Western Isles Health Board

Meeting: **BOARD MEETING**
Date: 27.06.18
Agenda Item: 7.1.1
Paper Number:
Location of Full Report: N/A

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Executive Sponsor: As above

Title: MENTAL HEALTH REDESIGN PROJECT – SUMMARY TO DATE REPORT

Purpose:	To enable Members to obtain a greater understanding of the background and influences which impact on the delivery of the project.

Recommendation:	***The Board / Committee is invited to:***	
	Note for Information / Assurance	Assurance
	Approve	
	Discuss	

Summary / Key Points:	***This should provide sufficient information to enable the committee to understand the key points of the paper being presented. If covering a large complex document specific pages or sections of relevance should be highlighted. This should enable members to contribute to a focused discussion and, if necessary, make an informed decision.***

1. BACKGROUND

1.1 NHS Western Isles provides healthcare to around 26,500 people across an archipelago of islands that makes up the Western Isles. Under the Integration Joint Board (IJB), NHS Western Isles provides a wide range of mental health and learning disability services, although the Child and Adolescent Mental Health service is not a delegated function. The functions that are delegated include inpatient, outpatient and community-based support. Mental health covers a range of services, including:

- general adult psychiatry
- psychiatry of old age
- substance misuse (alcohol and drugs), and
- learning disabilities.

1.2 The existing inpatient and community services have many strengths and we know that our staff provide high quality care and support to service users and their carers and families every day. However, like all Integration Joint Boards in Scotland, we are facing significant challenges, and we cannot keep delivering services the way we have in the past. We need to adapt our services to ensure they are sustainable and meet the future needs of the population. Patient safety is an overriding priority and, to ensure we can continue to deliver a high quality of care to a greater number of people, in order to deliver a sustainable mental health service, it has been necessary to look at the way we provide these services and look at alternative models of care.

1.3 Within this context, the Integration Joint Board expressed a preference in favour of service reform which delivered enhanced community mental health services but with short term hospital assessment for those who need it (Option 3). The consequence of fully implementing the this option will be the closure of the Western Isles Hospital designated Acute Psychiatric Unit (APU) and Clisham Ward for care of people with dementia.

1.4 In managing this process of change, intensive work has been undertaken with members of staff to explain the nature of the reforms and how we expect to change our service arrangements. All staff within both ward establishments, excluding domestic staff, are considered to be ‘at risk’ and they have been placed on a Mental Health Service Redesign ‘At Risk’ register for the purposes of redeployment into alternative mental health community posts, when the wards close and resources are freed up to enable this to happen. Members of the Joint Board will be aware that NHS Scotland has a no compulsory redundancy policy.

2. CLISHAM WARD

2.1 Clisham Ward, initially set up for assessment of people with dementia,. Under Option 3, Clisham will close as patients are assessed in line with NHS continuing care guidance, (MEL 22(1996); CEL 6(2008) and DL(2015)11 refer - see appendix 1). DL(2015)11 on Hospital Based Complex Clinical Care makes clear that *"As far as possible, hospitals should not be places where people live – even for people with on-going clinical needs. They are places to go for people who need specialist short-term or episodic care. Hospitals are highly complex institutions which should focus on improving the health of people with acute conditions before discharging them back into the community."* The letter goes on to clarify that eligibility to Hospital Based Complex Clinical Care should be based on the question *"can this individual's care needs be properly met in any setting other than a hospital?"* It supports the comprehensive multi-disciplinary assessment of individuals in hospital with the intention that, if such assessment indicates that the person does not require to be in hospital, "*they will be discharged and their post hospital care and support needs will be met at home by the community health and care team, with appropriate specialist support."*

2.2 As indicated above, Clisham Ward had taken on a longer term care role in recent years, which is now at variance with national directions for hospital-based care. Multi-disciplinary assessments of the patients in Clisham Ward have been progressed and, when a patient is identified as no longer requiring hospital care, arrangements are progressed to identify suitable homely accommodation. Such patients may be considered as 'delayed discharges' and form a cohort of individuals who are awaiting more appropriate accommodation outwith hospital. This process was enacted after the Joint Board's preference to decommission the Clisham Ward was expressed.

2.3 Clisham Ward is due to close when the current patient bed number reduces to three. The intention remains that these patients will be transferred into the medical wards for their care and when, as a result of multi-disciplinary assessment, they no longer require hospital based complex clinical care, will await placements in the community. It is anticipated that this point will be reached over summer 2018 but is dependent on vacancies occurring in the residential care sector.

2.4 As at 15th June 2018 the number of patients in Clisham Ward is seven.

2.5 Identified staff within the current Clisham staffing establishment will follow the three patients to the Medical Wards, providing care to the patients across the wards and additional input and training for the general nursing staff in the Wards. This will support and enhance the role of the Dementia Champions currently in place across these areas.

