Mental Health Recovery Service Business Case

August 2020

Contents

1. Introduction

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. In the Five Year Forward View for Mental Health (2016), it was noted that poor mental health carries an economic and social cost of £105 billion a year in England. Cost-effective interventions exist to prevent mental illness and to promote wider population mental health; it is widely accepted that investment in mental health services brings positive economic benefits and can deliver significant return on investments.

Locally, it is acknowledged that significant change and improvement is required on the Isle of Wight (IOW) to transform mental health services to achieve the national and regional priorities as set out in the Mental Health Five Year Forward View (5YFV), the NHS Long Term Plan, and the Hampshire and the Isle of Wight Sustainability Transformation Plan (HIOW STP). As a system, we are aware that making positive change to our current service model is critical to the delivery of outcomes that local people have told us are most important to them through development of the IOW Mental Health Blueprint in 2017, and through the recent service design process delivered through the partnership with Solent NHS Trust in 2020.

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 development and implementation of the Community Mental Health and Wellbeing Service (CMHWBS). This new service adopts a recovery based approach, placing far greater emphasis on people's strengths and potential than on their problems or deficits.

As we, as a system, have progressed along the transformation journey, there have been significant and far-reaching changes – not only in local service configurations post-transformation, but the strategic landscape has changed through the fostering of closer partnership working with our peers at Solent NHS Trust. The design process currently being undertaken in partnership with Solent NHS Trust in the Spring/Summer of 2020, builds upon our transformative journey to date. It describes a refreshed model of care for Mental Health and Learning Disability services on the island, incorporating the changes which have transpired over the past three years.

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 and with the most vulnerable: *Coronavirus and the social impacts on Great Britain: 12 June 2020, Office for National Statistics* reported that, nationally, over two-thirds of adults (69%) have said they were worried about the future, with a similar figure (63%) acknowledging feelings of stress and anxiety. There has been a great opportunity to learn and develop at a rapid pace with a great deal of innovation occurring in a short time-span. The pressure is now on to ensure a robust and resilient model is in place to support a potential influx of a demand arising from a mental health pandemic as we go in to the 'new norm'.

This business case outlines the next phase in transformation of the Island's Mental Health services by presenting the options for the future development of the Mental Health Recovery Service on the Isle of Wight with particular regard to the property known as 'Woodlands'.

Woodlands is currently an open rehabilitation ward for people with serious mental illness and forms part of the wider mental health offer commissioned from the NHS Isle of Wight Trust. It is a 10-bedded, mixed sex community rehabilitation unit which offers longer term rehabilitation for people who need to learn or relearn the skills required to live independently. It is CQC registered and thus, able to accept people detained under the Mental Health Act (2007), but the majority of patients who use this service are informal.

2. Strategic Context

2.1. National Drivers of Change

i. Mental Health Five Year Forward View

The Five Year Forward View for Mental Health (2016) set out a clear and compelling agenda for the reform of mental health care. The strategy is built around the evidence and opinion of the thousands of people who contributed to its development. The aim is to increase significantly the availability and quality of care and treatment for people with mental health problems – not only improving their outcomes and wellbeing, but also tackling the wider costs of mental ill health to the health service and society as a whole.

Of particular relevance to further development of the Mental Health Recovery service is the national 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 as well as other sectors.

This is expanded on within Recommendation 23 which clarifies that there should be:

> *"…a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery for people of all ages who have severe mental health problems and significant risk or safety issues in the least restrictive setting, as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and trial new co-commissioning, funding and service models."*
>
> The Five Year Forward View for Mental Health (2016)

ii. NHS Long Term Plan

The NHS Long Term Plan (2019) signals an extension of the commitments set out in the 5YFV, beyond 2020/21 to 2023/24 and serves to reaffirm the national commitment to the priorities set out in the 5YFV which are reflected in this business case.

iii. Hampshire and the Isle of Wight Sustainability Transformation Plan (HIOW STP)

The Hampshire and Isle of Wight (HIOW) Sustainability and Transformation Partnership (STP) has established a mental health programme, with representation from all local mental health providers, including the IOW NHS Trust, CCG and local authority, which is aligned with the NHSE Strategic Clinical Network for mental health, under the same leadership.

The programme has focused on system-wide transformation initiatives, including acute and crisis mental health care. The priorities have included mental health crisis pathways, modelling mental health acute and crisis resource, and reducing out of area placements in acute and rehabilitation services.

Engagement with the Programme Manager for the HIOW STP Rehabilitation and Recovery Programme has been undertaken to ensure alignment of the current short-term proposals with the long-term transformation of the Mental Health Recovery pathway on the Isle of Wight.

This alignment has been reflected within the interim findings of the '*Hampshire and the Isle of Wight STP Rehabilitation and Reablement – DRAFT*' paper. Although not yet ready for formal publication (and therefore not able to be incorporated fully within this business case pending final validation and approval for dissemination) some of the emerging themes include:

- Identification of a need for embedding rehabilitation within a wider local mental health offer that includes a range of provisions with different levels of support. The paper refers to a case study in Ireland in which service users were eight times more likely to sustain their community placement and avoid readmission when they had accessed rehabilitation services than those who did not.
- Identifying there are two levels of rehabilitation unit models: high-dependency rehabilitation units, and community rehabilitation units. The latter of which can take various forms including living in supported accommodation (residential care, supported housing and floating outreach).
- There should be a focus on supporting people locally and limiting the use of out-of-area placements wherever possible, except for people with particularly complex needs.
- Reablement services are an important part of the wider rehabilitation pathway.
- Consultation feedback highlighted transition and community support as key areas of current concern.
- Consultation also highlighted that key elements of delivering successful rehabilitation models include an outcomes-based approach, support from staff, environment, access to housing (including long-term solutions), staff training, communication (at all levels and interfaces), and clarity of roles.
- Whilst clinical input still forms part of rehabilitation, there is a shift towards a psychologically informed approach that prioritises building better support for transition; empowering people to develop their skills, share experiences with peers, and strengthening their networks to help prevent relapse.

iv. Care Act 2014

The Care Act was enacted to help improve people's independence and wellbeing. It makes clear that 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.

It also requires Local Authorities to also provide or arrange a range of services which are aimed at reducing needs and helping people regain skills, for instance after a spell in hospital. They should work with other partners, like the NHS, to think about what types of service local people may need now and in the future.

The key responsibilities placed upon Local Authorities include:

- Promoting individual well-being
- Preventing needs for care and support
- Promoting integration of care and support with health services etc.
- Providing information and advice
- Promoting diversity and quality in provision of services
- Co-operating generally
- Co-operating in specific cases

3 Promoting integration of care and support with health services etc.

(1)A local authority must exercise its functions under this Part with a view to ensuring the integration of care and support provision with health provision and health-related provision where it considers that this would—

(a) promote the well-being of adults in its area with needs for care and support and the well-being of carers in its area,

(b) contribute to the prevention or delay of the development by adults in its area of needs for care and support or the development by carers in its area of needs for support, or

(c) improve the quality of care and support for adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision).

Care Act (2014)

v. The Community Mental Health Framework for Adults and Older Adults

In 2019, NHS England, NHS Improvement and the National Collaborating Central for Mental Health collaborated to develop the '*The Community Mental Health Framework for Adults and Older Adults*' which 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 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:

- Empowering people to manage their condition or move towards individualised recovery on their own terms
- Supporting people to live well in, and encouraging them to contribute to and be participants of, their communities
- Assessment and support delivery is based upon an evidence-based biopsychosocial model
- Care is centred on an individual's needs and stepped up or down based on need and complexity, and on the intensity of input and expertise required at a specific time.
- Support should be delivered in a multi-disciplinary, collaborative approach with a full range of staff within each local community who deliver effective mental health care.

This framework has been supported by the HIOW STP and mental health models will be assessed against it, including with a view to developing pathways to support people with complex mental health difficulties such as those associated with 'personality disorder'.

2.2. Local Drivers for Change

i. Isle of Wight Blueprint for Mental Health (2017)

The Island's Blueprint for Mental Health has been finalised with extensive input from people across our Island. It sets out the vision of what we want to achieve together in the years ahead as we take forward our Mental Health Transformation Programme. Its aim is that, with our partners and local communities, we will become a mentally healthy island. We will promote self-care, prevention and wellbeing and will deliver high quality mental health services, at all times focusing on the person themselves being in control being empowered to live hopeful and meaningful lives, and developing personal, family and community resilience.

The proposed Mental Health Recovery Service will enable achievement of the aims of the Blueprint through delivery against the seven initial proposals for improvement:

- Supporting people to maintain good mental health and renewing our focus on delivering prevention (in this case, secondary prevention of future crises)
- Reducing stigma and raising mental health awareness
- Recovery
- Developing our workforce
- Making the money work
- Improving quality, outcomes and holding to account

ii. 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 which include:

- Improved health and social care outcomes

- People have a positive experience of care
- Person centred provision
- Service provision and commissioning is delivered in the most efficient and cost effective way across the whole system, leading to system sustainability
- Our staff will be proud of the work they do, the services they provide and the organisations they work for and we will be employers of choice

iii. Isle of Wight System Strategy

The Isle of Wight Health and Care Plan (2019) sets out an ambitious three-year plan to improve health and care on the Island, supporting people to live healthy, independent lives. It identified the following priorities for transformation:

- Investing in community services
- Improving mental health services
- Improving acute (hospital) services
- Making sure health and social care are as well-run, productive and financially sustainable as possible

It goes on to expand the goal to improve mental health services with further commitments to:

- Develop mental health services that support people of all ages, that start in the community and connect effectively with other specialist services
- Break down the boundaries between GPs, community and hospital services and involve third sector partners
- Focus on enabling people to live a full and meaningful life
- Do more to support recovery, developing our workforce so that we have the right mix of trained, skilled, and experienced staff
- Improve the range of community-based mental health services available to those who need them, including for those with the highest level of need
- Move NHS community mental health services away from the hospital site so that they are at the heart of the communities they serve

The current design process underway in partnership with Solent NHS Trust is building on this work with delving in to the practical details of what the next stages for Mental Health and Learning Disability transformation look like. The key aim of this process is to develop services that are:

- High quality, delivering safe, effective, caring and responsive services that are well led
- Improve service user and staff experience by allowing staff to use their time more effectively and maximising capability and capacity
- Improve operational resilience
- Eliminate clinical handoffs
- Work in partnership with the wider system delivering integrated services, with shared information and shared risk
- Financially sustainable and affordable
- Accessible and ensure that everyone is seen by the right person, right place , first time
- Sustainable in their workforce model

- Able to scale up and innovate quickly
- Co-produced
- Enable early intervention and prevention
- Future proof with resilience to scaling
- Raise awareness and challenge stigma

As of June 2020, the following aspects of the model have been agreed which are particularly relevant to the local provision of rehabilitation services:

- We will deliver an integrated model of care across all Mental Health and Learning Disability services based upon a hub and locality model, that ensures people with moderate and low complexity of needs are able to access services in their local communities, and those with high complexity of needs will have their care delivered through a centrally co-ordinated Mental Health and Learning Disability hub.
- The service will be easy to access, with 'no wrong door', locality bases, that encourage self-referral
- Locality teams will be aligned to Primary Care Networks, and be delivered in partnership with Local Authority, third sector and community physical health services, bringing holistic physical and mental health and social care together
- The central hub will deliver an integrated multiagency Crisis and Liaison Hub, an Assertive Outreach/Intensive Community Rehabilitation service, and a community Dementia Outreach service
- We will reduce the total number of acute inpatient beds including the 'closure' of Woodlands beds

The Strategic context at a national, regional and local level included above may appear, at first glance, repetitive but this only serves to underscore the driving need to develop a model which reflects the direction of travel and meet the needs of our population. 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

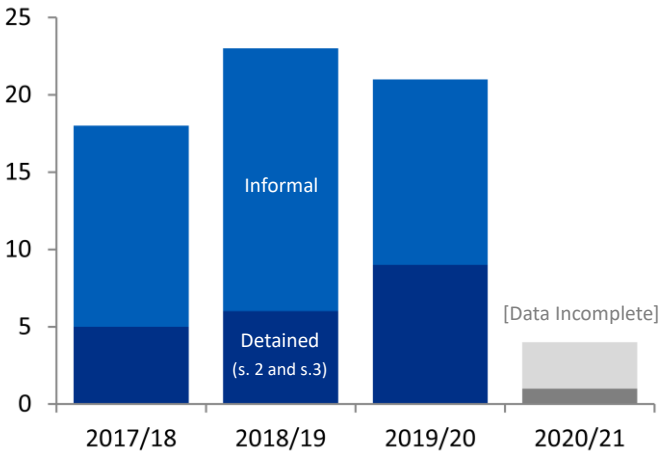
3.1. Current Service Model

i. Admission Status

The NHS Isle of Wight Trust is commissioned to treat and support people with mental ill health on a cluster basis, with the Woodlands service offering step-down rehabilitation from an inpatient stay.

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 (CMHS).

As of June 2020, the current residents at Woodlands are mainly people who are there on an informal basis – from 2017/18 to 2019/20 64% of service users were under this category. 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. (*See graph right for breakdown; for further details on statistics see Appendix 1*.)



Woodlands Admission Basis by Year (Year Point of Exit), NHS Isle of Wight Trust PIDS

Since December 2019, there has been a reduction in the use of the unit as an acute overspill as there has been a proactive approach to in-reaching from the inpatient setting since December 2019 with a development of a waiting list to ensure that patients who are appropriate for rehabilitation 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 (initial work-stream had identified a potential de-registration date of April 2020.) This 'soft-shadowing' approach has also meant that the team have been able to react flexibly to the wider system needs with the impact of Covid-19, although within the confines of the Key Challenges faced by the service as discussed in further detail below.

ii. Service Offer

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 people recover from their mental health problems and to regain the skills and confidence to live successfully in the community, and;
- Supporting them 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.

iii. Rehabilitation Team Delivery

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 10-bedded Woodlands site (located at Wootton Bridge), is a hospital CQC registered ward which is staffed on a 24/7 basis in line with clinical requirements.

The core team is formed of nurses, occupational therapists, psychologists and mental health support workers. Staff members work closely with the Reablement Team to deliver the most appropriate intervention(s).

iv. Reablement Team

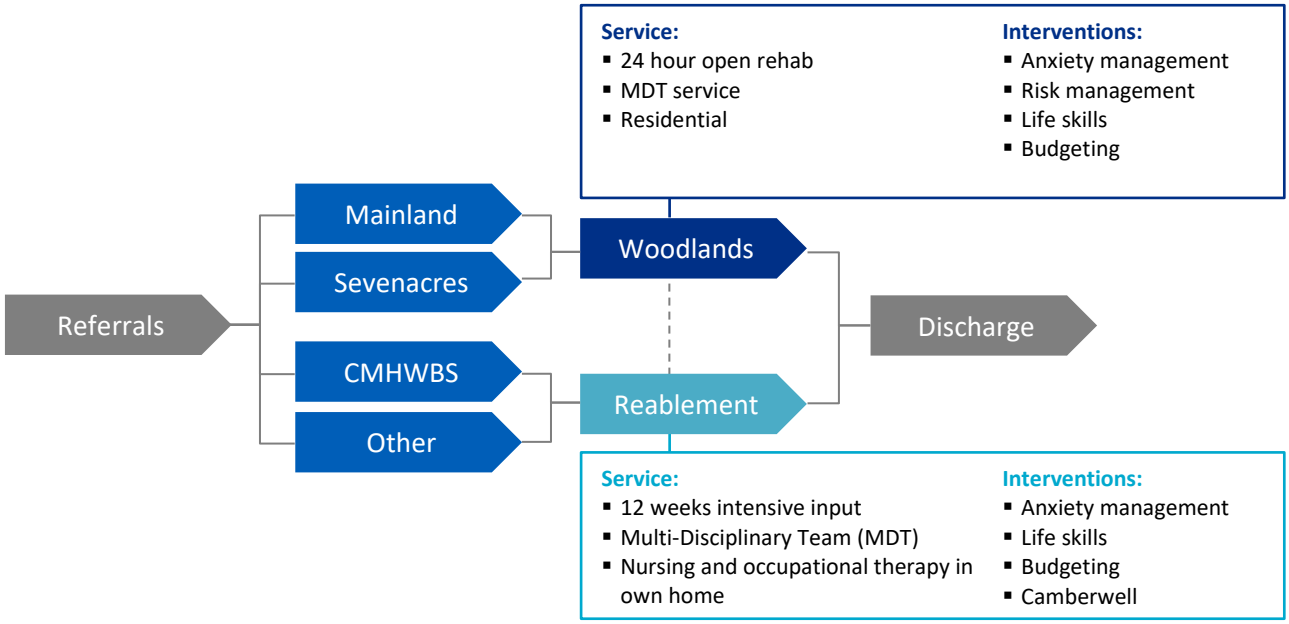
Since 2016 the Reablement Team has successfully engaged with and supported a total of over 200 adults with mental health needs who have required recovery based-holistic support in order to increase their ability and confidence to live their lives more purposefully and independently.

The focus and successfully achieved performance outcomes of the Reablement Team have always been very aligned with the general principles of the Care Act 2014, including the Act's eligibility criteria for a person having a need for, and requiring, care and support. In each case the Reablement Team's involvement with a person will have arisen from their needs which relate to their mental impairment/illness; and in each case they will have been unable to meet these needs, or the specified outcomes arising from these needs, on their own without additional support. Therefore without the skilled focused interventions of the Reablement Team there will either have been an actual, or likely, significant impact on that person's wellbeing. This is very much in line with the s.13 eligibility criteria of the Care Act.

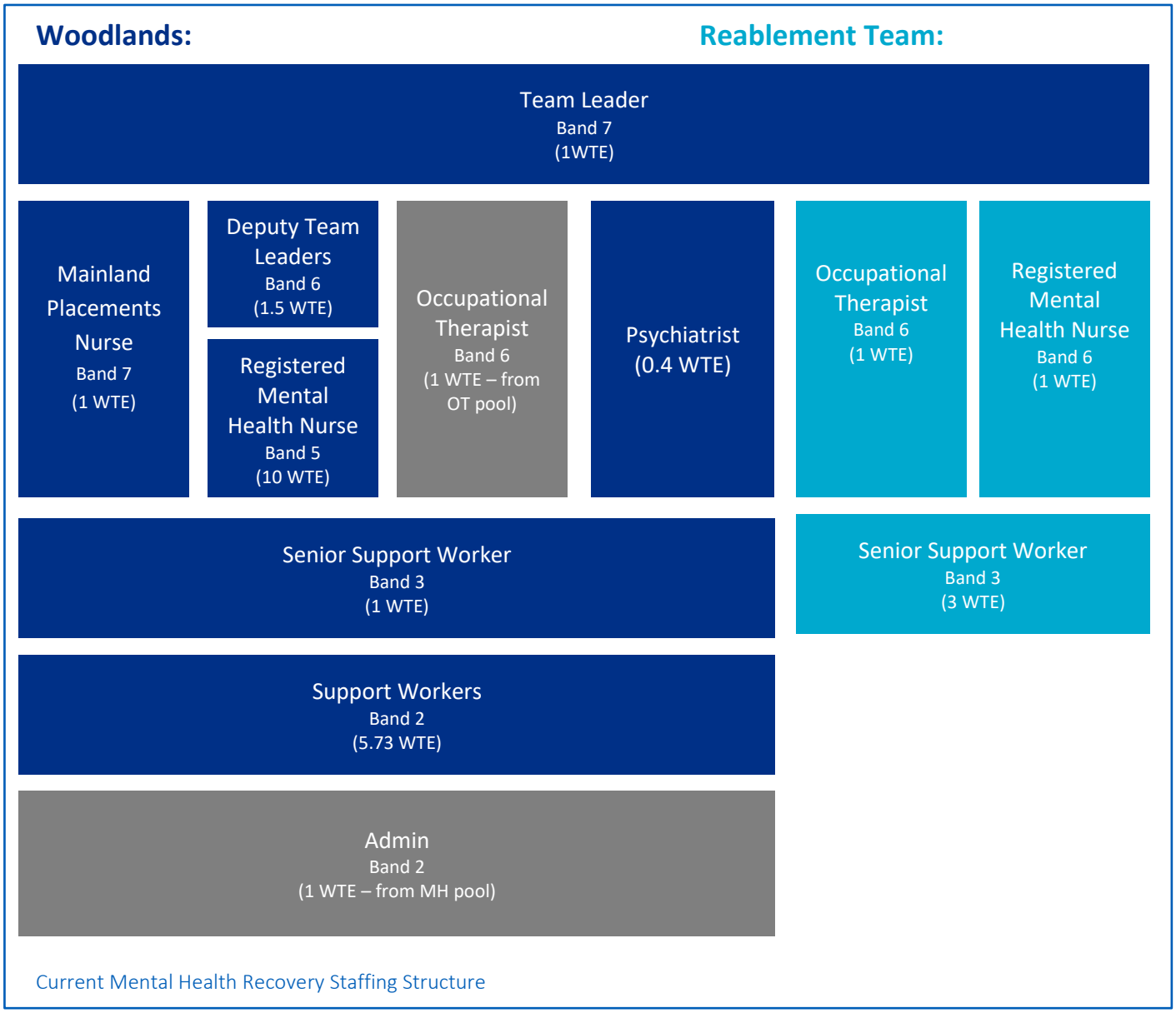
With respect to the specific outcomes which the Reablement Team have supported people to meet/achieve, these have been very person centred and holistic in nature. They have included areas although not exhaustively such as: supporting people to improve their structure and motivation to maintain their nutrition in terms of food preparation and food budgeting etc; increase people's ability to maintain their home environment in wide ranging areas; supporting people to overcome their social isolation, improve their social networks, improve relationships with people's families; supporting people to access and engage in work, training, education, volunteering; and supporting people to more confidently access and use community facilities and transport.

