# Mental Health Recovery Service Business Case - Summary

Draft v1.2
July 2020

# 1. Executive Summary

Poor mental health brings with it costs to individuals and their families, as well as to society as a whole through costs to public services: health, social care, housing, education, criminal justice, social security and the wider economy.

Locally, it is acknowledged that significant change and improvement is required on the Isle of Wight to transform mental health services to achieve the national and regional priorities set out. As a system, we are aware that making positive change is critical to the delivery of outcomes that local people have told us are most important to them.

In line with the programme of transformation developed to implement the Mental Health Blueprint, the Isle of Wight Mental Health services have already been undertaking a period of extensive transformation with the implementation of the Community Mental Health and Wellbeing Service (CMHWBS). Adopting a recovery based approach, and placing emphasis on people's strengths and potential.

As the system, has progressed along the transformation journey, there have been significant changes both in service configurations, and the strategic landscape through the partnership working with our peers at Solent NHS Trust.

To add to this, we are currently in the midst of responding to a global pandemic which has highlighted the importance of action on mental health across society. There has been a great opportunity to learn and develop at a rapid pace with innovation occurring in a short time-span.

This business case outlines the next phase in transformation of the Island's Mental Health Recovery Service on the Isle of Wight with particular regard to the property known as 'Woodlands' (a CQC registered open rehabilitation ward for people with serious mental illness).

# 2. Strategic Context

## 2.1. National Drivers of Change

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| Mental Health Five Year Forward View (MH5YFV) | The 2016 MH5YFV aim is to increase availability and quality of care and treatment for people with mental health problems. Of particular relevance to development of the Mental Health Recovery service is the ambition that, by 2020/21, adult community mental health services will provide timely access to evidence-based, person- centred care, which is focused on recovery and integrated with primary and social care and other sectors. |
| NHS Long Term Plan (LTP) | The NHS Long Term Plan (2019) signals an extension of the commitments set out in the MH5YFV, beyond 2020/21 to 2023/24 and reaffirms the national commitment to the priorities set out in the MH5YFV which are reflected in the business case summary. |
| Hampshire and Isle of Wight Sustainability Plan (HIOW STP) | The HIOW STP's mental health programme, has representation from local mental health providers, including the IOW NHS Trust, CCG and local authority, and is focused on system-wide transformation initiatives, including acute and crisis mental health care. Engagement with the programme manager for this work has been undertaken to ensure alignment of the current short term proposal with long term transformation of the Mental Health Recovery pathway on the island. |
| Care Act (2014) | The Care Act was enacted to help improve people's independence and wellbeing. Through this legislation, Local Authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support. This is to be achieved through the promotion of individual well-being and integration of care and support with health and wider services. |
| Community Mental Health Framework for | The 2019 framework outlined a vision for a new place-based community mental health model. This aimed to modernise community mental health services by shifting to a whole person, whole population health approach. The model moved away for siloed, inaccessible |

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| Adults and Older Adults | services, to one with joined up care, facilitating the right care for the individual in the most appropriate manner and setting. The key aspects of the framework included. This framework has been supported by the HIOW STP and mental health models will be assessed against this. |

### 2.2. Local Drivers of Change

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| Isle of Wight Blueprint for Mental Health | The island's Blueprint for Mental Health aim is that, with partners and local communities, we will become a mentally healthy island. Promoting self-care, prevention and wellbeing and delivering high quality mental health services. The proposed Mental Health Recovery Service will enable achievement of these aims. |
| Local Care Plan | The ambitions set out in the Blueprint align with the Island's system-wide objectives as set out in the Local Care Plan, including improved health and social care outcomes, people having a positive experience of care, person centred provision, service provision and commissioning is delivered in the most efficient and sustainable way, and staff will be proud of their work. |
| Isle of Wight System Strategy | The Isle of Wight Health and Care Plan (2019) sets out a three-year plan to improve health and care on the Island, supporting people to live healthy, independent lives. Improving mental health services is one of the four priority areas identified for transformation. The current design process underway in partnership with Solent NHS Trust builds upon this work. |

Although the finer details of the model can be adapted to meet local variations, there is a clear direction of travel – a rehabilitation blueprint – that can be utilised to implement a best practice approach. The below options have been developed with these system-wide objectives in mind.