2.6 Current Clisham Establishment details

WTE & Headcount as at 31.03.18

Roster Location	Head Count	WTE	Permanent	FTC
WIHB-Clisham	24	19.24	22	2

Staff by banding as at 31.03.18

Roster Location	Band 2	Band 5	Band 6
WIHB-Clisham	10	13 (5 RMN and 8 RGN)	1

3. ACUTE PSYCHIATRIC UNIT

3.1 The preferred option recognised the valuable work carried out in APU, but also recognised that there are limitations in the current ward and that the range of services available with specialist mainland providers is not available locally. We recognise the importance of consistency for patients and staff and have therefore stated that APU will remain open until assurance can be provided regarding the availability of acute mental health beds on the mainland. Our substantive mainland provider has recently reduced its available beds further in the light of inability to recruit staff for the psychiatric service. The planned changes in residential care will impact on the arrangement for the long term care of people with dementia and mental illness.

3.2 It is likely negotiations with mainland services to secure mainland beds will take some time and that a regional solution is required. This is being discussed under the North of Scotland Regional Health and Social Care Delivery Plan.

3.3 During this interim period, the APU redesign is the transitional model for option 3. We are working to redefine the service provided within APU to a criteria-led service, aiming to provide short term focused care for people who are acutely unwell and will operate with enhanced working between the in-patient and community teams – with one community mental health team serving Lewis and Harris and one team serving Uist and Barra. The introduction of rotation between in-patient and community teams will provide the staff with confidence and wider community experience in preparation for the move to an integrated Community Mental Health Team.

3.4 This will develop into one community mental health team, with a flexible staff workforce that can follow patients into the APU to provide the 24 hour care that is required on admission.

3.5 Working with consultant psychiatrists, we will be planning for the progressive relocation of these services to community settings, providing in-reach to the APU and acute wards as and when required, and supported by the requisite policies.

3.6 Current APU Establishment details

WTE & Headcount as at 31.03.18

Roster Location	Head Count	WTE	Permanent	FTC
WIHB-Acute Psych.	13	**12.34**	12	1

Staff by banding as at 31.03.18

Roster Location	Band 2	Band 3	Band 5	Band 6	Band 7
WIHB-Acute Psych.	2	1	7	2 (1 Secondment to community CPN post)	1

4. REDEPLOYMENT OF STAFF

4.1 All staff on the mental health ward establishment have returned their redeployment questionnaire and each member of staff has indicated their preferred employment options on the form, as per the policy requirements; these data have been entered on to the 'At Risk' register. As per Health Board Policy, all staff have been offered 1:1 interviews to discuss their redeployment options. A programme of interview dates is underway. This staff cohort will be placed onto NHS Western Isles' Redeployment Register when their ward closes and when there is no need for that post any longer.

4.2 Some staff have expressed a desire to remain by the patient bedside and to be redeployed into ward based posts in the acute service at the Western Isles Hospital, or into acute (RGN) community posts. We have recognised the benefits to the wider organisation of retaining some Clisham staff in medical wards in order to disseminate knowledge and skills in dementia care into acute services.

4.3 With movement of staff resources across to the Medical wards' budgets, mental health resources can be redeployed to areas where recruitment is known to be more challenging and progress with service development more rapidly than awaiting staff turnover.

4.4 Owing to the nature of the current contracts and additional hours worked, there is currently an issue in regard to pay protection that is being investigated.

4.5 Clisham staff 1:1 meetings are ongoing and, to date, the following preferences have been confirmed and recorded. Meetings are expected to be complete by end June 2018.

RMN trained staff. (5 staff)

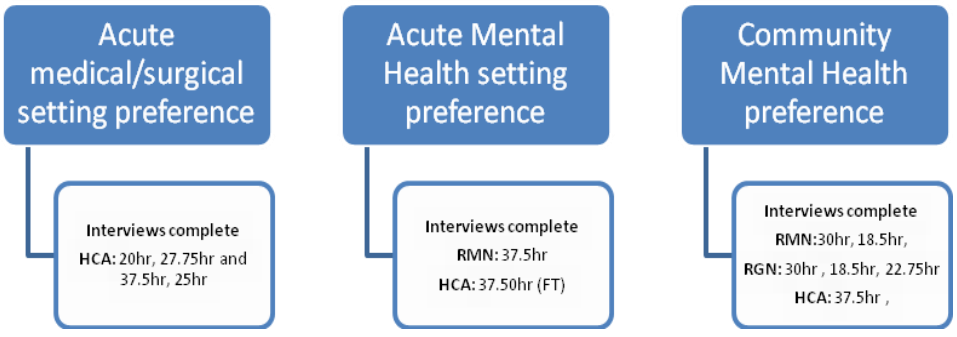
- Two staff interviews are outstanding, 2x 37.5hr. This includes one dual trained staff.

RGN trained staff (8staff)

- Five staff interviews outstanding. 25hr, 2x 22.75hr (Fixed Term), 30hr, 37.5hr.

