectation that this specialist input from SALT colleagues needs to be available to patients. We absolutely recognise the importance of this at the start of the patient journey, to optimise patient experience and outcomes.

30. **Are there any plans to have some sort of standardisation for community rehabilitation team to avoid ever growing variation - SS**

Yes. Good question. Community rehabilitation team standards are being developed and will be shared asap. In the interim, the NICE guidance gives some guidance and we will also post some current operational policies from existing Community Rehabilitation Teams in the coming month, as an example, ahead of standards being available.

31. **Can colleagues from CNTW give an idea of the timescales for repatriating 50+ people - EH**

Most patients were repatriated from 2014-2018. People had been in OAT placement anywhere from two years up to 12 years.

32. **We are all on the same journey and will come across similar obstacles is there a way we can learn from mistakes rather than replicate them. I have lots of learning I could share from Sheffield as well as lots of really good outcomes - JS**

Agree. It's absolutely a central tenet of GIRFT, to learn from one another - particularly from best practice examples and support - rather than having to reinvent the wheel many times over! It would be greatly appreciated if you're able to use the GIRFT good practice template to describe your learning. We will confirm this with you and then add it to the GIRFT website so others can learn

from your impressive work in Sheffield. I will ask our project manager Suzannah Davies to send the template to you.

33. **I agree that the wider the MDT model is, the more powerful that the care will be. I am a pharmacist working in rehab amongst other areas and this is the most demanding part of my job. Thank you for ensuring that all professionals are mentioned in the report. - JS**

We were very careful to ensure that the NICE rehab guidance included the MDT - which powers the positive results possible with and for our patients. Pharmacist colleagues are integral to the MDT, both in inpatient and community settings.

34. **For Emma - I think its concerning in relation to potential focus on this time scale of rehab re; funding and resource to the detriment of focusing resource on those needing rehab over a longer period of time. There are also other pots of funding potentially available to e.g. intensive home treatment covering similar timescales often linked to crisis services - completely agree shorter term rehab is part of a wider rehab offer/pathway but need to ensure that those requiring longer term intensive input don`t get forgotten or left in in-patient beds for long periods of time when they could have much better lives - AB**

Agreed!

35. **Will the Royal College review the Joint Commissioning Guidance for Mental Health Rehabilitation to allow for the wider diagnostic groups ie Personality Disorders, PTSD etc. that the community models have provided services to successfully and for the focus on successful OAPs repatriation models? – KO'S**

Where there are good examples of work in rehab teams with those with EUPD, it will definitely be helpful to write this up for others to learn from. In many trusts, patients with a primary diagnosis of EUPD may not be cared for in the rehab pathway. There is a specific EUPD specialist care and services, expected to be in place as part of the NHS Long Term Plan, Community Mental Health Framework. The national GIRFT MH rehab report includes some information from colleagues in NHSEI, who are developing a specific and specialist pathway for those with EUPD/PTSD, which is not within a rehab pathway. There will be some overlap with rehabilitation services and it will be up to local services to consider the best approach for their patients with them. People with EUPD have ended up in 'rehab placements', not because they needed rehab, but because anyone with a non-forensic placement need came out of a rehab budget. OAP repatriations often do include many people with EUPD who have not been well served by local, community, specialist options. Over time, if a different model emerges for this cohort, which describes a more integrated approach with rehabilitation services, it would certainly be possible to update relevant documents.

36. **For Priya- do you have a separate PD pathway in your trust. we have this ongoing challenges of accepting patients with primary disorder of PD which are expected to sit with us. - NS**

Answered by Priya: We have a PD Hub in the trust but not in North Cumbria, where we have a PD pathway but no specific 'team' as such. Our primary referral criteria is a diagnosis of psychosis. People with a primary diagnosis of EUPD will not be expected to sit within rehab services.

Answered by Sri: Where they are in placements, co-working or support from the rehab teams who have expertise around finding, matching needs, managing and transitioning between placements, can be used by those supporting this patient group. However, there is specialist knowledge and skills needed to support those with a primary diagnosis of EUPD and this is not generally within Rehabilitation teams, who deal mainly with people with psychoses. The national GIRFT rehab report discusses the pathway for those with EUPD and more detail is being worked up by colleagues in NHSEI.