Because the Reablement Team has worked with people on the model of a 12 week period of focused support, they have been very successful in supporting people to achieve permanent improvements in their ability to lead independent lives. By doing so, in many cases the Team has been potentially preventing these people from otherwise requiring a s.9 Care Act Assessment of Need by the Local Authority and thus, in some cases, a potential duty arising from this assessment for the local authority to meet these needs.

The following figures summarise the current model:



Current Mental Health Recovery Service Model



Current Mental Health Recovery Staffing Structure

The service supports a wide range of Mental Health conditions including:

Referral Reason to Inpatient Woodlands Team as Recorded on PARIS	2017/18	2018/19	2019 YTD
Assessment	1	8	8
Inpatient Assessment / Treatment	11	1	0
In Crisis	3	8	2
Ongoing or Recurrent Psychosis	2	4	4
Depression	0	3	0
Bi-Polar Disorder	0	1	0
Personality Disorders	0	1	0
Routine Assessment	1	0	0
Self-Care Issues	0	1	0

(Suspected) First Episode of Psychosis	0	0	1
Obsessive Compulsive Disorder	0	0	1
Grand Total	18	27	16

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:

v. Poor Patient Outcome and Risks to Safety

CQC reporting in June 2018 rated the inpatient rehabilitation service for adults of working age as 'Requires Improvement' overall. Although there have been improvements in some areas with the 'Getting to Good' programme of work, the September 2019 report remained at 'Requires Improvement'. Key areas of concern included:

> *"The service did not always provide safe care to patients. For example, patients admitted to the ward that should have been cared for on acute wards did not always receive an assessment of their needs and risk before admission, and their risk assessments did not recognise and mitigate for all the risks present within the environment. The service had no protocols or policies to support Woodlands staff to manage acute patients. Staff were experienced in caring for patients with mental health needs, but staffing numbers did not always enable staff to provide adequate support to both the acutely unwell, and rehabilitation patients present on the ward."*
>
> *"Patients did not receive the full range of recommended care and treatment interventions suitable for patients requiring rehabilitation care and consistent with national guidance on best practice. For example, patients were not able to store medicines in their room and self-administer in preparation for discharge, and the ward had only recently recruited a psychologist, and was yet to embed psychological input into the wards treatment programme."*
>
> CQC Isle of Wight NHS Trust Inspection report 04/09/2019

This can arguably be summarised as the inappropriate placement of acute patients in Woodlands, which is currently not designed to meet the needs of these acute individuals, resulting in the detriment of outcomes for both the acute patients and the intended rehabilitation cohort. The service is consequently not optimised to achieve its core precepts of helping people to gain the skills and confidence live well in the community with limited capacity to offer any out-reach support.

vi. Poor Patient Experience

There has historically been a fragmented and limited community mental health pathway which the current Mental Health Transformation Programme is seeking to address and improve the experience of people who use services. Services had become siloed with disconnect between interfaces resulting in a risk of becoming 'lost in the system' or, conversely, 'held on' for too long inappropriately by teams with expanding caseloads due to paternalistic concern for the patients that they would get lost or fail to get support once discharged. Patients who are able to transition between services often have to repeat assessments and provide their histories on multiple occasions.

Another aspect of the current model resulting in poor patient experience is the use of Out Of Area placements. The national drive is to cease out of area locked placements as people out of area do less well

because they are disconnected from their peers, families and friends. Besides the negative (or at least, less positive as sometimes the specialist clinical skills provided are in the individual's best interest) impact of OATs, there is also the financial impact. At present the impact of this is being mitigated by the Complex Care Specialist Nurse role. However, this is a single point of failure due to the expertise lying in one individual and requires resilience to be built-in to the system to ensure that the care of any complex patients care be safely and securely supported in future models.

vii. Island Demographics and Geography

Another dilemma in developing suitable options has been the Island's demography and population of 144,988. Issues around scale apply to many services on the Isle of Wight, along with the challenges around geographical isolation; there is a requirement for Island services to be configured in a way that strengthens their resilience as well as meeting the population's health requirements. This can potentially lead to merging of services on the Island that may be delivered separately elsewhere, or to work in partnership with mainland Providers.

Best practice commissioning guidance on provision of recommended levels of mental health rehabilitation care are:

- Community Rehabilitation Unit per 300,000 population
- Longer Term Complex Care Unit (also known as High Dependency Units in newer documentation) per 600,000 population

Based on these guidelines, the scale of population demand to the recommended levels are not sufficient to warrant development of specialist units and would consequently be unsustainable. The pathway needed is one that will support the individual needs of a diverse population without the benefit of economies of scale. Currently Island residents are placed as far away as Northampton; going forwards people living on the Island need to be able to access a Community Rehabilitation Service and a Longer Term Complex Care Unit within the STP footprint and have a new model of provision on the Island.

That a local offer is needed can be illustrated by the prevalence of mental health conditions. In the *HIOW Mental Health Delivery Plan (MHDP) 2020/21 – 2023/24* some stark figures were provided:

- The Isle of Wight has the highest prevalence of Serious Mental Illness in the STP footprint with a rate of 1.18%
- The suicide rate per 100,000 population was 10.87 in 2015-17 on the Isle of Wight –higher than the England average
- National averages show that people with SMI die on an average 15-20 years earlier than the general population and a 3.7 times higher death rate for ages under 75 than the general population.

viii. Workforce

Feedback regarding staff has been positive and this should be carried forward into any future model:

> *"CQC Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Staff involved patients in care planning and risk assessment and sought their feedback on the quality of care provided. Service users' views were incorporated, even when they differed from the clinical teams. Staff ensured that patients had easy access to independent advocates. Staff informed and involved families and carers appropriately."*
>
> CQC Isle of Wight NHS Trust Inspection Report (2019)

"• all the patients and relatives that we have spoken to have been extremely positive about the care, support and treatment that they are receiving at Woodlands
• relatives and the IMHA have commented on the significant improvement in the service since you have been in place as ward manager
• staff have felt extremely supported by you as ward manager during this time."

CQC Mental Health Act Virtual Inspection of Woodlands in Response to the COVID-19 Pandemic (June 2020)

However, there is a skills and wider capacity shortfall. The former has arisen due to the evolution of the Woodlands service into an acute / rehabilitation hybrid which poses the mixed issue of not having suitable competencies in place to support those individuals with acute needs, whilst contemporaneously not offering the opportunity to develop staff to the their full potential in delivering rehabilitative therapies. The latter issue is one regarding current and long-term recruitment – an issue which the Isle of Wight is not unique in facing. The HIOW STP MHDP noted that the region has been facing a shortfall with figures in May 2019 including a 15.3% Mental Health nursing vacancy rate and 11.4% clinical psychology vacancy rate, with an overall decline of 6% in Mental Health Therapy workforce. Top reasons cited for leaving stemmed from work life balance and retirement. This regional, and national issue, is exacerbated by the geographical isolation of the Isle of Wight.

In order to ensure a sustainable work-force there is a need to nurture our existing staff to develop to their full potential, as well as making the Island offer a more enticing one. This is something which can be tied to a culture of innovation, progressive and enriching work opportunities that enable staff to maximise their potential whilst taking it back to the heart of helping others achieve their own health and well-being goals.

As an element of that innovation there is a need to think more creatively about the resources we already have access to. Although a sustainable workforce plan looks to the future, there is also a driving need to develop a service which is operational today. One example of a current issue is the restricted access to senior clinical oversight in the current model which is clinically driven. This has led to ward-rounds reducing to only occurring on a weekly basis, resulting in delays in discharges and updating of treatment plans – the latter of which should ideally be happening in a dynamic way on a daily basis to optimise outcomes. By moving to a more multi-disciplinary workforce, there is an opportunity to develop more workforce resilience, introduce different skill-set and potentially different roles such as a consultant nurse led model. This Consultant Nurse role would help to mitigate the challenges of recruiting to consultant psychiatry positions.

ix. High Acute Turnover

In 2016/17, the Isle of Wight had the highest number of adult acute mental health beds and admissions per 100,000 weighted population 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*). This has prompted the transformation of the community mental health infrastructure. Progress has been noted as shown in the *NHS Benchmarking Report* (2019) which showed that the Isle of Wight, while still with the greatest number of acute beds per100,000 weighted population in the South East region, it had improved to seventh in the country with mean Length of Stay at 26 days (excluding leave). Currently the 10 beds in Woodlands are skewing this data in three ways:

- Due to the registered status they are included as acute beds although not the intended cohort nor in practice, primarily used in an acute manner adding to the appearance of being over-bedded
- Use as an overspill results in inappropriately placed patients being moved quickly adding to the high turnover effect

- Longer length of stays in Woodlands (as would be expected for a rehabilitative journey) extend the overall length of stay for reporting 'inpatient' beds.

x. 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. A meeting was held to discuss contractual options and some flexibility in timelines was agreed, enabling a delay of the formal decision being submitted to Southern Housing until the end of December 2019. The result of this was an extension of the contract until September 2020 with a month break clause which could be triggered once the future plans were agreed. Due to the suspension of the project, the contract has since been renegotiated by the NHS Isle of Wight Trust Estates team to ensure continuity of service. The new key elements of this extension are:

Term:	5 years
Date of Commencement:	01/03/2018 (backdated to expiration of previous lease)
Break Clause:	12 months' notice for termination by Southern Housing; 4 months' notice by NHS Isle of Wight Trust.

There is a risk that the Trust will incur an ongoing financial cost pressure from the leasing of Woodlands, and well as potentially damaging the relationship with the provider if they are unable to determine a long-term arrangement.

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 which was safe, quality and sustainable for the future. At this time, both the Trust and the commissioners are looking for innovative ways of delivering an outcomes focused, integrated Rehabilitation, Reablement and Recovery service within the available financial envelope, delivering efficiencies where possible. At this time, consultation included representative from people who use the services to help inform a business case.

As further areas of the Mental Health were identified as requiring improvement, the discrete Woodlands project was paused and a review of the whole pathway commenced with extensive public consultation in order to develop the '*Talking mental health: A draft blueprint for the island*'. Details of the engagement undertaken were collated in a Consultation Closure paper. 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).

People who attended the co-production / consultation events explained that any future model of Island Mental Health support must:

- Support people to stay in their community; promoting individuals to make the best use of their community resources (and in some cases actually gain access to community resources rather than rely on the statutory / traditional provision currently in place)
- Be flexible and increase choice
- Build self-value and be recovery focussed with services designed to meet the needs of the person rather than the person fitting in with what is provided
- Help people to achieve personal health and wellbeing goals
- Transform lives; increasing independence, empowerment and development of self-worth
- Tackle isolation, connect people and increase social inclusion

- Support access to mainstream services
- Be sustainable

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

Phase 1 - Utilisation of existing consultation information and engagement with key stakeholders to develop an interim service model to address immediate quality, patient experience and safety concerns raised by CQC as well as respond to contractual requirements. This would result in an interim model which is aligned with the current and prospective patient choice along with the Strategic Drivers outlined at the start of this document, namely:

- To receive care closer to home
- To have clearer, more joined up pathways
- To increase communication and integration with other teams
- To support additional psychosocial needs such as employment and housing
- To require any support / intervention plans to be developed holistically in partnership with the individuals ('work with' rather 'do to')

A Phase 1 Comms and Engagement plan was developed (*see Appendix* 1 and *Appendix 2* with input from the Woodland's Service Lead, Service User Representative, HIOW Partnership CCG Senior communications and engagement officer which was approved by the Project Group with approval from NHSE Assurance subject to sign-off from the Health Oversight and Scrutiny Committee. The councillors were engaged with for their feedback in February 2020 with positive reactions and a subsequently scheduled presentation due with HOSC in March 2020. However, final sign off has been paused as a result of the Covid-19 emergency response phase with a suspension of work on the project in place until mid-June 2020.

A Phase 2 consultation was also intended to continue applying targeted consultation with people who use the service and staff to ensure that an iterative model could be developed by understanding what does and doesn't work well over the duration of the Phase 1 model. This would then be utilised to help shape the future long-term model which would be implemented at the end of Phase 2.

3.4. High Level Timelines

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

Stage1 2016-2017	ENGAGEMENT TO INFORM MH BLUEPRINT ▪ Whole Integrated System Redesign (WISR) Case for Change - Mental Health was one of 6 key focus areas which significant engagement including: ▪ Public Meetings, Coproduction workshops, Surveys ▪ Engagement on Mental Health, Suicide Prevention and Dementia Awareness Strategies ▪ Engagement on Children and Young People's Transformation Plan and Transitions Protocol
Stage 2 Sep - Dec 2017	MH BLUEPRINT- FIRST DRAFT ▪ MH Blueprint Drafted ▪ Internal Stakeholder Consultation ▪ Core MH Alliance Consultation ▪ Hampshire and IOW Mental Health Alliance ▪ Best Practice Visits ▪ Local Authority Lead Member for Mental Health identified
Stage 3 Jan – Jun 2018	STAKEHOLDER ENGAGEMENT & CONSULTATION ▪ Board Approval for Engagement and Consultation ▪ Stakeholder Engagement and Consultation - Internal and External ▪ Media Campaign ▪ Engagement and Consultation Workshops ▪ Locality Meetings, Parish Council Meetings, GP Practice visits
Stage 4 Jun - Jul 2018	MH BLUEPRINT- FINAL DRAFT ▪ MH Blueprint Final Draft ▪ MH Transformation Steering Group Final Approval ▪ Board Final Approval ▪ Action Plan Development
Stage 5 Jul – Mar 2020	REHABILITATION, REABLEMENT AND RECVOERY WORKSTREAM INITIATED ▪ Multi-stakeholder project group initiated under MH Transformation Programme to take forward developed action plan ▪ Peer visits to explore models ▪ Scoping of best practices and data analysis ▪ Completion of Quality Impact Assessment ▪ Financial modelling ▪ Engagement with NHSE Assurance to work up options ▪ Phase 1 comms and engagement plan developed
PROJECT SUSPENDED Mar – Jun 2020	COVID-19 EMERGENCY RESPONSE PERIOD ▪ Flexible shadowing of service approach ▪ SDIP engagement with service users to keep feedback iterative and current
Stage 6 Jun – Jul 2020	PROJECT REINITIATION ▪ Refresh of local data and financial modelling ▪ Incorporation of changes since suspension of project (local and regional) to complete design process ▪ Extensive feedback from SLT incorporated into design including request to include an Assertive Outreach Pathway as an element of the Recovery Service
Stage 7 Jul – Aug 2020	APPROVAL OF OPTION ▪ Governance followed for approval of business case through internal, partner and regional processes
Stage 8 Sep – Feb 2020	IMPLEMENTATION PHASE I: INITIATION ▪ Ongoing comms and engagement with stakeholders including 30 day staff consultation ▪ Operational plan developed (including HR and OD plans, IT support, and PIDS); implementation commences (October target for ceasing acceptance of detained patients) ▪ Workforce recruitment, training and mobilisation for agreed option ▪ Contractual and CQC registration requirements updated (1 Feb target for deregistration)
Stage 9 Feb – Mar 2020	IMPLEMENTATION PHASE II: PHASED CASELOAD INCREASE ▪ Subject to option selected, phased approach enabling staff to up-skill and become accustomed to new ways of working
Stage 10 Apr - Jun 2021	PROJECT CLOSURE ▪ 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 Benefit / Risk Matrix has been included as Appendix 3. Further details are provided on the following pages:

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

	Option 1 Do Nothing	Option 2 Tiered Estate Model	Option 3 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
Cost (£000)	1,669	2,059	1,989
Variation to Current (Option 1 in £000)	-	139	68

4.1. Option 1: Do Nothing

i. Summary

Option 1 is to provide notice to Southern Housing that the registration status of Woodlands would remain in place and that the current licence would be renegotiated prior to the contracted expiration date in September 2020. During the intervening period, Woodlands would remain as a 10-bedded inpatient rehabilitation unit with no amendments to staffing structure, interventions offered or eligible patient cohort. 'Getting to Good' projects would continue in line with the Trust's internal improvement plan to address the risks highlighted by the CQC as far as possible within the confines of the existing offer including maintaining **Membership** status of the Royal College of Psychiatrists CCQI Quality Network for Mental Health Rehabilitation Services.

Example of Model: Isle of Wight

Example CQC Rating: **Requires Improvement**

Note: Rated 'Good' for caring and 'Inadequate' for productive use of resources

Based on current data the service would be able to offer:

Caseload:	18 per annum (Plus 17 OOA placements)	
Average Length of Stay in Service:	55 weeks	
Cost:	**Total Income**	**- 1,366,454**
	Total Costs	**1,668,686**
	Total Direct Costs	1,174,957
	Total Indirect Costs	493,728
	(Profit)/Loss	302,232
	Reablement LA Income	- 147,000
	Revised (Profit)/Loss	155,232
	*Transfer of CMHT Resource	0
	Revised (Profit)/Loss	155,232
	Change in Trust Expenditure from current pathway - Option 1	-
	For full details see Appendix 7: Financial Modelling	
Staffing:	Current template (*see p.4*)	

ii. Benefits

- People are supported with their accommodation and to return to work or meaningful activity with choice and control. However, the extent of this is constrained within current service model, staffing capacity and training limitation.
- Able to continue to support overspill of acute patients from Sevenacres
- Able to continue to offer step-down for detained patients from forensic services

- By pausing transformation of the Mental Health Recovery Pathway, able to focus transformation resources on other areas of the mental health pathway to minimise risk of spreading resources to thinly or causing service users to become unsettled through constant change

  Note: There is a possibility that, whilst 'Transformation resources' are protected for use elsewhere, the positive effect may be off-set by effectively 'locking-in' resources into inpatient beds that could be more effectively used to develop island wide community services for people with complex needs.