## 3. Current Situation

### 3.1. Current Service Model

The main aim of the service is to provide integrated health and social care to individuals with enduring and complex mental health conditions in order to:

- Provide specialist assessment, treatment, interventions and support to help recovery from mental health problems and regain the skills and confidence to live successfully in the community, and;
- Supporting people to manage their own condition, get a job, make friends, and maintain safe and secure housing of their choice enabling people to achieve their own life goals.

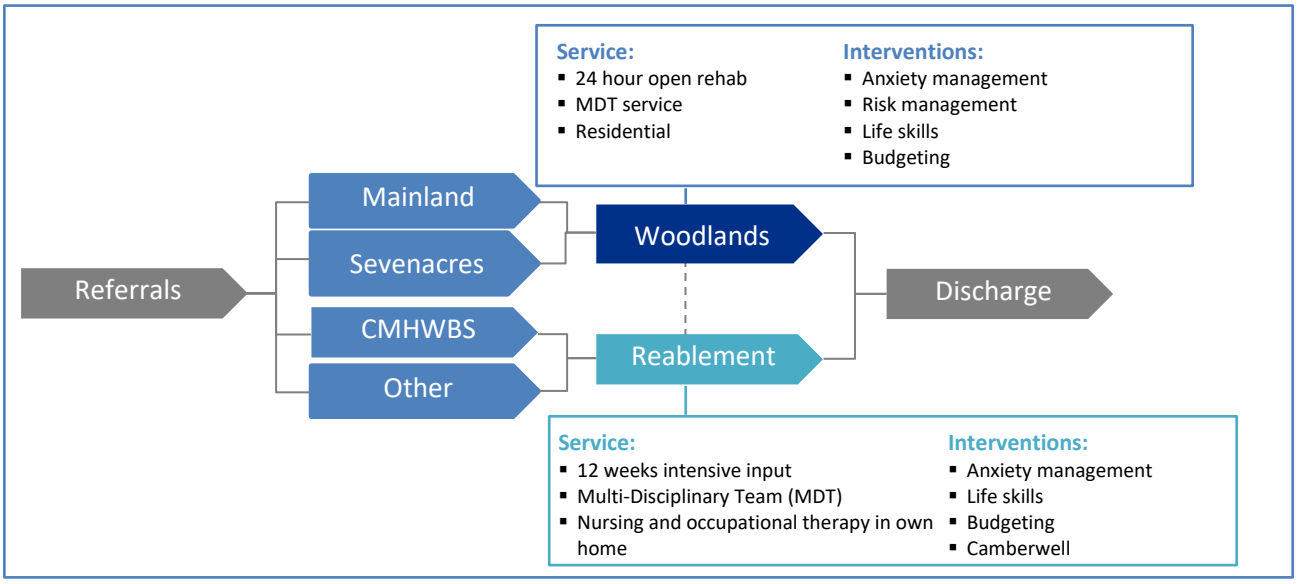
Admission to the unit is via referral - predominantly from acute inpatient facilities. It may also be accessed via forensic services, for the repatriation of people returning from specialist out of area placements, or by referral from the Community Mental Health Service. However, there has been in-reach from the inpatient setting since December 2019 with a waiting list to ensure appropriate patients access the service.

This has been part of a soft-shadowing approach to de-registered status to optimise patient care delivery, minimise risk to patients and staff through inappropriate acute placements, as well as mitigate potential patient issues arising from de-registration if the decision was made to proceed with de-registration

The team based at Woodlands (which compromises a 24hr ward team and an office hours community reablement team) provides both in-reach services to the acute wards, as well as out-reach support to people within their communities. The core team is formed of nurses, occupational therapists, psychotherapist and support workers.

The current residents at Woodlands are mainly people who are there on an informal basis. Others, however, have accessed the service on detained basis under the Mental Health Act (MHA), or via a court order in Part 3 of the MHA. Generally these residents have a high level of need, as well as restrictions placed upon them as a result of their section.