HCA untrained staff. (8 staff)

- Two staff interviews outstanding, 18.50hr, 30hr post



4.5 Staff who have indicated that their preferred employment option is to be redeployed into one of the new community mental health posts will remain on the 'At Risk' register after their ward closes, and this will become the platform from which redeployment into new mental health posts will occur.

4.6 The current posts identified within the new model are:

- Mental Health Liaison Nurse
- Adult CPN
- Dementia CPN
- Dementia Nurse
- CBT Therapist
- Nurse Therapist
- Mental Health Occupational Therapist
- Support Workers
- Mental Health Worker (Barra) – Post has been advertised.
- Alcohol Detox/Liaison Nurse
- Substance use nurse.

4.7 Job descriptions are in draft and are progress through the organisational job matching process. This supports wider service design work which will detail the requisite capacity across localities and describe the interplay with community, primary and secondary care.

4.8 APU 1:1 staff meetings will follow in July 2018.

5. COMMUNITY MENTAL HEALTH TEAMS

5.1 In the Western Isles the Community Teams provide support for residents across the range of islands; with one team that covers Lewis and Harris and one team covering the Uists and Barra

5.2 Current Community Mental Health Establishment details

Roster Location	Head Count	WTE	Permanent	FTC
WIHB-CPN L&H	9	8.3	8	1
WIHB-CPN-U&B	2	2	2	0

Roster Location	Band 3	Band 5	Band 6	Band 7
WIHB-CPN L&H	1	1	6	1
WIHB-CPN-U&B	0	0	1	1

6. INTEGRATION

6.1 Research into Community Mental Health Teams across the UK indicates that Community teams should consider components relating to crisis and early interventions in addition to the broader Community Mental Health Teams. However, with the relatively small patient numbers in the Western Isles, it is not sustainable to have individual crisis and early intervention teams. The Mental Health Redesign is investigating having a flexible workforce, with the right skill mix that can be drawn into teams as necessary.

6.2 The Crisis and Early Intervention teams are multi-disciplinary teams consisting of CPN, Support Workers, Consultants, Social Workers, Housing, Criminal Justice, Third Sector, Pharmacist, AHPs pulled into the teams as the patient need requires. This will necessitate integration of statutory and non-statutory services staff to enable efficient and effective working practices. Consideration will be given to the co-location of staff to enable a more integrated approach to patient care.

7. THE CHANGING LANDSCAPE

7.1 There are many changes in health and social care delivery with an ever changing landscape impacting on the Mental Health Redesign. These include the new GP contract, the advent of a Regional Health and Social Care Delivery Plan, alongside shared approaches to common issues across Scotland and the Scottish Mental Health Strategy.

7.2 The New GP contract implications are not yet fully understood. People with longstanding mental health problems form a significant cohort in primary care. Further work is needed on the role of primary care in the Mental Health Redesign, with GPs reporting mental health problems as a major priority and the challenge of identifying people who are struggling before they reach crisis point.

7.3 The Regional Delivery Plan has a direct impact on the Redesign process as the number of mainland bed available is not known. Locally, APU will remain open until assurance can be provided regarding the availability of acute mental health beds on the mainland. Our substantive mainland provider has recently reduced its available beds further in the light of inability to recruit staff for the psychiatric service. The planned changes in residential care will impact on the arrangement for the long term care of people with dementia and mental illness.

7.4 Work is being progressed on a shared approach to mental health service delivery and priorities across the North of Scotland Boards as part of the Regional Delivery Plan. The issue of access to mainland beds remains and there is work being progressed with the other island Boards to develop a joint approach to our mainland providers.

7.5 Discussion around Out of Hours (OOH) provision, including remote access to consultant services, is taking place with NHS Shetland. There are currently differing OOH arrangements for CPNs in the two health boards, although consultant-delivered care is the same and the different models are being explored to see how to provide the most effective and efficient service round the clock.

Dr Maggie Watts
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NHS Western Isles

APPENDIX 1

Continuing care circulars

MEL 22(1996) accessible at http://www.sehd.scot.nhs.uk/mels/1996_22.pdf

CEL 6(2008) accessible at http://www.sehd.scot.nhs.uk/mels/CEL2008_06.pdf

DL(2015) 11 accessible at http://www.sehd.scot.nhs.uk/dl/DL(2015)11.pdf

Western Isles Health Board

Risk:	***Are there any significant risks related to this topic?*** ***Yes*** ☐ ***No*** ☑ ***If yes, please describe below:***
	Risk Register – If the risk on the Corporate Risk Register please detail, including the specific Risk ID

Competence **Financial Impact**	***Does the topic have any impact on the following Governance Standards:*** ✓ ***Yes*** ☐ ***No*** ☑ ***If yes, please describe below:***
Clinical Impact	***Yes*** ☐ ***No*** ☑ ***If yes, please describe below:***
Human Resource Impact	***Yes*** ☐ ***No*** ☑ ***If yes, please describe below:***

Approval Pathways	***Committees presented to:***	***Date:***
	Integration Joint Board	21.06.18
	Committees to be presented to:	***Date:***
	Corporate Management Team	July 2018