- Offers continuity of model for service users
- Recognises the good feedback from CQC and may help staff feel valued and respected

> *"…expressed his warmth for the Woodlands staff team in terms of their ongoing support and welcome provided to him during his frequent visits."*
>
> Service User Feedback, February 2020

> *"The staff had 'cherished me'…Woodlands 'helped me to get my life back on track.."*
>
> Service User Feedback, February 2020

- System status quo maintained – in particular no changes to GP care or Local Authority benefit arrangements.

iii. Risks

A Quality Impact Assessment has been completed for the Mental Health Recovery Pathway Project. (*See Appendix 4*). Key potential impacts include:

- To 'Do Nothing' doesn't fit with originally stated direction of travel for the Mental Health Transformation Programme, local / national strategic drivers, or addresses any the requests or concerns raised by our stakeholders – including our Island residents who use the service, or may do in the future.
- CQC report highlighted several high risks to patient safety with current model which is deemed as 'Requires Improvement'
- The use as an acute overspill results in the acute patients not obtaining the intensive support they need due to the different skill sets of staff and less-secure environment in which they are placed; this increases the risk of immediate harm as well as long-term poorer outcomes such as heightened risk of relapse and dependency on statutory services.
- Use as an acute overspill results in rehabilitation patients experiencing a less-constructive and more restrictive environment, resulting in poorer outcomes and reduced independence
- Staffing costs are likely to remain high due to vacancies and the need to work to a clinical/ward staffing model requiring the use of agency staff to cover the shortfall; this staffing situation is anticipated to continue for the foreseeable future
- Irrespective of implementing any changes, there is likely to be an increase in costs against the current model due to inflation (currently estimated to be an additional £5k for the lease of Woodlands alone; the cost of ongoing high volume of Out of Area Placements are also likely to attract additional costs from Providers in line with rates of inflation.) We are also unable to quantify the impact that COVID-19, which has had extensive economic impact in the UK, will have on charges set by Providers.
- If subsequently decide to renegotiate the contract with Southern Housing at a later date, the organisation may lose reputational faith and goodwill from current decision not to continue with the contractual relationship.

4.2. Option 2: Tiered Estate Model

i. Summary

The NHS IOW Trust, NHS IOW CCG, IOW Local Authority and Southern Housing would work in collaboration to convert the current 10-bedded ward into a house of multiple-occupancy for up to 9 residents at any one time. There would be 8 bedrooms on the ground floor with shared facilities, and a self-contained flat on the first floor; enabling an upgrade in the quality of accommodation, as well as reflecting the differing stages of recovery. The new Recovery Service, including Reablement, Intensive Rehab and Assertive Outreach pathway, would be co-located on site within the community and will be staffed by NHS, Adult Social Care and peer support workers, enabling a fully integrated, holistic approach to care and support delivery.

There would be the onward option to link in with Overbrook (4 bedrooms with shared facilities), as well as Hannah House and Milligan House as 'moving on' accommodation, helping to facilitate the move between more intensively supported accommodation towards independence – close working with the Local Authority Housing team and sharing of skills and knowledge within the team will enable a more fluid transition and increased levels of confidence within individuals.

The team would work more flexibly, linking in with the developing Community Mental Health and Well-being Service as well as continuing to provide in-reach in to the acute service. It would offer a range of interventions aligned with the clinical evidence within *Rehabilitation Services for People with Complex Mental Health Needs* (Joint Commissioning Panel for Mental Health, 2016) with a focus on all areas of rehabilitation, re-enablement and recovery to ensure people live valued lives, safely within the community, with increasing independence.

One of the key differences in interventions available through Option 2 in comparison with Option 1 is the incorporation of a new Assertive Outreach pathway within the Recovery service – something which has been repeatedly highlighted as a current gap in service provision during the 2020 Redesign workshops . *Based upon the National Service Framework for Mental Health (MHNSF)* (1999), Assertive Outreach or assertive community treatment is a form of intensive case management (ICM) that provides 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. A Cochrane review of ICM by Dietrich *et al* (2010) concluded that, compared to standard care, ICM reduced hospitalisation and increased retention in care. It also improved social functioning globally. Staff providing comprehensive assertive outreach care for clients will visit them at home, act as an advocate, and liaise with other services such as the GP or social services. Help is usually needed to find housing, secure an adequate income, and sustain basic daily living - shopping, cooking, and washing, for example. This additional strand would facilitate support for people with multiple, complex needs such as the criteria identified within the *Department of Health Mental Health Policy Implementation Guide for the MHNSF* (2000):

- History of violence or persistent offending
- Significant risk of persistent self-harm or neglect
- Poor response to previous treatment
- Dual diagnosis of substance misuse and serious mental illness
- Unstable accommodation or homelessness
- Subject to Care Programme Approach (CPA)
- Detained under the mental health act on least one occasion the past two years
- Difficulty in maintaining lasting and consenting contact with services
- A severe and persistent mental illness (i.e., schizophrenia, major affective disorder) associated with a high level of disability

- History of frequent use of inpatient or intensive home-based care (i.e. more than two admissions or more than six months in inpatient care in the past two years)

The MHNSF noted that, of 23 controlled studies, 61% reported significant reductions in hospital admissions through the utilisation of Assertive Outreach techniques and rehabilitative support.

As the site would not be registered, any compulsion (to reside or receive treatments) would be via Community Treatment Orders (CTOs) or guardianship orders.

Through these changes there would be an aspiration to achieve **Associate** status with the Royal College of Psychiatrists CCQI Quality Network for Mental Health Rehabilitation Services in line with the Standards for Inpatient Mental Health Rehabilitation Services (2016).

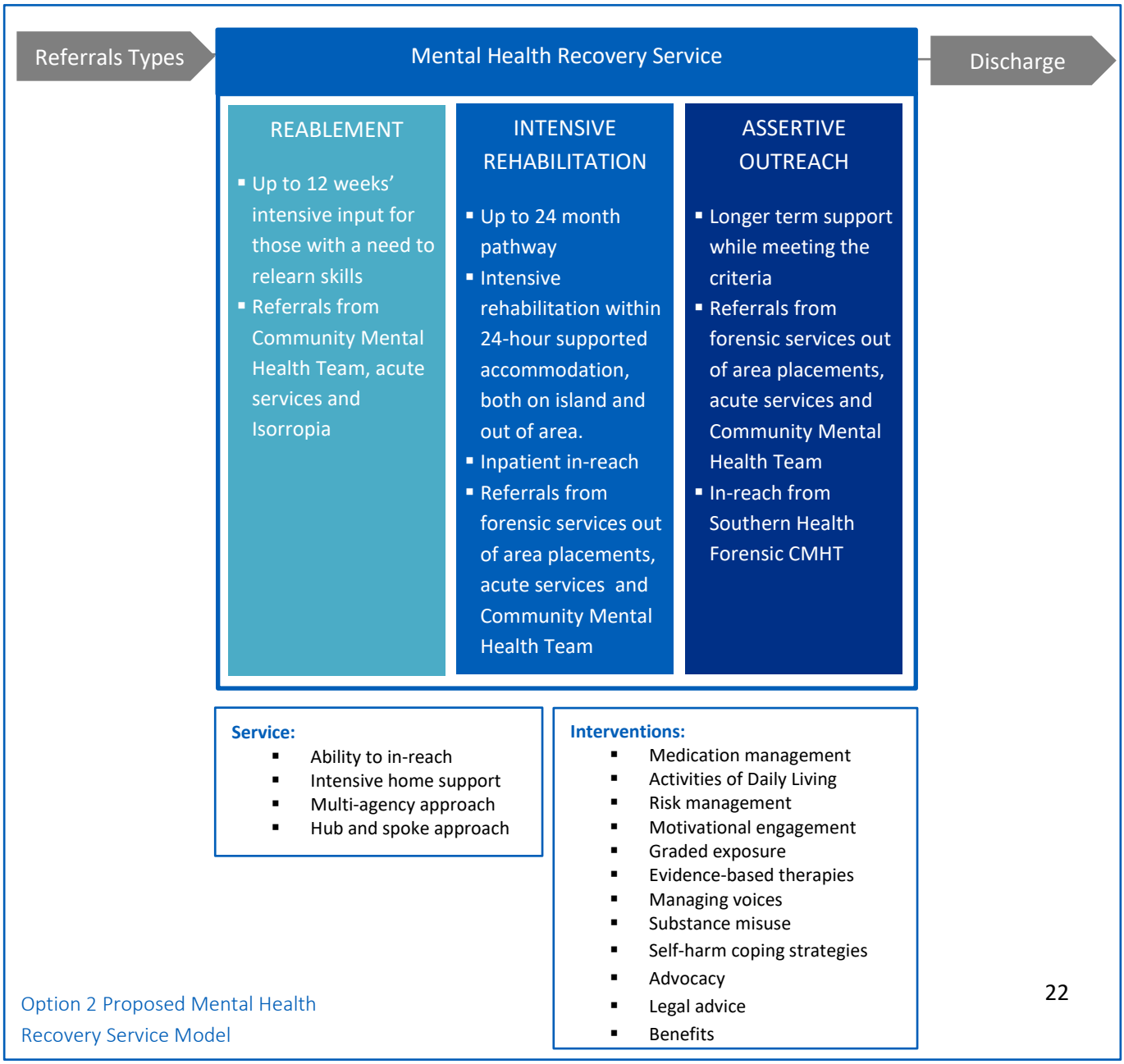
Example of Model: Dorset

Example CQC Rating: **Good** with Outstanding elements

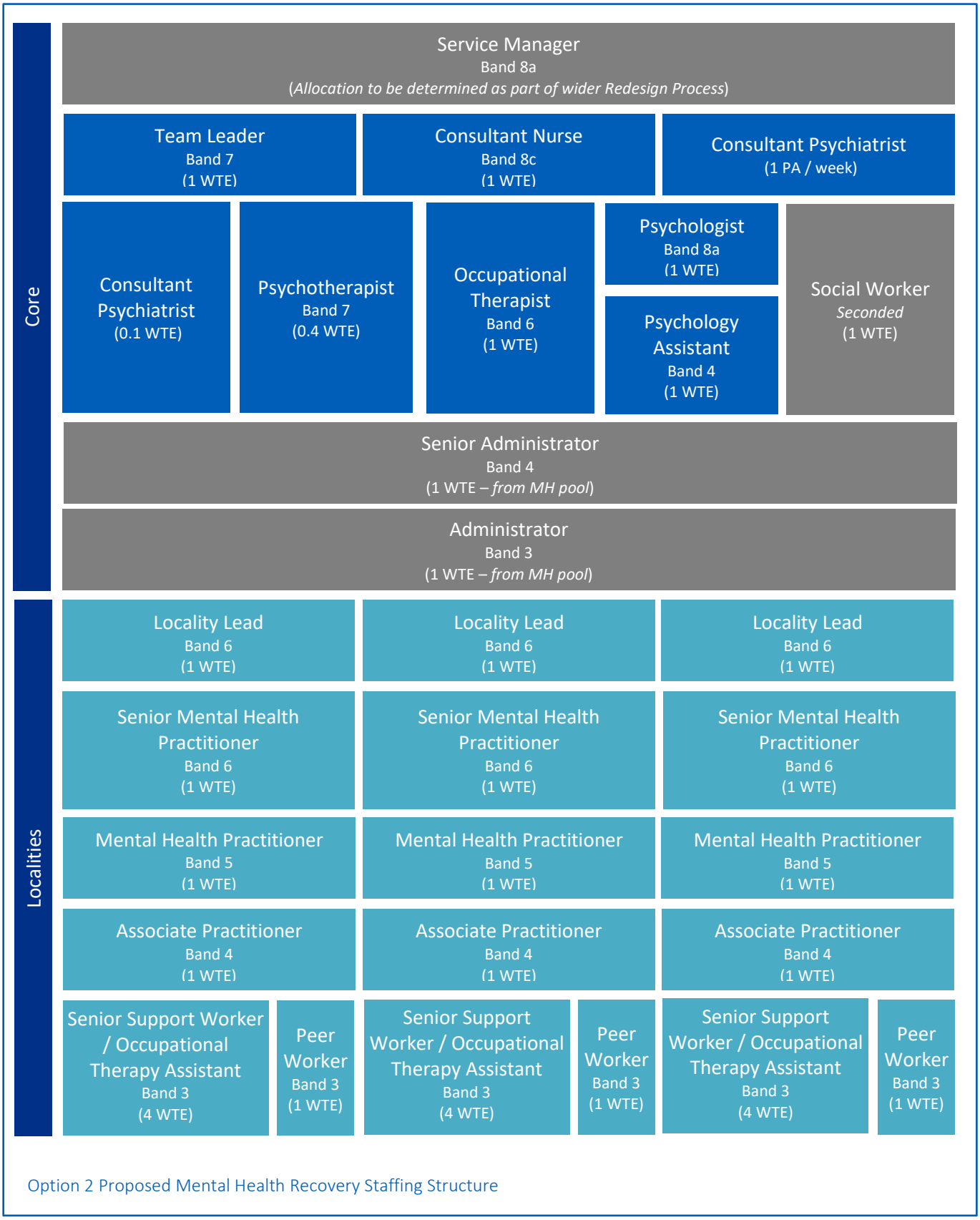
(*See Appendix 5*)

Caseload:	80 people per annum Based on the existing 10 beds supporting 18 people per annum, the existing model works at 180% turnover. 9 people (8 bedrooms and 1 moving on flat) at 180% equates to 16 people per year. The number of individuals identified as currently eligible for the widened service scope include a further: ▪ 13 people in residential placements ▪ 4 people in Overbrook ▪ 17 Out of Area placements ▪ 30 meeting the Assertive Outreach criteria* **Applying Department of Health Mental Health Policy Implementation Guide for the MHNSF (2000), this was calculated by analysing current caseloads to identify individuals who have been:* ▪ *Subject to Care Programme Approach (CPA)* ▪ *Detained under the mental health act on least one occasion the past two years.* ▪ *Diagnosed with a severe and persistent mental illness (i.e., schizophrenia, major affective disorder) associated with a high level of disability* ▪ *Frequent users of inpatient or intensive home-based care services (i.e. more than two admissions or more than six months in inpatient care in the past two years).* As the above categories are either highly complex with lower occurrence rate within the population (e.g. those requiring specialist interventions which can only currently be accessed via mainland providers,) or a long-term-needs with little variance (such as individuals currently meeting the Assertive Outreach criteria), the above additional numbers are currently predicted to have little variance for the purpose of modelling.
Average Length of Stay in Service:	Estimated to be up to 2 years with the intention for individuals to move on to the most appropriate setting once they have reached their optimum recovery potential

Cost:	**Total Income**	**- 1,366,454**
	Total Costs	**2,059,285**
	Total Direct Costs	1,602,814
	Total Indirect Costs	456,471
	(Profit)/Loss	692,831
	Reablement LA Income	- 147,000
	Revised (Profit)/Loss	545,831
	*Transfer of CMHT Resource	- 251,913
	Revised (Profit)/Loss	293,918
	Change in Trust Expenditure from current pathway - Option 1	138,686
	For full details see Appendix 7: Financial Modelling	
Staffing:	New structure as outlined below	



Option 2 Proposed Mental Health Recovery Service Model



Option 2 Proposed Mental Health Recovery Staffing Structure

ii. Benefits

Improved Personal Experience and Outcomes

- People are supported with their accommodation and to return to work or meaningful activity with choice and control, aided by close partnership working with Local Authority Employment and Housing Services, as well as integrated skills and role development within the team.
- Multi-tiered choice of residency with no additional capital cost (review of staffing template required) as part of optimal rehabilitation; the flexibility of the model enables staff and resources to be tailored to meet individual's varying needs and support level in a range of settings.
- People feel confident that they have access to the right level of good quality care and support at the right time, and are able to move in and out of services freely, according to their needs. The integration with Local Authority Services – inclusive of a substantive Social Worker within the team – will enhance this ease of movement not only between health services, but also wider Local Authority support services (a One Island System approach.
- In-reach ensures continuity of patient support – and accommodation - along their mental health journey and a person-centred step-down approach helps to minimise the risk of relapse through earlier intervention and prevention; reducing requirement to use inpatient services and maintain system flow in the least restrictive environment.

> *"…felt that she would have benefitted from having a further period of support provided her by Woodlands staff after she moved out from Woodlands."*
>
> Service User Feedback, February 2020

> *"…having to be risk assessed every time he left Woodlands was 'damned inconvenient'…[but] Woodlands was better than being at Sevenacres as 'no one ever wants to be in hospital'."*
>
> Service User Feedback, February 2020

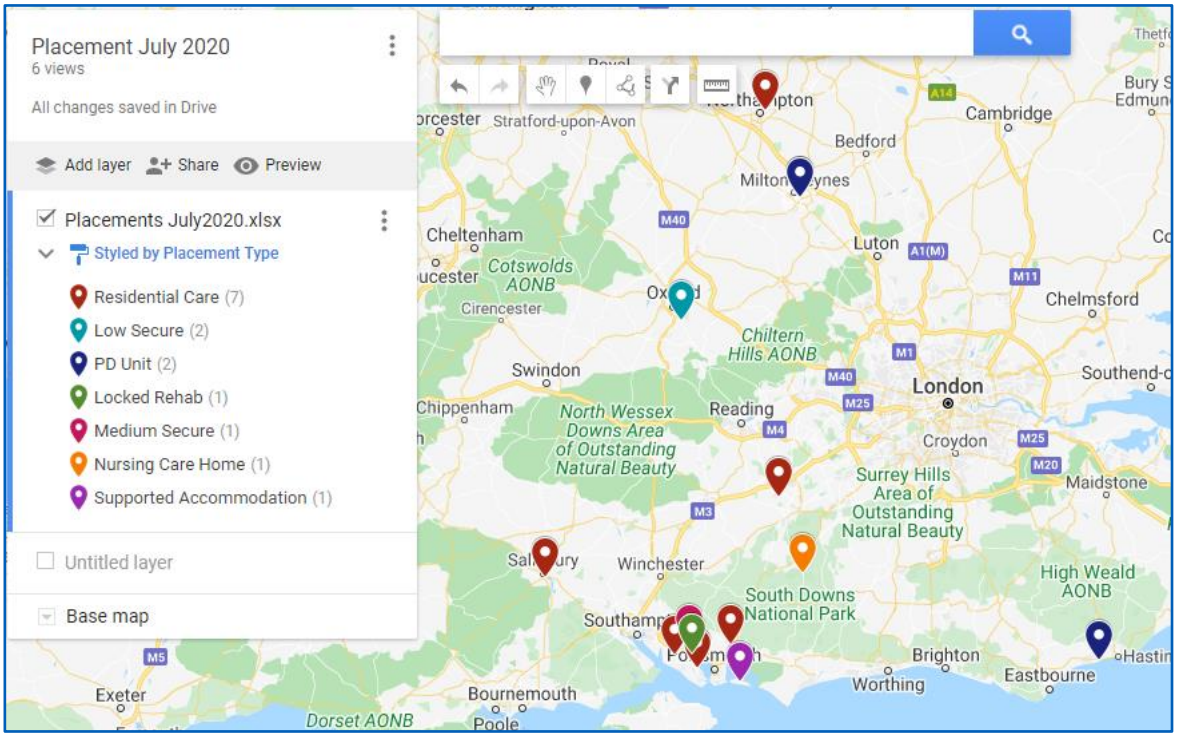
- This model will develop and promote a strong Care Act 2014 ethos and focus supporting people, their families and carers to promote individual well-being and prevent reliance on statutory care and support provided by the Local Authority by resolving their unmet needs. The integrated Multi-Disciplinary Team will ensure that this ethos is universal across the recovery pathway, rather than being addressed in discrete siloes. The aspiration is to ensure that fulfilment of statutory duties and outcomes, for both health and social care partner organisations, are supported by *all* team members.
- People have hope and aspirations to learn and recover through access to a wide range of activities and opportunities to use their own knowledge and experience to help and support others, thereby taking ownership of their own recovery, this will contribute to a reduction in over-reliance on a medical and bed based (be that hospital or residential care homes) model of delivery. The approach recognises increased self-determination and control, rooted in citizenship rights, which is often the basis of recovery for people who have felt negatively defined and disempowered by their mental health problems and by the system itself.

> *"Woodlands should not feel just that it's about sectioned people, it should be about supporting people to take responsibility in getting on with their lives and being on the journey in our recovery."*
>
> Service User Feedback, February 2020

- There is currently a fragmented and limited community mental health pathway which is under development through the Mental Health Transformation Programme, a re-design of the Mental Health Recovery provision will help to address this aspect of the pathway. This will in turn reduce the

difficulties for people accessing services and navigating the system, and contributes to an increased continuity of care.