Figure 3.1 – Current Mental Health Recovery Service Model




## 3.2. Key Challenges to be Addressed

Whilst there are a range of challenges being faced along the pathway, the following have been highlighted for addressing within the development of the future model:

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| Poor Patient Outcomes and Risks to safety | CQC reporting in June 2018 rated the inpatient rehabilitation service for adults of working age as 'Requires Improvement'. Although there have been improvements, the September 2019 report remained at 'Requires Improvement' and suggesting inappropriate placement of acute patients in Woodlands. |
| Poor Patient Experience | There has historically been a fragmented and limited community mental health pathway. Services have disconnected interfaces resulting in a risk of patients being 'lost in the system' or, 'held on' for too long. Another aspect of poor patient experience is the use of Out Of Area placements. At present the impact of this is being mitigated by the Complex Care Specialist Nurse role. However, this is a single point of failure. |
| Island Demographics and Geography | There is a requirement for services to be configured in a way that strengthens their resilience and meets the population's health requirements. This can potentially lead to merging of services on the Island, or to work in partnership with mainland Providers. Based on these guidelines, the scale of population demand to the recommended levels are not sufficient to warrant development of specialist units. |
| Workforce | Feedback regarding staff has been positive and this should be carried forward into any future model. However, there is a skills and wider capacity shortfall, due to the evolution of the Woodlands service into an acute / rehabilitation hybrid. There is also restricted access to senior clinical oversight. |
| High Acute Turnover | In 2016/17, the Isle of Wight had the highest number of adult acute mental health beds and admissions in the country; however, this is accompanied by the shortest average length of stay in the country for acute admissions for adult mental health (*NHS Benchmarking 2016/17*). Progress has been noted as shown in the *NHS Benchmarking Report* (2019), but currently the 10 beds in Woodlands are skewing this data. |
| Contractual Termination | The Trust needed to inform Southern Housing in September 2019 of its intentions regarding the future of Woodlands in line with the existing contract's break clause. Some flexibility in timelines was agreed, enabling a delay of the formal decision being submitted to Southern Housing, and an extension of the contract until September 2020 with break clause which could be triggered once future plans are agreed. |

## 3.3. Incorporating Feedback

In 2017 it was identified by the CQC that the Woodlands pathway would benefit from a review and realignment with national best practice to ensure that Island residents were receiving parity of care. Analysis of service user feedback was used to inform the direction of travel for the Mental Health Transformation Programme - one strand of which was the Mental Health Rehabilitation, Reablement and Recovery pathway (title now shortened to Mental Health Recovery Pathway).

The views and opinions from stakeholders were incorporated within the development of the project and interim service models. It was identified that there is a contractual timeframe and programme timeframe, leading to a development of a two phased approach to the transformation of the existing pathway.

- PHASE 1 - Development an interim service model to address immediate quality, patient experience and safety concerns raised by CQC.
- PHASE 2 – Consultation with people who use the service and staff to ensure that an iterative model can be developed This will be utilised to help shape the future long-term model.

## 3.4. High Level Timelines

The following key milestones have been factored in to the Options proposed:

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| **Stage1** 2016-2017 | ENGAGEMENT TO INFORM MH BLUEPRINT<br>▪ Engagement on Mental Health, Suicide Prevention, Dementia Awareness Strategies and Children and Young People's Transformation Plan and Transitions Protocol, and system redesign case for change |
| **Stage 2** Sep - Dec 2017 | MH BLUEPRINT- FIRST DRAFT<br>▪ MH Blueprint Drafted and Internal Stakeholder and Core MH Alliance Consultation<br>▪ Hampshire and IOW Mental Health Alliance and Local Authority Lead Member for Mental Health identified |
| **Stage 3** Jan – Jun 2018 | STAKEHOLDER ENGAGEMENT & CONSULTATION<br>▪ Board Approval for Engagement and Consultation<br>▪ Stakeholder Engagement and Consultation |
| **Stage 4** Jun - Jul 2018 | MH BLUEPRINT- FINAL DRAFT<br>▪ MH Blueprint Final Draft, action plan, and MH Transformation Steering Group Final Approval |
| **Stage 5** Jul – Mar 2020 | REHABILITATION, REABLEMENT AND RECVOERY WORKSTREAM INITIATED<br>▪ Multi-stakeholder project group initiated, completion of Quality Impact Assessment and financial modelling<br>▪ Engagement with NHSE Assurance to work up options. Phase 1 comms and engagement plan developed |
| **PROJECT SUSPENDED** | COVID-19 EMERGENCY RESPONSE PERIOD |
| **Stage 6** Jun – Jul 2020 | PROJECT REINITIATION<br>▪ Refresh of local data and financial modelling and feedback from SLT incorporated into design. |
| **Stage 7** Jul – Aug 2020 | APPROVAL OF OPTION<br>▪ Governance followed for approval of business case through internal, partner and regional processes |
| **Stage 8** Sep – Feb 2020 | IMPLEMENTATION PHASE I: INITIATION<br>▪ Comms and engagement with stakeholders, oOperational plan developed, w for agreed option<br>▪ Contractual and CQC registration requirements updated (1 Feb target for deregistration) |
| **Stage 9** Feb – Mar2020 | IMPLEMENTATION PHASE II: PHASED CASELOAD INCREASE<br>▪ Subject to option selected, phased approach enabling staff to up-skill |
| **Stage 10** Apr - Jun 2021 | PROJECT CLOSURE<br>▪ Review of learning lessons and service user / staff feedback regarding changes to inform ongoing SDIP |

