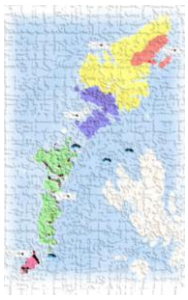
Integration Joint Board 22.06.17
Agenda Item: 8.1
Purpose: For Information



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WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

MENTAL HEALTH REDESIGN

PURPOSE OF REPORT

1. This paper profiles the redesign of mental health services in the Western Isles, including the public engagement work taken forward over the last year to determine which model of provision best suits the local operating environment.

COMPETENCE

2. There are a number of HR and financial issues which will be considered as part of the implementation process.

SUMMARY

3. The review of mental health services has been a long-standing objective of NHS Western Isles, which was subsequently accommodated within the IJB strategic plan. The report sets out the detail of the redesign and engagement work to date.

RECOMMENDATIONS

4. It is recommended that the IJB:
    a. Notes that the public engagement and consultation (January-May 2017) has now been completed, which has included full engagement with Locality Planning Groups;
    b. Notes that we are now developing more refined operational models on the back of five work-streams.

Ron Culley
Chief Officer, Health and Social Care
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BACKGROUND

5. The redesign of mental health services has been a long-standing objective of NHS Western Isles. A previous proposal for change was developed in 2013, but for operational reasons was unable to be progressed. With the advent of health and social care integration, we now have an opportunity to build on previous development work to look at options for reform.

6. Following initial engagement events, the Mental Health Services Redesign Steering Group (consisting of representatives of the NHS, local authority, third sector gencies and Scottish Health Council representation) developed a set of anticipated outcomes together with a number of options for reform. These options were subsequently considered at an Options Assessment Event held on 2nd December 2016. The Panel consisted of service users, caregivers, service providers from the third sector and service providers from the statutory sector from across the Western Isles. All had been invited to participate by virtue of having been delegates to previous events, on the mental health mailing list, being a current service user or caregiver with a mental health service, or being from an agency represented at the Mental Health Services Redesign Steering Group. The event focussed on a structured assessment that included the background to the work and an outline of the needs assessment (including a summary of models of remote and rural mental health care from other parts of the UK and worldwide).

7. The participants were invited to discuss and prioritise the set of benefits criteria that had been approved by the Steering Group. The four options considered are as follows:

   Option 1 - **Status Quo**. This would involve the retention of existing ward capacity, including the beds for people with dementia in the Clisham ward, and for adults with mental illness in the Acute Psychiatry Unit. It would maintain the community services provision in line with existing capacity. Most NHS resources would therefore remain at Western Isles Hospital, with a small team of Community Psychiatric Nurses (CPN) & third sector mental health workers spread across the localities. Current challenges would remain in respect of reliance on single handed or visiting practitioners in the more remote areas. Third sector provision would remain uneven across the islands.

   Option 2 - **Minimal Change**. This model would see a small reduction in the number of hospital beds and a small increase in the capacity of community health services. There would be 12 mixed (acute mental health and dementia) beds. This reduction would, in principle, allow for modest investment in community facilities. No change to third sector or council services.

   Option 3 – **Significant Change**. This would be a new community focused model intended to provide care in community settings. It would involve the development of new care pathways and would promote the recovery approach for people with mental health problems. Mental health staff across agencies would work in the community and a hospital bed would only be used if a person needs a short term detention or immediate assessment. Were this to happen, the community psychiatric staff looking after the person would care for them in hospital for up to 72 hours. Beyond this time, if inpatient services were needed, these would be accessed on the mainland. It would involve enhanced care pathways across community settings, and closer integration of statutory and third sector provision. The redeployment of hospital staff into the community would enable flexibility in the CPN team, a greater focus on prevention and early intervention and permit care to follow the patient into hospital.

Option 4 – **Maximum Change**. This would also be a new model, similar to Option 3, but fully community based. The community services would work in a more integrated way and be more able to prevent deterioration in mental health before the need for inpatient care arises. In the event that hospital care is needed, this would be provided on the mainland, and short term care whilst awaiting transport would come from the general hospital staffing, guided by the mental health team. All staff and services would be located in community settings.

8. Option 3 was selected by the Option Assessment Panel and this preference for Option 3 was subsequently endorsed by the Health Board and IJB in December 2016, and followed up by approval of a costings paper prior to further stakeholder engagement.

9. Over the course of the last three months, the Director of Public Health has led a series of community and stakeholder engagement events around our preferred model of delivery. A number of themes emerged from that initial engagement work, including support for the general concept of recovery (which means supporting people to live well with their mental health condition), support for a community based model focused on independent living, and support for a better integrated service across healthcare, social care, housing and third sector agencies. There has been full engagement with Locality Planning Groups, which has been supportive of the preferred option 3, and engagement has been positive. The principal concern raised has been around access to and location of a hospital bed, should that be required.

10. Having completed the public engagement work, the process of due diligence will be completed in order to get to a refined operational delivery model. This will emerge from the work of five work-streams, carried out in partnership with statutory and third sector agencies and supported by input from service users and caregivers, which will seek to capture the relevant workforce, performance management and quality assurance, clinical, resource and recovery strategy/service pathways information. The process will seek to define change across different population groups, including people with a dementia diagnosis, substance misuse and specific mental illnesses, while reflecting the variations across the diverse geographical area.

11. Once this work is complete, the IJB and Health Board will be asked to agree a final service model, as we move to implementation. Regular updates will continue to be provided throughout this process.

END.