- The prevention-focused, recovery based approach adopted in this model will provide support mechanisms to help people better manage their condition. This can also be delivered be delivered in partnership with the CMHWBS by providing assertive outreach to individuals with complex needs who are currently on the CMHWBS caseload but are at risk of requiring an inpatient staying without more intensive, wraparound support.
- People consequently experience seamless care and support on their journey to recovery and are enabled to live a full and meaningful life despite mental ill health.
- The improved environment is fit for purpose and future proofed. This will contribute to reducing the current clinical feel to it, when it should feel more homely and welcoming for the people who use this service.
- Due to complexity of the cohort of individuals placed out of area, traditional models of care were not always able to meet their needs. Whilst the Complex Care Specialist Nurse has been working to bring / establish placements as close to the Isle of Wight as possible, there are still people in placements more than 100 miles away including as far away as Northampton (*see below*) This enhanced model would enable more complex individuals to be safely supported and become settled on the island. This helps the individual to maintain connections with their family, friends and community for their own benefit and wellbeing, and to the benefit of their friends and family.



- De-registration would result in the inability to accept overspill from acute wards enabling the right care to be delivered to rehabilitation patients with the most appropriate environment; acute patients would not be at risk due to incompatible staffing skills / accommodation, addressing the safety concerns raised by the CQC.

Improved Service Delivery

- Model trajectory results in a quadrupling of caseload capacity.
- Maintains and develops quality provision that is evidence based and NICE compliant with the added benefit of embedding of a robust of a multi-disciplinary approach to interventions.

- Brings the Woodlands and Reablement Teams together to improve the sustainability and resilience of the Mental Health Recovery service as a combined entity.
- Will comply with the CQC improvement requirements.
- People working in the service will be supported to feel confident and competent in their work, and enabled to deliver high quality services with compassion, in a healthy work environment, making better use of their skills, improving job satisfaction and reducing sickness rates. This may in turn result in improved staff retention, with reduced use of agency staff.
- Robust administrative support to assist with complex legal, housing and accommodation reports frees up time for delivery of patient facing support.

Wider System Alignment

- Nurtures an increased degree of partnership and alliance working with the acute services, primary care and wider community resources for people with mental health problems.
- Aligns with service user aspirations raised during the Mental Health Blueprint consultation and the Community Mental Health and Well-being Service direction of travel.
- Ensures alignment with NHS LTP, HIOW STP priorities, IOW CCG Corporate objectives and IoW Local Authority Corporate Plan and Homeless Strategy.
- More community-centric approach to model (outward facing) aligns with care closer to home agenda with ability to link with the PCNs, locality hubs and both existing and envisaged Third Sector alliances (CMHWBS).
- Reduction in in-patient days / Length of Stay in hospital and associated wider social costs through in-reach, resulting in a reduction in system costs incurred for treatment and social care.
- Reduction in lost work-days and employment support benefits.
- Reduction in expenditure on judicial system and public welfare services through improved health and social outcomes.
- There will be wider range of choices and increased capacity to assist with repatriation of Island resident currently in mainland provision. Thus reducing the need for off-Island placements and associated costs which then may provide a risk / benefit share opportunity.
- By providing in-reach services for rehabilitation this will help facilitate flow out into the recovery service, freeing up beds on the acute ward, increasing potential capacity in the acute setting and thus reducing the need for over-spill accommodation.
- Timeline for the implementation of the long term model can be aligned with the national developments in the *Community Mental Health Framework for Adults and Older Adults* (2019).

iii. Risks

- Loss of ward registration status mean will no longer be able to accept detained referrals; although small in numbers, alternative option(s) will need to have capacity to accept.

  Mitigation: In mitigation of risk to any existing detained patients currently accommodated by Woodlands, it is proposed that advanced care planning is undertaken and that new detained patients are not accepted from an agreed cut-off date to ensure that these individuals have the appropriate accommodation and support in place from date of de-registration.

  In mitigation of potential harm to future patients who may have accessed these beds on a detained basis, there is a wider design process underway which is looking at the differing tiers of support across the system as a whole, including both acute and wider community services to ensure there is an offer in

place for all degrees of complexity in a purpose-designed manner ensuring safety and quality of support. An STP-wide design process is also underway, considering the development of a footprint High Dependency Unit offer.

- Removal of over-spill capacity from inpatient services may create short-term pressures on acute services whilst the impact of the Mental Health Transformation Programme becomes embedded and in-reach approach is developed in the new model.
- Training will be required to move from existing model to the proposed model and there is no additional budget to facilitate training.

  Mitigation: Further to alignment with Category 9 of the Mental Health Investment Standard, which may enable access to additional funding, there is a NHS Isle of Wight Trust central Mental Health training fund which is accessible for service organisational development. Due to the combined circumstances surrounding Covid-19 and Mental Health Investment Standard, this central training fund is currently fully accessible for 2019/20.

  In the NHS Operational Planning and Contracting Guidance 2020/21, NHSE/I also advised that the government has announced £150 million of new investment in continuing professional development (CPD) for all nurses, midwives and AHPs in trusts and general practice. This funding is designed to enable employers to provide a £1,000 training budget over the next three years for each nurse, midwife and AHP in addition to current provider investment in CPD, supporting staff to ensure they continue to be able to develop the skills to deliver high quality care for patients.

  Finally, additional Covid-19 response funding is available at present to support the recovery and restoration of the NHS. Whilst there is currently no cut-off date for accessing this additional funding stream, time is a factor that needs to be considered as it will not be available indefinitely.
- There would be a change to the staff establishment and some job roles, e.g. Registered Nursing would no longer be required at nights due to removal of ward status, and this may be viewed negatively by some staff members which may in turn result in some people opting to leave.

  Mitigation: It is recognised that there is a need to undertake both comms and engagement with staff, as well as complete an organisational development review to be able to facilitate a change in models. The former is to be completed throughout the process to ensure that staff join the journey of change and a key part of this will be a 30 day consultation period to help refine the operational implementation planning right at the beginning. Besides collating the ideas and experience from staff, this will help reduce anxiety over unknown changes.

  We would also like to complete an organisational development diagnostic piece of work at the beginning of the operational planning process, aligning with the broader development piece that the Mental Health Division is due to undertake. This would need to include:

  - *Current assessment of workforce capacity and capability issues, including skills/specialism deficits*
  - *OD requirements to address the above, including a timeline and RAG rated training*
  - *Views of the workforce*
  - *Stages that would be required to move the staff from where they are now to where we need them to be, i.e. organisational change, recruitment etc. aligning with a Partnership approach*
  - *Risks and issues relating to workforce.*

  This will help further understand current skills, individual aspirations and personal preferences and, in turn, inform the training package planning, recruitment and, potentially, redeployment support within the wider service should some people prefer to opt to take up the wider mental health service vacancies to maintain an inpatient skill-set.

  Training would currently be focussed on strengthening psychologically informed interventions, communication with service users in challenging circumstances and reflection. We recognise that the

most significant change will be working in a very different environment and the focus will be on ensuring that the staff are equipped with the skills and confidence to optimise their potential.

It is recognised that this work may have two financial impacts; that of the training itself, and that of back-filling staff to release them for training. The diagnostic review piece will be essential in drawing this out fully and the funding streams identified above will meet the costs. However, in selecting this option a commitment would be required to design and deliver a robust training package. Whilst ongoing recurrent training commitments may be much lower, the transition period will not only require a front-loading change management process but also the impact of Covid-19 on mental health will require additional support – both for heightened complexity status of people accessing the services post-lockdown, as well as supporting staff with their own health and wellbeing. Access to additional funds during 2019/20 to pump-prime the model have been indicated above.

- There is a potential missed opportunity of not covering Support Worker level roles through a Voluntary, Community and Social Enterprise (VCSE); this may appear out of alignment with local and national increased system-working and savings opportunity as commonly, Third sector employers recruit to a lower substantive wage and have reduced percentage rates of on-costs.

  Mitigation: *Both routes of recruitment to the lower banded roles have been discussed with a recognition of the potential benefits that an arrangement could have which has resulted with the blended approach to roles above. The key reasons why Trust-based employment was chosen for the development of this option include:*

  - *Continuity of Clinical Governance, Oversight, Training and Culture:*
    This is particularly important with regard to the high complexity and often challenging nature of this cohort – especially those who would be eligible for Assertive Outreach support. By having one structure, there is no disparity of care for the individuals, optimising their support and outcomes, maintain continuity and supportive, structured environment.

    > *"…currently the power is in the hands of the staff [but hoped that in a future model] residents would experience a feeling of a shift in power more in favour of ourselves, although this needs to be maintained as a balance as I have experienced in the past elsewhere that things can become a mess without sufficient trust or structure with residents becoming like children without order'."*
    >
    > Service User Feedback, February 2020

  - *Staff-Wellbeing:*
    As mentioned above, this cohort of individuals requires very complex support with a great deal of staff support required for their competencies, reflection, confidence and personal mental health and well-being. By having one staffing structure, employees are able to access the same-level of support. They would have the additional benefit of being able to access the Trust Occupational Health and Education services.

  - *Recruitment Appeal:*
    Whilst the financial difference between the on-costs for a Band 3/4 are relatively small against the wider costs of the service, these small changes are more significantly felt by the individual receiving their pay. This would make the post more desirable to higher calibre applicants. The reputation of the NHS for good pay, pensions, additional benefits and – particularly felt during the pandemic economic fallout – job security is nationally recognised, again creating a draw for recruitment.

  - *Reduction in Disparity:*
    Having members of the same team on differing contractual terms and conditions can create conflict – particularly where the aim is to develop a more patient-centred holistic approach. By recruiting to

the same terms and conditions it is hoped to minimise internal conflict and remove the risk of developing a 'that's not my job' culture.

- *Increasing Progression Opportunities:*
  The staffing structure was reviewed to increase the opportunities for people to progress (thereby attracting higher quality candidates) whilst maintaining a bottom-heavy structure so that there is more patient facing WTE hours available, thereby improving patient outcomes.

- *Recruiting Innovatively:*
  By having a blended approach to the roles, internal recruiters are able to assess the current staffing skill set as a whole and then recruit more creatively through a blend of Support Workers and Occupational Therapy Assistants. There may be further opportunities for individuals to move around the division to gain further skills / improve system resilience.

- *Minimises 'At Risk' Potential:*
  There are existing Support Workers within the current Woodlands and Reablement Teams; by maintaining an in-house approach to recruiting to the lower bands, this minimises the potential negative impact on our existing staff members.

- *System Working:*
  The local and national drive is to reduce siloes and increase system working; the model's approach is to increase the interdependencies with the CMHWBS and Isorropia, thereby optimising the existing and developing VCSE sector in a safe way whilst focusing specialist skills on those with more complex requirements.

- *View to the Future:*
  To facilitate a VCSE provider to deliver the Band 3/4 tier of the workforce would require a tendering and procurement process. This would significantly delay the improvements to the Rehabilitation and Recovery service. There would be two severe to catastrophic level risks in instigating a further 12-18 month delay to improvements in service delivery. The first is that the CQC has identified the current service as not safe (as discussed above). There is thus a significant health and wellbeing risk to both patients and staff. The second is that we are currently in a period with access to additional funding to double-run and facilitate the service transformation. If such a significant delay was added, it is possible that the model would be able to make the proposed on-cost savings but at the loss of the current injection of funding. There would also be the additional costs of consultation and market warming events. On top of this, it is highly probable that a period of additional public and service user consultation would be required by NHSE/I.

- There is the risk of voids arising which cannot be filled with acute patients; the housing provider will be unlikely to cover these so the cost of the void will need to be covered elsewhere within the system. There is a potential to risk share with the council but this has not yet been agreed. The negative 'outcomes' of the loss can be mitigated by utilising the staff more flexibly across the system.

  Mitigation: *There would be a part-mitigation of costs as people who don't have an existing tenancy elsewhere (estimated c. 80% of current residents), post-deregistration they would be eligible to claim housing benefits to part-pay for their room. It is not anticipated that any potential voids would be for an extended duration due to the in-reach aspects of the service and close working with the CMHWBS.*

- The senior management team at the Local Authority has changed which may affect identified priorities and support of the project. Of particular regard to the proposal was the commitment to provide a Social Worker within the staffing template which may be withdrawn. In the Department of Health's *Social work for better mental health* (2016), the benefit of including Social Workers in deliver of mental health support was recognised as they offer advanced relationship-based skills, including warmth, empathy

and genuineness, to help people define and reach their own goals; something which is so often valued by people using services and their families. They have particular key skills in tackling the stigma, discrimination and exclusion people with mental health problems often face. Their legal and statutory knowledge of enablement, care and support systems makes social workers systems leaders for multiagency practice. Their role in mental is underpinned by a commitment to promote wellbeing, improve the quality of services and promote the rights of people with mental health needs. Further to this, social work is no longer just about allocating public resources when people's needs have deteriorated. As the Care Act 2014 has clarified, adult social care is about helping people to seek earlier support, anticipate their own needs and use their personal resources and supports most effectively. These can prevent, reduce and delay dependency on higher intensity care and support services – this aligns perfectly with the proactive in- and out-reach approach of the model to ensure issues are de-escalated and support wrapped around the individual. Finally, a Social Worker is required to undertake Care Act and Approved Mental Health Professional (AMHP) assessments – by including this provision in-house, the team will be able to facilitate people's journeys across historically siloed organisational boundaries. There is also an additional identified need for housing officer in reach support to the service which is yet to be agreed.

Mitigation: The Local Authority has been engaged with the project since it's initiation up until its suspension during the emergency Covid-19 response. Re-engagement meetings are now being held. The main concern previously raised was the immediate financial cost pressure to the Local Authority arising through de-registration as the change in registration status would mean that any person eligible for benefits or s.117 Mental Health Act aftercare funding would be eligible from point of entering Woodlands, rather than point of exiting – including those already present at time of de-registration. In mitigation of this risk it was proposed to set aside a pot of funding within the budget to facilitate a transition period to be used either for covering of any voids (lower risk as routinely at 100% occupancy with a waiting list even with current configuration) or to phase financial impact on Local Authority.

Secondly, many of the benefits that current inpatients would become eligible for would be funded from central government with minimal impact on Local Authority.

Thirdly, there are three key proposed benefits to the Local Authority that will help mitigate this risk. Firstly, the service will deliver support that will achieve Care Act (2014) benefits such as, per para 6.60, interventions will identify 'needs [of service users] that could be reduced, or where escalation could be delayed, and help people improve their wellbeing by providing specific preventative services'. The proposed new service will help deliver this outcome for significant numbers of service users whom would otherwise be much more likely to require assessed Care Act unresolved individual outcomes. The second is a medium term financial benefit as, by improving the rehabilitation model on the Island, individuals entitled to s.117 aftercare support from both the NHS and Local Authority will experience either a reduced or delayed requirement for separate individualised s.117 support packages in the community. The third is a long-term financial gain – by supporting sustained recovery, there will be fewer people eligible for s.117 Mental Health Act aftercare as there will be fewer detained people flowing through the system. The most significant financial impact of the latter point would be seen with the reduction in costs associated with mainland placements. As the snapshot view below illustrates this:

	June 2019	June 2020	July 2020
Total Out of Area Placements (inc. NHSE/I funded placements)	19	17	18
Number of CCG only funded placements	2	3	4
Number of CCG/LA funded placements (50:50 split)	11	9	10
Average weekly placement rate (non NHSE/I)	£1,835	£1,973	£1,949
Highest weekly placement rate (non NHSE/I)	£2,883	£3,500	£3,500
Total week's cost to CCG	£13,842	£16,419	£19,726
Total week's cost to Local Authority	£8,174	£7,257	£7,566
Extrapolated 52 weeks cost to CCG	£719,801	£853,787	£1,025,733
Extrapolated 52 weeks costs to Local Authority	£425,071	£377,384	£393,434
Extrapolated 52 weeks system costs	**£1,144,872**	**£1,231,171**	**£1,419,167**

The table above illustrates that the number of Out of Area placements is fairly static with long-term support required. E.g. one resident as of June 2020 was admitted in May 2013. Even where positive changes have been facilitated by the role of the Complex Care Specialist Nurse to help make reductions in off Island placements the financial impact is worsening as the cost of placements increase. This latter is reflected across the average, highest and overall financial impact of these placements. Under 'Reason why cannot return to home area, four of those on current placements are noted as having 'No provision'. For every week these four people alone are on the mainland, it costs the system £7,087 or £368,538 per year.

- To mitigate any potential risk to both staff and patients during the transition period, it would be recommended that a phased implementation approach be applied to enable a bedding-in period, and then gradually increase the caseload over a period of several months.
- There is a risk that, to secure the support of the accommodation provider, any arrangement regarding maintaining the Woodlands building may be locked-in to for several years, this would stagnate progress for any future development.

  Mitigation: *This risk may be mitigated by keeping a strong positive, relationship with the current Provider at all stages of project development, as well as maintaining transparent communications regarding any future aspirations such as increased partnership working with the Local Authority. However, care will be required to avoid bias favouring the incumbent provider to ensure a fair and open market will be achieved if a subsequent procurement is desired.*
- The change to deregistered status would shift the duty of care for any additional physical healthcare issues from Secondary Care to Primary Care. As Woodlands is based in Wootton this would primarily impact Medina Healthcare (Wootton Practice) with a risk that they may not have capacity to support an additional 9 people on their caseload.

  Mitigation: *It is acknowledged that comms and engagement work with Primary Care would need to be strengthened and direct engagement with Medina would be required once the direction of travel has been approved. This will enable the safe infrastructure of physical healthcare support to be clarified. However, positive transformation of the rehabilitation service would help to ensure parity of physical and mental health, building upon the 2011 paper 'No Health Without Mental Health'.*

  In 2011 paper it notes that having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50% and doubles the risk of coronary heart disease in adults. People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population. They have higher rates of respiratory, cardiovascular and infectious disease and of obesity, abnormal lipid levels and diabetes.

  Whilst the initial impact would increase the practice's caseload by 9 people, the long term effects could potentially reap much greater rewards for Primary Care. By increasing the caseload capacity of the team, it would be able to support and improve the mental health and wellbeing of this particularly complex cohort, improving their mental health outcomes and thus, indirectly, reducing the risk associated with long-term physical health conditions.

  This would ultimately help reduce the pressure on Primary Care. It would also have the added benefit of releasing system savings for both Primary and Secondary Care through reduced number of consultations and A&E visits. E.g. the SCWCSU completed a piece of work in October 2019 which reviewed the Isle of Wight's High Intensity Users activity for the preceding 12 months. The Top 10 HIUs attended A&E 344 times with 8 out 10 also having a diagnosis of psychiatric or social problems. In respect of Primary Care 115 patients had more than 100 Primary Care Consultation, of those 60% had a co-existing condition with a psychosocial code. Whilst some of these individuals may be more appropriately supported by the CMHWBS, others would benefit from more intensive rehabilitation to empower them to manage their own health conditions as well as teach them the skills required to cope in the community from a position of strength.

4.3. Option 3: Dispersed Support Model

i. Summary

Option 3 is a radical change to the way the Mental Health Recovery services are delivered by the removal of estates-based services. This would, structurally, be very similar to Option 2, but would require the closure of Woodlands in lieu of the recovery team working flexibly across all localities to deliver health and social care support to people in their own homes or supported accommodation arrangements such as time limited tenancies. The teams would have a central hub within the new localities as is being developed as part of the Community Team offer. The service would run seven days a week with a 09:00 – 21:00 offer.

The Recovery team would provide an in-reach service to inpatient beds, working in line with Care Act compliant goals and outcomes. This support can then follow the person out into the community where they are able be supported by differing degrees of intervention according to level of need and complexity including an assertive outreach community team and the Reablement team.

Strong working relationships with local housing associations would be essential, as well as a robust and well-trained staffing template; the wraparound support would be very intensive e.g. a support worker per person with access to two nurses and support from psychology – operating at an almost 1:1 ratio.