## 4. Options for Consideration

It is important to ensure that the whole Recovery Pathway is safe, effective and financially viable. The following options have been developed using local qualitative and quantitative information, which has then been considered in light of our peer partner models and other national approaches to delivering recovery services. Three options were developed as a result of this work. These options have been summarised below, and a summarised comparison review can be found on the next page (detailed reviews of these options can be found in the full Mental Health Recovery Business Case).

### Table 4.1 – Option summaries

| Option1<br>Do Nothing | Option 2<br>Tiered Estate Model | Option 3<br>Dispersed Model |
|---|---|---|
| Key Features:<br>▪ Woodlands remains a registered unit with 10 beds<br>▪ Trust pays for staffing and estate (LA contribution for Reablement)<br>▪ Teams remain split between Rehabilitation, Reablement and Complex Care Specialist Nurse (Out of Area Placements)<br>▪ Care is clinically driven with a consultant led model<br>▪ Contract renegotiated with Southern Housing to provide long-term lease<br><br>Key Benefits:<br>▪ Beds can be used for overflow of detained patients when acute capacity reached<br>▪ No additional cost pressure to system baseline figure<br><br>Key Risks:<br>▪ Patient safety at high level of risk due inappropriate environment and staff training to support acute patients as service not designed for acute support<br>▪ Positive outcomes for patients limited increasing risk of relapse / long-term harm<br>▪ Long-term cost to system increased through limited success in rehabilitation | Key Features:<br>▪ Woodlands is de-registered and converted to 8 beds and 1 flat<br>▪ Trust pays for staffing and estate (LA contribution for Reablement)<br>▪ Estate costs paid on a licence basis through eligible benefits / self-funding<br>▪ Reablement, Intensive Rehab and Assertive Outreach pathways within the Recovery service, including Out of Area Placements caseload<br>▪ Care is based on a person-centred biopsychosocial model which is consultant nurse-led<br><br>Key Benefits:<br>▪ CQC safety risks addressed with appropriate environment and staff training<br>▪ Responds to current consultation feedback and strategic drivers for change<br>▪ Staff skills and delivery of support optimised for improved outcomes<br>▪ Increased community approach with more robust in/out reach support<br>▪ Service users able to develop their accommodation history<br>▪ Increases efficiency and value for money<br><br>Key Risks:<br>▪ Increases cost at baseline level<br>▪ Reduced options for detained patients<br>▪ LA may not support changes as individuals eligible for local benefit will be able to receive payments from point of entering Woodlands instead of exit | Key Features:<br>▪ Woodlands is no longer used; no dedicated accommodation used as a base with teams completely agile across community<br>▪ Trust pays for staffing only (LA contribution for Reablement)<br>▪ Accommodation is based on people's homes / extant community housing stock<br>▪ Reablement, Intensive Rehab and Assertive Outreach pathways within the Recovery service, including Out of Area Placements caseload<br>▪ Care is based on a person-centred biopsychosocial model which is consultant nurse-led<br><br>Key Benefits:<br>▪ CQC safety risks addressed with appropriate environment and staff training<br>▪ Responds to strategic drivers for change<br>▪ Staff skills and delivery of support optimised for improved outcomes<br>▪ Increased community approach with more robust in/out reach support<br>▪ Increases efficiency and value for money<br><br>Key Risks:<br>▪ Increases cost at baseline level<br>▪ Reduced options for detained patients<br>▪ LA may not support changes as individuals eligible for local benefit support may not welcome financial impact from becoming eligible to receive payments from point of entering Woodlands instead of point of exit<br>▪ Requires additional consultation on service model due to changes beyond scope of current feedback<br>▪ Requires fully mature health and social care integration<br>▪ Requires robust, accessible community housing stock<br>▪ Requires additional recruitment and training to new way of agile working |