Through these changes there would be an aspiration to achieve **Accredited** status with the Royal College of Psychiatrists CCQI Quality Network for Mental Health Rehabilitation Services in line with the Standards for Inpatient Mental Health Rehabilitation Services (2016).

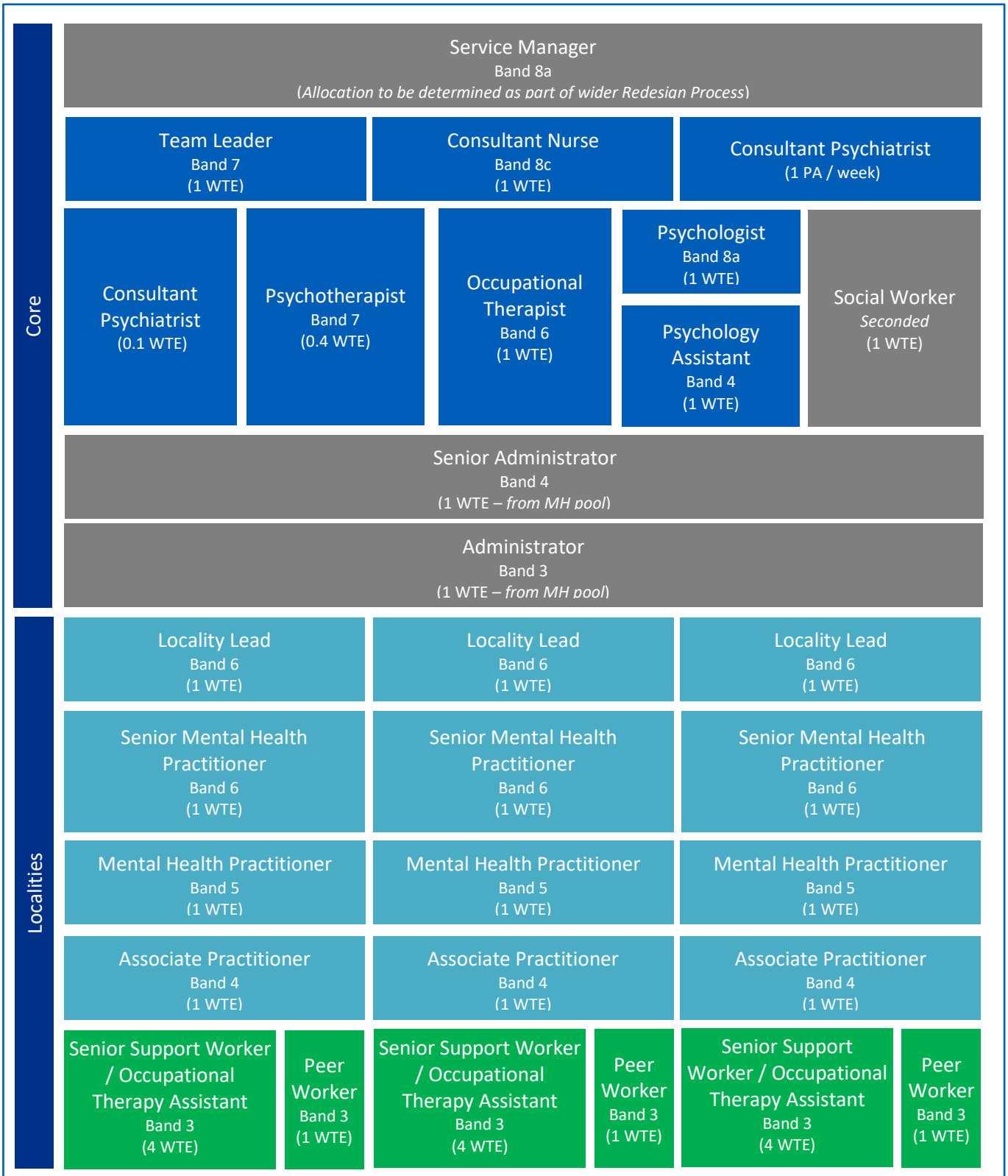
Example of Model: Sheffield

Example CQC Rating: Good with elements of Requires Improvement

(*See Appendix 6*)

Caseload:	120 people per annum In addition to the 80 people identified in Option 2, there were be a further 40 people identified from the CMHWBS caseload for more intensive out-reach support. These are individuals which the Community Mental Health Team identify as potentially benefitting from the more intensive support but fall shy of the criteria outlined. Current scoping identified 29 people who may currently be suitable for intensive rehabilitation and 37 for Assertive Outreach.
Average Length of Stay in Service:	55+ weeks; time in *service* is likely to be longer as this will incorporate a more detailed step-down approach into the community

Cost:	**Total Income**	**- 1,366,454**
	Total Costs	**1,988,599**
	Total Direct Costs	1,547,129
	Total Indirect Costs	441,471
	(Profit)/Loss	622,145
	Reablement LA Income	- 147,000
	Revised (Profit)/Loss	475,145
	*Transfer of CMHT Resource	- 251,913
	Revised (Profit)/Loss	223,232
	Change in Trust Expenditure from current pathway - Option 1	68,001
	For full details see Appendix 7: Financial Modelling	
Staffing:	New structure as outlined below	



Option 3 Proposed Mental Health Recovery Staffing Structure

ii. Benefits

Benefits similar to Option2:

Improved Personal Experience and Outcomes

- People are supported with their accommodation, within the locality in which they live, and to return to work or meaningful activity with choice and control
- People feel confident that they have access to the right level of good quality care and support at the right time, and are able to move in and out of services freely, according to their needs.
- This model will develop and promote a strong Care Act 2014 ethos and focus supporting people, their families and carers to promote individual well-being and prevent reliance on statutory care and support provided by the Local Authority by resolving their unmet needs.
- In-reach ensures continuity of patient support along their mental health journey and a person-centred step-down approach helps to minimise the risk of relapse; reducing requirement to use inpatient services. This approach optimises early intervention / prevention, as well as flow, benefits.
- People are actively supported with their accommodation and to return to work or meaningful activity with choice and control, using an Individual Placement and Support Competence Framework approach to support the latter.
- People have hope and aspirations to learn and recover through access to a wide range of activities and opportunities to use their own knowledge and experience to help and support others, thereby taking ownership of their own recovery, this will contribute to a reduction in over-reliance on a medical and bed based (be that hospital or residential care homes) model of delivery.
- There is currently a fragmented and limited community mental health pathway which is under development through the Mental Health Transformation Programme, a re-design of the Mental Health Recovery provision will help to address this aspect of the pathway. This will in turn reduce the difficulties for people accessing services and navigating the system, and contributes to an increased continuity of care.
- The prevention-focused, recovery based approach adopted in this model will provide support mechanisms to help people better manage their condition. This can also be delivered be delivered in partnership with the CMHWBS by providing assertive outreach to individuals with complex needs who are currently on the CMHWBS caseload but are at risk of requiring an inpatient staying without more intensive, wraparound support.
- People consequently experience seamless care and support on their journey to recovery and are enabled to live a full and meaningful life despite mental ill health.

Improved Service Delivery

- Model trajectory results in a trebling of caseload capacity.
- Maintains and develops quality provision that is evidence based and NICE compliant with the added benefit of embedding of a robust of a multi-disciplinary approach to interventions. Furthermore, the change to delivery method aligns to the national CMHT framework, which will be supported by Mental health Investment Standard and national MH transformation money.
- Brings the Woodlands and Reablement Teams together to improve the sustainability and resilience of the Mental Health Recovery service as a combined entity.
- Will comply with the CQC improvement requirements.
- People working in the service will be supported to feel confident and competent in their work, and enabled to deliver high quality services with compassion, in a healthy work environment, making better

use of their skills, improving job satisfaction and reducing sickness rates. This may in turn result in improved staff retention, with reduced use of agency staff.

Wider System Alignment

- Nurtures an increased degree of partnership and alliance working with the acute services, primary care and wider community resources for people with mental health problems.
- Aligns with service user aspirations raised during the Mental Health Blueprint consultation (see p.5) and the emerging Community Mental Health and Well-being Service direction of travel.
- Ensures alignment with NHS LTP, HIOW STP priorities, IOW CCG Corporate objectives and IoW Local Authority Corporate Plan and Homeless Strategy.
- More community-centric approach to model (outward facing) aligns with care closer to home agenda with ability to link with the PCNs, locality hubs and both existing and envisaged Third Sector alliances (CMHWBS).
- Reduction in in-patient days / Length of Stay in hospital and associated wider social costs through in-reach, resulting in a reduction in system costs incurred for treatment and social care.
- Reduction in lost work-days and employment support benefits.
- Reduction in expenditure on judicial system and public welfare services.
- By providing in-reach services for rehabilitation this will help facilitate flow out into the recovery service, freeing up beds on the acute ward, increasing potential capacity in the acute setting and thus reducing the need for over-spill accommodation.

Additional Benefits

- Maintains people in their own community environments to build local personal infrastructure.
- Removes the risk of stigma associated with staying at a 'Mental Health Service'.
- Opportunity to link in with wider housing regeneration projects which are already underway e.g. Ryde Village.
- Opportunity to look at alternative accommodation options e.g. Shared Lives.
- Opportunity to attract capital investment from third sector / housing providers, increasing the stock of social housing for the Island. This may generate more market interest by widening the tender scope to include the Band 3 and 4 level support workers, increasing competiveness and potential financial savings.
- Loss of building removes requirement for staffing at night; frees up resource to provide direct support to service users and increase caseload capacity.
- Removes risk of ward 'paternalism' and encourages a community outlook.
- Opportunity to work with Southern Housing to use the Woodlands site more creatively for alternative purposes.

iii. Risks

Risks similar to Option2:

- Loss of ward registration status mean will no longer be able to accept detained referrals; although small numbers alternative option(s) will need to have capacity to accept. Besides the impact on the individuals and their families / friends, there would be an associated cost with finding accommodation

for those already detained and unable to be safely supported in the community until alternative accommodation could be found. Currently there are 4 people on the current caseload which would fall within this category who would be at risk of requiring a temporary out of area placement. Allowing for a 6 month period (26 weeks) to find appropriate accommodation on the Island and re-stabilise the individual after experience a period of change through relocation, this would cost the CCG c.£51,298 per individual at the average non-NHSE/I placement rate or c.£91,000 per individual at the current highest rate. For four people this would multiply up to c.£205,192 and c. £364,000 at the respective rates to create an additional cost pressure to the system.

- Removal of over-spill capacity from inpatient services may create short-term pressures on acute services whilst the impact of the Mental Health Transformation Programme becomes embedded and in-reach approach is developed in the new model.
- Training will be required to move from existing model to the proposed model and there is no additional budget to facilitate training.
- There would be a change to the staff establishment and some job roles, e.g. Registered Nursing would no longer be required at nights due to removal of ward status, and this may be viewed negatively by some staff members which may in turn result in some people opting to leave.
- Duration in the service may be longer due to a phased step-down approach to embed positive outcomes and reduce risk of relapse which may externally appear as performing poorly.
- The senior management team at the Local Authority has changed which may affect identified priorities and support of the project. Of particular regard to the proposal was the commitment to provide a social worker within the staffing template which may be withdrawn. There is also an additional identified need for housing officer in reach support to the service which is yet to be agreed.
- To mitigate any potential risk to both staff and patients during the transition period, it would be recommended that a phased implementation approach be applied. The proposal would be to commence the new service 01 April 2020 with a caseload of 15 people to enable a bedding-in period, and then increase the caseload by 1 person per month. Overall, there would be a 3-5 year development trajectory – potentially to end at a model similar to Option 3. The negative impact of this approach would be an increase in time for benefit realisation.

Additional risks include:

- This would involve a radical change in the way staff works which may generate anxiety with existing staff, leading to potential retention issues.
- There would be a need to undergo a significant culture change which may create a risk of failure if staff are not engaged.
- The initial caseload would have to be smaller to Option 2 in order to factor in travel time between appointments in the community; this is predicted to improve as the way of working becomes embedded and processes become more efficient but the immediate impact would not be seen.
- Although estate costs for patient accommodation would be removed, there would be alternative financial impacts which would need to be covered by the service envelope e.g. staff transportation, parking costs and central base(s) for the staff to work from and archive paperwork.
- There would be an increased need for a robust remote working system e.g. good Wi-Fi connections and laptops to update notes.

Mitigation: The above 5 points of potential risk can largely be mitigated through slight amendments to the courses of action identified in addressing similar risk raised with regards to Option 2. They can chiefly be addressed through communications and engagement throughout the process, the proposed workforce organisational development strategy, phased implementation as outlined in the high level timeline, and the utilising of this year's Covid-19 funding to additional pump prime the service.

- Furthermore, with a Dispersed Support model there is no estates base to work from; arrangements will need to be made within the wider Trust estates portfolio from which to deliver training.

  Mitigation: Impact of this will be minimum as little training is delivered at Woodlands, with the majority either being e-learning accessible at all Trust sites or centrally at the St. Mary's site.

- As a new service, Option 3 would need to go out to procurement which would create a time pressure due to the potentially long procurement process versus the comparatively short time frame remaining on the lease. The risks identified in Option 2 regarding sub-contracting workforce would also need to be mitigated as part of any bid.
- Due to the significant change in model, the existing consultation process would be most likely be insufficient to achieve NHSE/I approval. Thus more extensive consultation would be required, costing time and money financial investment.
- There would be an increased reliance on partnership working which requires the rest of the system to already be mature e.g. third sector support to deliver and robust housing processes in the council.
- Delayed Transfers of Care (DTOCs) may arise if there is a housing stock shortage; this would also require a change to the way staff on acute wards are working to facilitate the transition / identify onward accommodation.

  Mitigation: In order to minimise the impact of these risks, an extensive period of time would be required. However, this would not negate the significant safety risks currently present and highlighted by the CQC during the next 12-18 months.

5. Recommendation

> *"Given chronic underinvestment in mental health care across the NHS in recent years, efficiencies made through achieving better value for money should be re-invested to meet the significant unmet mental health needs of people of all ages across England, and to improve their experiences and outcomes."*
>
> The Five Year Forward View for Mental Health (2016)

The Care Act 2014, the NHS England Five Year Forward View, and now the NHS Long Term Plan, all emphasise the need for change in the capabilities and attitudes of professionals to deliver services fit for the future. 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 health and social care outcomes for the people who access our health and social services, as well as their families and carers. We also seek to create healthy, positive working environments for our staff across all our partner organisations.

The proposed models also seek to echo the Department of Health's call for more innovation in effective social models in mental health – tackling the social determinants of health and wellbeing and addressing the social trauma that underlies a lot of mental health need – are needed to create sustainable, relevant and affordable mental health services in the future. If we prioritise a person-centred focus when 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 in the way of working or risk destabilising the whole of the Mental Health Transformation Programme; a concern which has been heightened by the subsequent CQC inspection of the Sheffield in 2020. This report published in April 2020 illustrated that in other areas within the Mental Health division which is not directly associated with community and rehabilitative care, there has been a period of either stagnation or worsening quality. Whilst such occurrences are usually factorial, at a macro view this would suggest that focus intense and radical transformation may result in very positive outcomes in the development of a particular service, it can come at the expense of other aspects of system delivery.

There would also be a requirement for a significant period of time to be spent on further consultation, engagement and observance of procurement timelines. This would delay implementation of the final model for a further 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) and there will be a missed opportunity to take advantage of additional funds available to pump prime a service transition.

Whilst this innovative way of working may be the ultimate goal of a Phase 2 pathway development, it is felt that the risks of implementing the Option 3 Dispersed Model would too great at this point in time. Instead, the preferred Option is to pursue Option 2 Tiered Accommodation Model. This would facilitate significant and wide-reaching positive transformation that would enable immediate changes to take effect.

The following table summarise the degrees of alignment of the Option 2 Model with the drivers for change outlined at the beginning of this document:

Degree of Confidence in Alignment:

1 Little/None 2 Somewhat 3 Fairly Well 4 Well 5 Fully

National Drivers of Change		
Mental Health Five Year Forward View	5	Fully aligns with Recommendation 23 inclusive of providing Rehabilitation and Assertive Outreach services within the community
NHS Long Term Plan	5	As above
Hampshire and the Isle of Wight Sustainability Transformation Plan (HIOW STP)	4	Finalisation of *Hampshire and the Isle of Wight STP Rehabilitation and Reablement – DRAFT* required to confirm strategic direction of STP but appears to align well with current proposals. Work required to ensure integration and access to any High Dependency Unit proposals for STP
Care Act 2014	5	Fully aligned with principles, eligibility criteria and support the Local Authority in the discharge of it duties.
The Community Mental Health Framework for Adults and Older Adults	4	The Option aligns well with the approaches outlined in the framework for a community facing service. However, there are some variations for a accommodation-based rehabilitative service as the framework focusses more on a Community Mental Health Team such as the Island's CMHWBS.
Local Drivers for Change		
Isle of Wight Blueprint for Mental Health (2017)	5	Fully aligns with the feedback from residents and service users regarding the culture and outcomes that they wish to see with the services but avoids radical changes that have not been consulted on.
Local Care Plan	3	Aligns fairly well with the Local Care Plan's outcomes. However, there are some short term financial cost pressures that would impact the NHS Isle of Wight Trust and, potentially, the NHS Isle of Wight CCG through widening of service scope. Also potential short-term cost pressure to Local Authority through shift of eligibility of benefits to point of entry rather than point of exit. However, the model makes the money work hard (increases efficiency) through changing approach to help more people so that the cost per person significantly decreases. There are also longer term savings that should arise through reduction in s.117 aftercare applications / reduction in need, reduction in Out of Area Placement costs and reduced costs associated with Primary Care, Emergency Department and Inpatient attendances. Whilst the intention is to deliver the change in service model through recycling existing service line budgets, additional financial support for the transition may also be potentially accessed via the MHIS or Covid-19 Restoration funding. *Addendum: On progressing through the approval process, it has been recognised that the implementation of the community recovery service is fundamental to many elements of the rest of the Mental Health transformation model falling into place. It was proposed that this business case may also be eligible for NHSE/ transformation funds to assist with pump priming money to enable this. Whilst this business case is not dependant on the application being successful, it would be beneficial in expediting the implementation process (particularly fast-tracking the mobilisation of the new Assertive Outreach element of the team), phased caseload increase and subsequent move to a more advanced model.*

Isle of Wight System Strategy	4	The Option aligns well with Isle of Wight Health and Care Plan (2019) in achieving positive transformation of Mental Health services, reduction in beds, developing more sustainable workforce and making the money work more efficiently. The downgrade from fully aligned is due to the financial aspects detailed under *Local Care Plan*.
Key Challenges to be Addressed		
Poor Patient Outcome and Risks to Safety	5	This fully addresses the CQC concerns regarding unsafe placement of inappropriate placements in Woodlands and development of rehabilitative skills to optimise service user outcomes.
Poor Patient Experience	4	This model will address the identified negative patient experience regarding transition through active (rather than passive) in- and out-reach as well as reducing the reliance on Out of Area placements. This has only been downgraded from fully aligned in recognition that Service Users have provided positive feedback regarding the staff which has also been recognised by the CQC. In implementation of any changes it will be important to work with staff and service users in the process in order to ensure that the practical transition preserves this.
Workforce	4	The model changes addresses some of the harder to fill vacancy issues through shifting to a Nurse Consultant led-model, redeployment of staff more effectively and building in a model that is both practical in delivery of care as well as being attractive to those seeking to progress in their career. This has been downgraded slightly as the implementation of the plan will require commitment to an Organisational Development piece of work and training package. There may still be some staff who will wish to be redeployed and it will be important to work as a system (both within the Division and with our partners) to ensure that any vacancies can be filled without destabilising other areas because people wish to move to the new model because it is exciting and new. Without this piece of work, scoring would need to be downgraded to a 3.
High Acute Turnover	5	This is fully aligned; firstly through data cleansing of beds being appropriately label (right bed, right patient) improving data reporting, as well as improving long term rehabilitation outcomes. The widened service scope increases the options and tools available to support people in their own homes within their community rather than repeat admissions when the complexity of their conditions escalates.
Contractual Termination	5	This is fully aligned to address the contractual arrangements before the current expiration date of 28/02/2023.
Incorporating Feedback	4	The model fully aligns with the high-level feedback from the consultation undertaken to date. This has been downgraded slightly as some feedback from Service Users identifies aspects of Woodlands that are liked; making changes will imbalance the status quo. Whilst the majority of changes may be met positively at a macro level it will be important to ensure that, in developing the operational implementation plan, that the finer details retain positive learning wherever possible at the micro-level. An important aspect will be change management throughout the process to ensure a two-way consultation continues throughout implementation.