### Table 4.2 – Summarised Comparison Review

| | Option 1<br>Do Nothing | Option 2<br>Tiered Estate Model | Option 3<br>Dispersed Model |
|---|---|---|---|
| Similar Model | Isle of Wight | Dorset | Sheffield |
| Addresses CQC safety concerns | No | Yes | Yes |
| Addresses CQC outcome concerns / improves quality | Partial | Yes | Yes |
| Increases accessibility to support delivered by the right person, right place, first time in the least restrictive setting | No | Yes | Yes |
| Facilitates early intervention / prevention of secondary relapse | Partial | Yes | Yes |
| Alignment with national and regional drivers | Partial | Yes | Yes |
| Alignment with local drivers | Partial | Yes | Yes |
| Alignment with consultation feedback | Partial | Yes | Partial |
| Improves service efficiency and operational resilience | No | Yes | Yes |
| Increases integration with other services and system partners | No | Yes | Yes |
| Improves workforce sustainability and resilience | No | Yes | Partial |
| Total Income | -1,366,454 | - 1,366,454 | - 1,366,454 |
| Total Costs | 1,668,686 | 2,059,285 | 1,988,599 |
| Total Direct Costs | 1,174,957 | 1,602,814 | 1,547,129 |
| Total Indirect Costs | 493,728 | 456,471 | 441,471 |
| (Profit)/Loss | 302,232 | 692,831 | 622,145 |
| Reablement LA Income | -147,000 | -147,000 | -147,000 |
| Revised (Profit)/Loss | 155,232 | 545,831 | 475,145 |
| *Transfer of CMHT Resource | 0 | -251,913 | -251,913 |
| Revised (Profit)/Loss | 155,232 | 293,918 | 223,232 |
| Change in Trust Expenditure from current pathway - Option 1 | - | 138,686 | 68,001 |

## 5. Recommendation

**Recommendation: Option 2 Tiered Accommodation Model**

The outlined options acknowledge the national and local direction of travel that requires innovative approaches to utilising available finances without disinvesting. We need to make the money work smarter to achieve better outcomes for our Island residents and create healthy, positive working environments for staff.

By prioritising a person-centred focus approach, incorporating both health and social care needs whilst considering the pros and cons of the three options, then the recommendation would be to adopt and implement Option 3 Dispersed Model as the preferred direction of travel. However, it is recognised that this would involve an extensive and rapid transformation to the service which relies heavily on the system being mature enough to accommodate the change without destabilising the wider Mental Health Transformation Programme. There would also be a requirement for further time to be spent on consultation, engagement and observance of procurement timelines, delaying implementation of the final model by c. 12-18 months. As a consequence of this delay, service users and staff will be at risk of direct harm (as highlighted by the CQC).

Whilst this innovative way of working may be an aspiration, it is felt that the risks of immediately implementing the Option 3 Dispersed Model would too great at this point in time. Instead, the recommendation is to pursue Option 2 Tiered Accommodation Model with integration of the Care Act focussed Reablement Team and establishment of the Assertive Outreach Team to address the current pathway gap for individuals requiring intensive case management providing a clinically effective approach to managing the care of severely mentally ill people in the community over a sustained period of time with an emphasis on continuity of care. This would facilitate significant and wide-reaching positive transformation in other work-streams, as well as laying the foundations for further service development within the Recovery Model.

The additional benefit of choosing Option 2 would be to enable the system to safely build the infrastructure across all partner organisation required to shift to an even more radical Option as soon as clinically possible – such as Option 3 – further down the line in a safe a controlled way by building strong foundations within the workforce, methods of intervention, culture and service users' own resilience to change.