The additional benefit of choosing Option 2 would be that it would enable the system to safely build the infrastructure 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.

Consequently, we would also recommend that as part of the operationalisation of the Option 2, a robust Service Development and Improvement Plan is created with ownership by both staff and service users accessing Woodlands. This would enable a 'live' development status to be maintained, minimising delays through further consultation requirements and mitigating anxiety that a potential Dispersed Model may generate amongst staff and service users.

Thus through embracing a culture of continued service development and improvement, it will be possible to implement as safe and efficient model for the present, that is adaptable to the ever-changing landscape of the Isle of Wight mental health needs.

Recommendation: Option 2 Tiered Accommodation Model

Appendix 1: Current Performance

Data extract provided by Performance Information and Decision Support, Isle of Wight NHS Trust as of October 2019:

1. Direct Admissions into Woodlands Ward

Gender	Age band	2017/18	2018/19	2019/20 YTD
Female	<20	0	0	0
	20-29	1	0	2
	30-39	0	0	0
	40-49	0	0	0
	50-59	0	1	0
	60-69	0	0	0
Total		1	1	2
Male	<20	0	0	0
	20-29	2	1	0
	30-39	0	1	3
	40-49	0	0	0
	50-59	1	1	0
	60-69	0	0	0
Total		3	3	3

2. Transfers - Transfers from any other MH or Acute Hospital Ward to Woodlands Ward

Gender	Age band	2017/18	2018/19	2019/20 YTD
Female	<20	0	0	0
	20-29	2	5	0
	30-39	0	1	0
	40-49	0	2	1
	50-59	1	1	0
	60-69	0	0	1
Total		3	9	2
Male	<20	0	0	0
	20-29	2	6	4
	30-39	3	1	1
	40-49	3	2	2
	50-59	2	3	0
	60-69	2	0	1
Total		12	12	8

3. Number of Discharges/Transfers out and Average LOS on Woodlands Ward in Weeks by Period of Transfer out/Discharge

Average LOS spent on Woodlands ward during the entire inpatient spell by period of inpatient spell discharge.

	Average LOS (Weeks)	2017/18	2018/19	2019/20 YTD
Including Home Leave	Median LOS	9	17	12
	Mean	32	26	24
	Max LOS	134	100	89
Excluding Home Leave	Median LOS	8	10	12
	Mean	29	21	18
	Max LOS	129	95	62

4. Referrals to Inpatients Woodlands Team on PARIS and the Reason for Referral

Count	2017/18	2018/19	2019 YTD
ASSESSMENT	1	8	8
INPATIENT ASST/TREATMENT	11	1	0
IN CRISIS	3	8	2
ONGOING OR RECURRENT PSYCHOSIS	2	4	4
DEPRESSION	0	3	0
BI POLAR DISORDER	0	1	0
PERSONALITY DISORDERS	0	1	0
ROUTINE ASSESSMENT	1	0	0
SELF-CARE ISSUES	0	1	0
(SUSPECTED) 1ST EPI PSYCHOSIS	0	0	1
OBSESSIVE COMPULSIVE DISORDER	0	0	1
Grand Total	18	27	16

Appendix 2: Communications and Engagement Plan

1. Background

Woodlands is a 10-bedded site that provides both in-reach services to the acute wards, as well as out-reach support to people within their communities. It is currently a CQC-registered ward which is staffed on a 24/7 basis in line with clinical requirements.

The core team is formed of nurses, occupational therapists, psychologists and mental health support workers. Staff members work closely with the Reablement Team to deliver the most appropriate intervention(s).

The current residents at Woodlands are mainly people who have been detained 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.

In line with mental health transformation plan, the CCG is proposing to declassify the site as a clinical ward and instead convert it into a community ward. It will become a nine-bedroom facility and one purpose-built flat. The aim is still to help support those who have experienced mental health issues to have the network around them to integrate within the community.

This work involves de-registering the site with CQC and also changing the staff model to reflect the community outlook of the site. There will also be a change in terms of the cohort of people that have access to the service.

2. Recommendations

Service users and those most-likely to be in scope to use services soon, and staff directly involved should be prioritised, where possible, to be told of updates, in particular how it will affect them and the next steps.

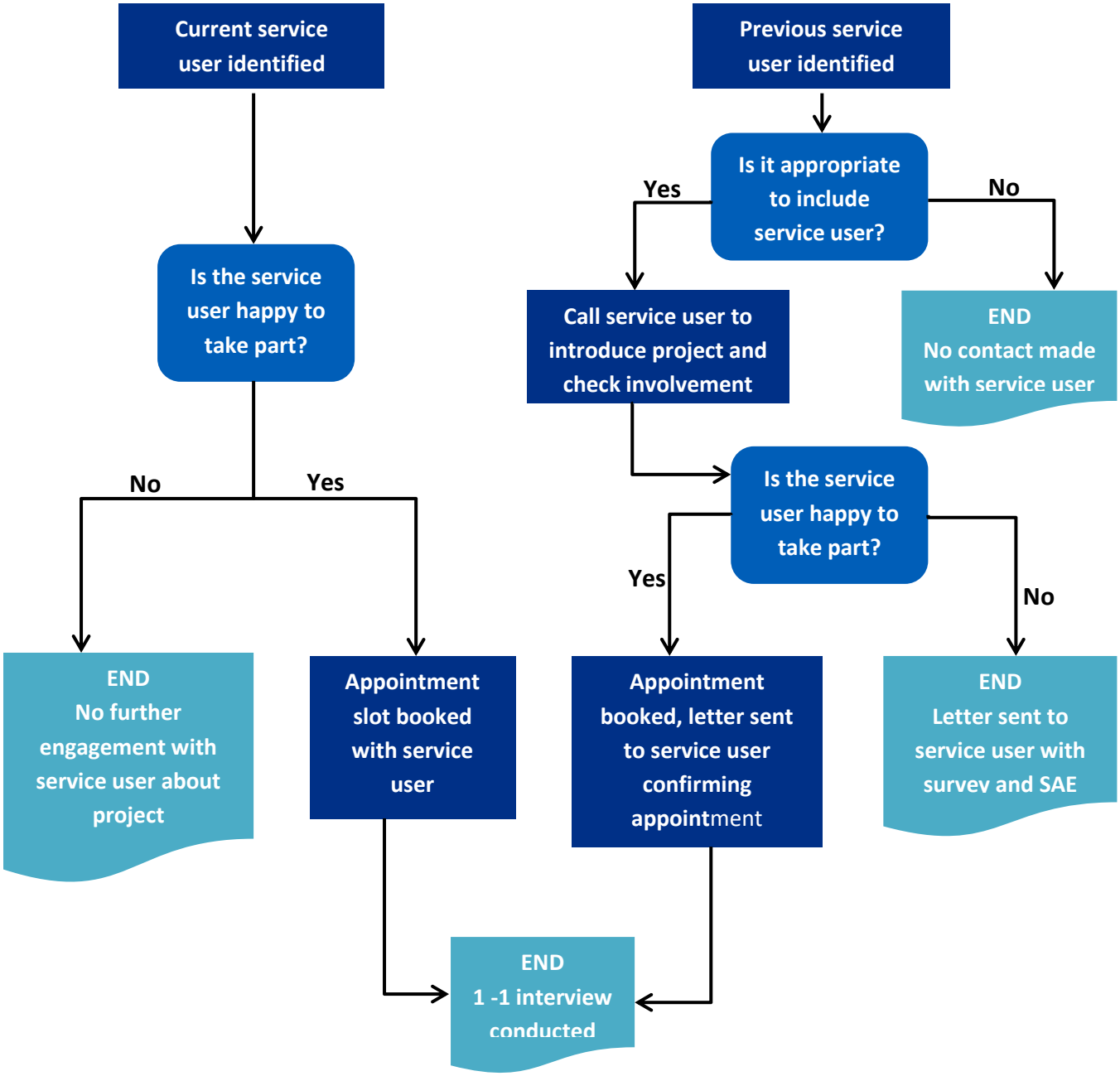
To be open and transparent we should also engage with key stakeholders, which include Isle of Wight Council's health, overview and scrutiny committee, primary care and other mental health service providers/charity so they are aware of the change.

3. Activity

Engagement will be with current service users (10) and previous service users (30 – 40), and will be in the form of semi structured interviews and surveys. It is expected that there will be 15 in depth interview in total, 10 with current service users and 5 with previous service users, however this may increase if more previous service users are happy to take part. There will be an option of a postal survey for those service users who do not wish to take part in amore in depth interview.

4. Process for Engagement

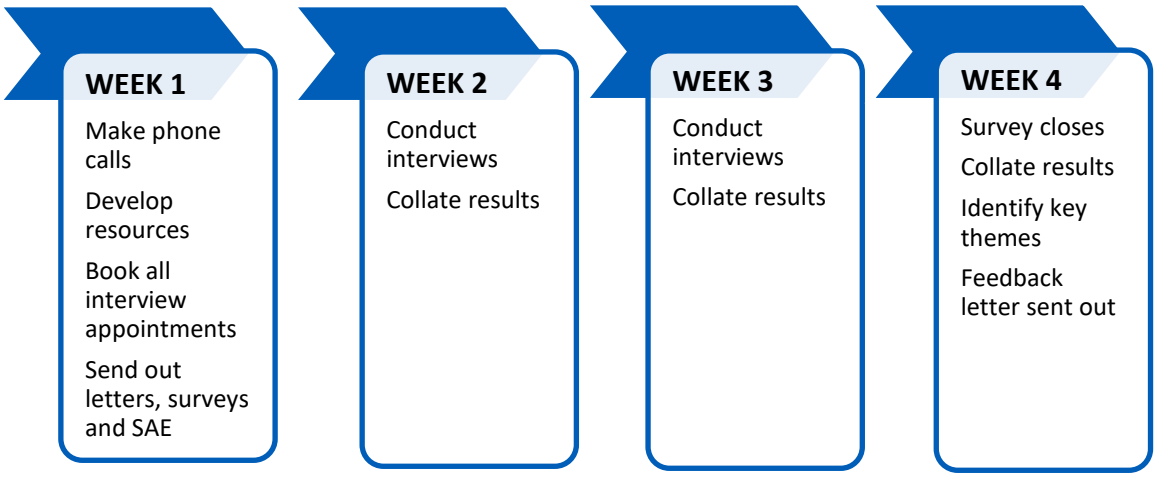
The below diagram shows the process for engagement:



5. Time frames

It has been agreed that the engagement work will start from XX/XX/XX and will run for a period of 4 weeks closing on XX/XX/XX

The diagram below shows the weekly planned activity.



6. Resources

The following key resources need to be developed for the communications and engagement work

- Briefing slides for HOSC on process
- Script for initial call with FAQ sheet– to keep top consistent message
- Letter to service users x2 – to cover those who are happy to take part inan interview and those who are not
- 1 page summary of proposed changes
- Semi structured interview process
- Survey
- Appropriate format to collate feedback into
- Feedback letter for those who have taken part on key findings

7. Comms and Engagement Plan

Below is a draft communications and engagement plan to reflect the above. A RAG status has been created to show progress on communication activities.

Green	This action is performing to plan
Amber	One or more aspect of action viability - time, cost, scope - is at risk. However this can be managed
Red	There are significant issues with this action
Blue	Action complete

8. Draft Communications and Engagement Plan

Activity	Timeframe	Approach	RAG status
Create briefing sheet to inform Hosc about the changes	XX/XX	A high level update to share with Hosc councillors on the changes, why they are taking place and the benefits. Seek their endorsement of the plan	**Green**
Develop initial call script and FAQ document to help shape communications in a coordinated way	XX/XX	It's important to consider the key points we would like to make, but also understand the key questions/concerns or comments that are likely to arise from delivering information. It's important to ensure the information we provide is clear, concise and helps provide a response.	**Green**
Initial calls to previous service users to book interviews or send out surveys	XX/XX	As this is a vulnerable cohort and intial call will be made to previous service users before sending a letter to see if they would like to take part in a 1-1 interview, before calling service user will be reviewed to check appropriate	**Green**
Create letters to service users	XX/XX	Follow up letters developed x2 1. Confirming appointment if would like to take part in an interview 2. Thanking for time and providing a survey and SAE if they would like to provide feedback this way	**Green**
Development of proposed changes summary	XX/XX	1 page overview document to be sent out with letters explaining the proposed changes and why they need to be made	**Green**
Development of a survey	XX/XX	We want talk to service users/patients on the changes and gain insight to help develop the service. A quick way to do this is create a short survey that can be posted out/made available online/pick up a copy from Woodlands with a clear cut-off date for responding	**Green**
Development of semi structured interview sheet for 1 -1 interviews	XX/XX	To complement the survey a focus group can often help dig a bit deeper and find out more information – we would need to create a template of how this can be conducted.	**Green**
Conduct interviews	XX/XX	Semi structured interviews to take place, with staff member that service user feels happiest to discuss these with	
Collate information from 1-1 interviews and surveys and pull out key themes and ideas that come from both sets of information	XX/XX		
Create letter for service users/friends and family on an update	XX/XX		
Primary care update	XX/XX		

Appendix 3: Stakeholder Matrix

<table>
<tr><td rowspan="2">Higher Power</td><td>

Satisfy

Opinion formers to be briefed on what is happening to be able to review the analysis of their position regularly.

- NHSE/I Assurance
- HOSC
- Local Care Board
- NHS IW Trust Board
- NHS IW CCG SMT
- Mental Health Transformation Programme
- Mental Health Partnership Board
- GPs (higher stake-holding for Medina Practice)
- NHS IW Primary Care Commissioning Team
- NHS IW Community Care Commissioning Team
- Healthwatch

</td><td>

Manage

Key stakeholders who should be fully engaged through communication and consultation.

- NHS IW Trust Mental Health services
- Local Authority – Housing
- Local Authority – Finance
- Local Authority – Adult Mental Health Social Workers
- NHS IW CCG / Trust - Finance
- NHS IW CCG / Trust - Quality
- NHS IW CCG Communications Team
- NHS IW Trust Communications Team
- Southern Housing

</td></tr>
<tr><td>Lower Power</td><td>

Monitor

These stakeholders need to be aware of the programme, kept informed on the main developments and have an opportunity to respond

- PCN Clinical Directors
- NHS IW CCG CDG
- One Wight Health GP Federation
- Practice managers
- Practice administration teams
- CSU Information Governance
- CSU Data Analysis

</td><td>

Inform and Engage

These stakeholders need to be kept informed and up-to-date on the programme. They will also need to be involved and engaged on the programme appropriately.

- Service User and their families / carers
- Public
- Patient Participation Groups
- Patient Support Groups
- NHS Trust Estates Team
- NHS IW Trust IT Team
- NHS IW Trust Information Systems
- NHS IW Trust PIDS
- Thames Valley and Wessex Forensic Network
- West Hants CCG
- CQC

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<tr><td></td><td>Lower impact/stake-holding</td><td>Higher impact/stake-holding</td></tr>
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Appendix 4: Options Benefit / Risk Matrix

Benefit	Option 1	2	3
People are supported with their accommodation and to return to work or meaningful activity with choice and control			
Able to continue to support overspill of acute patients from Sevenacres			
Able to continue to offer step-down for detained patients from forensic services			
By pausing transformation of the Mental Health Recovery pathway, able to focus transformation resources on other areas of the mental health pathway to minimise risk of spreading resources to thinly or causing service users to become unsettled through constant change			
Offers continuity of model for service users			
Recognises the good feedback from CQC and may help staff feel valued and respected			
System status quo maintained			
Multi-tiered choice of residency with no additional capital cost (review of staffing template required) as part of optimal rehabilitation; the flexibility of the model enables staff and resources to be tailored to meet individual's varying needs and support level in a range of settings.			
People feel confident that they have access to the right level of good quality care and support at the right time, and are able to move in and out of services freely, according to their needs.			
In-reach ensures continuity of patient support along their mental health journey and a person-centred step-down approach helps to minimise the risk of relapse; reducing requirement to use inpatient services.			
□ People are actively supported with their accommodation and to return to work or meaningful activity with choice and control, using an Individual Placement and Support Competence Framework approach to support the latter.			
People have hope and aspirations to learn and recover through access to a wide range of activities and opportunities to use their own knowledge and experience to help and support others, thereby taking ownership of their own recovery, this will contribute to a reduction in over-reliance on a medical and bed based (be that hospital or residential care homes) model of delivery.			
There is currently a fragmented and limited community mental health pathway which is under development through the Mental Health Transformation Programme, a re-design of the Mental Health Recovery provision will help to address this aspect of the pathway. This will in turn reduce the difficulties for people accessing services and navigating the system, and contributes to an increased continuity of care.			
The prevention-focused, recovery based approach adopted in this model will provide support mechanisms to help people better manage their condition. This can also be delivered be delivered in partnership with the CMHWBS by providing assertive outreach to individuals with complex needs who are currently on the CMHWBS caseload but are at risk of requiring an inpatient staying without more intensive, wraparound support.			
People consequently experience seamless care and support on their journey to recovery and are enabled to live a full and meaningful life despite mental ill health.			
The improved environment is fit for purpose and future proofed. This will contribute to reducing the current clinical feel to it, when it should feel more homely and welcoming for the people who use this service.			

Benefit	Option 1	2	3
Due to complexity of the cohort of individuals placed out of area, traditional models of care were not always able to meet their needs. This enhanced model would enable more complex individuals to be safely supported and become settled on the island.			
De-registration would result in the inability to accept overspill from acute wards enabling the right care to be delivered to rehabilitation patients with the most appropriate environment; acute patients would not be at risk due to incompatible staffing skills / accommodation, addressing the safety concerns raised by the CQC (*see p.5*).			
Model trajectory results in a trebling of caseload capacity.			
Maintains and develops quality provision that is evidence based and NICE compliant with the added benefit of embedding of a robust of a multi-disciplinary approach to interventions.			
Model is aligned to existing financial envelope with reallocation along the pathway to work more efficiently in order to safely support a trebled caseload.			
Brings the Woodlands and Reablement Teams together to improve the sustainability and resilience of the Mental Health Recovery service as a combined entity.			
Will comply with the CQC improvement requirements.			
People working in the service will be supported to feel confident and competent in their work, and enabled to deliver high quality services with compassion, in a healthy work environment, making better use of their skills, improving job satisfaction and reducing sickness rates. This may in turn result in improved staff retention, with reduced use of agency staff.			
Nurtures an increased degree of partnership and alliance working with the acute services, primary care and wider community resources for people with mental health problems.			
Aligns with service user aspirations raised during the Mental Health Blueprint consultation (see p.5) and the emerging Community Mental Health and Well-being Service direction of travel.			
Ensures alignment with NHS LTP, HIOW STP priorities, IOW CCG Corporate objectives and IoW Local Authority Corporate Plan and Homeless Strategy.			
More community-centric approach to model (outward facing) aligns with care closer to home agenda with ability to link with the PCNs, locality hubs and both existing and envisaged Third Sector alliances (CMHWBS).			
Reduction in in-patient days / Length of Stay in hospital and associated wider social costs through in-reach, resulting in a reduction in system costs incurred for treatment and social care.			
Reduction in lost work-days and employment support benefits.			
Reduction in expenditure on judicial system and public welfare services.			
There will be wider range of choices and increased capacity to assist with repatriation of Island resident currently in mainland provision. Thus reducing the need for off-Island placements and associated costs which then may provide a risk / benefit share opportunity.			
By providing in-reach services for rehabilitation this will help facilitate flow out into the recovery service, freeing up beds on the acute ward, increasing potential capacity in the acute setting and thus reducing the need for over-spill accommodation.			

Benefit	Option 1	2	3
Timeline for the implementation of the long term model can be aligned with the national developments in the Community Mental Health Framework for Adults and Older Adults (2019)			
Closure of Woodlands would meet the contracting deadlines and funding currently allocated to estates could be repurposed to support individuals achieve their personal outcomes.			
Maintains people in their own community environments to build local personal infrastructure.			
Removes the risk of stigma associated with staying at a 'Mental Health Service'			
Opportunity to link in with wider housing regeneration projects which are already underway e.g. Ryde Village			
Opportunity to look at alternative accommodation options e.g. Shared Lives.			
Opportunity to attract capital investment from third sector / housing providers, increasing the stock of social housing for the Island.			

Risk	Option 1	2	3
There is likely to be an increase in costs due to inflation (currently estimated to be an additional £5k)			
Form September 2020, there would be no accommodation arrangement in place which would merely delay the model decision and development			
If subsequently decide to renegotiate the contract with Southern Housing, may lose reputational faith and goodwill from current decision not to continue with the contractual relationship			
To 'Do Nothing' doesn't fit with originally stated direction of travel for the Mental Health Transformation Programme or local / national strategic drivers			
CQC report highlighted several high risks to patient safety (*see p.5*) with current model which is deemed as 'Requires Improvement'			
The use as an acute overspill results in the acute patients not obtaining the intensive support they need due to the different skill sets of staff and less-secure environment in which they are placed; this increases the risk of immediate harm as well as long-term poorer outcomes such as heightened risk of relapse and dependency on statutory services			
Use as an acute overspill results in rehabilitation patients experiencing a less-constructive and more restrictive environment, resulting in poorer outcomes and reduced independence			
Staffing costs are likely to remain high due to vacancies and the need to work to a clinical/ward staffing model requiring the use of agency staff to cover the shortfall; this staffing situation is anticipated to continue for the foreseeable future			
Loss of ward registration status mean will no longer be able to accept detained referrals; although small numbers alternative option(s) will need to have capacity to accept			
Removal of over-spill capacity from inpatient services may create short-term pressures on acute services whilst the impact of the Mental Health Transformation Programme becomes embedded and in-reach approach is developed in the new model.			

Risk	Option 1	2	3
Training will be required to move from existing model to the proposed model and there is no additional budget to facilitate training			
There would be a change to the staff template and some job roles, e.g. Registered Nursing would no longer be required at nights due to removal of ward status, and this may be viewed negatively by some staff members which may in turn result in some people opting to leave			
Duration in the service may be longer due to a phased step-down approach to embed positive outcomes and reduce risk of relapse which may externally appear as performing poorly			
There is the risk of voids arising which cannot be filled with acute patients; the housing provider will be unlikely to cover these so the cost of the void will need to be covered elsewhere within the system. There is a potential to risk share with the council but this has not yet been agreed. The negative 'outcomes' of the loss can be mitigated by utilising the staff more flexibly across the system			
The senior management team at the Local Authority has changed which may affect identified priorities and support of the project. Of particular regard to the proposal was the commitment to provide a social worker within the staffing template which may be withdrawn. There is also an additional identified need for housing officer in reach support to the service which is yet to be agreed.			
To mitigate any potential risk to both staff and patients during the transition period, it would be recommended that a phased implementation approach be applied. The proposal would be to commence the new service 01 April 2020 with a caseload of 15 people to enable a bedding-in period, and then increase the caseload by 1 person per month. Overall, there would be a 3-5 year development trajectory – potentially to end at a model similar to Option 3. The negative impact of this approach would be an increase in time for benefit realisation.			
As a new service, would need to go out to procurement which would create a time pressure due to the potentially long procurement process versus the comparatively short time frame remaining on the lease. Due to the existing short term lease contract negotiations would need to start promptly which could result in a protracted process to achieve agreement.			
This would involve a radical change in the way staff works which may generate anxiety with existing staff, leading to potential retention issues.			
There would be a need to undergo a significant culture change which may create a risk of failure if staff are not engaged			
There would be an increased reliance on partnership working which requires the rest of the system to already be mature e.g. third sector support to deliver and robust housing processes in the council			
Delayed Transfers of Care (DTOCs) may arise if there is a housing stock shortage; this would also require a change to the way staff on acute wards are working to facilitate the transition / identify onward accommodation.			
The initial caseload would have to be smaller to Option 2 in order to factor in travel time between appointments in the community; this is predicted to improve as the way of working becomes embedded and processes become more efficient but the immediate impact would not be seen			
Although estate costs for patient accommodation would be removed, there would be alternative financial impacts which would need to be covered by the service envelope e.g. staff transportation, parking costs and central base(s) for the staff to work from and archive paperwork			
There would be an increased need for a robust remote working system e.g. good Wi-Fi connections and laptops to update notes			

Appendix 5: Mental Health Recovery Pathway QIA

To be completed by the plan lead	Name of Project	Mental Health Recovery Pathway
	Programme Lead	Gordon J Pownall, Deputy Head of Commissioning (MHLD)
	Short description of the plan, including financial value.	The Isle of Wight NHS Trust has a mental health rehabilitation inpatient service however as Commissioners for health and social care, we recognise now that whilst this has been a traditional model of care and support, for the majority of people, we can improve their experiences by providing the same intensity of support in a community setting. The Mental Health Recovery Pathway Project is a part of the Isle of Wight's Mental Health Transformation Programme, as well as the Hampshire and Isle of Wight Mental Health Sustainability and Transformation Plan. It will oversee the transformation of the Isle of Wight adult mental health services operating at the acute-community interface, within a revised financial envelope. It will be responsible for developing and implementing co-produced system wide proposals. This will include: ▪ Creating a vision for the new Mental Health Recovery Pathway (identified in previous documents as the Reprovision of Mental Health Rehabilitation, Reablement and Recovery) ▪ Transforming provision at the acute and community interface ▪ Strengthening individual and community resilience and support High Level Approach to transformation: 1. **Deregistration of Woodlands** 2. **Procurement of Short Term Model to Enable Transformation** 3. **Scoping to Develop Long Term Model:** Steps to achieve this will include scoping peer models, reviewing NHSE 'best practice,' benchmarking and incorporating feedback. To include establishment of baselines and identifying scope for improvements / setting trajectories and priorities for project resource. *Reassessment of QIA/EIA would be required at this point to ensure continued alignment.* 4. **Agreeing the Long Term Model:** Using the information gathered from step 1, develop business case and submit through governance process for cross-system Business Case Approval. 5. **Mobilisation of Phase 1 Model** Financial Envelope: To be confirmed as part of the financial modelling included within the project delivery plan.

Quality Impact Assessment (QIA)		Description of the impact	QIA Impact Score (score between +3 and -3 refer to score key below)

To be completed by the quality team member	How might the plan affect clinical outcomes/effectiveness?	▪ By providing a robust psychosocial recovery pathway, the need for repeat hospital admissions should become the exception rather than the 'go to' response to MH crisis and / or relapse.
		▪ The service is being designed to help people recover from the difficulties of longer term mental health problems; it will support people to establish resilience in their lives that will reduce the risk of MH crisis or relapse
		▪ It will help to support individuals to deal with (problems) challenges, to get their confidence back and to support development of the skills needed to help the person live as independently as possible, reducing dependency on statutory and other services including benefits and welfare payment systems.
		▪ It will provide a sustainable solution for people who have not had the support to develop stability to remain independent in the community
		▪ Individuals will benefit from a structured environment and community based recovery programmes that are available.
		▪ The service will be able to look after holistic needs and work in an integrated way so that each person experiences joined up support from family and friends who understand their needs and can build long lasting, therapeutic relationships with them.
		▪ Dependence on statutory services does little to promote recovery – the service will provide a safe, structured way for individuals to develop and implement their own recovery plan to support clinical progress and achieve positive outcomes.
		▪ The service will ensure the delivery of annual physical health checks that take place within primary care and review completion of physical health checks at each contact with the person.
		▪ The service will work in partnership with community resources that enable people to:
		  ▪ Access and / or maintain employment
		  ▪ Access and / or maintain education / training
		  ▪ Access and / or maintain settled accommodation of their own
		  ▪ Access and /or engagement in their local community
			+3

	How might the plan affect patient safety?	▪ The primary benefit will be a positive impact on people's long term wellbeing, independence and safety – they will be provided with a smooth transition from secondary tier services into the community with no sudden withdrawal of support. This will provide time to develop a community network of support, the personal skills needed to progress with their own lives and aspirations and develop plans to prevent/manage crises to reduce reliance on secondary services.
		▪ If will offer safe, bridging accommodation for up to a maximum of two years when people are moving to a placement with less support and supervision. E.g. if they are leaving a forensic or secure service, or from a treatment ward to their own home in the community.
		▪ Through a supportive, person centred, holistic approach the service will help to reduce:
		  ▪ Suicide, deliberate harm or severe self-neglect
		  ▪ Causing harm to others
			+2

		▪ Breakdown in support arrangements ▪ In the short term there is a small risk that the existing patients under the care of the Ministry of Justice will still need to be detained upon deregistration of the current 'ward based' service. However, the Ministry of Justice has already set a precedent for conditional discharges at Woodlands. The proposed delivery plan includes working with all of the individual patients at Woodlands to update their care plans to positively support their transition through the process. ▪ There are wider system interdependencies with other transformational programmes of work, the closure of Shackleton why/how will Shackleton (OAMH) impact on the recovery pathway? which need to be acknowledged and mitigated on an ongoing basis throughout the lifetime of the project. ▪ There is a potential impact on detained individuals at Sevenacres as from December 2019 Woodlands would no longer be an option, reducing the choice of paths for onward support.	
	How might the plan affect patient /carer experience?	▪ Support people to stay in their community; make communities more inclusive with less reliance on statutory services ▪ Be flexible and increase choice ▪ Build self-value and be recovery focussed – services designed to meet the needs of the person rather than the person fitting in with what is provided and helping them to achieve personal health and wellbeing goals ▪ Transform lives, increase independence and empowerment and develop self-worth ▪ Tackle isolation, connect people, increase social inclusion and support to access mainstream services ▪ Be sustainable, promoting individuals to make the best use of their community resources (and in some cases actually gain access to community resources rather than rely on the statutory / traditional provision currently in place) ▪ Where people have been placed out of area, they will have access to help to return to the Island at the earliest opportunity in order to maintain their family and social support networks	+3
	How might the plan affect equity and access? *Consider: age, disability (mental and physical), sex, race, religion/ belief, sexual orientation, gender re-assignment and, in employment, marriage/civil partnership and pregnancy and maternity.*	It is anticipated that this project will improve access by delivering support in the community. This will also ensure parity of access in comparison with mainland access to services, including partners within the STP. The service will: ▪ Work in partnership with community and secondary tier NHS services to promote positive attitudes towards the people supported and ensure their ability to be able to access mainstream NHS services ▪ Encourage reasonable adjustments to be made to ensure that no person receives a less than equitable service ▪ Reduce the health inequalities that people with learning disability and mental health conditions experience currently	+1
	What measures have you put in place to mitigate any negative impacts on one or more groups?	N/A – no negative impacts on any of the protected groups are predicted.	0

	Will this plan have an impact on (non) clinical workforce? Consider : • Competencies and training • Recruitment • Retention • Numbers required • Skill mix • Sustainability	Workforce modelling to be completed as part of the project factoring in: ▪ Trust members of staff ▪ Community MH and Wellbeing Service It is anticipated that there would be some training required to understand any new approach to the pathway.	-1
	Number of (non) clinical staff affected?	Workforce modelling to be completed as part of the project.	-1
	Number of patients and carers affected?	Population demand and capacity modelling to be included within the project milestones. ▪ Current number of Woodlands patients:8 ▪ Current number of Ministry of Justice patients: number too low to be identifiable ▪ Current number of off-Island patients:18	0
	Other Impacts - (impact of the proposal on other services, patient groups, carers, staff or reputation of the organisation)	▪ Improved cost effectiveness of current services ▪ Reduction in referrals to secondary care / inpatient services ▪ Potential increased average length of stays but reduction in turnover rates – improving appropriateness of care delivery according to need ▪ Efficient and sustainable pathways with clear referral forms with relevant clinical protocols/guidelines ▪ Woodlands lease is due for renewal; this will ensure alignment and the development of the most beneficial specification / contract – notice to be given on current arrangement to develop short and long term models to enable transformation of services. ▪ Project resource is limited due to ongoing CCG business as usual and other competing priorities within the Mental Health Commissioning team; completion of this project may impact on the ability to deliver in other areas. ▪ Procurement advice will be required to minimise any legal risk associated with procurement – this has been included within the project milestones. ▪ Potential increase in demand above planned levels if community model used as community 'beds' rather than as an interface to support rehabilitation. ▪ There is a potential reputation risk if the deregistration of Woodlands is externally viewed as a negative 'ward closure'; to be mitigated through consultation and (comms) communication plan to ensure transparency on changes and improvement to the way the pathway is delivered which is not a reduction on the capacity to provide support.	0

	QIA Outcome	
	Quality impact (Negative, Neutral, Positive, not applicable)	Positive (+7 overall)
	Quality Team member comments	The move from in-patient bed based rehabilitation to rehabilitation and recovery integral to community living is considered best practice. The holistic approach to care and support provides opportunities for people to benefit from person-centred care, meaningful employment and or education and longer term accommodation in a non-specialist setting but with specialist support from statutory and non-statutory agencies.
Privacy Impact Assessment (PIA)		
	Scheme/project lead to consider the requirements for a PIA. Please seek advice from the IG manager as required.	
QIA Assessment Summary		**YES/NO, including description of impact/reason**
To be completed by the quality team member	Does the QIA identify an impact on clinical outcomes/safety/ experience/ access/ workforce (use scoring below)?	The scheme describes the positive impact on patients, their experiences and clinical outcomes whilst acknowledging the impact on staff affected by the de-registration of Woodlands in terms of the training and development required to deliver a different model of rehabilitation and recovery (+3)
	Does the Quality Team support the (QIPP/financial recovery/ change to a service and care pathway) plan at Stage 1?	Yes
	Does the (QIPP/financial recovery change to a service and care pathway /) plan require referral to QIA Stage 2?	No
QIA sign off		
To be completed by the quality team member	Names & designations of Quality Team member signing off this QIA	Karen Morgan, Senior Clinical Quality Manager, IWCCG Louise Spencer, Deputy Director of Quality and Nursing, IWCCG
	Date	06/11/2019

Quality Impact Score	**Suggestion – the assessment suggests that this plan/scheme**
Negative	This development will/may have a negative impact
Neutral	There is no anticipated change in the impact of this development
Positive	This development will have a positive impact
Not applicable	This question is not relevant at this time
Please take care when completing this assessment. A carefully completed assessment should safeguard against	

QIA impact score key						
-3	**-2**	**-1**	**0**	**+1**	**+2**	**+3**
High negative impact	Moderate negative impact	Low moderate impact	neutral	Low positive impact	Moderate positive impact	High positive impact

Appendix 6: Dorset Case Study

The county of Dorset has a resident population of 776,304 (all ages 2018/19). Statistics suggest that by 2020/21 the number of people in Dorset forecasted to have a serious mental illness will increase to approximately 7,882.

In November 2017, a Mental Health Rehabilitation Review was commenced to address challenges faced by the rehabilitation model which was in place at the time. Key issues included:

- Inequity of accessibility to services across the county
- Numbers of Out of Area placements
- CQC standards not met across the rehab inpatient services
- Long waits for people who would benefit from rehab or AOT
- AOT has higher than optimal caseload
- People being held on incorrect caseload when compared to their needs

A scoping piece of work was completed including consultation with seven community events and five outreach events, as well as scoping national best practice and peer models with eight benchmarking visits across the country.

The resulting Strategic Outline Case comprised of:

- High dependency unit (14 beds)
- 2 NHS step down units (2*11 beds)
- Community team/s including community rehabilitation team, separate assertive outreach team/s
- Supported housing/other residential home settings (21 Beds)

In July 2019, the CQC inspected the Dorset Healthcare University NHS Foundation Trust 'Long stay rehabilitation mental health wards for working age adults' provision and found examples of Outstanding practice:

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good ↑ Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019
Long-stay or rehabilitation mental health wards for working age adults	Good ↑ Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019
Forensic inpatient or secure wards	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
Child and adolescent mental health wards	Good Nov 2017	Outstanding Nov 2017	Outstanding Nov 2017	Good Nov 2017	Outstanding Nov 2017	Outstanding Nov 2017
Wards for older people with mental health problems	Good ↑ Sept 2019	Good →← Sept 2019	Outstanding ↑ Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019
Community-based mental health services for adults of working age	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
Mental health crisis services and health-based places of safety	Good ↑ Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good ↑ Sept 2019	Good ↑ Sept 2019
Specialist community mental health services for children and young people	Requires improvement Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
Community-based mental health services for older people	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
Community mental health services for people with a learning disability or autism	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
Community forensic mental health team	Good Nov 2017	Outstanding Nov 2017	Outstanding Nov 2017	Good Nov 2017	Good Nov 2017	Outstanding Nov 2017
Overall	Good ↑ Sept 2019	Good →← Sept 2019	Outstanding ↑ Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019

Dorset Healthcare University NHS Foundation Trust,
CQC Inspection Report, July 2019

Appendix 7: Sheffield Case Study

The current JSNA places Sheffield's population at 582,506. As part of the '*Hampshire and the Isle of Wight STP Rehabilitation and Reablement – DRAFT*' paper, it noted that some of the challenges faced by Sheffield included:

- No community provision
- Inpatient operating at c. 120% capacity
- 65 Out of Area placements with associated high financial impact
- High Length of Stays

To address these challenges, a psychologically informed, multidisciplinary approach was developed split across a two tier model of high intensity, locked inpatient ward and an Assertive Outreach / Community Mental Health Team; the latter of which support people to access housing tenancies.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020	Inadequate ↓ Jan 2020	Inadequate ↓ Jan 2020
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Forensic inpatient or secure wards	Requires improvement →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Requires improvement →← Jan 2020	Requires improvement →← Jan 2020
Wards for older people with mental health problems	Inadequate ↓ Jan 2020	Requires improvement ↓ Jan 2020	Good →← Jan 2020	Requires improvement ↓ Jan 2020	Inadequate ↓↓ Jan 2020	Inadequate ↓↓ Jan 2020
Wards for people with a learning disability or autism	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community-based mental health services for adults of working age	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020
Mental health crisis services and health-based places of safety	Inadequate →← Jan 2020	Requires improvement →← Jan 2020	Good →← Jan 2020	Requires improvement →← Jan 2020	Inadequate →← Jan 2020	Inadequate ↓ Jan 2020
Community-based mental health services for older people	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018	Good Oct 2018	Outstanding Oct 2018
Community mental health services for people with a learning disability or autism	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community-based substance misuse services	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Good Oct 2018	Good Oct 2018
Overall	Inadequate ↓↓ Feb 2020	Requires improvement ↓ Feb 2020	Good →← Feb 2020	Requires improvement ↓ Feb 2020	Inadequate ↓ Feb 2020	Inadequate ↓ Feb 2020

Sheffield Health and Social Care NHS Foundation Trust,
CQC Inspection Report, April 2020

Appendix 8: Financial Modelling

1. Overview

	Option 1	Option 2	Option 3
Income 2021			
Woodlands OBD's	- 1,057,016	- 1,057,016	- 1,057,016
Woodlands Daycare	- 149,470	- 149,470	- 149,470
Woodlands Community Contract	- 159,968	- 159,968	- 159,968
Reablement	-	-	-
Total Income	**- 1,366,454**	**- 1,366,454**	**- 1,366,454**
Costs 2021			
Direct			
Mental Health Recovery Service(Reablement/Woodlands)	1,097,512	1,546,906	1,491,220
Admin (Sevenacres CC)	26,014	55,908	55,908
Mainland placement	51,431	-	-
Total Direct Costs	**1,174,957**	**1,602,814**	**1,547,129**
Indirect (Overheads)			
Administration	18,948	18,948	18,948
MH Management	53,190	53,190	53,190
General Overheads	239,246	239,246	239,246
MH Medics	130,086	130,086	130,086
Rent and Associated costs			
Provision for payment of voids			
Rent and Associated costs	52,257	15,000	
Total	**493,728**	**456,471**	**441,471**
Total Costs	**1,668,686**	**2,059,285**	**1,988,599**
Financial Impact 2021			
(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

Caveats Informing Calculations:

* In addition to this the CCG currently funds a figure of **£654,758** for assertive outreach in the SLA. It has been identified that we have approximately 30 AOT eligible people as evidenced by PIDS that currently sit on the CMHT case load, this equates to about three Band 6 roles and three Band 3 roles plus on costs (£204,807 without Overheads). The expectation would be these resources would transfer across from CMHT to the AOT, reducing the shortfall in options 2 and 3.

** Secondly there would be and expectation of savings in relation to the repatriation of out of area and mainland placements. Current estimations provided by the Complex Care Specialist Nurse equate to approximately £489,320 per annum. This saving would be seen within the wider system via the CCG. These savings would need to be seen recurrently, with additional funding provided to the Trust's MH Contract to support the shortfall of funding Option 2 or 3 would generate in supporting the service. Option 2 and 3 currently generate an increase in cost of £138,686 or £68,001 compared to the current service in Option 1.

1. Option 1

2020-21 Pay Rates	Working Pattern	Band	Point	UI	WTE	ENH %	WEF Month*	Basic / SMP £	ER's £	FYE 20/21 £	PYE 20/21 mth-mth £
Senior Support worker band 3	Monday - Friday 9-5pm	3	4	34	4.00	0%	1	84,568	19,489	104,057	8,671
Activity coordinator band 3	Monday - Friday 9-5pm	3	4	34	1.00	0%	1	21,142	4,872	26,014	2,168
Deputy Leader band 6	7 Days 9am - 5pm	6	5	65	1.00	0%	1	33,176	8,324	41,500	3,458
Deputy Leader band 6	7 Days 9am - 5pm	6	5	65	0.40	30%	1	17,252	4,328	21,580	1,798
Deputy Leader band 6	7 Days 9am - 5pm	6	5	65	0.40	60%	1	21,233	5,327	26,560	2,213
Occupational Therapist band 6	Monday - Friday 9-5pm	6	5	65	1.00	0%	1	33,176	8,324	41,500	3,458
Psychiatry Input Consultant (2 days)	2 Days per Week										
Team Leader band 7	Monday - Friday 9-5pm	7	5	75	1.00	0%	1	40,894	10,537	51,431	4,286
Complex Care Specialist Nurse	Monday - Friday 9-5pm	7	5	75	1.00	0%	1	40,894	10,537	51,431	4,286
Nursing Staff Band 6 Weekdays	5 Days 9 - 5pm	6	5	65	1.00	0%	1	33,176	8,324	41,500	3,458
Nursing Staff Band 5 nights		5	3	53	0.27	0%	1	7,192	1,745	8,937	745
Nursing Staff Band 5 nights		5	3	53	2.77	30%	1	97,236	23,593	120,828	10,069
Nursing Staff Band 5 nights		5	3	53	0.51	60%	1	21,864	5,305	27,169	2,264
Nursing Staff Band 5 Weekends	2 Days 9 - 5pm	5	3	53	2.00	0%	1	53,940	13,088	67,028	5,586
Nursing Staff Band 5 Weekends	2 Days 9 - 5pm	5	3	53	0.40	30%	1	14,024	3,403	17,427	1,452
Nursing Staff Band 5 Weekends	2 Days 9 - 5pm	5	3	53	0.40	60%	1	17,261	4,188	21,449	1,787
Nursing Staff Band 5	7 days 1 - 9pm	5	3	53	2.00	0%	1	53,940	13,088	67,028	5,586
Nursing Staff Band 5	7 days 1 - 9pm	5	3	53	0.40	30%	1	14,024	3,403	17,427	1,452
Nursing Staff Band 5	7 days 1 - 9pm	5	3	53	0.40	60%	1	17,261	4,188	21,449	1,787
Band 2 HCA Night (2 on shift)	7 night 9pm - 7am	2	3	23	0.13	0%	1	2,578	581	3,159	263
Band 2 HCA Night (2 on shift)	7 night 9pm - 7am	2	3	23	1.39	43%	1	38,344	8,635	46,979	3,915
Band 2 HCA Night (2 on shift)	7 night 9pm - 7am	2	3	23	0.25	85%	1	9,063	2,041	11,103	925
Band 2 HCA Early	7 days 6:30 - 2;30pm	2	3	23	1.50	0%	1	29,006	6,532	35,537	2,961
Band 2 HCA Early	7 days 6:30 - 2;30pm	2	3	23	0.20	43%	1	5,530	1,245	6,776	565
Band 2 HCA Early	7 days 6:30 - 2;30pm	2	3	23	0.20	85%	1	7,155	1,611	8,766	730
Band 2 HCA Late	7 days 1.30 - 9.30pm	2	3	23	1.50	0%	1	29,006	6,532	35,537	2,961
Band 2 HCA Late	7 days 1.30 - 9.30pm	2	3	23	0.20	43%	1	5,530	1,245	6,776	565
Band 2 HCA Late	7 days 1.30 - 9.30pm	2	3	23	0.20	85%	1	7,155	1,611	8,766	730

Band 3 Admin Staff	Monday - Friday 9-5pm	3	3	33	1.00	0%	1	21,142	4,872	26,014	2,168
Absence Cover								15.7%		151,463.06	12,622
Social Worker band 6 - LA Funded £39k											
Non-pay										59,767	4,981
Total Available					**26.52**					**1,174,957**	**97,913**

*Lines indicated in BLUE above indicate separate SLA

** The Psychiatry input indicated in GREEN would be accessed via the medics budget and equate to 0.4 WTE at a rate of £44,000 Basic / SMP or £3,667 per month (20/21)

2. Option 2

2020-21 Pay Rates	Working Pattern	Band	Point	UI	WTE	ENH %	WEF Month*	Basic / SMP £	ER's £	FYE 20/21 £	PYE 20/21 mth-mth £
Admin											
Admin Mid-point 1 WTE	9-5 Mon-Fri	3	03	33	1.00	0%	1	21,142	4,872	26,014	2,168
Admin Mid-point 1 WTE	9-5 Mon-Fri	4	04	44	1.00	0%	1	24,157	5,737	29,894	2,491
Central Model											
Psychology Assistant Mid-point 1 WTE	9-5 Mon-Fri	4	04	44	1.00	0%	1	24,157	5,737	29,894	2,491
Occupational Therapist Mid-point 1 WTE	9-5 Mon-Fri	6	04	64	1.00	0%	1	33,176	8,324	41,500	3,458
Team Leader Mid-point 1 WTE	9-5 Mon-Fri	7	04	74	1.00	0%	1	40,894	10,537	51,431	4,286
Psychotherapist Mid-point 0.4 WTE	9-5 Mon-Fri	8a	04	8a4	0.40	0%	1	18,301	4,772	23,073	1,923
Social Worker Mid-point 1 WTE	9-5 Mon-Fri (seconded)	7	04	74	1.00	0%	1	40,894	10,537	51,431	4,286
Psychologist mid-point 0.6 WTE	9-5 Mon-Fri	8a	04	8a4	0.60	0%	1	27,452	7,158	34,610	2,884
Consultant Nurse TOS 1 WTE	9-5 Mon-Fri (Possible Training Schemes)	8c	06	8c6	1.00	0%	1	73,664	19,936	93,600	7,800
Consultant Psychiatrist 0.1 WTE	9-5 Mon-Fri				0.20		1				
Locality 1											
Locality Lead Mid-point 1 WTE	Average 24/7	6	04	64	1.00	0%	1	33,176	8,324	41,500	3,458
Senior MH Practitioner Mid-point 1 WTE	Average 24/7	6	04	64	1.00	0%	1	33,176	8,324	41,500	3,458
MH Practitioner Mid-point 1 WTE	Average 24/7	5	04	54	1.00	22%	1	32,903	7,983	40,887	3,407
MH Practitioner Mid-point 1 WTE	Average 24/7	4	04	44	1.00	22%	1	29,472	6,999	36,471	3,039

Senior Support Worker Mid-point 1 WTE	Average 24/7	3	03	33	4.00	26%	1	106,556	24,556	131,112	10,926
Peer Worker Mid-point 1 WTE	Average 24/7	3	03	33	1.00	26%	1	26,639	6,139	32,778	2,732
Locality 2											
Locality Lead Mid-point 1 WTE	Average 24/7	6	04	64	1.00	0%	1	33,176	8,324	41,500	3,458
Senior MH Practitioner Mid-point 1 WTE	Average 24/7	6	04	64	1.00	0%	1	33,176	8,324	41,500	3,458
MH Practitioner Mid-point 1 WTE	Average 24/7	5	04	54	1.00	22%	1	32,903	7,983	40,887	3,407
MH Practitioner Mid-point 1 WTE	Average 24/7	4	04	44	1.00	0%	1	24,157	5,737	29,894	2,491
Senior Support Worker Mid-point 1 WTE	Average 24/7	3	03	33	4.00	26%	1	106,556	24,556	131,112	10,926
Peer Worker Mid-point 1 WTE	Average 24/7	3	03	33	1.00	26%	1	26,639	6,139	32,778	2,732
Locality 3											
Locality Lead Mid-point 1 WTE	Average 24/7	6	04	64	1.00	0%	1	33,176	8,324	41,500	3,458
Senior MH Practitioner Mid-point 1 WTE	Average 24/7	6	04	64	1.00	0%	1	33,176	8,324	41,500	3,458
MH Practitioner Mid-point 1 WTE	Average 24/7	5	04	54	1.00	0%	1	26,970	6,544	33,514	2,793
MH Practitioner Mid-point 1 WTE	Average 24/7	4	04	44	1.00	0%	1	24,157	5,737	29,894	2,491
Senior Support Worker Mid-point 1 WTE	Average 24/7	3	03	33	4.00	26%	1	106,556	24,556	131,112	10,926
Peer Worker Mid-point 1 WTE	Average 24/7	3	03	33	1.00	26%	1	26,639	6,139	32,778	2,732
Absence Cover								15.7%		209,385	17,449
Non - pay										59,767	4,981
Total Available					**35.20**					**1,602,814**	**133,568**

*The Psychiatry input indicated in GREEN would be accessed via the medics budget and equate to 0.2 WTE at a rate of £27,314 Basic / SMP or £2,276 per month (20/21).

3. Option 3

2020-21 Pay Rates	Working Pattern	Band	Point	UI	WTE	ENH %	WEF Month*	Basic / SMP £	ER's £	FYE 20/21 £	PYE 20/21 mth-mth £
Admin							1				
Admin Mid-point 1 WTE	9-5 Mon-Fri	3	03	33	1.00	0%	1	21,142	4,872	26,014	2,168
Admin Mid-point 1 WTE	9-5 Mon-Fri	4	04	44	1.00	0%	1	24,157	5,737	29,894	2,491
							1				
Central Model						1					
Psychology Assistant Mid-point 1 WTE	9-5 Mon-Fri	4	04	44	1.00	0%	1	24,157	5,737	29,894	2,491
Occupational Therapist Mid-point 1 WTE	9-5 Mon-Fri	6	04	64	1.00	0%	1	33,176	8,324	41,500	3,458
Team Leader Mid-point 1 WTE	9-5 Mon-Fri	7	04	74	1.00	0%	1	40,894	10,537	51,431	4,286
Psychotherapist Mid-point 0.4 WTE	9-5 Mon-Fri	8a	04	8a4	0.40	0%	1	18,301	4,772	23,073	1,923
Social Worker Mid-point 1 WTE	9-5 Mon-Fri (seconded)	7	04	74	1.00	0%	1	40,894	10,537	51,431	4,286
Psychologist mid-point 0.6 WTE	9-5 Mon-Fri	8a	04	8a4	0.60	0%	1	27,452	7,158	34,610	2,884
Consultant Nurse TOS 1 WTE	9-5 Mon-Fri (Possible Training Schemes)	8c	06	8c6	1.00	0%	1	73,664	19,936	93,600	7,800
Consultant Psychiatrist 0.1 WTE	9-5 Mon-Fri			0.20		1					
							1				
Locality 1						1					
Locality Lead Mid-point 1 WTE	Mon- Fri Day	6	04	64	0.80	0%	1	26,541	6,659	33,200	2,767
Locality Lead Mid-point 1 WTE	Saturday	6	04	64	0.10	30%	1	4,313	1,082	5,395	450
Locality Lead Mid-point 1 WTE	Sunday	6	04	64	0.10	60%	1	5,308	1,332	6,640	553

Senior MH Practitioner Mid-point 1 WTE	Mon- Fri Day	6	04	64	0.80	0%	1	26,541	6,659	33,200	2,767
Senior MH Practitioner Mid-point 1 WTE	Saturday	6	04	64	0.10	30%	1	4,313	1,082	5,395	450
Senior MH Practitioner Mid-point 1 WTE	Sunday	6	04	64	0.10	60%	1	5,308	1,332	6,640	553
MH Practitioner Mid-point 1 WTE	Mon- Fri Day	5	04	54	0.80	0%	1	21,576	5,235	26,811	2,234
MH Practitioner Mid-point 1 WTE	Saturday	5	04	54	0.10	30%	1	3,506	851	4,357	363
MH Practitioner Mid-point 1 WTE	Sunday	5	04	54	0.10	60%	1	4,315	1,047	5,362	447
MH Practitioner Mid-point 1 WTE	Mon- Fri Day	4	04	44	0.80	0%	1	19,326	4,590	23,915	1,993
MH Practitioner Mid-point 1 WTE	Saturday	4	04	44	0.10	30%	1	3,140	746	3,886	324
MH Practitioner Mid-point 1 WTE	Sunday	4	04	44	0.10	60%	1	3,865	918	4,783	399
Senior Support Worker Mid-point 4 WTE	Mon- Fri Day	3	03	33	3.20	0%	1	67,654	15,591	83,246	6,937
Senior Support Worker Mid-point 4 WTE	Saturday	3	03	33	0.4	30%	1	10,994	2,534	13,527	1,127
Senior Support Worker Mid-point 4 WTE	Sunday	3	03	33	0.40	60%	1	13,531	3,118	16,649	1,387
Peer Worker Mid-point 1 WTE	Mon- Fri Day	3	03	33	0.80	0%	1	16,914	3,898	20,811	1,734
Peer Worker Mid-point 1 WTE	Saturday	3	03	33	0.10	30%	1	2,748	633	3,382	282
Peer Worker Mid-point 1 WTE	Sunday	3	03	33	0.10	60%	1	3,383	780	4,162	347
Locality 2											
Locality Lead Mid-point 1 WTE	Mon- Fri Day	6	04	64	0.80	0%	1	26,541	6,659	33,200	2,767
Locality Lead Mid-point 1 WTE	Saturday	6	04	64	0.10	30%	1	4,313	1,082	5,395	450
Locality Lead Mid-point 1 WTE	Sunday	6	04	64	0.10	60%	1	5,308	1,332	6,640	553
Senior MH Practitioner Mid-point 1 WTE	Mon- Fri Day	6	04	64	0.80	0%	1	26,541	6,659	33,200	2,767
Senior MH Practitioner Mid-	Saturday	6	04	64	0.10	30%	1	4,313	1,082	5,395	450

point 1 WTE											
Senior MH Practitioner Mid-point 1 WTE	Sunday	6	04	64	0.10	60%	1	5,308	1,332	6,640	553
MH Practitioner Mid-point 1 WTE	Mon- Fri Day	5	04	54	0.80	0%	1	21,576	5,235	26,811	2,234
MH Practitioner Mid-point 1 WTE	Saturday	5	04	54	0.10	30%	1	3,506	851	4,357	363
MH Practitioner Mid-point 1 WTE	Sunday	5	04	54	0.10	60%	1	4,315	1,047	5,362	447
MH Practitioner Mid-point 1 WTE	Mon- Fri Day	4	04	44	0.80	0%	1	19,326	4,590	23,915	1,993
MH Practitioner Mid-point 1 WTE	Saturday	4	04	44	0.10	30%	1	3,140	746	3,886	324
MH Practitioner Mid-point 1 WTE	Sunday	4	04	44	0.10	60%	1	3,865	918	4,783	399
Senior Support Worker Mid-point 4 WTE	Mon- Fri Day	3	03	33	3.20	0%	1	67,654	15,591	83,246	6,937
Senior Support Worker Mid-point 4 WTE	Saturday	3	03	33	0.4	30%	1	10,994	2,534	13,527	1,127
Senior Support Worker Mid-point 4 WTE	Sunday	3	03	33	0.40	60%	1	13,531	3,118	16,649	1,387
Peer Worker Mid-point 1 WTE	Mon- Fri Day	3	03	33	0.80	0%	1	16,914	3,898	20,811	1,734
Peer Worker Mid-point 1 WTE	Saturday	3	03	33	0.10	30%	1	2,748	633	3,382	282
Peer Worker Mid-point 1 WTE	Sunday	3	03	33	0.10	60%	1	3,383	780	4,162	347
Locality 3											
Locality Lead Mid-point 1 WTE	Mon- Fri Day	6	04	64	0.80	0%	1	26,541	6,659	33,200	2,767
Locality Lead Mid-point 1 WTE	Saturday	6	04	64	0.10	30%	1	4,313	1,082	5,395	450
Locality Lead Mid-point 1 WTE	Sunday	6	04	64	0.10	60%	1	5,308	1,332	6,640	553
Senior MH Practitioner Mid-point 1 WTE	Mon- Fri Day	6	04	64	0.80	0%	1	26,541	6,659	33,200	2,767
Senior MH Practitioner Mid-point 1 WTE	Saturday	6	04	64	0.10	30%	1	4,313	1,082	5,395	450
Senior MH Practitioner Mid-point 1 WTE	Sunday	6	04	64	0.10	60%	1	5,308	1,332	6,640	553

MH Practitioner Mid-point 1 WTE	Mon- Fri Day	5	04	54	0.80	0%	1	21,576	5,235	26,811	2,234
MH Practitioner Mid-point 1 WTE	Saturday	5	04	54	0.10	30%	1	3,506	851	4,357	363
MH Practitioner Mid-point 1 WTE	Sunday	5	04	54	0.10	60%	1	4,315	1,047	5,362	447
MH Practitioner Mid-point 1 WTE	Mon- Fri Day	4	04	44	0.80	0%	1	19,326	4,590	23,915	1,993
MH Practitioner Mid-point 1 WTE	Saturday	4	04	44	0.10	30%	1	3,140	746	3,886	324
MH Practitioner Mid-point 1 WTE	Sunday	4	04	44	0.10	60%	1	3,865	918	4,783	399
Senior Support Worker Mid-point 4 WTE	Mon- Fri Day	3	03	33	3.20	0%	1	67,654	15,591	83,246	6,937
Senior Support Worker Mid-point 4 WTE	Saturday	3	03	33	0.4	30%	1	10,994	2,534	13,527	1,127
Senior Support Worker Mid-point 4 WTE	Sunday	3	03	33	0.40	60%	1	13,531	3,118	16,649	1,387
Peer Worker Mid-point 1 WTE	Mon- Fri Day	3	03	33	0.80	0%	1	16,914	3,898	20,811	1,734
Peer Worker Mid-point 1 WTE	Saturday	3	03	33	0.10	30%	1	2,748	633	3,382	282
Peer Worker Mid-point 1 WTE	Sunday	3	03	33	0.10	60%	1	3,383	780	4,162	347
Absence Cover									201,829		
Non-Pay									59,767		
Total Available				**35.20**					**1,547,129**		

*The Psychiatry input indicated in GREEN would be accessed via the medics budget and equate to 0.2 WTE at a rate of £27,314 Basic / SMP or £2,276 per month (20/21).